A DEPARTURE IN HOSPITALS — THE NATIONAL HOSPITAL FOR SPEECH DISORDERS
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As far back as we have any history there have been physicians, and for at least one thousand years we know that there have been persons with impediments in their speech—for is it not mentioned in the Bible, in both the Old and the New Testaments, in Isaiah, in St. Mark, and in other places?

From that time on to the present, scientific men have considered and written about defective speech, but strange as it may seem, it did not receive the attention it deserved from the medical profession, and to date when specialism is the outcome of progressive medicine, defective speech is still a neglected specialty.

Medicine, like all other sciences, has made wonderful progress, the ultimate result being better knowledge and more efficient practice. Our conception of pathological conditions is constantly changing. We discard old ideas,—we get new ones. So tremendous has been the recent advance of medicine that no one man can understand more than a small fraction of it; thus physicians have become more or less dependent on the skill, ability, and specialized training of other physicians for sufficient knowledge to care for patients intelligently. It was not generally realized that a person who suffered from defec­tive speech was just as much entitled to specialized hospital care as one who suffered from, as for example, eye, ear, nose or throat trouble.

While we have eye hospitals, nose and throat hospitals, skin and cancer hospitals, and numberless special institutions, we did not have one general specialized voice and speech hospital in the entire United States. By that I mean a hospital devoted solely to the cure of patients suffering from various disorders of voice and speech.

The natural outcome of such a condition—very few men interest­ed in the subject and no special hospitals—compelled that vast army of sufferers to look elsewhere for help, consequently, it was the same as in the old days when veneral diseases were not taken largely into
consideration and those suffering were treated through advertisements in drug stores, museums and other places, by people in all walks of life.

The defective speech sufferers have been and still are going through a similar process. They have been receiving courses of treatment from school teachers, Christian Scientist, Osteopaths, and the very latest is Chiropractic. For instance, a Chiropractic professes to cure a stutterer by twisting his neck in single two dollar treatments or he twists it by the case for fifty to one hundred dollars, but to no avail. With it all those having speech trouble still carried their burden and kept on suffering.

These prevailing conditions demonstrated only too clearly for many years the ever growing necessity for some central hospital or organization to help speech cripples and try to make life more livable for them; an institution or hospital whose policy it was to take a very broad view of its duty to all those who came under its care, particularly the poor and neglected; a dignified humanitarian type of institution approved by physicians of the highest ethical standing and irrevocably opposed to quacks and fads.

There seldom is any speech defect that stands alone. Usually it is so intimately associated with other defects, physical, mental or moral, that in order thoroughly to remove the speech defect the associated defects must be treated also. Therefore, necessarily, the hospital or clinic had to be not only a medical institution, but an educational and social one as well, for it had to raise standards and inculcate good habits of all kinds in its patients.

We definitely realized that there was great need for a co-operative work, one in which there was an intimate relationship between medical, re-educational and social therapy. In other words, a center where the doctor, the teacher or educator, and the social worker, were represented in complete harmony.

About five years ago, The New York Clinic for Speech Defects, which has since changed its name to—The National Hospital for Speech Disorders—was founded. During that time thousands of patients have applied for treatment. They have come from every State in the Union. Children and adults came suffering with every conceivable ailment of voice and speech. They had defective speech conditions due to harelip, feeble lips, cleft palate, relaxed palate, jaw conditions, (protrusions or recessions), teeth anomalies, tongue conditions; various voice abnormalities arising from palate or laryngeal
conditions such as nasality, aphonia, hypophonia, phonesthemia, falsetto voices again, conditions of stuttering, stammering and lisping, deaf mutism, audimutitas and idioglossia. We have seen numerous patients with diseases or conditions of nervous origin giving rise to various disturbances of speech, such as agitophasia (speech agitans), imbecility, and idiocy, hereditary ataxia, progressive muscular atrophy, congenital hydrocephalus, spastic spinal paralysis, bulbar paralysis, syphilis, multiple sclerosis, bell's palsy, post diptheritic paralysis; cases of tumors of the speech areas (aphasia), also medulla conditions: epilepsy, chorea, spasmodic tics, hysteria, insanity.

The NUMBER of conditions just enumerated will at once show the extensiveness of speech disorders.

Our patients present many interesting and complicated speech problems. A special type are the stutterers. Stuttering or hesitating speech is a neuropathic manifestation which has become a veritable obsession of a psychopathic or psychasthenic person, this state being the result of an unconscious motive. If trying conditions occur, lowering the resistance to a given point, then when an emotional disturbance of some force occurs, such as a shock, a fright or an illness the mental state is developed which precipitates the stuttering symptom. Another prevalent condition that many of our patients suffer from, a disorder characterized by defective enunciation, is the inability to form correctly or to utter any or all of the sounds of speech. These patients are classified as stammerers and lispers, and must not be confused with stutterers, as stutterers show hesitating speech, while stammerers and lispers show mutilated speech.

It is surprising how many people apply for treatment who suffer from agitophasia, or speech agitans, a condition of excessive rapidity of speech, in which sounds or syllables are unconsciously omitted, slurred, mutilated, or in any way imperfectly uttered, causing at the same time the speech accent to become distorted. These patients have great difficulty in making people understand what they say, so much so that they have a hard time in holding positions.

Another form of mutilated speech, particularly observed in young children is idioglossia. These patients seem to speak a distinct language of their own. Parts of words or whole words may be slurred, disjointed or otherwise mutilated. In severe cases, they are quite unintelligible except perhaps to their little brothers and sisters, who often are the only ones who understand them.
We have many children who suffer from auditory dumbness. The dumbness of children that hear, when young, is a condition of retarded speech development which is due to general physical weakness. These children have good speech understanding, and under careful supervision and treatment can acquire normal speech.

Besides these cases of hearing dumbness, we have, of course, had many cases of deaf-mutism. These patients being of a special class, their speech training is of a special nature, and it is not necessary for me to elaborate, as every one knows of the progressive work that is now carried on for the deaf.

Cleft palate patients always prove interesting problems. In these cases, strange as it may seem, the speech or voice defect does not coincide with the size of the palatal defect; for there are small defects which greatly interfere with the production of speech while in some large defects of the palate, even with harelip, one finds tolerably good speech without even resorting to the use of mechanical interference.

Cleft palate cases are operative and non-operative. On account of our nonoperative cleft palate cases and the numerous conditions of dental anomalies, protrusions or recessions of the jaw, etc., that are present in all kinds of defective speech cases, we have found it necessary, in order to get the desired results, to conduct a fully equipped dental department, where special obturators, plates and MacKenty splints are made, and orthodontia work is carried out for malocclusion cases.

Patients with voice anomalies are more numerous than most people realize. The frequency of these conditions can be readily explained by the multiplicity of functions which require the use of good voice, as in the case of clergymen, lawyers, actors, orators, teachers, and salesmen. Laryngeal or pharyngeal trouble of professional voice users becomes a serious problem on account of the fact that their livelihood depends upon their voices. A shrill high pitched woman's voice, a falsetto voice, in an adult male is most embarrassing and distressing. A flat non-melodious voice, a nasal voice causes a change in speech often making it indistinct and of course distressing to the patient.

Speech is the great vehicle of human intercourse. Business and social life depend on it. To put it bluntly, if you can TALK you can put your ideas over. You can win success. You become independent. If you CANNOT talk, if your lips and tongue refuse their
service, you CANNOT put your ideas over. You are dependent, and on account of continued conflict with everyday life, which to the normal speaking person is no conflict at all, you belong to a class apart, and you naturally develop neurotic tendencies.

To my mind, of the various kinds of defects that both children and adults are prone to, there is none so depressing or far reaching as a speech abnormality.

The world has been treating these people mostly as a joke. I am sure that anyone here can easily recall any number of funny stories they have heard, especially about stutterers. From my observations and personal contact with them at the Clinic, I know that defective speech is nothing short of a tragedy; for these people are unadjusted to their speech environment; they can never muster up courage or power to get anywhere, speech or otherwise; and they need much consideration, besides the many forms of treatment.

A composite therapy of a psychological, medical, re-educational and social nature, is absolutely essential for the cure of those suffering from defective speech. The doctor, the educator, and the social worker are the greatest factors for good, when they are fused together in such a harmonious union that their adjustment completely saturates the maladjustment of these long suffering patients. In order to carry out such a co-operative work, a department in clinics was necessary, and that prompted the founding of our Institution. It is hardly possible to enter extensively in an elaborate description as to how the work is carried out through this composite therapy. I wish however to stress the social phase because we have found it to be of utmost importance for the attainment of desired results. Right here I feel it appropriate to state that although the social service work in all hospitals has made tremendous strides in the last few years, it still does not reach far enough, for the day is coming when social service as a regular department in an institution will be classed as important and on a par with a medical or surgical department. When a patient has a surgical or medical condition, it is always accompanied by a maladjusted mental condition and just as much consideration should be given to his mental status as is given to his medical or surgical status. The Social Service Department should not just consist of a desk and one or two people in a corner of a large building, but should have proper accommodations, the right kind of equipment and a large enough force to carry out intelligently and consistently, local and field welfare work. By so doing the stay of patients in
hospitals will be cut down by half and the results obtained will be better in every way.

As already mentioned we have found that the social service phase of the work carried out by our clinic is of utmost importance for the attainment of desired results. The family and personal history give a clue to the general status of the patient. After a patient has attended the clinic and has become acclimated to the conditions found, he has a heart-to-heart talk with the director. The results are amazing. We all possess undiscovered gifts. Life's conflicts, especially to those suffering from defective speech, are so tremendous and severe that these gifts are starved out. Though the soil is fertile and the seed fell there, unfortunately appalling surroundings and personal conditions did not allow it to develop.

Most of those suffering from speech defects are highly strung or sensitively organized. They are emotional, temperamental and easily influenced. If nothing is done to help them to establish mental stability, what is the result? They help to recruit our vast army of truants, delinquents, vagrants and gangsters. From a weak, good-natured individual is evolved one with tendencies toward criminality. Think what it must be during the storm and stress of adolescence, to be in dread of making oneself absurd; to be cut off from spontaneous, normal social life; to be always seeking a cure and to find only "the hope long deferred that maketh the heart sick." No wonder many a stutterer who begins life wholesomeminded and normal as any of us turns crabbed and misanthropic under his torment and breaks down nervously at the end.

It is wonderful when someone has the large-heartedness to dig down to the bottom of us, to find the treasure there and tell us what to do with it, and at the same time to keep up belief in us till belief is justified. We are always making the mistake of undervaluing the possibilities of those we meet. In the history of the world the voyage of discovery has proved very profitable. We find it equally profitable when delving into the life history of our patients. Obstacles that appear insurmountable melt away. A little boost when one is slipping, a suggestion, a push when weak or in doubt, saves the day many a time. A talk on indifference, on personal energy, an explanation in simple words of the pathological condition present, the futility of searching for magical help, always promotes better understanding. Hard work and constant application are essential to overcome handicaps, hopelessness and discouragement.
An infusion of the spirit of sympathy and optimism, of good-fellowship and helpfulness, of praise and encouragement, is prolific in results.

To foster that spirit, our Ephphatha Club has proved invaluable. Investigations showed that social life was practically an unknown quantity to our patients. They complained that if they could only meet people and talk and associate with them the way other folks do they would be forever happy and could bear their cross of affliction. It's the same old story over again—our association with our fellowmen is the big thing in life after all.

On taking up treatment at the clinic one automatically becomes a member of the Ephphatha Club. The adults belong to the Senior Ephphatha Club and the children to the Junior. The members hold regular debates on the topics of the day, lectures are given by members and outsiders, discussions and divers other things occur in which the principal objective is the attainment of normal speech. A step further toward social life was gained when the club gave a sociable. In other words, a regular old-fashioned party—music, dancing, recitations, pink lemonade and ice cream. All that is necessary to say about the success of our parties is that when the first one was over one of our patients, an American thirty-eight years old, came to the director and told him that it was the first party he ever attended, for, stuttering since childhood, no one was ever interested enough in him to make him do something he was always afraid to do, mingle socially. This is hardly conceivable to the uninitiated. However, when one considers that attempts at speech are an embarrassment both for the speaker and listener and this torment has been constantly present for a long period of time, it is readily understood why these sufferers lead a hopeless life. The Ephphatha Club, which is a branch of the clinic's social service has turned out to be a great benefactor to its members.

While our Clinic is at present small, being a four story brownstone building, still without a doubt its position is unique; for it stands alone as being the first public hospital of its kind in the country devoted solely to the cure of speech and voice disorders. We are proud that we have started a pioneer movement and succeeded in establishing such an institution in a great city like New York.
THE NECESSARY CHANGES TO BE EFFECTED IN THE METHODS OF SOCIAL SERVICE AGENCIES WORKING WITH UNMARRIED MOTHERS*

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This country of ours is so wide, with such varying conditions existing in the different sections, that allowance should be made for diverse methods. How totally unlike must be the working out of problems in the West, in the South, or in New England! !

Is not our mission rather the reiteration of fundamentals the same everywhere as human nature is the same; and the giving of suggestions based upon experience, therefore worth trying, and upon theories resulting from experience also worth trying?

The city will carry on its work in one way while the methods of the rural districts will diverge widely. The Federal Children's Bureau study of Massachusetts in 1914 shows that "more than two-fifths of the mothers of infants born in Boston resided elsewhere," and that "comparisons of statistics for communities of various populations, in the state, indicated that the problem in rural areas and small towns, is practically as great as in all cities save the largest."

Most of us can speak of the work in the big cities only. What do we actually know about the rural districts and small towns? I had occasion last year to visit a small city in Pennsylvania where the treatment of an unmarried mother problem had been entirely unintelligent. There was no machinery with which to do anything.

In an important manufacturing city in Massachusetts, there is crying need for help. Conditions among the young people are shocking; neglect and dependency are dealt with in an archaic fashion; children are placed in institutions that fall below the ordinary standards of decency, and no one goes to the rescue.

Should not the next great move of the organized agencies be a widening of their influence? The Federal Bureau is, of course, striving for that. The Child Welfare League of America, the State

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Charities Aid in their county work, and a few other agencies are doing their part towards the same end. But what are the rest of us doing, except in giving time occasionally to people who come from all parts of the globe for advice? When a worker from Alabama tells us that she has an "Infant Asylum" that she wishes to transform into a Child Placing Agency, and says, "How shall I do it?" should we not help her in planning and in carrying out the plan, no matter how much time it takes? We have Extension Secretaries to raise money—why not Extension Secretaries to broaden our field of work? It seems to me that one function of a Council of Social Agencies, might be the extension work.

The question has been raised as to whether a family agency should deal with the illegitimacy work, on the hypothesis that the mother, father and child, constitute a family. This is, of course, biologically true, but from the standpoint of the agency contemplating treatment, the three principals can seldom form a unit. The mother’s family may be a prime factor, but statistics show that in a large proportion of cases (about one-third in the Massachusetts study) one or both parents of the mother were dead, not living in the United States, or divorced or separated. Even if the mother’s home exists intact, there is every reason why, in most cases, it would be unwise for her to return to it. If her behavior is the result of poor standards in that home, and there has been no subsequent improvement in them, why advise her return?

The girl’s mother has usually been weak and unable to control her, and the companionship of the neighborhood has been undesirable. The time is a strategic one in which to give the girl a whole new set of values. By all means, help the family as well, but do not use the girl as a horrible example, nor make any avoidable experiments with her. We all agree, certainly that when the home is suitable, every effort should be made to encourage the girl to become a member of it once more.

There would be many advantages in having one agency with clearly defined policy make the investigation, and follow out a plan for treatment. Perhaps the answer may be a family agency with sub-departments. Certainly the child-placing agency cannot be left out, as in many cases its help is needed at the outset. A transfer from one agency to another is unfortunate, and two agencies working simultaneously, confuse the issue. It may be that specialization has led to carelessness in keeping family relations strong. If that is the
case, the remedy may be better thinking and better teaching, rather
than re-organization. This is an open question in my mind.

The success or failure in the individual case depends, as we all
know, largely upon the original investigation, which should be made
with sure and telling strokes—no fumbling nor unnecessary probing
of the wound, but with all possible thoroughness. Failure here is
costly in the extreme. Examples have piled up in the experience of
every agency. I remember one in which the girl's grandfather—who
later, entirely provided for her—was not visited until a period of
two years had elapsed; and another, in which the girl's sister—living
at some distance—was not approached. The first agency dealing with
the case, felt that communicating with the sister would be a breach
of confidence, and had spent a considerable sum of money on the
care of the baby. The second agency refused to consider placing the
child until this relative had been consulted. The result was that the
baby went to the aunt with the consent of the irresponsible mother.

The worker enters the situation at a crisis when the mother's
courage is at its lowest ebb. She is dazed, on the defensive, and after
many months in practicing concealment, has trained herself to lie
with ease and fluency. The person who attempts to win her con­
fidence and co-operation, must be clear-minded and practical, sym­
pathetic but never sentimental. She must have in her inner con­
sciousness the feeling that the mother is not intrinsically different
from other women; but rather, that she has failed to conform to the
law, largely because of lack of proper standards, of poor home train­
ing, and because the schools have failed to live up to their oppor­
tunities.

A worker must recognize these factors, giving to each its proper
value, and to do so should have lived long enough to have accumu­
lated a body of experience through which to interpret the lives of
others. She should be a trained worker; she should also have warmth
of personality; good sense, as well as a sixth sense; tolerance, in­
sight, and above all, a love for her fellow man.

You may say that a worker of this type is hard to find, and this,
I grant you; but it is certainly possible to find her, and profitable for
the agencies dealing with unmarried mothers to search diligently for
the right person, instead of employing young, inexperienced people.
Time and money will be saved, for early solutions will often be the
result, instead of long, expensive treatment, begun and carried out
on an insufficient basis of facts.
During the period of pregnancy the mother should receive the best pre-natal care, and it is to be hoped that more Clinics for the purpose will be established, and the public taught to use them.

Family care is, in my opinion, the best during this time—provided the placing is thoroughly well done, which means, of course, careful supervision. The sooner we can enable the girl to live among people who are going about their regular work in life, the better. When she is one of a family group, and finds that although her condition is known, she is still kindly received and treated with consideration, her courage begins to return, and she is better able to take a balanced attitude in regard to her own trouble. Then, too, she is all the time part of the normal life, and more prepared mentally to assume her new responsibilities. In the foster home she may be as thoroughly instructed in housework as in the Maternity Home where especial stress is laid upon this. Many of the Homes are turning out girls capable of earning good wages, while others assign the girl to the task in which she shows efficiency, and keep her at it: Economical for the Home but costly for the girl.

The mother and the baby receive expert obstetrical and medical treatment in most of the Maternity Homes, and leave in good condition. A strong, spiritual appeal is made, and the girl frequently responds most encouragingly, leaving the Home with a new and better outlook upon life. To my mind, the only drawback in Maternity Home Care is the grouping together of girls who have been through a common experience, and through other revolting experiences, about which they are only too ready to compare notes. The custom of having girls return to the Home for parties, etc., is, I think, unwise. The friendships formed there are best terminated when the girls leave the Home, as they too often result in a drifting back into the old life. I have known instances where an acquaintance acquired at the Maternity Home, succeeded in undermining entirely, the work of an agency. There is a crying need for private care of the better type of girl suffering from venereal disease, and I hope that the Maternity Homes will undertake this work.

It is difficult to decide between Maternity Home and family care. There is danger in stressing too strongly one method when diversified work minimizes smugness and creates new ideas.

Often the mother goes to a hospital for confinement—and may I say a word here in regard to unintelligent treatment at several points. The obstetrical work may be excellent—usually is—but the social
side of the case is frequently disregarded. Even when there is a Social Service Department, the Medical Department fails to refer the case until the day of discharge when "hit or miss" treatment results.

On one memorable afternoon at about five o'clock, three unmarried mothers were referred to me—all to leave the hospital the next day—Saturday, by the way. That sort of delayed referring is very costly, as the mother and baby must be boarded pending investigation and plan. In another similar instance, the mother's story—which the Social Service Department had had no time to look up—was entirely false, and the mother bolted from the temporary foster home, leaving a foundling to the care of the State.

In my opinion, the physicians could make much greater effort than they do in persuading the mothers to nurse their babies—at least during the hospital period. If the plea that the baby's welfare demands it, fails, the mother may still be made to understand that her own recovery will be much surer and more rapid if the baby is breast fed. Too often the request of the mother is accepted without argument.

Is it possible to give longer confinement care and to discharge patients only when in fit condition? The mother who is barely able to stand on her feet has a pretty desperate outlook when there is no home to return to.

Another pressing demand is for proper convalescent care. The hospitals are recognizing the necessity for this in most types of cases, but still think that a mother with a two weeks' old baby, is able to fend for herself.

What of the mother and baby when real life begins again? The basic principle now is to make the mother recognize her responsibility (to make the father realize his as well—but I will not discuss the prosecution). If the mother nurses the baby, the tie between them is stronger, without doubt, and the baby has a better chance; partly because so few physicians, the country over, are skilled in pediatrics. The formula prescribed by a pediatrician, will usually keep the baby in fine condition; but, since we are not always sure of expert advice, the breast feeding is safer for a period of several months. The mother should not attempt hard work of any sort for two or more months, and this period may well be devoted to giving her child the best possible start.
The physical condition of the mother should be watched much more closely than is generally the case, except in the best Maternity Homes. Often she has had no proper care at the time of delivery, and repair work is imperative. One girl, whose history I know well, was confined in a hospital, and was treated afterward by a private physician; but in spite of this she dragged about half sick, and unable to carry on any steady work. It was only after two years when she came to the attention of a private agency, that the repair work so plainly indicated, was done, and the girl able to begin her nurse's training. Then, too, there is frequently the lighting up of an old gonorrheal infection. If this is not discovered, think of the hazard to the mother, the baby, and the community at large! I am thoroughly convinced that, in a large number of cases, the mothers are in such a thoroughly depleted condition, that sustained work is impossible; hence, the prognosis for any plan involving sustained effort is failure.

Whether the baby is with the mother or in a separate foster home, he should also be under medical supervision, and visited by a trained nurse if possible. When this can be achieved, the foster mother can be trained to give a very high grade of care, preparing formulae with accuracy, following directions implicitly, and observing keenly the condition of the baby. The nurse by frequent visiting can detect early symptoms, and forestall trouble of a serious nature. Especially good care is needed for most of the babies who come to the agencies, as they often have had poor starts, being under weight, improperly fed, and suffering from all sorts of troubles. The intensive care brings them up with astonishing rapidity. Where it is not possible to have nurses do the visiting, Milk and Baby Hygiene Stations may be used; District Nurses may be called upon; and, failing these, the nearest hospital may be induced to give the required supervision. The important thing is not to trust to chance in the care of a baby.

Psychiatric study we all recognize as important. In getting away from the old idea that only the insane and feeble-minded need special study, we recognize the value of it for everyone. It is, however, not possible to have every mother examined by a psychiatrist; and it then rests with the social worker herself to study the girl, and to help her to develop mental poise. Here again is an argument for trained workers.

When a child comes to us suffering from mental conflict we give him a complete change of environment, and a new mental content; in
other words, plenty of interests—things that will be of interest to
him, not necessarily to us. Most of the unmarried mothers are in a
state of mind, which, if not technically a conflict, is the result of
many conflicting emotions. She sees life from an entirely distorted
angle, and thinks in a confused way. We probably have little con­
ception of the sordidness of her thoughts. The surest way of filling
her mind with new thoughts, is by giving her an occupation that she
finds absorbing. If her previous experience has been along domestic
lines, and she is at all capable, the plan of placing her with her baby
in a housework position, is comparatively easy; that is, in normal
times. At present the closing of mills and factories has resulted in
a labor market overstocked with women clamoring for housework
positions. Naturally, any employer (except one whose definite plan
is to render service) would prefer a worker who can give her entire
time to household duties. The baby certainly complicates the situa­
tion, adding inevitably to the expenses, and demanding time and
thought. The mother is also frequently a cause of much anxiety to
the employer. Many enter into the arrangement not fully aware of
the difficulties involved, in spite of the efforts of the social worker
to make this clear. That this housework plan for the mother does
work out successfully, we can prove by many instances. The Massa­
chusetts Division of Aid and Relief, has obtained satisfactory results
in this way, and with the least hopeful girls.

Suppose, however, that the girl has done nothing but factory or
shop work—perhaps she has been a bundle girl in a Ten Cent Store,
or has spent her working days in a Chocolate Factory. Her home
has been poor, and she has had no instruction even in the rudiments
of housekeeping. She has never been inside the doors of a well­
regulated home, and is unable to visualize it. The chance that she
will succeed in a housework position is slender. She is accustomed
to many people and shifting scenes; she craves excitement and free­
dom from restraint. When she is placed with her baby she may at
first greet happily the protection of the home, and the peace of it in
contrast to the stress and strain she has undergone—but this acquie­
scence is usually short-lived. She is apt, then, to become indifferent;
to make no effort to learn to do her work properly; to neglect the
baby, and to become thoroughly irresponsible. A break is inevitable
and a new plan necessary. The new plan will be more difficult to
work out because built upon the failure of the first. In my opinion,
it would have been far better, after the first convalescent and rest
period in which the mother and baby are kept together, to arrange
a plan that would, in a measure at least, fit in with her mental equipment and past experiences. She need not go back to the Ten Cent Store, but may, perhaps, be given a short course in filing or comptometry, which will fit her for a minor office position. Or, if she is able to do rather more difficult work, she may have the Commercial School or Trade School training. This, of course, involves expense, as her board and tuition must be paid and the baby must be cared for. Generally, what the father contributes only partially covers the expense, and there are seldom relatives able or willing to bear the burden; hence, the agency interested must come to the rescue. Nevertheless, I believe that the money paid at first in this really constructive program, is far smaller than the expense involved in frequent shifts of the mother and baby from one job to another; extravagance of the mother—due to lack of co-operation—and ultimate failure.

When the girl realizes that we believe sufficiently in her ability to make good to send her to school, her self-respect rises, for she enters upon a definite plan, probably, for the first time in her life. She is among people who do not know her story, and who are too busy to have any particular interest in it. This she needs, for she has been much on her own mind, and has been the storm center of the family. Gradually she gets her balance, and in getting it, sees more clearly the baby's place in her life; for the new work need in no way diminish her love for the baby, nor preclude the possibility of doing much for him. This presupposes that the mother and the baby are carefully, I may say, skillfully placed, for no job in Social Work demands more skillful handling by worker and foster mother. If the girl herself is in a warm, home atmosphere, where she is one of a happy family group, she expands wonderfully, and in her growing cheerfulness and ability to express herself, includes the baby. The baby's foster mother, by making the mother's visits joyful occasions, strengthens the tie and the sense of responsibility. When the mother finds a whole family rejoicing in every little doing and saying of the baby, she feels proud that she is the mother, and, almost unconsciously to herself, begins planning for him and making little garments. The mother instinct asserts itself more forcefully than if she were unhappy, demoralized by self-pity, and so egocentric that the needs of the baby were a burden, resulting in indifference and neglect, with flashes of remorse.

I may seem to have overlooked the part that a religious appeal may make to the girl. In reality I assume that from the beginning
the worker has been striving to reach the spiritual side—to touch the real girl that has nearly been lost sight of. That spiritual side is often hard to find, overlaid as it is with false living and false thinking. Frequently, in fact, generally, she will shy away if she hears religious terminology, for she does not wish to be reformed. She does, however, sincerely want something real to tie to. Often she says bitterly that when her family cast her out, she went to the church because she had been taught that people were supposed to turn to it in times of trouble, but that there also she had received no help. It is hard to win her back to a softened mood. The experienced worker makes every effort to do this and is often successful in time, always endeavoring honestly to encourage the girl's return to her own church. It is often necessary for the worker herself, to contribute a new philosophy of life. I wish that the churches would do more than passively allow this girl to enter their doors. She needs help all along the way, and she needs, there of all places, to feel that she is not different from other people.

The question of recreation is not adequately provided for, it seems to me. The girls placed separately from their babies have many opportunities to make friends, and to have good times under the supervision of the foster families, or in their own homes when these have been suitable for the girls to return to.

But what of the girls doing housework? A study made last year for this Conference was enlightening, with its conclusion that the social and recreational opportunities offered were few. Even the seventeen most encouraging answers to the question covering this point, showed little to satisfy a girl.

To quote a few statements which I may be pardoned for repeating:

"Family have a car and are very generous with invitations."

"Recreational opportunities consisted of occasional concerts and entertainments at the church, and association with maids at a near by private school."

"Mother could go to church with the family, and went out driving with them occasionally."

"Family occasionally took girl to church suppers and entertainments."

"Coming back to the Maternity Home occasionally for dinner, or to spend part of evening."
The following replies were almost entirely negative:

"None."

"No recreational opportunities offered; no time."

"Very few: Moving pictures occasionally; shopping; errands."

"Occasional afternoon off, not regular."

"Mother too tired from housework and care of child to enjoy any recreation; attended church fairly regularly."

"None but child and church."

How long would anyone, particularly a young girl, go on with so restricted and humdrum a life? In case after case we find that she submits for a period of about eight, nine or ten months. She then breaks loose in one way or another—returns to her old companions; picks up new, undesirable ones; returns home late, or stays away all night, and so on. We are only too familiar with the outcome.

If we are to succeed in the long run with the mothers in housework, we must think ahead in a broad and understanding way. We must study each girl and meet her individual problem. And we must keep ahead; not waiting for disaster and then groping for a remedy. There are many little indications of restlessness and impatience that tell the story.

There can be nothing harder than to find recreational opportunities for the unmarried mother. The community has in it no place for her; the young people who are desirable, shun her, and many of the churches ostracize her from their girl's clubs. But if we are to succeed, we must give her something interesting to think about, and something to do besides work. All our ingenuity and resourcefulness applied at that point will pay.

We must also recognize the moment when the housework plan has served its purpose and should be exchanged for another; and be ready and flexible enough to think it out. In this type of work there is no such thing as "resting one's case," so to speak—something is happening all the time; the situation is in flux, and to quote Kipling, the worker must possess "infinite resource and sagacity." I hope that I do not seem to stress this too strongly.

"After all these early placings and preliminaries, then what happens to the mother and child?" one is constantly asked. And I wish we knew. The lack of follow-up is one of our weak points, as we are all free to admit. The tremendous pressure of new work forces upon
us a choice, and we are pretty apt to deal with the crisis at hand. In a certain number of cases we know that marriage has solved our problem, and doubtless started others of a different nature. The marriage to the father of the child is seldom wise or possible. The very term applied to it—"Forced"—argues its failure. There is no real basis of love and respect, and there are usually mutual recriminations which end often in serious quarreling and separation. The child in this unhappy home fares ill. He is often a bone of contention between the parents, and is discriminated against when there are other children. He becomes conscious of the fact that he is in some way different from the others, and may later develop a difficult psychological condition as a result.

The marriage of the mother to a self-respecting man, not the father of the child, is without doubt the most favorable outcome. Often the child may be adopted by the mother's husband, taking his name, and the waters seem to close over the old disgrace. I can think of four comparatively recent cases in which this has happened. The mothers were—one Russian Jewish, one American Protestant, one Canadian Protestant, and one Negro Protestant. An encouraging indication that this happy solution may occur with any type.

All babies are born with one responsibility—to grow. The illegitimate baby has one more in the minds of many people; that is, to reform his mother; or perhaps, rather to act as a deterrent. You may say that as the baby is not conscious of the responsibility, it fails to exist for him; but in point of fact it is pretty sure to affect his whole life, whether he stays with his mother or not. It is a grave question as to how far the welfare of the child should be sacrificed to that of the mother, and as to how far he actually does steady her. In many cases the steadying influence of the child is tremendous, but in others it is hard to detect.

In thinking of outcome, we should not forget the question of stigma, which Mrs. Sheffield discussed so ably in her paper read at the National Conference last year. Both the mother and child are bound to suffer to some extent, and our task is to make the suffering as bearable as possible.

What shall we do with the child that is actually on our hands? He may go back into the mother's home, possibly being adopted by the grandparents or by other relatives; he may be taken care of entirely by his father, who has turned out to be far more interested than the mother. At the present time I am dealing with two of
these children, and in both cases the fathers are men of good standing, who are fond of the children, and greatly concerned about their welfare. The mothers are thoroughly irresponsible and have broken away from all restraint and decency. The child may fail to find harbor among his own people, and may become a State or City charge, or the ward of a private Social Agency. His chances of happiness are in any event uncertain. When he is little, he takes for granted whatever is bestowed upon him; but soon he begins to think and to see that his life is not peopled in just the same way as are the lives of other children. Faint memories return to him, casual remarks, taunts—which lead to a desire to know where and to whom he belongs. The force of the longing for people of one’s own is well illustrated by the story of a white girl in ignorance of the fact that her mother was a negro, until she was 16 years old. When she finally learned the truth, she demanded that she be taken from the good foster home where she was placed to see her mother. After the first interview with the black mother, she exclaimed to the worker—“Thank God, I’ve got my own folks!” Agencies are continually beset with people of middle age who are searching records for information about their parentage. “I don’t care what my mother was,” they sometimes say, “I want to know who she was and all about her.” Owing to the pitifully brief records, and the poor case work of a score of years ago, it is seldom possible to give any help. The blood tie is strong, and we should, I believe, reckon with this fact in providing for the illegitimate child; giving him the opportunity to be with his own people, if it is at all possible.

The hurried and ill-considered separation of mother and baby, and the careless placing of the baby for adoption, are frequently due to a quick sympathy for the mother and child, with no real consideration for their ultimate welfare. But there are certainly cases where adoption is advisable. When the mother is totally unable to care for her child, or when her life can be worked out safely and with better prospect of success without him; as, for instance, when she marries a man who will give her a good home and care for her, but who refuses to take the baby. If the baby’s inheritance is safe and the child himself normal, he may come to his own—so to speak—in a wisely selected foster home, where, after a year or more of trial, he may be adopted.

At a recent meeting of the Boston Conference on Illegitimacy, there was a general consensus of opinion that adoptions should be
made with the utmost care and deliberation, and stress was laid on a long-trial period.

The present careless methods of most of the courts in regard to adoptions were also stressed, and numerous instances given to show the dire results. When the records frequently fail to show even the address of the adopting parents, it is time to register an objection.

Would it be the function of this Conference to make a move toward securing investigation for certain Court cases—adoptions, guardianships, marriage of minors? A general movement in various parts of the country, might in time meet with better success.

The longer I work with the baffling problem of the unmarried mother, the less I seem to know about it, and when I endeavor to put thoughts together in any form, the result is a succession of questions—as tonight.

There are a few points that may be summed up safely:

- Great care in diagnosis;
- Mature and well-trained workers;
- More intelligent social care during the hospital period, and better convalescent care;
- Breast feeding for the baby at first, and during a period of several months when possible;
- Careful medical supervision for mother and baby;
- Thorough study of the mother from a psychiatric point of view, with consideration of these findings before placing her at work;
- Understanding supervision, whatever her employment;
- Special training often worth while;
- Opportunities for self-expression and recreation necessary;
- Adoption only advisable when made with great care and after due consideration of family ties.

I should like to add a plea that every worker may be encouraged to use her influence to help create a less hostile public opinion in regard to these unmarried mothers. At best we can only patch up broken lives; but with a kindly, tolerant attitude on the part of the community, the battle would be half won.
THE SOCIAL TREATMENT OF THE UNMARRIED MOTHER WITH HER CHILD*

ELEONORE L. HUTZEL

Detroit, Michigan

An unmarried mother who makes up her mind to keep her child with her is a woman who sacrifices everything to her mother love. She may even sacrifice what seems at the time to be the best interest of her child. It is, however, her mother right to make an effort to care for her child. Many times, as we have seen, her efforts result in failure—I still do not feel that we are privileged to bring pressure to bear that might influence a woman to release her child, if she is old enough to assume the responsibility for it and is moderately intelligent. Even in cases where the mother only succeeds in caring for her child for a short time, I feel that it is worth while, because first, a child has the benefit of its mother's milk, second, the experience helps to develop the mother, and third, the separation comes easier when it is at the suggestion of the woman herself.

There are two groups of mothers who should be separated from their children as soon as possible. The first group includes the very young girls, (I mean girls under sixteen years). I think that if possible a plan should be made for the child to be separated from the mother at birth. The welfare of the child can be provided for by having it wet-nursed. We try to keep our young pregnant girls away from older pregnant women. Even in the hospital wards it seems advisable that if possible the child mother should be separated from other mothers. She understands so little of her experience and her sex life is so immature that when she is properly protected she forgets quickly and recovers with little sense of loss—within a few years she will have forgotten her experience. The other group where the welfare of the child demands that it be taken from the mother, is the group of abnormal and feeble minded mothers. These women are fully developed sexually and their feeling for their children is intense although uncontrolled. They are bound to suffer when their children are taken from them but it is necessary.

*Read before Inter-City Conference on Illegitimacy, Philadelphia, April, 1921.

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Taking up the normal group, that is the girl over sixteen of moderate intelligence, the first thing we can do for her to help her keep her child is to give her good medical care during pregnancy and at the time of delivery. Nothing is more discouraging to a person with heavy responsibility than poor health, and poor health will result from improper medical care. Our next opportunity is to provide instructive employment during the weeks before delivery and after the birth of the child when the mother is unable to be self supporting. A pregnant woman should be left with friends if possible or be boarded in the home of capable interested persons. She should be made to feel as sensibly as possible about her circumstances. It is helpful if she can have with her, or be in close touch with some member of her family. Certain cases seem to require institutional care during pregnancy and the first weeks following delivery. Our experience has been that a so called, Maternity Home, where care is given to women during this period can be made wholesome and helpful. We have as one of the activities of the Social Service Department of the Woman's Hospital a home for pre-natal and post-natal care. The home is known as Valley Farm and is situated about twelve miles out of Detroit. It is a large country home with about three acres of garden and recreation grounds. Only a small part of the women cared for by the department are sent to the home. We do not, however, reserve it for a certain type. We use it for anyone for whom we are not able to provide other care. The home accommodates thirty adults and twenty-five babies. We have so far been able to accomplish just a few of the many things planned. We have made the home almost entirely self-governing. This is a difficult thing because most of the women remain at the home for only a few months. Practically all of the suggestions for the self government plan have come from the women themselves. The attitude of the women in our home is noticeably different from that usually found in places where unmarried mothers are cared for. The mothers all nurse their own babies and are responsible to the nurse for the care of the baby. All of the work in the home, except the heavy work, is done by the mothers under the supervision of officers. The women working in the different departments wear uniforms. The uniforms are made as attractive as possible. When off duty the women dress as they choose. They are permitted to go to the city alone and are allowed to have guests. Every effort is made to teach responsibility, personal cleanliness, simple household duties, and care of infants. We are frank with the
mothers in regard to the difficulties which they will encounter in their efforts to care for and provide for their children, but at the same time we make them feel that the satisfaction which comes from the effort, makes it worth while. We feel confident that the women cared for at Valley Farm go back into the community stronger because of the weeks which they have spent in a home where every effort is made to teach them to live a normal, healthy and wholesome life.

In order that we may make an intelligent plan for our women, it is necessary that a complete investigation be made. Information in regard to physical surroundings, social influences, and personal contracts must be obtained. Our worker must learn to know her woman. In her study, she must be assisted by a psychiatrist and a physician. She must learn the reason for the sex delinquency, and her plan must strengthen the weak points in the woman's life.

Although we feel that the case worker and the home worker can do much for a woman by their friendly intercourse with her, each woman is after all, only one of the many cases. There are people, however, to whom these women are near and dear. Can we render any greater service than to interpret our women to their own people? It seems to me that this is even more important than to secure support from the fathers of the children. Our case work is based on this thought so that naturally our cases fall into the following groups: (1) the woman who has a family living in the city, (2) the woman who has a family living elsewhere, (3) the woman who has no immediate family, (4) the woman who lacking an immediate family, has interested friends, and (5) the woman who is alone.

As soon as a worker in our department comes in contact with a woman who is separated from her family, she begins her plan to bring them together. Sometimes she does not succeed in doing this until after the baby is born, but she always holds it in mind and in almost every case she succeeds. We try to bring about this contact before the birth of the baby because we find that the woman who has confided in her family makes a better recovery after delivery and has a better supply of milk for her baby.

Taking up the family situations in the order in which they were mentioned—first, the woman who has a family living in the city. If she returns to her old home with her child, she must acknowledge that it is illegitimate. Our experience has been that it is unfortunate for both mother and child to do this. Whenever possible we urge the family to move to a distant part of the city. This can be accom-
The Unmarried Mother

plished with certain types of family. But the more substantial type, those who own their own homes or are well known, cannot readily make any such change. In such cases we sometimes separate the mother and baby. The mother goes to her parents, and the baby is placed in a boarding home for a short time. After a few months the parents take the child. They tell their friends and neighbors that they are boarding it for the child caring society. Our nurse, who supervises the baby, is pointed out to the neighbors as the agent of the child caring society. This plan is often carried out when only certain members of the family know of the real parentage of the child. A married brother or sister living in another city can often be persuaded to take the mother and baby. We have not found it satisfactory for a woman whose family are living in the city to room away from home or to work at housework with her baby.

Second, the woman who has a family living elsewhere. Detroit social agencies, as those in every other city, are called upon to help women whose homes are elsewhere. The most difficult thing in such cases is to persuade the woman to be frank with her family. It is so much easier for her to keep her trouble from them than for the woman whose parents live in the city. When she finally does tell them, it is generally possible to obtain their co-operation and a plan can be made for the mother and child to return home. Investigation of the home situation is made before a woman is returned to her parents. Whenever possible, co-operating agencies are called upon for this service, when no agency is available, a worker is sent out from our office. The cases where a woman has returned to her home town, using a married name, have worked out most satisfactorily. I appreciate that there must be a great difference of opinion on this point, but as I review the cases which have come under my observation during the past six years, I feel that the results have justified using a married name. I recall one case especially, Mary. She was a well educated girl who came to us from a very undesirable hotel where she had been left by a stranded Musical Comedy Co. Her father was the only physician in their home town. There was one other daughter, a semi-invalid. Mary, on examination, showed a serious heart complication so that physicians advised that her father be informed of her condition and her approaching confinement. The patient could not be told of her danger and we were unable to persuade her to tell her father of her condition, so that we wrote him without her knowing it. I should like to explain that it is against our policy to communicate with relatives without the consent of the
mother unless her physical condition is such that our physicians feel that her life is in danger. The father was so concerned about the danger to his daughter that he hardly considered the child until at its birth. At that time, he came to Detroit, and returned to his home without his daughter knowing that he had been there. When he saw the baby he said, "If you can think of any way I can take it home without people knowing that it has no father, I will care for it and its mother." When our patient was well enough we told her that her father knew about her baby. She wrote to him. It was planned that a notice should be sent to the local paper saying that Dr. B.'s daughter was returning to her father's home after the death of her husband. That was four years ago. I hear from Mary several times each year. Only her father and one other person know that she was not married to the father of her child, the other person is the man she married a year ago. I know of many cases where the results have been equally satisfactory. The restless girl who left the small town is only too content to return if a home can be provided for her and her child.

Third, the woman who has no immediate family. After we have convinced ourselves that the woman who says she has no immediate family is telling the truth, we try to find interested relatives or friends. Very often we can interest these persons sufficiently so that they will give our mother and baby the same help and protection that the closer relatives furnish other cases. Workers should bear in mind when making a plan to place a mother and baby with a friend, that the situation in the home is not the same as when a woman is placed with relatives. In the home of relatives we can depend upon the interest of the family group. In the home of a friend, we very often find that the other members of the family are disinterested or even antagonistic. Appreciating this situation, a worker will carefully ascertain the attitude of the various persons in the home before making her plan.

Fourth, the woman who is alone. There are always a number of women who seem entirely alone—older women who have been separated from their families for many years or foreign born women whose families have remained in the home country. This group includes also those of the other groups who are unwilling to return to their homes or who are unable to do so. Arrangements must be made to have these women room in homes where the landlady will care for the child while the mother is at work or to find positions at
domestic service where the women are permitted to have their children with them. We try never to place a woman at domestic service unless she is especially fitted for that work. I feel that our experience in this field has been far from satisfactory. Placing women in positions of domestic service provides a satisfactory temporary plan which enables a mother to nurse her baby. After a few months, however, the mother, unless she is unusually efficient, is neglecting either her work, her baby, or herself. The children do not get proper training and as they grow older are unruly and troublesome. The employer is frequently dissatisfied and if she keeps the girl, does so only because she is sorry for her—oftentimes giving much care to the baby herself. I know of only three cases among those we have placed in domestic service where the mothers have been able to work year after year, keeping their children with them. They are all older women, trained domestic servants, and capable managers. Even in these cases it has been necessary to plan rest periods for the mothers.

We try to place our women in substitute homes, that is, we endeavor to find a room where the housewife will care for the child during the day and where the woman will have real friends. This requires that the income of the mother be large enough so that she can pay $15 a week to cover room rent, care of the child, breakfast and dinner. Most unskilled and semi-skilled women in Detroit can only earn from $15 to $25 a week. In order to make it possible for mothers to keep their babies with them, we provide additional training whenever possible. This often times means that the child caring societies are asked to board a child without charge for a few months or even a year. Special training is secured for women who are in the homes of their parents with their babies as well as for those who are forced to depend upon themselves, because we appreciate that when the earnings of the mother are large enough so that her child is not a burden, on her parents, the home situation is better. We have at various times provided training in stenography, domestic science, dress-making and nursing. We have given assistance during the time in which a woman was becoming skilled in the operation of power machines or other types of factory work. We have insisted upon work in continuation schools for many of our mothers, who were just over school age. In all cases where the mother keeps her child, we advise that she make effort to secure assistance from the father of the child. It is through our efforts in these cases that we feel the inadequacy of our present laws, and they constantly
strengthen our determination not to be satisfied until we have succeeded in improving conditions.

In ninety-eight percent of the cases that come to us, we are able to obtain permission to interview the man who is alleged to be responsible for the child, or to verify the information that the woman has been promiscuous. In sixty-five percent of the cases, we are able to locate the fathers of the children. In twenty percent of the cases, a settlement is made through the courts. Fifteen percent are settled by marriage. Twenty-five percent are settled out of court. Five percent refuse to accept assistance. The court settlements vary from $150 or $200 (to cover expenses in cases where a child is placed for adoption), to $2,500, when a lump sum is taken in settlement. The average settlement is $500. In cases where a weekly support for fourteen years is obtained, the amount ordered varies, from $3.50 a week to $15.00, the average being $4.50. Except during the past eight months when collection of money has been difficult because of unemployment, we have made good collections on court order. Settlements made out of court vary from the settlement of $100 or $150 made before the case comes to our attention to the agreement to pay several thousand dollars or to make weekly payments of $5 or $8. We have found that settlements made out of court have been satisfactory. In speaking of settlements made out of court, we refer to cases where paternity is admitted before a Circuit Judge and the father of the child is placed under bond without a court hearing. We do not approve of settlements made without the sanction of the court.

The assistance which a woman is able to receive from the father of the child is often the only thing which makes it possible for her to keep the child. For this reason I feel that every effort should be made to obtain this assistance, but there is another reason which seems just as important. There is much said about the mothers of the children and their development through the effort which they make to face the problems which confront them. If we honestly feel this, then we are not justified in denying the fathers of the children the same opportunity to make good. I am glad to be able to say that in most of our cases where we have been able to talk to a man before he has been advised by an attorney, we have succeeded in obtaining his co-operation and friendship.

The supervision of the mother and child after the plan has been made, is a department of our work which I am afraid the agencies
too often neglect. This neglect is the natural consequence of the ever increasing demand for investigation and plan for new cases. An investigation is such a definite thing—supervision such an indefinite thing, that it is easy to understand why things are put off once a plan is made and a woman and child established. We who are working with the unmarried mother, must learn that the placement is only the beginning of our work. Recognizing the attitude of society and appreciating the limitations of our women, we must keep in close enough touch with the situation so that we can anticipate and ward off trouble. We must remember that our plan necessitates that a woman who has had sex experience, sometimes over a considerable period, must live a chaste life and we must be very patient with her.

There are then certain definite things which we can do for the unmarried mother. We can work for laws, which will give the child more adequate support from its father, we can teach people to respect the mother because of the real effort she is making, we can provide good medical care, we can help to increase the mother's earning capacity and we can work to re-establish her in her home.

In order to accomplish these things, we must get away from the old idea that we are protecting an unmarried mother by allowing her to be separated from her family and by permitting her to release her child at birth. We must persuade her that her effort to secure support for her child from its father is the sensible and dignified thing to do. We must get away from the idea that a woman illegitimately pregnant must be hidden away.
INTER-RELATIONSHIPS

II. THE CONVALESCENT HOME

J. L. BEARD

As hospitals and dispensaries develop steadily toward more accurate diagnosis, the pathological side is bound to over-shadow, perhaps somewhat unfairly, other phases in considering the patient. Thus the term "maison de santé," which is used with so much optimism by the French, might better be transferred to the Health Center and Convalescent Home where on the one hand early diagnosis and prevention are stressed and, on the other, the positive ideas of health, reconstruction and normal living are kept in mind at all times. As soon as possible we graduate those recovering in the wards and select from the clinics others as candidates for "preventive convalescence," or recuperation, each one imbued with the idea of attaining or at least approaching the same objective. The "laissez-faire" rule that, when a need arises, provision will be made to meet it seems to be exemplified in general by the rapid expansion of this field. As these places increase in number, a survey of the unmet needs for future guidance should be carefully considered as has been already done in the case of New York.¹

One of the many dove-tailing functions of a social service department is that of providing special care for recuperating or potential patients. On the other hand, a large proportion of convalescent homes insist that all applications for admission from hospitals must come through the social service department if it exists. Hence has come about a mutual dependence between two groups. This cooperative relation of necessity has brought about a cordial feeling regarding the helpfulness of each toward the other. Inevitably also there has been more or less friction and misunderstandings have arisen. Is it not opportune now to air these grievances with the idea that each may do her part, to help the patients in this final step to their ultimate recovery? Having used these institutions for patients from my hospital and later occupied for a short time the admission desk of a convalescent home, I feel that my observations may be of value to stimulate a relation even better than now exists.

As co-operation has for its basis understanding, it seems fundamental that we should know the capacity of the institution, types of
cases handled and along what lines they attain their best results. What are their rules for admission? What diseases, conditions and individuals are excluded? Is there a waiting list? Is there a definite time when treatment will terminate or does the condition of the patient determine his discharge? It is well to know personally those who control admissions and also worth while to visit the place not only to see where we send our clients and learn what is done for them but also to meet the director and get the spirit of the place. While there we are able to see the group being treated and can deduct much in regard to benefit received and if any possible harm may result. In our office we should have a pamphlet describing the work and pictures of the place. This can be of real value in helping a doubting patient to the conviction that his needs may be met there. A supply of application forms should always be on hand.

Next, we will consider the patient. First, has an accurate diagnosis been secured? I grant that it is often difficult to insist that a hurried physician be a little more specific than "general debility"; but, as that term at times has been found to cover some things really serious where convalescent care will not alleviate the disease but may even delay recovery by postponing indicated treatment, our responsibility in the matter seems obvious. Or a case of "chronic bronchitis," is so often incipient tuberculosis, the doctor unwilling in a mistaken idea of kindness to "brand" the patient. Such an individual needs to have some social case work practiced upon him, topped off with a visit to the institution. He probably has not realized that not only does he expose many people in depleted condition to infection; but, as such a place is not adapted to treating that disease, valuable time is being lost while the lungs become further invaded each day. In instances like this an X-ray and other refined tests represent money well spent.

Mental cases are usually classed as ineligible for they are rarely benefited and usually made much worse by group life. An ill-considered reference of this sort may be just enough to cause serious results. In November, 1921, Burke Foundation of White Plains, New York, made a start toward meeting the needs of this large group by experimenting with some neurasthenic and mental cases selected from one hospital by the chief psychiatrist, a man who understands the needs of each patient and the possibilities of the institution. During six months, thirty-four such cases were treated with good results, as a whole. The number is really not large enough
yet for drawing generalizations. But it has been found that recupera-
tion in these cases is slower and hence the stay must be longer than the
average. One feature of the treatment is to offset egocentric ten-
dencies by stimulating social responsibility through placing in their
care those in a more or less helpless condition, such as cripples.
For the sake of the large majority, it seems best to exclude
cases of epilepsy, venereal diseases in their infectious stages, incon-
tinence of urine, discharging faecal fistula and visible repulsive
lesions such as a malignant growth or any other condition which may
cause not only annoyance to others but will reflect also on the patient
himself when he finds that he is ostracized or made the object of
unpleasant comment.

All institutions caring for children have stringent rules about
contagious disease, and debar not only contracts but sometimes even
those coming from an infected neighborhood. The reason for this
is obvious as measles might close such a place for a whole summer
and many sent to recover from one disease might in their depleted
condition succumb to a contracted disease or one of its sequellae.
As unfortunately racial intolerance in some form is common to most
of us, how can we expect a feeling of democracy among a group of
half-sick people who in the main are poorly educated? Hence, the
usual rule is that such are excluded whom the majority will not
tolerate. People who insist upon following certain peculiar dietary
habits and those who are on special diet, excepting always those
taking milk only, are best not sent to those places which set a table
not conforming to their needs or beliefs.

It hardly would seem necessary to mention that workers should
keep in mind such diseases and conditions which render patients
ineligible, clearly stated on the application forms of all large homes.
But in my one month's experience, examples of all of these diseases
as well as patients obviously unsuitable in other ways were referred
from social service departments. The most lenient interpretation of
such an action is ignorance of the plainly stated rule. For instance,
a patient arrived a few hours late because he had had an epileptic
seizure in the street car. It is true that he was recovering from
pneumonia as stated in the diagnosis, but the social worker admitted
that he had had daily fits in the hospital. Naturally, his disappoint-
ment was keen and his attitude toward the one who had put him to
this needless exertion and humiliation was not that of gratitude.
Again, we find some who go directly to the superintendent of the home after being refused by the admitting agent. They have been known to take or send the patient in a taxi, under the impression apparently that a request made in that way could not be refused. It goes without saying that in nine cases out of ten the patient cannot be taken because of lack of space and I know of no institution of this kind where the head does not endorse the decision of his subordinates. Not to mention the probable disappointment to the client, an action so discourteous will naturally result in a less kindly attitude toward the perpetrator.

Still keeping in mind the welfare of our patient, we must consider what beside health will be secured. Will the place give him new ideals and interests? Will it stimulate him to return to the normal, work-a-day world or will it tend to make him lazy and selfish, fixing the notion that the world owes him a living? Do we consider the possibility of him being a disturbing element, the center of a discontented group or even an active influence for evil? Remember that it costs more to run a convalescent than a vacation home and avoid using the place as a reward for good conduct or a dumping ground for undesirables. Furthermore, one who is merely tired is not always helped by association with those who have recently been or are potentially ill. Do we impress upon those we send the fact that they are guests and courtesy is due the host? Do we make him feel that he represents the hospital and must be a credit to us? Do we see that he views this opportunity as something of importance to his life as a whole as well as a medical prescription? Do we always heed a request which may be made to raise the general tone of the place by choosing a few gentlemen or well behaved children?

We might style as preventive treatment in co-operation a readiness to meet others more than half way. Sometimes we are asked to secure patients needing preventive convalescence. This may mean educating our clinic doctors in this unspectacular form of health conservation. Outside agencies, especially relief societies, are often glad to have such opportunities for clients who are in the arrested or pre-tuberculous stages. When notified of unexpected vacancies, every effort should be made to find patients as the home desires to function to its full capacity. For example, many patients do not care to leave the city even for their own better health during winter or the holiday seasons. This has led to many places closing for half the year with consequent loss of efficiency. If a study of end results
is being made by the institution our duty is to follow up and report promptly. Recommendations for treatment accompanying the discharge slip are sent to be carried out. Such tasks repay in but a small measure the help given. Let us do all we can to encourage them in their work. Let us make them glad to receive our patients and establish such confidence in our good will and judgment that if ever we have to request a favor (by which I do not mean violating rules) we know it will be granted if possible.

Now let us attempt to evaluate the service rendered our hospitals and patients in terms of results. Do we do our bit of publicity by calling the attention of our doctors to the patients restored to normal health or do they know only those who did not make such good progress? Are the results lasting? Do the patients come back with new ideals in personal hygiene and general living? Has their ambition taken a new lease of life? Do we encourage them to talk about the place after their return? In this connection persistent poor reports remind one that "there is no smoke without some fire."

In instances where patients have been discharged in disgrace, do we investigate the charges and try to rectify the matter through apology or explanation? Do we often think of passing on expressed appreciation, written or spoken? Do we also have sufficient courage to give kindly suggestion or constructive criticism? When a patient deplores the fact that an institution does not permit payment for treatment, do we always let him know that he may make a gift to the place? Where there is a sliding scale of charges, aren't we somewhat prone to take for granted that our clients cannot pay anything? When a patient is returned as unsuitable due to poor diagnosis, the doctor responsible should be made to understand how much is involved—loss of time and discouragement to the patient, waste of a bed and time in the institution which might have been given to another and a reputation for careless work on the part of the social service department.

Statistics of co-operation are being evolved by various agencies and may be worked out in this connection. To make our statements accurate regarding our relations with convalescent homes, I would suggest that record be kept for at least a year of all the applications made for this type of care with their subsequent history involving length of time between application and acceptance or rejection, rejection after admission, length of stay in the institution, number of
patients leaving the home against advice and the number discharged
too early, opinions of patients as to treatment and doctors as to results.

Now that we have considered the beam in our own eye, let us
look at the mote in our neighbor's. As social service departments are
desirous to place their patients and admitting agents have the right
of refusal, the latter have many opportunities to show a spirit of
generosity or the reverse. When all conditions apparently are met
and either no answer is received to the application or the patient is
refused on arrival after acceptance, clearly an explanation is due;
for, important as it is to keep beds filled and the institution function­
ing to capacity, the welfare of the patient should be the first con­
sideration. I have in mind a patient convalescent from an operation.
A certain church house seemed an appropriate place and the superin­
tendent was asked for a vacancy. She in turn said that she could
take the woman on a certain day, but stated that an enclosed applica­
tion must be filled and signed by their president and that it must be
sent by mail to her town address. Days went by but no answer came
and later it was learned that she was in Florida. In the meantime,
a letter came, upbraiding the social service department for not sending
the patient. There's such a thing as being tied up by red tape.

When cases are refused, sometimes the reasons for refusal are
not clearly understood. For instance, if pulmonary tuberculosis is
suspected, most workers will meet a request for an X-ray and further
tests of the lungs, especially if an acceptance is promised if the result
is negative. I wonder how many controlling admissions realize the
discouragement to the patient who is refused at the door on the
physical findings when he has waited some time for the opportunity,
has journeyed to the place and maybe given up a chance to go else­
where. Much depends upon the personal equation, for examining
physicians like most human beings have idiosyncrasies, emphasizing
certain symptoms and rendering a patient ineligible while the doctor
in the hospital honestly thought him suitable. Black-listing of institu­
tions may be traced to such happenings. It is interesting to note that
periodic inspections of convalescent homes is already a fact as the
Association for the Study and Prevention of Heart Disease of New
York City visits each institution receiving cardiacs every six months.
This has resulted in valuable suggestions for all concerned and may
be a forerunner of an extension so that all homes and conditions
may eventually be covered. There is also a trend toward a central
clearing office for convalescent care in New York City but that important move toward greater efficiency lies in the future.

If it is necessary to refuse an application because of lack of space or ineligibility, help may be given by naming other places where he may be accepted. If the social worker has made a mistake, why should the unfortunate patient be made to suffer? A clear statement should always be made about applicants desired, in particular the border line cases, and, if a new type is to be undertaken, word should be sent to all interested unless the experiment is to be started with a well chosen group when the most co-operative departments would naturally be the ones selected to secure the material.

Regarding waiting lists there are two opinions. Some wish to accommodate all eligibles. This inevitably leads to a delay, sometimes of a month or longer, so that the patient's condition, which rarely is static, is improved beyond the need for this special care or he has become worse and is too ill to go. Many refuse to grant vacancies for more than a week ahead except when the appointment is made for (1) surgical cases immediately after operation where prognosis is fairly uniform and (2) a few chronics whose condition varies but slightly but can be helped.

Another question for discussion is about the length of stay. Many homes have an inflexible rule in which patients are permitted to stay for a definite period, determined by the rules of the institution and not the patient's condition. In a few instances, one week, a shorter period than any operating under a fixed rule, is all that is necessary or even desirable, while on the other hand eight weeks is sometimes not too long and the patient is just beginning to be benefited by the end of the third week. As in case work, each must be considered on its individual merits.

When a patient is discharged, the hospital should be informed so that it may resume its responsibility and carry out the suggestions of the home. Here let me emphasize two main gaps left in the convalescent cycle—(1) failure to tie up the patient to his clinic immediately upon his return home and (2) delay in restoring him to the sphere of production (including the field of the school child and housewife), thus tending to nullify the character building objective of this treatment. If a repeater has been sent, the social service department should be informed of the mistake made, but at the same time the home should always be ready to accept or even seek con-
structive criticism, such as the advisability of establishing occupational therapy, suggestions for the medical or nursing departments or new types of patients to be admitted. One person or department should be held responsible in each hospital for convalescent care and it will simplify the work of admission agents if they insist upon dealing with them and them only.

As these institutions increase in number and deal with a steadily growing list of diseases, including the various kinds of preventive convalescence, the relationship with social service departments is bound to become a more important factor each year. Let us then make it a point that we cultivate a spirit of harmony based on mutual understanding and a desire to promote and not hinder the better health of the community, the permanent results of the hospital and the restoration of the patient to a normal life.

REFERENCES

At a meeting of the Hospital Social Service Workers which was held here at The Johns Hopkins Hospital a month or two ago, I was impressed with the eagerness on the part of several of the speakers to define hospital social service. Should the social worker be an admitting officer, should she be a medium for the exchange of confidences between the hospital and its dispensary patients, should she conduct an employment bureau, or render semi-nursing care to its discharged patients? Brought up as I have been under the shadow of our own Social Service Department, it had never occurred to me before that a hospital would think of apportioning any of its above-mentioned housekeeping duties to its social service workers. While I was meditating on these ideas there visited our Clinic three or four people who are about to launch community studies in public health. One was a physician who is Assistant Director of a Child Guidance Bureau in New York. Another visitor was a physician who is to assist in a mobile Child Hygiene Clinic which the State of New Jersey is about to send into its rural communities. Another visitor was a physician who has charge of public health work in a Canadian province. The days on which these visitors were with us were not particularly rich in Clinical material. As is my custom I turned to one of our social workers, after going over a case and said, "Before a physician can come to any conclusion in regard to the diagnosis and disposal of this patient he must have a home visit to find out something about the setting in which the psychopathological process has developed. One would like to know how this patient behaves at home, how she eats and sleeps, what the attitude of the family is toward her, and how much truth there is in her story." The case under discussion was briefly as follows:

L. M. was a married woman of 30, who was referred to us from the Nose and Throat Department of this Hospital with a diagnosis
of "Cancerphobia." The official story was that following a slight Otitis Media six months ago she had developed a fear of cancer in her head. In spite of repeatedly negative examinations and X-rays, the patient remained unconvinced. On examination the patient quietly declared that she had a cancer on the left side of her head, and in fact believed it might be in other parts of her brain as well. Her fears were expressed in the emotional setting of mild apathy. Her plans were to travel from one doctor to another until she found one who would agree with her. The general picture of the case suggested a mental disorder more serious than an ordinary obsessive fear, and bordering rather upon distortion. A social service visit to the home confirmed the above suspicion. It was found that the patient had been avoiding people for over a year, and followed her husband stealthily about the streets suspecting his fidelity. She visited the priest at least once a week, and had threatened to kill her husband and child, both of whom had been suffering from her progressive decline in housekeeping interests. The simple request for the above-mentioned information from the social workers evidently impressed our visitors. Their interest in things medical waned visibly as their interest in things social increased. They asked for our social service outlines of case records, for systems of filing, and for types of correspondence. Upon their return the next day they put these questions:

Are your social workers nurses? Are they college graduates? Where have they been trained, and how long did it take? How do they get the co-operation of the family, school and constructive agencies in the community? To the above inquiries I replied: "A few of our social workers are nurses, a few college graduates, but neither nurses' training nor a college diploma are pre-requisites of social workers of this Hospital.” As to the training I could only say that our workers have been trained in practical case work here under the direction of the Social Service Department, and have had such theoretical work as could be given them by our own medical staff. As to the third inquiry about the manner in which the co-operation from school and family and constructive agencies was obtained, I could but show them the results in concrete histories.

From the above story it seems to me that we are answering in our own hospital community, the question of defining the function of the social worker, even though we have not put this question into a formal definition. Our workers are doing something specific and
concrete, something which the art of healing needs, and is apparently groping after in many places. They are the medium for the exchange of view point between physician and patient. The purpose of their mission is essentially the same, whether it is in the department of medicine, surgery, pediatrics, tuberculosis or psychiatry. It is always an inquiry into the individual story of distress—its prime sources, its aggravations, its possibilities of modification. These inquiries may be divided and sub-divided into topics of investigation to the covering of many pages with absolute facts, and yet the vital spot of the whole case missed. How then does the social worker get at the essence of her case problem? Evidently that family remedy called "the fundamentals of case work" so greatly advertised by social educators can take only a modest share of the credit in the training of an efficient worker.

To me it has always seemed that social service like medicine is a mixture of science and art. As a mixture it works or it does not work, and we praise or blame it for efficiency or failure. And the ingredient most commonly charged with success or failure is the science rather than the art of the mixture. Not long ago I saw a letter of inquiry illustrating this point. It asked for details of technique used in the education of the family in regard to the patient's temperamental difficulties, and to this was added the inquiry, "Have you standardized this technique in any way?" Social Service as an art deals with qualities which are inborn and cannot be acquired. Or as Sir William Osler once said in speaking to a group of physicians, "Pasture is not everything, and that indefinable though well understood something, which we know as breeding, is not always an accompaniment of professional skill."
Doubtlessly, you have allowed yourself to wonder what becomes of the hundreds of patients that pass through the hospital—the ones you see being discharged more or less disabled, who are dependent upon their own ability for their support. Thrown as they are into the mad race for jobs—"each one for himself, and the devil take the hindermost," it must have occurred to you that in some of these cases it would take an extraordinarily strong character to prevent complete discouragement from enveloping the person, resulting in suicide, beggars and dependents upon society through its charitable organizations. It does not take much imagination to picture the struggle of those who do not succumb, who fight, but find the lost leg, the lost arm, the weak back, the necessary cane or crutch, a bar to any but the jobs that remind the person constantly that he is an outcast because he has unfortunately been injured. If we but stop to consider, we will realize that there is often an economic as well as a humanitarian problem involved, as excellent qualifications and skill in some particular line may be lost for want of advice and guidance.

In a certain hospital, at the present time, are two boys—one 21 years of age suffering from paralysis which will confine him for the rest of his life to a wheelchair. This boy fell and fractured his spine in an elevator accident resulting in the loss of the use of both legs. The other, 24 years old, is suffering from poly-arthritis, brought on by lead poisoning. This young man, after completing the regular elementary school course followed in the footsteps of his father and became a bricklayer. However, being interested to further develop his education, he attended evening high school for three years. Both these young men are American born, and strike one at once as being exceptionally courageous and intelligent lads. Every-
thing is being done to make them comfortable—the nurses are attentive, social service workers cheering.

These boys are not idle, much of their time is spent in the occupational therapy section of the hospital, where they are engaged in simple forms of work. Both of these young men are happy, optimistic and, together, are laying plans for their future. The day is coming, however, when they must leave the hospital. Removed from its protection and the security which it offers, and, being absolutely dependent upon their own ability to maintain themselves, the question at once arises: “After the hospital—what?”

It does not require much imagination to appreciate how soon their optimistic outlook upon their future would be destroyed when they are absolutely dependent upon their own resources for food and shelter, and we can easily imagine how quickly their morale would be reduced through the sympathy of friends and their dependence upon charity.

It was upon these two boys that the writer happened one day, and after talking with them a few minutes, asked them what they intended to do after they left the hospital. They had plans, but upon these plans they needed advice and their promotion required outside assistance and influence. Nothing concrete of this nature had been offered to them. Optimistic though they were, their faces lighted up when I was able to tell them that the State of New York wanted to help them and had an agency which had been organized for this very purpose.

The Bureau of Rehabilitation, organized under the State Department of Education, is no paper organization, but a real, live red-blooded practical bureau, a State agency offering its services to every injured person who finds himself handicapped by a disability, whether that disability was congenital or occurred through accident, injury or disease. This Bureau helps disabled persons to help themselves. It endeavors to ward off discouragement. It aims to preserve skill and to develop productive power and to turn the person out self-supporting and able to hold a job upon his ability to deliver the goods rather than upon someone's sympathy for his condition.

The necessity of reaching these injured persons in the hospital while they are cheerful and optimistic as the boys already referred to must be apparent without argument to anyone who knows human nature. The mind at ease, free from worry, responds more readily and co-operates more earnestly. If the Bureau is to do its best work,
therefore, every social service worker should use its services liberally. "An ounce of prevention is worth a pound of cure." Physically, in many of these cases, the "pound of cure" has been necessary because someone neglected the "ounce of prevention," and I am urging the liberal use of the Bureau, as it constitutes the "ounce of prevention" in the injured person's future relations with society and his fellow workers after leaving the hospital.

As you meet your patients, may I ask that you consider more than ever their future, and remember that there is an agency prepared to advise these persons and to prepare them for self-supporting jobs that they may rightfully once more assume the responsibility of citizenship. The co-operation of every social service worker in the hospitals is urged in this greatest of conservation movements.
Without attempting to present anything new I shall enumerate once more the physical defects commonly associated with malnutrition. It is often impossible to prove that these defects are always causes of malnutrition, and yet their frequent association with it is so striking a coincidence that they must be considered as possible causes if every case of malnutrition is to be properly treated.

Malnutrition is a condition of poor health characterized by one or more of the following conditions: under weight for height, too slow a rate of gain in weight, chronic fatigue, flabby tissue, anemia and lack of resistance to disease and infection.

It is often helpful to consider the physical defects accompanying malnutrition in connection with the various systems of the body. In mentioning these defects I shall try to suggest the probable method of their action as causes of this condition.

Beginning with the Digestive System: There may be dirty, carious or abscessed teeth producing poisons which are constantly swallowed, surely with no benefit to the body. Such diseased teeth have often been an important factor in the production of enlarged and infected adenoids and tonsils with their deleterious effect on the health. Extensive abscesses at the roots of temporary teeth may injure the unerupted permanent teeth beneath. Malocclusion, whether due to early thumb-sucking or the use of pacifiers, and also tender, carious or abscessed teeth may prevent proper mastication and thus obviously interfere with digestion.

Chronic intestinal indigestion and cyclic vomiting are potent factors in preventing proper growth. Either there is constantly insufficient digestion of certain food constituents and therefore only
a limited utilization of their nutritional value or there is a constant accumulation of some of these partly broken down foods which in this incompletely digested state act as poisons. This accumulation goes on to the point of explosion when there may be fever, vomiting and possible diarrhea, all involving the necessity for a time of a much restricted diet. Each such attack causes a loss of weight which may or may not be regained in the intervening time between it and the next attack. Such cases are fairly common.

Also, though not exactly a physical defect, the condition of infection by intestinal parasites, especially the tapeworm, must as truly be corrected as that of carious teeth. The parasite is "an unwelcome guest in the house," not included in the family budget and inevitably a drain on the host.

Under the Respiratory System come: First, pathological adenoids and tonsils. Enlarged, they obstruct free respiration, cause mouth-breathing and colds with the corresponding loss of weight frequently accompanying such attacks. They favor middle ear abscesses and prolong their time of healing and therefore the time of suppuration, a condition which is always a drain on the system. If diseased they are a constant source of absorption of poisons and may cause rheumatism and its accompanying heart diseases with their additional hindrance to proper growth and health. Frequently one of the most noticeable symptoms caused by pathological tonsils and adenoids is a poor appetite. It is self-evident how this influences a child's nutrition.

Deviations of the nasal septum, bony and cartilaginous thickening of this septum also act in the same obstructive way to respiration as do enlarged tonsils and adenoids.

There are two lung conditions, not exactly physical defects, which greatly retard the steady growth of a child; Bronchial Asthma and Chronic Bronchiectasis. The former is well known, the latter is a condition of dilation of some of the terminal bronchi so as to form small cavities. Children with this condition are prone to frequent infections taking the form of attacks of bronchitis. With each attack gain in weight is, at the very least, retarded. Lasting over months and years it is easy to see what a profound effect such attacks would have upon the health. They are, to be sure, diseases in themselves but often the accompanying malnutrition is the outstanding factor at the time the child is seen.
One of the most interesting groups of defects is that of the Nervous System. It is hardly necessary to remind one's self of the far-reaching influence of this system upon every organ and vital process of the human body. Appetite, digestion, assimilation and even excretion are at the mercy of its influence. When this system is irritated and unbalanced all of the parts and functions of the body may also be thrown out of kilter. In this case it is a disturbed nervous system which is the physical defect, and to remove it one must remove all the factors causing this defect to exist. One of these factors is eye-strain. For instance, a child is totally discouraged because she can not keep up with her class at school. She eats and sleeps poorly, is constipated, sulks indoors, becomes pale and has frequent headaches. She is given proper glasses. At once she can use her eyes without strain, the headaches disappear, she studies better, regains her class, is with her friends again, feels happier, eats and sleeps better and plays out of doors more, thus recovering her color. Her whole difficulty had been the need of glasses. Her nervous system had been so irritated by poor sight as well as by all of its resulting discouragement that it had seriously affected her health. Bed wetting in older boys and girls, or the tragic and common condition of innocently acquired vaginitis, act in much the same way. Or take a child trying to accomplish too much, endeavoring to care for her younger brothers and sisters at home, to carry a heavy school schedule as well, and, in addition, to engage in games and entertainments with his or her friends. This is a poorly organized life because overcrowded and not only tires physically, but, being impossible of proper accomplishment, is a constant drain upon the nervous system.

So much for defects grouped in systems.

There are a few general considerations which should be mentioned before finishing this short statement of the physical defects associated with malnutrition.

Almost universal in cases of malnutrition is poor posture. It is often hard to know when this is the result of poor health or when a cause. Often when a cause it is increased by the under-nourished state it originally caused. Among its various forms are sloping shoulders, the all too frequent prominent abdomen and receding chest often referred to as fatigue posture, and the more marked forward, backward or lateral curvatures of the spine. Before taking up the probable way in which these forms of poor posture act to produce malnutrition, the deformities commonly found should first be
mentioned as they act in much the same way. Congenital dislocation of the hip, hunchback, flat feet, etc., often have a real causative influence in producing malnutrition. It is most probable that these two groups act deleteriously to health by causing the lungs or the abdominal organs to be abnormally compressed perhaps causing congestion and so hindering their proper functioning. Or they may act deleteriously upon the health by necessitating an unusual strain upon certain muscles because of the abnormal position in which the body must be held.

Lastly, blood of poor quality can not be expected to properly nourish the organs and tissues of a body satisfactorily. Thus anemia alone may be all that needs correction in order to bring about proper health.

In conclusion, may I repeat that I have not tried to give you anything new. I have tried to give you a point of view—a medical point of view—which it is absolutely necessary to have in approaching each case of malnutrition in addition to the point of view of the investigator into home economics, hygiene, and into food and food habits.
At the invitation of the Association for the Prevention and Relief of Heart Disease of New York City, a number of those interested in a discussion of the best means of securing a more complete co-operation of the agencies actively working on the heart problem in the United States and Canada, met in St. Louis on Wednesday, May 24th, 1922 with Dr. Robert H. Halsey, acting as Chairman.

After a brief review of the work of the Association for the Prevention and Relief of Heart Disease of New York City since 1915, and that of other recently formed associations, and an explanation of the reason for which the meeting was called, Dr. Halsey asked Dr. Haven Emerson to present the tentative plan which was in brief as follows:

I. New or additional national associations are undesirable unless they fill an obvious and urgent need. The magnitude of the health and economic problems connected with heart disease clearly justifies the present proposal.

The possibilities of prevention of heart disease alone justifies our undertaking. So little progress has been made even in the large cities that the need still applies broadly to all the people of the country.

II. The New York Association has been cautious and developed gradually and has waited for evidence of need of co-ordination before asking for this conference. The need has seemed clear to us for the past two years.

III. The New York Association has in a measure been acting as a national information bureau in the social aspects of cardiac dispensary service, until now but moderate changes and extensions of its activities are required to permit its office to act as host in the first stages of a national organization.

IV. The big national Association or Committee should start slowly and proceed conservatively and thus no very great
enlargements of equipment or budget should be first thought of.

For the present and for a year we are prepared to offer to defray the office and secretarial expenses of any national society that may be decided upon.

V. In forming a representative national Board or Committee to represent the entire country the 50% of our population and medical practice and more than 50% of our problem which is in the rural population must not be neglected.

VI. The functions of such a national group would be co-ordination of efforts, development of research, collection and distribution of information, public health and industrial education, to develop sound public opinion as to the true meaning and seriousness of the problem.

It is of great importance to live within our means and to rely upon the gradual expansion of our project through education of the laity.

Each local organization should retain its independence and responsibility for development of its own resources to meet its particular problems.

The “cardiac movement” is broadening and accelerating so rapidly that it needs standards, direction, control and mutual interest and needs it now.

Dr. Halsey then asked for further suggestions from the different groups.

Dr. James B. Herrick, President of the Chicago Association, spoke of the appreciation of the aid always available through the New York Association and of the hearty approval of the plan for a national development as offered by Dr. Emerson. Dr. Herrick spoke of their recently formed Association in Chicago as just having emerged into the breathing stage. Though not speaking officially, Dr. Herrick gave assurance of the complete support of the group of doctors from Chicago for a national association.

Dr. William S. Thayer, Baltimore, spoke of his earnest approval of the project as suggested and urged co-operation among all groups to forward this important public health problem. Dr. Thayer spoke of the National Research Council, and their need for just the sort of assistance that a group developing this work could give. He
urged the immediate adoption of some definite plans to nationalize the movement.

Dr. Joseph Sailer, President of the Philadelphia Association, also approved the plans for a national body. He expressed his belief in the value of local and state associations as the basis of a national body. While not speaking officially, Dr. Sailer felt that the Philadelphia Association would want to aid, so far as possible, in this movement.

The development of the heart work in New York City, which Dr. Halsey commented upon showed a growth from three clinics in 1915 to thirty-eight clinics on April 1st, 1922, with 5,480 active patients. He then called upon Dr. White to continue the discussion.

Dr. Paul White, Chairman of the Boston Association of Cardiac Clinics, told of the interest in preventive measures spreading in New England and said that a few meetings to discuss the Heart Disease Problem had been held in Boston under the auspices of their Committee on Cardiac Clinics. As a result an Association would soon be incorporated in Boston. Dr. White was in hearty sympathy with the plan as outlined.

Dr. Halsey asked if there was further discussion; if not, a motion for the appointment of a committee would be in order.

Dr. Alexander Lambert made a motion that a committee of five be appointed by the chair to carry out the above project as suggested by Dr. Emerson. This motion was unanimously carried.

There being no further business, the meeting was adjourned.

Respectfully submitted,

M. L. Woughter,
Acting Secretary.

Dr. Robert H. Halsey appointed the following committee:

Dr. Lewis A. Conner, New York City—Chairman
Dr. James B. Herrick, Chicago
Dr. Joseph Sailer, Philadelphia
Dr. Paul D. White, Boston
Dr. Hugh McCulloch, St. Louis
EDITORIAL

No uncertain action was recently taken by the House of Delegates of the American Medical Association on two matters which directly concern public health and welfare work. The resolutions in opposition to the Sheppard-Towner bill and to the post-war activities of the American Red Cross in public health work are significant.

The opposition to the Sheppard-Towner bill must be studied from the viewpoint of the general practitioner who has an ever-increasing fear of State medicine because of the abuse of this free service by those able to pay for medical care.

The doctor has been trained to believe that his chief duty is to relieve suffering and to prevent disease. This has naturally forced him to cope with social conditions which are so often interwoven with the medical problem. But of late there has been a tendency for non-medically trained persons to dictate to the medical profession what their social welfare duties were. Herein lies a cause of the recent action of the American Medical Association. According to some doctors who have been leaders in the welfare movement, the social worker needs to get to work on the basis of greater dependence on the doctor for prognosis of the patient’s future ability and disability, and the consequent plans for family rehabilitation, rather than merely requiring a diagnosis.

The profession which still retains the ancient rite of requiring each new member to take the Hippocratic oath, and which on the other hand has created remarkable services for humanity, cannot be driven, although it may be won by reasoning. The most effective means of attaining greater medical co-operation is through the action of those far-sighted men who are already in medical social service. The leadership in the field may safely be trusted to them. It is the far-sighted medical group which is recreating the hospital service of which Devine states: “The modern hospital, well-equipped and administered, is one of the most remarkable and creditable of the institutions to which science and philanthropy have given rise... The conception that the community has a responsibility to present preventable disease, to assume the burdens of illness which the individual cannot carry is in complete harmony with the best traditions of the medical profession... this new view of health as in large part a social responsibility... It is doubtful whether with all its imperfections any
other comparable institution, university, law, press, comes nearer to fulfilling its legitimate purpose." The most significant hospital development of the present is the progress in out-patient service. It appears that the future hospital of the best type will provide a central dispensary with ward service provided as an adjunct for the acutely ill. The future relationship of such a hospital organization to public health and medical social work is interesting and important.

The Council on Hospitals and Medical Education of the A. M. A. has estimated the annual dispensary visits to be 30,000,000. It does not require a great effort of imagination to estimate the possible increase in hospital social service when for thorough work every dispensary has an adequate social service department. At present the critical need is the early development of cordial co-operation between the medical and non-medical social agencies. This will be best accomplished by a mutual recognition that each has its own limited field. It is just as much a waste of time for a non-medically trained mind to attempt to assist a physician in a medico-social problem as it is for a hospital social service worker to attempt to solve a complex family rehabilitation problem once the medical crisis has passed.

Dogmatism may be eliminated by adherance to the policy of keeping the needs of the patients to the fore, rather than blind devotion to the policies of any organization. This is difficult, for leaders in existing organizations claim they can only preserve the best interests of their own organizations by a measure of autocracy.

REFERENCE

CURRENT COMMENT

A POINT OF VIEW AS TO THE SEGREGATION OF THE SOCIAL WORKER

J. B. DAWSON

Secretary, Organized Charities, New Haven, Conn.

Miss Mary Richmond once made a remark to the effect that from time to time civilization drops part of its baggage and must retrace its steps to recover it. What we describe as social work is an outgrowth of an attempt to recover the lost art of neighborliness. Fundamentally it was to bridge the gulf between those on the one hand whose lives had been broadened and enriched by the development of industry and community organization and those who had fallen victims to the social maladjustment incidental to this development. The role of the social worker in the early settlement and charity organization movements was that of an interpreter to the end that helpful communication might be kept open between these two isolated groups. We have enlarged upon this early conception. We have multiplied many times our form of service. We have devised new, and we hope, more intelligent ways of dealing with the multiplicity of problems of human behavior. We have developed a technique and we have created new and complex agencies for applying the results of our knowledge and experience. Along with the development of this new machinery has gone the specialized job of keeping it in working order and on the move. In this first-hand contact with people in adversity to a point where he is chiefly concerned with the administration of an agency and with the definition and direction of the policies which that agency has to carry out. Upon his knowledge, wisdom and discretion will greatly depend the effectiveness of the agency's service to a larger clientele. But it is a clientele which the executive in a larger agency rarely if ever sees. Is there not a real danger that the social worker in such a position may drop part of his baggage and find himself in a position of isolation as dangerous and unwholesome as that against which social work itself is a protest?

Is it true that the executive has frequent contact with his co-workers, many of whom themselves have first-hand acquaintance
with the society's clients? It is true that he may make a point of attending a case conference. But even if the presentation of human problems by co-workers or case conference be faithful to human nature the position of the executive is still further imperilled by the fact that not he himself but somebody else has to go out and act upon the excellent advice he has given. In the matter of the society's dealings with individuals the salutary effect of realizing through one's own failures the finite nature of one's own wisdom scarcely ever comes home to the executive.

It is doubtful whether any mechanical expedient can ever overcome these besetting dangers inherent in the function of the executive. The remedy seems to lie in other directions. First there must be a conscious effort for what Wallas\(^1\) calls "the artificial organization of co-operative thought." We must strive at least for that ideal of intellectual co-operation in "which men combine and compare each other's observations, follow up by logical processes each other's suggestions, and assign to each of a group of co-operative thinkers the part in a complex inquiry for which he is best fitted by his talent and training." Secondly, as a part at least of that talent which is to place the executive in the group of co-operative thinkers—must we not have what Seeley described as "the enthusiasm for humanity." Again to quote Richmond\(^2\) "unless the great experiences common to all humanity, the issues of birth and death, of affection satisfied and affection frustrated, the chances and hazards of daily living, unless such things as these greatly appeal to us we are not ready to adopt social case work as our major interest, and, it may be added, neither are we equipped to direct the social case of others."

REFERENCES

\(^1\)"Our Social Heritage." Graham Wallas. Yale University Press, 1921. 59.

NOTE—Mr. Dawson wrote this comment in answer to a request for a discussion of Recommendation I in Section VIII of the Analysis of Hospital Social Service in New York City, Hospital Social Service, 1922, V, 253, that Directors of Departments shall be free from details of case work.—EDITOR.
The National League of Nursing Education, the American Nurses' Association, and the National Organization for Public Health Nursing opened their joint convention with an address by the Mayor of Seattle. After the introductory proceedings the respective presidents of the Associations, Miss Anna Jamme, of San Francisco; Miss Clara Noyes, of Washington, and Miss Elizabeth Fox, of Washington, briefly reviewed the current policy of their organization. Miss Anne Goodrich, of the Department of Nursing and Health of Teachers' College, New York, gave the address of the evening on the "Objective of the Nurse In a Democracy." She finds that the nurse has a responsibility and an opportunity for contribution to democracy through spiritual, physical and professional integrity in her life. She believes that intellectual integrity is forced upon the nurse through the opening of the doors of knowledge to her. "We have no right to absorb the great thought of the world without making our contribution to it." Spiritual integrity is the thing that makes the cause so far-reaching that we instinctively put forth every effort to do a finished and fine work for the betterment of the race. The nurse's objective, therefore, is to fulfill the pledge of the forefathers that all men shall be born free and equal.

Miss Fox spoke of the remarkable recognition of public health nursing as a public service by those in positions of authority. Within a few years the public health nurses employed in public agencies will greatly outnumber those of private organizations.

Among many constructive papers during the sessions, one by Dr. William P. Lucas on "The Normal Development of the Child," was a resume of the physical and social factors necessary to develop normal children. Dr. Lucas is a pediatrician and Medical Director of the University of California Hospital, where the Children's Clinic is an interesting and efficient department.

Miss Katherine Tucker gave the leading paper of the session on Visiting Nursing, under the topic, "Place and Value of Visiting Nursing In the Community." She made the point that the public health nurse and the case worker are discussed as though there was
a distinction. If a nurse is doing a good job in the home and in the community she is a health case worker. The program for the future inclines toward a democratic basis of the work. The rich need preventive health instruction quite as much as the sick poor. Miss Tucker laid emphasis on this phase of the working policy of the public health nurse. She then listed the types of care and recommended that occupational therapy be included among them as a therapeutic element. She finds the volunteer to have a definite place in the organization, especially in work which relates to child care. Attendance at clinic and certain follow-up care may be assumed by volunteers under supervision. The board of managers have an important place in the organization as they are now understood as neither giving or receiving patronage, but as well informed, and therefore, qualified promoters of the work. As participants they are interested to become familiar with its entire scope. On the matter of generalized versus specialized nursing care, the early method of placing specialized workers was experimental. A later plan has been to incorporate the specialized features in a general method under a specialized supervisor. An essential step is that of working out definite methods of cooperation with social and health agencies. In a general sense growth in this field is similar to that in other welfare work. Miss Tucker reviewed the history of the movement briefly. Increasing emphasis upon preventive work has been the direct trend. Curative and preventive work must go hand in hand as the one complements the other. In any form of field welfare the family is the unit of approach. This has been demonstrated most effectively by the tuberculosis and the social case workers. The large end results of their work create community welfare, including health. The nurse has the open sesame in the home for both positive and curative treatment as she makes a demonstration of service which the family can understand. In reply to the query as to the place of the public health nurse in the whole health program, Miss Tucker believes that she is the middle of it as she operates in all directions.

Other papers during this session were on "Occupational Therapy as a Visiting Nurse Service," by Idelle Kidder, Director of the School of Occupational Therapy of Missouri. Miss Kidder reviewed the work she has established during her period in the St. Louis School, through co-operation with social service departments of the city. N. F. Cummings read a paper on "Recent Developments in Hospital Social Service and Their Application to Public Health." "The Rela-
tion of a Board of Directors to Visiting Nurse Work," was given by Caroline A. Dieck, of Portland. Her paper, written from the standpoint of the lady manager, was witty and constructive. She reviewed the growth of interest in lay women in the professional aspect of the work. A demonstration in contagious disease technique completed the session.

An important session was devoted to "Workers in the Field of Public Health and Their Relation to Each Other," Miss Anne Goodrich, presiding. Dr. W. F. Snow, Director of the American Social Hygiene Association, gave a resume of the vital points of this relation based upon his experience in a national field which calls for cooperation with many agencies. He said that we must have specialists such as the pathologist, the sanitarian, health officer and public health nurse. Each one must be licensed. There must be some plan whereby their service is available to and within the means of the average person. The educational facilities, methods of using them and provision for further development of each department must all be provided. In addition the administrative measures for all must be plastic to permit of growth without too much disturbance of the work. Better team work among these divisions and more complete meeting of the needs is the urgent call of the hour to the public health nursing profession. In the abstract sense all nurses are public health nurses, but in its concrete application nurses must have public health education and equipment to do real public health work. The cults of today which are so distressing to the medical and nursing professions are but reaction by the people against the element of discordance and opposing views in the medical and nursing field. We have not prepared the public for changing policies among ourselves nor have we adjusted ourselves to change. We need more equable organization in the whole field and to clear our viewpoints of each other. To think of the different groups more from their individual purposes than from our superficial observation of them, for we do not know them well. The most effective means of carrying our knowledge of preventive work in the medical field is through the private nurse and physician. At present the medical schools do not provide this form of education but it will no doubt receive consideration later. "The hand writing on the wall is that we must study the needs of the people and to do our full duty we must know something about all welfare work and know our limitations in order to appreciate when and how we may get the knowledge we have not." The doctor, nurse, teacher and
social worker must appreciate the essential elements of each other's field. The trained educators have the first responsibility in instruction of the young. The nurse belongs in all groups as she has the basic foundation for which as yet her training in public health, alone provides. We need chiefly to realize team work.

Miss Koehne, of Washington University, spoke on nutrition work in the health field. She stressed the need of competent training for the work and cited examples of workers who assumed the responsibility without training. Miss Amelia Feary, Secretary of the Federation of Social Agencies of Tacoma, gave a clear and direct comment on the strength of the combined public health and social training. She summed up the field requirements for it as, first a need to see eye to eye. We should have a common background of knowledge and a common training in essentials of public health and social welfare. The social worker needs to recognize the symptoms of disease sufficiently to know when an examination is needed. She should have a general knowledge of physical ills and on the positive side she should understand how to build good health and to promote good mental habits. The public health nurse must know the principles of good case work, and be sufficiently familiar with the different agencies to pick out resources. The public health field has superior advantage to any field of social work. In the community chest drive in Tacoma it was found that the people needed to be educated in all other branches of welfare work but the service of the public health nurse represented something tangible to them. The latter has the advantage of combining the phases of education, curative work and prevention in one group. Therefore, she can obtain direct results.

The most important meeting of the week's sessions was the one devoted to the Report of the Committee on Nursing Education by Miss Josephine Goldmark, executive secretary for the committee. In 1918 Miss Nutting, Director of the Department of Nursing and Health of Teachers' College, conferred with the executives of the Rockefeller Foundation upon the urgent need of a study of public health nursing education. The present report is now offered for consideration. Miss Goldmark has summarized in the committee report the conditions which have surrounded nurses' training. The obvious deficiencies which have become increasingly apparent with development of modern medical care are outlined and constructive recommendations made for the future. Without reviewing the outstanding obstacles in nursing education it is pertinent to comment that
as a demonstration of tangible service in public welfare the nurse has certain proven qualities of responsibility and resourcefulness in fitting herself to existing conditions which have resulted in practical service of the most serious character. The conclusions of the report are extensive in scope. The role of the nurse in public health work is summarized as follows: Conclusion I—That since constructive health work and health teaching in families is best done by persons: (a) Capable of giving general health instruction, as distinguished from instruction in any one specialty, and (b) Capable of rendering bedside care at need. The agent responsible for any such constructive health work and health teaching in families should have completed the nurse's training. There will, of course, be need for the employment, in addition to the public health nurse, of other types of experts, such as nutrition workers, social workers, occupational therapists and the like. That as soon as may be practicable all agencies, public or private, employing public health nurses should require as a prerequisite for employment the basic hospital training, followed by a post-graduate course, including both class work and field work in public health nursing.

Conclusion 2—That the career open to young women of high capacity in public health nursing or in hospital supervision and nursing education is one of the most attractive fields now open, in its promise of professional success and of rewarding public service; and that every effort should be made to attract such young women to this field.

Conclusion 3 requires that the standards of nursing education for bedside care shall not be lowered in any particular. Conclusion 4 provides for attendants’ training. Conclusion 5 relates to the inadequacy of present training methods.

Conclusion 6—That with the necessary financial support, and under a separate board or training-school committee, organized primarily for educational purposes, it is possible with completion of a high school course or its equivalent as a prerequisite, to reduce the fundamental period of hospital training to twenty-eight months and at the same time by eliminating unessential, non-educational routine, and adopting the principles laid down in Miss Goldmark's report to organize the course along intensive and co-ordinated lines with such modifications as may be necessary for practical application; and that courses of this standard would be reasonably certain to attract students of high quality in increasing numbers.
Conclusion 7 — Superintendents, supervisors, instructors, and public health nurses should in all cases receive additional special training beyond the basic nursing course.

Conclusion 8—That the development and strengthening of university schools of nursing of a high grade for the training of leaders is of fundamental importance in furthering nursing education.

Conclusion 9—That when the licensure of a subsidiary grade of nursing service is provided for, the establishment of training courses in preparation for such service is highly desirable; that such courses should be conducted in special hospitals, in small unaffiliated general hospitals or in separate sections of hospitals where nurses are also trained; provided the standards of such schools be approved by the same educational board which governs nursing training schools; and that the course should be of eight or nine months duration.

Conclusion 10—That the development of nursing service adequate for the care of the sick and for the care of the modern health campaign demands as an absolute prerequisite the securing of funds for the endowment of nursing education of all types; and that it is of primary importance in this connection, to provide reasonably generous endowment for University Schools of Nursing.

The discussion of the report was opened by Dr. Richard O. Beard of the University of Minnesota. He said that in the main the findings of the report are precisely similar to the opinions presented in the discussions of every phase of nursing during the convention. The nurse has been over-trained and under-educated. The serious responsibility of medical and surgical duty in hospitals is of grave and complex nature which has resulted in military discipline for the same reasons which permit it in war time. The long term period of this type of training developed characteristic defects. The economic state of many hospitals which maintained a large proportion of free service with rigorous conditions and sparse equipment accentuated the faults in the institutions. The nurses themselves are the leaders in organizing the remedy for their deficiencies of training and are meeting the situation with the same high sense of duty which qualified the earlier period. Readjustment is already under way. This is in a measure due to the progressive spirit of executives of individual institutions who discerned the coming measures. Eighteen universities are already affiliated with hospitals in giving nursing education. Dr. Beard announced that the Central School of Nursing of
Minneapolis has recently been created in affiliation with the University of Minnesota.

Dr. Beard emphasized the economic problems which the situation presents. It is of first importance that the community in whose interest the plans are made shall appreciate the serious financial responsibility. Adequate endowment for university schools is essential before any tangible progress can be expected. It has always been comparatively easy to obtain funds for community welfare wherever the need is made clear, therefore with the efficient methods of approach there is reason for confidence of the success of the present urgent requirements for good nursing and public health service according to the most modern knowledge.

The report does not discuss the social aspects of public health nursing. The detailed report of Miss Goldmark's three years survey will be issued in pamphlet form in a few months.
PROGRAM OF THE AMERICAN HOSPITAL ASSOCIATION

Monday, September 25, 1922

Opening General Session—Dr. George D. O'Hanlon, President, presiding.

Invocation.

President's Address—By Dr. George D. O'Hanlon, President.

Report of the Trustees—Read by the Executive Secretary.

Report of the Treasurer—By Dr. Robert J. Wilson, Treasurer.

Report of the Executive Secretary—By Dr. A. R. Warner, Executive Secretary.

Report of the Membership Committee—By Dr. Walter H. Conley, Chairman; Superintendent Metropolitan Hospital, Welfare Island, N. Y.

Second Report of the Committee on Forms and Records with particular reference to Annual Reports—By Dr. A. C. Bachmeyer, Chairman; Superintendent Cincinnati General Hospital, Cincinnati, Ohio.

Monday Evening, September 25th

General Session and Section on Construction — Dr. George D. O'Hanlon, President, presiding. Mr. E. S. Gilmore, Chairman; Superintendent Wesley Memorial Hospital, Chicago, Ill.

Report of the Special Committee on Floors—By Mr. Frank E. Chapman, Chairman; Director, Mount Sinai Hospital, Cleveland, Ohio.

Report of the Exposition Committee on Buildings, Construction, Equipment and Maintenance—By Dr. S. S. Goldwater, Chairman; Director, Mount Sinai Hospital, New York, N. Y.

Round Table Discussion—Construction Section—Mr. E. S. Gilmore, Chairman, presiding; Superintendent Wesley Memorial Hospital, Chicago, Ill.

Construction Problems.

Tuesday Morning, September 26th

General Session—Dr. George D. O'Hanlon, President, presiding.

Reports of Exposition Committee:
General Furnishings and Supplies—By Dr. Harold W. Hersey, Chairman; Joint Administrative Boards, Columbia University and Presbyterian Hospital, New York, N. Y.

Clinical and Scientific Equipment and Supplies—By Dr. A. B. Denison, Chairman; Assistant Director, Lakeside Hospital, Cleveland, Ohio.

Foods and Food Equipment—By Dr. C. W. Munger, Chairman; Superintendent, Blodgett Memorial Hospital, Grand Rapids, Mich.

Laundry Equipment and Supplies—By Dr. W. P. Morrill, Chairman; Superintendent, Shreveport Charity Hospital, Shreveport, La.

Tuesday Afternoon, September 26th

Section Meetings

Dispensary Section, in the Theatre—Mr. John E. Ransom, Chairman; Superintendent Michael Reese Dispensary, Chicago, Ill.

Dietetic Section, in the Convention Hall—Miss Lulu C. Graves Chairman; Supervising Dietitian, Mount Sinai Hospital, New York, N. Y.

Tuesday Afternoon, September 26th

Dietetic Section

Miss Lulu Graves, Chairman; Supervising Dietitian, Mount Sinai Hospital, New York, N. Y.

Discussion on Children's Department in Hospitals—By Dr. Frank Howard Richardson of the Children's Diagnostic and Nutritional Clinics of North Carolina, and Children's Department of Brooklyn Hospital, Brooklyn, N. Y.

The Organization of Dietary Departments in Hospitals—By Marior. Peterson of Lakeside Hospital, Cleveland, Ohio.

A Round Table Discussion on Hospital Equipment.

Tuesday Evening, September 26th

General Session—Dr. George D. O'Hanlon, President, presiding.

Report of the Special Committee on Renovation of Gauze and Standard Dressings—By Dr. A. B. Danison, Chairman; Assistant Director, Lakeside Hospital, Cleveland, Ohio.

The Liability of the Hospital—By Mr. John A. Lapp, Managing Editor, The Nation's Health, Chicago, Ill.

Report of the Dispensary Committee—By Mr. John E. Ransom,
Chairman; Superintendent, Michael Reese Dispensary, Chicago, Ill.

Report of the Legislative Committee—By Dr. C. G. Parnall, Chairman; Medical Director, University Hospital, Ann Arbor, Mich.

Tuesday Evening, September 26th
Rotary Dinner (open to all)—Speaker on “The Hospital Phase of the Crippled Children’s Movement.”

Wednesday Morning, September 27th
Section Meetings

Social Service Section, in the Theatre—Miss Mary E. Wadley, Chairman; Social Service Department, Bellevue and Allied Hospitals, New York, N. Y.

Trustee Section, in the Convention Hall—Mr. Arthur A. Fleisher, Chairman; President, Jewish Hospital, Philadelphia.

Wednesday Afternoon, September 27th
Section Meetings

Nursing Section, in the Theatre—Miss Laura R. Logan, Chairman; Superintendent of Nurses, Cincinnati General Hospital, Cincinnati, Ohio.

Administration Section, in the Convention Hall—Dr. C. G. Parnall, Chairman; Medical Director, University Hospital, Ann Arbor, Michigan.

Wednesday Afternoon, September 27th
Nursing Section

Miss Laura R. Logan, Chairman; Director of the Department of Nursing, Cincinnati General Hospital.

A Discussion of the Report of the Rockefeller Committee and Its Effect in Practice Upon the Hospital Nursing Department—By Amy M. Hilliard, R. N.; Superintendent, Samaritan Hospital, Troy, N. Y.

The Use of Ward Helpers—By S. Lillian Clayton, R. N.; Director of Nursing, Philadelphia General Hospital, Philadelphia, Pa.

The Role of the Hospital Nursing Department in the Community Health Program—By Annie W. Goodrich, R. N.; Director of Nursing, Henry Street Settlement, New York, N. Y.
Wednesday Evening, September 27th

General Session—Dr. George D. O’Hanlon, President, presiding.
Report of the Nomination Committee—By Dr. D. L. Richardson, Chairman; Superintendent, City Hospital, Providence, R. I.
Appointment by the President of three tellers for the voting.
Report of the Constitution and Rules Committee—By Mr. Richard P. Borden, Chairman; Trustee, Union Hospital, Fall River, Mass.

Thursday Morning, September 28th

General Session—Dr. George D. O’Hanlon, President, presiding.
Report of the Committee on the Training of the Hospital Social Worker—By Michael M. Davis, Jr., Chairman; Executive Secretary, Committee on Dispensary Development, New York, N. Y.
Round Table—Mr. Asa S. Bacon, Chairman, presiding; Superintendent, Presbyterian Hospital, Chicago, Ill.

Thursday Evening, September 28th

Closing General Session.
Announcement of Election Results.
Reports of any other Committee.
Closing Business.
The New President, Mr. Asa S. Bacon, takes the Chair.
Announcement of Committee Appointments.
The Association for the Next Year—By the new President.
Adjournment.

Wednesday Afternoon, September 27th

Administration Section

Dr. C. G. Parnall, Chairman; Medical Director, University Hospital, Ann Arbor, Michigan.
“The Training of Hospital Executives”—By Willard C. Rappleye, M. D.; Executive Secretary of the Rockefeller Committee.
Discussion:
Winford H. Smith, M. D.; Director of Johns Hopkins Hospital.
Frederic A. Washburn, M. D.; Director of Massachusetts General Hospital.
Daniel D. Test; Superintendent, Pennsylvania Hospital.
Report of the Committee on Hospital Forms and Records:
A. C. Bachmeyer, M. D.; Superintendent, Cincinnati General Hospital.
F. E. Chapman; Superintendent, Mount Sinai Hospital.
John F. Bresnahan, M. D.; Superintendent, Bridgeport Hospital.

OBSERVATION AND CONFERENCES

A program of clinics and features of interest in hospital social service departments in hospitals of Philadelphia and New York has been carefully arranged by Miss Irene Hayward, Chairman of the Middle Atlantic District for Philadelphia, and Miss Jessy C. Palmer, Chairman of the Committee on Hospitality for the North Atlantic District. Folders, giving the full details of the nature of the work, hours, addresses and routes of transit to the clinics in both places, have been prepared and will be available, at Atlantic City.

A trip to Burke Foundation Convalescent Home at White Plains, N.Y., is arranged for September 29th. Transportation from the Woman's City Club, 35th Street and Park Avenue, the New York headquarters, will be provided. Lunch will be served at the Burke Foundation. On Saturday, September 30th, another interesting excursion to Welfare Island and the Municipal Institutions will be given, with transportation and luncheon at the Island.

Conference and tea for prospective students will be arranged by the executives of the New York School of Social Work.

There are over fifty departments of hospital social service in New York and thirty in Philadelphia, where every variety of clinic and medical social work may be observed. Every facility will be afforded through information service in the Convention Headquarters in Atlantic City and at the Woman's City Club for the visits and conferences.
The Child Health Organization of America

At Lake Mohonk, New York, June 26 to July 1, 1922, a conference was held to discuss Health Education and the Preparation of Teachers. The Conference was called by the United States Bureau of Education and the Child Health Organization of America. Dr. C. E. A. Winslow, Professor of Public Health of the Yale University School of Medicine was chairman of the Program Committee, and Dr. Thomas D. Wood of Teachers College, Columbia University, and Vice-President of the Child Health Organization, directed the conference as chairman of sessions.

The children in our schools cannot be chosen. They must be taken as they are. The teacher, however, can be chosen. Her qualifications can be looked into. Therefore the qualifications of the teacher to teach health were the first consideration of the conference. The main headings under which they were grouped were the individual characteristics of the teacher herself and the special knowledge she should be equipped with.

In discussing the child or the object of health teaching the questions considered were: In what part of the curriculum should the child be taught health, what should he be taught, and how should he be taught it?

The results of the Conference may be epitomized in five questions and answers:

1. What sort of a person must the teacher who teaches health successfully be? She must be "health-minded" and so gloriously well herself that she fairly oozes health and happiness.

2. What must the teacher of health know? She should have a knowledge of the general principles of applied chemistry, applied biology, applied physiology, applied psychology, and applied bacteriology, and a course in health education in which the fundamental subject-matter taught should be derived from the following fields: Personal Hygiene, Nutrition, Social Hygiene, Mental Hygiene, Health and Care of Infants and Young Children, Health of Childhood and Adolescence, First Aid and Safety, Hygiene of the Worker, Home Nursing and Care of the Sick, School Hygiene, Physical Education and Principles of Health Education and Practice Teaching.
3. What should the child be taught about health? In kindergarten through the fourth grade primary emphasis should be laid upon habit formation; in the fifth and sixth grades the child should gain a conception of the functioning of the body as a whole, although the content of the course should still be correlated with health habits and practice; in the Junior and Senior High Schools, while continuing to fix the habits and broaden the knowledge of the boy or girl, problems arising from group activities offered in school, home and community should be stressed.

4. In what part of the curriculum should health be taught? It should permeate the whole curriculum.

5. How should the child be taught health? He should first be interested in health by concrete appeals to his imagination; when he begins to ask questions he should be given the scientific information necessary to answer them in a way that will appeal to his reason, and he must be given abundant opportunity to practice the health habits.

The Child Health Organization of America has recently issued three pamphlets. One contains two articles on the value of weighing and measuring school children by Doctors L. Emmet Holt and Thomas D. Wood. They refute two articles by C. K. Taylor in The Outlook of March 15 and May 10, 1922, which deny the value of and ridicule these objective tests. "Many Roads to Health" is a compilation of lessons and compositions selected from the written work of the Open-Air Class of Public School No. 158, New York. To these twenty-six underweight children the ideal of health was presented constantly, correlating this subject with the regular class-room work of the fifth and sixth grades. It suggests methods which might be copied in popularizing personal hygiene. "Miss Jenkins' Sketch Book" makes its special appeal to the individual child. Each page contains a picture for coloring with a rhyme about a fruit or vegetable. To stimulate initiative, a few pages are left blank on which the child is instructed to picture and describe fruits and vegetables he is familiar with, but which have not been presented.
ANNUAL MEETING OF THE CATHOLIC
HOSPITAL ASSOCIATION

The seventh annual meeting of the Association was held at the Catholic University, Washington, D. C., June 20th to 23rd. Rev. M. J. Curley, Archbishop of Baltimore, gave the conference sermon in which he urged devotion to the spiritual values in care of the sick. Father Moulinier, of Milwaukee, gave the leading paper of the opening session, in which he told how the correlation of the scientific and the spiritual aspects of hospital treatment of the sick may lead to higher community life. He spoke of the need for trained personnel in executive positions and of the rapid progress in all phases of the hospital field. Therefore, the advantage of a complete exhibit of supplies and equipment at hand is of equal interest to the meetings for discussion of problems. A symposium on hospital organization followed which considered scientific methods of the work, economy of organization and administrative affairs. All phases of modern hospital administration were reviewed during the sessions.

The conference on hospital service and dispensary workers advocated the establishment of cardiac clinics as organized by the Association for Prevention and Relief of Heart Disease of New York. Fees in dispensary service and lectures for nurses on the social work of the hospital were discussed.

A session on hospital social service was held with Miss Elizabeth Cosgrove, Director of Social Work in Mercy Hospital, Pittsburgh, chairman. There was a representative attendance of Sisters, public health nurses and interested individuals. After the opening remarks there was a free interchange of ideas and experiences. Miss Cosgrove gave a paper on this subject at the general sessions. She presented the value of good co-operation with outside relief and welfare agencies. It was brought out that something would be gained in service to the patient if the head nurses would notify the social service department of the expected departure of patients twenty-four hours in advance. There is urgent need of more psychiatric clinics in general hospitals. The social workers present at the session asked for more interest in their field from the hospitals in general.

A symposium was held on the mental side of hospital care with a paper by Dr. A. C. Gillis, Professor of Neurology and Psychiatry, University of Maryland School of Medicine. He gave a resume of
the advance in methods of care of the mental conditions of patients since the period of the early hospital. He asked for greater appreciation of this phase of therapy which now is far less interesting to the general staff than surgical and general medical treatment.

Miss Agnes O'Dea, Chief Dietitian of Johns Hopkins Hospital, reviewed the standard requirements of service in the hospital dietary.

Miss Lucy Minnigerode, Superintendent of Nurses of the United States Public Health Service, discussed professional ethics and recreation for nurses.

NEWS NOTES

COMING MEETINGS

September 5-8—League for Conservation of Public Health of California, Pasadena, California.

September 23-25—Protestant Hospital Association, Atlantic City, New Jersey.

September 25-28—American Hospital Association, Atlantic City, New Jersey.

September 25-28—American Occupational Therapy Association, Atlantic City, New Jersey.

September 25-28—Semi-Annual Meeting, American Association Hospital Social Workers.

October 12-14—American Child Hygiene Association, Washington, D. C.

October 16-18—American Dietetic Association, Washington, D. C.

October 16-19—American Public Health Association, Cleveland, Ohio.

CINCINNATI GENERAL HOSPITAL

The report of the Social Service Department of the Cincinnati General Hospital for the year 1921 contains a summary of practical service under the auspices of one worker, an assistant and a secretary. This is attained through co-operation with other agencies. The work is classified under several types. Co-operation with the Ohio Humane Society in social care of the unmarried mother and her child. The hospital social worker forwards the case history to the State Society.
The hospital takes care of the health issue. All obstetrical cases are visited as soon as admitted to the ward that prompt service may be ensured if there is a social need. The Neurologic Clinic is visited by a worker from the Associated Charities that follow-up care be given from her agency. Certain data relative to the admission of all patients is obtained by the hospital social worker. The Federal Board of Vocational Education has arranged with the department to refer such patients to them as need re-education and placement in occupation. The hospital social worker is included in the weekly conferences of the Pediatrics Department on cases which are ready for discharge. Home follow-up care is given the children by nurses of the Babies' Milk Fund, in co-operation with the hospital social service department. Certain social problems with deserted children have been carried by the hospital social service staff. Dr. Bachmeyer, Superintendent of the Hospital, advises that all foreign-born patients of less than five years' residence who were indigent, should be reported to the Immigration Bureau for special investigation. Other special services have been given by the visitors from the Juvenile Court, the visitor from the Catholic Charities and through volunteer aids. Through these avenues about fifty per cent of the patients who are treated at the hospital, representing an average of over 450 a day, were aided in some way by the social service department. As the staff of the department grows the scope of the work will naturally adopt other methods current in larger organizations. At present it represents a policy of good team work.

ANNUAL MEETING NATIONAL EDUCATION ASSOCIATION

Endorsement of the measures for an international education policy and of the Towner-Sterling bill which provides for national leadership in education, were the outstanding features of the annual meeting of the National Education Association. There was decided opposition to the latter measure in leading Boston papers and from municipal officials. The discussions from leading speakers at all the meetings were in its favor. Prof. Strayer, of the legislative committee, made an eloquent appeal for the bill and reviewed the history of New England, which had contributed to the policy it promotes.

The international policy of education was endorsed in discussions and through a resolution which favors the leadership of the educa-
tional profession in international relations. Forty-five nations have been invited to take part in a world conference on education to be held with the meeting of the National Education Association in 1923.

THE NEW YORK SCHOOL OF SOCIAL WORK

The following courses in preparation for hospital social work are announced for the coming year:

Physiology and Hygiene, Medical and Nursing Practice, Problems of Disease, Medical Social Problems, Mr. Michael Davis and Miss Antionette Cannon; Public Health, Social Casework, Community Organization, Human Behavior, Statistics and Research, Field Work, Electives in Industry, Child Welfare, Penology, and other subjects.

Four years of college work is a standard requirement for admission to the school. The entrance requirements may also be met by students with less than four years of college work but with a graduation from an approved school of nursing or other special training and experience.

Time. The course is designed to cover two academic years for students not entering with advance credit. Nearly half the working week is to be devoted to supervised practice, the remainder to lectures, discussion, reading, and written work.

Credit. Credit will be given for courses or for field work already completed which are judged by the head of the department to be the equivalent of courses or field work offered in this curriculum.

For further information send for the special bulletin. Address the Registrar, New York School of Social Work, 105 East Twenty-second Street, New York City.

The week of July 3-8 was given over to Baby Welfare interest in London. The special feature was the cause of child adoption in Great Britain. Until the present time, legal adoption of children was impossible, but the present conference was planned to modify the laws. Dr. Henry Dwight Chapin, of New York, gave an address before the conference on "An Alternative to the Institutional Rearing of Children."

The Commonwealth Fund will finance a child health program in three typical cities for a period of five years. The general qualifi-
cations of the first city is that it shall be from 15,000 to 25,000 in population, with an infant mortality of one hundred per thousand live births. The program will include prenatal care and child care from its earliest period. The American Child Hygiene Association and the Child Health Association of America will assume responsibility for the work. The first city will be selected from the upper half of the Mississippi Valley.

DEMOnSTRATION PEDIATRIC CLINIC

A demonstration pediatric clinic, equipped to present recently approved methods, is being organized by the Section on Pediatrics of the Associated Out-Patient Clinics of New York City. The new committee: Dr. Roger H. Dennett, chairman; Dr. W. P. St. Lawrence, vice-chairman; G. E. Sturges, M. D., executive secretary, are planning the location and this will be determined on the competitive basis. The competition will be open to all member institutions of the Associated Out-Patient Clinics.

Dr. Haven Emerson has been appointed full-time Professor of the Department of Public Health Administration at Columbia University of New York.

Miss Mary Beard, formerly Superintendent of the Instructive Visiting Nurse Association of Boston, has been persuaded to return to that position after a year abroad. The Baby Hygiene Association of Boston will be combined with the I. D. N. A. when she returns to duty on October 1st.

A new dispensary has been opened in connection with St. Francis' Hospital, Wichita, Kansas. It is non-sectarian and will furnish medical care and drugs free of charge. A social worker is in attendance.

A night clinic has been opened at the Reconstruction Hospital, New York, on Monday, Wednesday and Friday nights, from 7-9 o'clock. It is for service to disabled persons who are employed in the day-time, but who still require some after-care.
EDUCATION OF THE BLIND

An extension course for education of the blind will be given by the Graduate School of Education with co-operation of the Massachusetts Department of Education, Division of the Blind, and the Perkins' Institution of the Blind. It is designed to give a comprehensive survey of work with the blind and the semi-sighted. The course will consist of lectures, demonstrations and field practice. It is open to teachers, school nurses, public health nurses, social workers and volunteers. The first meeting will be held on October 6th, in Lawrence Hall, Cambridge, Massachusetts. Inquiries should be addressed to Professor H. W. Holmes, Dean of the Graduate School of Education, 5 Lawrence Hall, Cambridge, Massachusetts.

A meeting was recently called by the Associated Out-Patient Clinic, of New York, to consider the problems of eye clinic work. Ophthalmologists from all the member institutions were asked to join in formulating methods on professional standards, limited equipment, over-crowding, abuse of clinics by those able to pay, unfinished business such as failure in meeting the demands of prescriptions for glasses, non-uniformity of fees, record problems. A study was made by the Executive Committee of the points outlined in nine institutions in New York. Summary of the findings will be presented later.

The annual meeting of the California State Medical Association was held in the Yosemite Valley on May 15-18. Dr. Ray Lyman Wilbur, President-elect of the American Medical Association, gave an extemporaneous talk, in the general sessions, on hospital social service. Miss Marguerite Wales, Director of Social Service of the Stanford Clinics, of San Francisco, read a paper on policies of the work in her field.

Miss Louise Wenzel, formerly head worker of the Social Service Department of Barnes Hospital, St. Louis, has been added to the staff of the Committee on Dispensary Development of the United Hospital Fund of New York.

The Fifth Avenue Hospital, formerly the Hahnemann Hospital of New York, now occupies the new and modern quarters at Fifth Avenue and One Hundred and Fourth Street. The Laura Franklin Free Hospital for Children will be merged with the Fifth Avenue
Hospital. The new plant is organized on the plan of single rooms only for patients, irrespective of their ability to pay.

The United Neighborhood House has joined with the National Plant, Fruit and Flower Guild in creating a distributing center for flowers at the Grand Central Station, New York. Commuters and others may leave flowers for the sick patients who are known to the settlement houses of the city.

A Mental Hygiene Clinic has been established at Lebanon Hospital, New York. Ida Solar, R. N., is the medical social worker in charge.

Miss Mollie Sinclair, Executive Secretary of the Admission Office of Burke Foundation of New York, is assembling information on the convalescent homes of this country. The readers of the magazine who are familiar with the homes in their vicinity are hereby requested to send information as to the correct names and location of such homes that further inquiry may be addressed to their executives. The directory will be available to interested organizations when complete. It is hoped thereby to stimulate further convalescent activities. Address information to Burke Foundation, 325 East Fifty-seventh Street, New York.

Among the more recent applications of the Sturgis Research Fund of the Burke Foundation are: 1—Review of the foundation's seven years' experience in convalescence of lung abscess. 2—Study and report upon diets in institutional and group convalescence. 3—Appointment of Dr. E. T. Morrison, of New Rochelle, as visiting physician to carry on further investigations bearing upon the country recuperation of cardiacs. 4—Engagement of Miss Hortense Kahn, of Johns Hopkins University, to review (by special permission) the eighteen years' experience of Campbell Cottages, the New York Hospital country branch, at White Plains, with view to approximating some standards of child convalescence for American cities. 5—Aid in the support, for one year, of certain studies now being directed by Dr. May G. Wilson through the Research Cardiac Clinic of the New York Nursery and Childs' Hospital. 6—The establishment upon a surer basis of neuropsychiatric convalescence in New York, in cooperation with the various specializing clinics and sources.
BOOK REVIEWS

"Principles of Hospital Administration and the Training of Executives," W. C. Rapplye, Executive Secretary for the Committee, New York, 1922. The brevity of this report gives emphasis to a statement of the essential requirements of hospital administration and the training of executives, in the light of knowledge obtained through a study by the executive secretary of a representative committee. The committee includes medical men, hospital executives and educators whose qualifications comprise broad knowledge of the attributes of preventive medicine and, therefore, competent authority for the findings of the report. Its special characteristic lies in the fact that it correlates the chief function of the hospital of the past with the wider scope of the future policy as outlined in it. A large part of the conclusions are given to the responsibility of the hospital as an institution devoted to community health and preventive education.

The hospital as a public health center is presented with an emphasis which seems to minimize the treatment of acute disease. The clauses relating to the medical background of the hospital executive, are flexible while the public health and social requirements are stated in positive terms. This is in marked contrast to the findings of the Rockefeller Committee Report on Nursing Education, including public health, which insists upon the full period of training in care of the sick. Social medicine is hardly prepared to eliminate either etiology, pathological physiology or any phase of diagnostic work, especially when assuming critical educational work in preventive measures in close association with treatment of acute disease. The hospital is stated to be better fitted for community health work by reason of its intensive medical background than any other agency.

The responsibility of the hospital in community welfare has been introduced in positive form through occasional discussions previous to this report which now recognizes this phase in an authoritative appraisement which will result in discussion of the measures outlined by professional workers who have hitherto been indifferent or unaware of their importance. Naturally the acceptance of these measures will be modified according to individual resources and policies. It is certain that vigorous impetus will be given the field of social service in the hospital and all phases of out-patient work. Health as a positive and not a negative element in social welfare is
the crux of the policy, not only in this publication, but in proceedings of health and welfare agencies in every field. These interests are agreed with the conclusion of the report which endorses evolution attained through education rather than revolution. “Attempts to superimpose artificial programs and standards, to legislate rather than to educate are illogical.”

The conclusions on training of executives are similar in regard to the hospital as a community health and educational center to recommendations given during the last year by Dr. L. A. Baldwin, Superintendent of the University of Minnesota Hospital, and Dr. Winford Smith, Superintendent of Johns Hopkins Hospital. The subject matter of training in the report is classified under: Public health, social sciences, organization, hospital functions and history, business science, institutional management, personnel administration, community hospital needs, physical plan and jurisprudence. The significant elements of the summary are the absence of medical preparation as a requirement and the primary importance of public health. Among numerous surveys and studies this one is brief, clear and definite.

N. F. C.

“Handbook of Organization and Method in Hospital Social Service,” Margaret S. Brogden. The Norman Renmington Company, Baltimore, Maryland, 1922. The Social Service Department of Johns Hopkins Hospital represents the correlation of the best in social medicine and the welfare of the patients since the early work of Dr. Charles Emerson. The department is regarded, not only as an efficient local service, but as an authoritative source of advice and information by workers in this and allied fields, wherever medical social work is growing. The worker with acumen has confidence in the informant who has established her method. The majority of directors of such departments have assembled in loose leaf ledger form, their method of office and field work policy, for the convenience of the staff and to insure uniformity of system.

At least one well known supervisor has kept a record of her own history as a director and the lessons learned thereby, for the use of a possible successor. These policy books are shown with the bulletins, record and other material at the exhibits and annual meetings of hospital social service groups, where visitors may study the systems of co-workers.
Miss Brogden's book in its earlier form was shown at the Montreal meeting of the American Association of Hospital Social Workers with other similar Policy Books. As a result inquiries on her methods of organization increased. The printed volume is a practical and interesting addition to the limited bibliography on medical social work. It comprehends the complete routine of the Johns Hopkins Hospital Social Service Department. There are several pertinent quotations and comments from the writings of Dr. Richard Cabot and Miss Mary Richmond. The book is valuable, first because it presents methods which have been tried out thoroughly during Miss Brogden's ten years of experience, and also because these methods have won recognition and co-operation from the medical associates of Johns Hopkins University and from community social agencies.

The data on records and history writing is clear and compact and will meet a real need of the field worker, who has not yet established her own system to her entire satisfaction. Probably there is no more perplexing field than record work and, therefore, this series of forms which is now available for study, or for application in similar or modified form, will serve as an interesting example of correlation of the medical and social requirements for hospital care. Special attention is directed to the classification of the medical data in the record system of the Policy Book.

We are thankful to Miss Brogden for the quality and good print of the pages, and for the various bits of pertinent philosophy as to human relations which are so often an important ingredient of the working day.

N. F. C.

"Warfare In the Human Body," Morley Roberts. E. P. Dutton & Co., New York. 1921. The field of medical science has always been of interest to laymen as witnessed by Pasteur and Lavoiser and others who devoted their lives to research and analysis through scientific labors. Dr. Arthur Keith writes in his foreword of this author's book: "In these essays he has earned for himself the freedom of the City of Realities of Science." The series of essays are largely given to analysis of principles of inhibition and growth of tissues in the human body as compared to sociological life. Certain influences of each are described and their similarity noted in a scholarly and logical manner although the physical data is not supported by experimental evidence. It is said that the highest type of intellect is that
which discovers likenesses, while the second order is that which discloses differences.


The average new theory undergoes a period of criticism. However, in natural law decay leads to repair and the discovery of new method. Among the social elements reviewed is the phenomenon of tribal or social changes. The chaos of the past was a preliminary of civil life. The manifestations of zoological and political union are believed by the author to be biological. This is illustrated by a discussion of malignancy. Differences in environment which are due to marked social changes may lead to renewed health or to progressive disease according to their nature. Order depends upon control, and in society malignancy is the result of disorder. The biological theory of the organism is of a federation of organs and tissues living in interdependence yet on a basis of hostility if control becomes lax. Another essay considers repair in evolution. Many theories have influenced the community for a time but have lapsed as intense action created a crisis. A national calamity or other social shock results in new energies.

Morley cites a ship at sea as a social organism in constant action. The crew are united by duties and a routine mode of life. They also have a nucleus of enmity. The book is written in technical terms and it will appeal to the analyst, who will receive from it the zest and originality which are derived from looking at old facts in new ways.

N. F. C.

"A Mind That Found Itself," Clifford W. Beers. Longmans, Green & Co., New York, 1921. (Fifth edition). A widely read human document has recently gone through its fifth edition. Written in a popular way, it is, at the same time, good literature and contains the great fundamental principles of mental hygiene. It is the autobiography of a man impelled to attempt suicide because of delusions and further tells of his subsequent treatment in a small private, large semi-private and state hospital for the insane, and his gradual return to mental health. The period of depression followed by that of elation is clearly depicted with a description of the usual unintelligent and often brutal supervision given by doctors and attendants. Early,
in the recovery stage, he conceived the idea of using his experience toward bettering the condition of those suffering from mental ills or defects which culminated in writing this book of which William James said: "It reads like fiction, but it is not fiction." That it carried its message to thoughtful people may be judged from this statement by Jacob Riis: "In losing your reason you found, I hope, ours for us in this pitiful matter."

After giving us the story of his "least happy years," we are told of the constructive work which the author has since done in a supplement entitled "The Mental Hygiene Movement." During the first three years (1909-1912) the National Committee for Mental Hygiene devoted its attention to developing the growth of a better attitude toward mental illness and its problems and organizing the interest of psychiatrists, psychologists, social workers, and others who realized the importance of the work. In 1912 it entered the field of organized preventive medicine under the leadership of Dr. Thomas W. Salmon. The main divisions of the work are (1) original inquiries and surveys (which may later take the form of inspecting), (2) popular education concerning the care and treatment of the insane and preventable causes of mental disease and deficiency, and (3) the organizing and advising of agencies for promoting the objects for which the committee labors.

Publicity has been promoted through carefully prepared exhibits, surveys over a large part of the country and demonstration psychiatric clinics. During the war, the work of the neuro-psychiatric units proved of unquestionable value, a feature planned largely by Dr. Salmon. The dignified, sound way in which support was secured may be summed up by first awakening the interest of a group of leading people, largely of the professional class, who circularize, through letters and copies of the book, people of wealth who might be glad to help finance such an undertaking.

We are told that in New York in 1919, one death in twenty-two in the whole adult population occurred in hospitals for the insane. At the end of 1919, thirty-six per cent of all hospital patients cared for as beneficiaries of the Veterans' Bureau were mental or nervous cases. Greater institutional care is needed for the mental defectives as less than 50,000 are provided for institutionally out of an estimated 300,000. About 500,000 delinquents going through our courts annually are really mental cases.
All social workers will find much to interest them in this very readable story, particularly if they are not well acquainted with the field of mental hygiene. The second part contains valuable suggestions for the development of an organization and illustrates a novel variation in the form of recording its history. A comprehensive bibliography and directory of mental hygiene agencies form useful appendices.

J. L. B.

**ABSTRACTS**

"The Family in China," F. H. McLean. *Family*, 1922, III, 78. Dr. Louise Morrow, formerly director of social work in the University of California Hospital, is giving a year to study of the Chinese language and people in order that she may be fitted to train Chinese workers for family welfare work. The students are mostly university graduates and, therefore, are qualified to assist Dr. Morrow in developing and adapting methods of this type of work to the Chinese. The American Association for Organizing Family Work is acting in an advisory capacity as far as the great distance between the two interests permits. In return the experiment provides much useful data for American workers by bringing to their attention lessons of family responsibility which are demonstrated by the Chinese character. Much useful knowledge of legal, historical and philosophical characteristics has been secured by means of the study of the "Chinese Family System" by Dr. Sing Ging Su. The family life of the Chinese represents marked solidarity which is in a measure repressive of the individual nature. It will seem to such people the most natural thing to consult relatives as to the solution of a family problem. For instance, homes for old people are unknown in China. This experiment will prove a valuable one by contrast of methods and conditions in the two countries.

"Report on An Investigation of the Department of Hospitals and Dispensaries of the City of Buffalo, N. Y.," Haven Emerson, M. D. 1922. As charges of inefficiency were brought against the Department of Hospitals and Dispensaries of Buffalo, last year, a committee of citizens secured Dr. Haven Emerson to make a study. It resulted in the almost complete vindication of the department. The data is in pamphlet form for distribution. It defines hospital standards for
community service; management; correlation of public and private agencies; diagnostic facilities for physicians; and comments on local agencies which are directly connected with the hospitals. Emerson recommends certain adjustments which will increase the hospital service where the need has been made apparent by the study. There is deficiency in contagious service; slight shortage of hospital bed care for both medical and surgical cases; the convalescent care of hospital cases is almost unknown. Prophylactic dental treatment is seldom found in dispensaries. Infant welfare work in Buffalo is below the standard. Arrangements were made with the City Bureau of Public Welfare that social workers be secured to determine the economic status of patients except when they come from well known agencies. District nurses link up with this form of social service which is sometimes given by them. The social worker visits patients upon arrival that special needs be referred to the right agency. A Visiting Nurse visits the patients upon their dismissal to ascertain their required follow-up care. Thus it is seen that co-operation between these community agencies is thorough. The report advises that a standardized system of relations of such nurses with medical men be determined. In the infant welfare work better nursing records are desirable. A further recommendation is made that a medical advisory board be formed to act with the District Nursing Association. Medical education in affiliation with hospitals is well organized in Buffalo. On the fundamental elements of hospital and dispensary service in Buffalo the findings of the report present a most satisfactory history. The minor but very utilitarian lacking services as outlined are likely to be available soon where the larger institutions are well established. This report is interesting as one which presents well a sound system of community care of the sick. A point of interest is the operation of the health centers as branch dispensaries in modified form. They provide treatment, including bed care, for certain cases. The plan is practical and unique. The hospitals are competent but not over elaborate.

"Training in Sociology and Public Health an Essential in Medical Education," S. W. Welch, Jour. Amer. Med. Ass'n, 1922, LXXIX, 342. The author finds after a review of medical education during the past twenty-five years that there has been no definite advance because the remarkable knowledge of preventive medicine which has been achieved during that time was not available to the physician in
his preparatory period. The vital facts of natural law which control the transmission and prevention of disease, with scientific methods of using this knowledge will be made a part of medical education. Much of this new knowledge is still in elementary and unstandardized form. The competent use of nutritional facts which are essential for maintenance of a sound physique, of community shelter and all phases of environment which pertain to health are as fundamental as the treatment of acute disease. The author outlines five essentials of preventive medical education, as follows: Comprehension of human nature in its social aspect; sanitation; communicable disease and bacteriology; hygiene in its relation to social and medical sciences; psychology in relation to behavior of individuals and groups. The Council on Medical Education and Hospitals advises that the last two years of undergraduate medical study be given to four majors: medicine, surgery, obstetrics and public health.

"Mutual Interest of the Profession and the Public," W. S. Rankin. Jour. Amer. Med. Ass'n, 1922, LXXIX, 281. Among the interests which draw the profession and the lay public together is the common care of preventable disease. It is a serious menace and source of loss in the community. Thirty per cent of the maternity cases are unattended by physicians in this country annually. The children in such families represent a large number of those who have inadequate medical care. At the age of adolescence another phase of susceptibility to disease is found. The number without competent attention in the field of venereal disease is estimated to be several times greater than those who are under care. The Life Extension Institute of New York found that of sixty per cent of the people examined who needed medical care through its service, only twenty per cent were getting it. These few facts merely suggest the possibilities of preventive education and adequate medical attention. The available resources of medical science may broaden their function to distribute much more printed matter and to promote more popular addresses. The local doctor makes his calls in a spirit that is akin to that of the pastor. He is the primary educator. Rankin appeals to the county medical societies to face the community health deficit and to organize clinics wherever they will meet a community educational and remedial need. The clinic will in time introduce the need for a local hospital. "Public organization to care for disease will follow and never precede professional organization."
"Alcohol and Syphilis as Causes of Mental Disease Under Prohibition," G. H. Kirby. *Scientific Temperance Jour.*, 1921, XXX, 193. The author has reviewed the data obtained from Bellevue Hospital and Long Island College Hospitals and has drawn the following conclusions. Alcoholism has declined perceptibly in the general population during recent years, the beginning of the decline antedated by some years the restrictions due to war and the passage of the federal prohibition amendment. Coincident with this decline there has occurred a remarkable fall in the number of alcoholic psychoses, the lowest figure on record having been reached in 1920. During the first period of the World War there was noticeable recrudescence in both alcoholism and alcoholic mental disturbances, but after the United States entered the war in 1917 there was a sharp fall which so far as alcoholic psychoses are concerned has not again been interrupted. From the standpoint of mental hygiene the situation may be regarded as encouraging. A noticeable advance has been made in the direction of controlling one of the outstanding causes of mental disease, viz, alcoholism and as regards a second great cause, viz, syphilis. There are indications that education, prophylaxis, and improved methods of treatment are beginning to yield some results, as yet slight, but nevertheless sufficient to be considered a sign of progress.

"Economic Levels and Tuberculosis Groupings," W. C. White. *Nation's Health*, 1922, IV, 428. The author reviews briefly some points of the medical aspect of tuberculosis as an introduction to the social groupings. Variations in race susceptibility have been demonstrated through studies with animals which show the characteristics of the Irish, Italian and Jewish strains of each. They in turn vary in rural and urban life. Recent laboratory demonstrations have given evidence for the theory that one bacillus may produce old age tuberculosis and another young adult tuberculosis similar in variance to the typhoid and paratyphoid organisms. Another recent theory is that the tubercle bacillus belongs to the animal and not the plant group which changes the character of preventive work. The social work of the past twenty-five years has been on the basis of nations, states, counties, cities as available divisions. Lack of correlation of the work has followed this plan. The industrial group is a more consistent basis of treatment. At least one-third of the day of the average person is spent in industry. His health is a factor in indus-
trial economy, therefore, we advise periodic examination. The Mobile Dispensary Unit makes industrial examinations easier than the former plan of sending patients to the local dispensary. Large numbers of tuberculosis patients need never give up their labor if they are examined in time for the detection of the incipient condition. The social readjustment which makes for a tranquil environment is an important part of the care of the employees. Experience in industry has proved that by intelligent medical social service supervision of the two-thirds period outside the working hours many patients may remain at work.

"Health Service for Garment Workers," Theresa Wolfson. Hospital Management, 1922, XIII, 70. Initiative in health questions was taken by the members of the International Ladies Garment Workers' Union—and a splendid modern health center known as the Union Health Center, owned and patronized by the workers, is the result. Resulting from the strike about twelve years ago the Joint Board of Sanitary Control, composed of representatives of the employers, the workers and the public was established, to set standards of shop sanitation and secure and retain co-operation of the employers and workers in attaining them. Under the direction of Dr. George M. Price, the board was able to effect a great change in the sanitary conditions but he soon recognized that the original field would have to be supplemented by curative work and a medical clinic was started to which the workers could go for physical examination and treatment. A dental clinic was also started. The International Ladies Garment Workers' Union realized that their members exclusively were benefiting by the curative work done and they decided to enlarge the scope and established their own Health Center in 1920. The Union Health Center has both a curative and preventive function among the workers of the ladies garment industry. The patients attending the medical clinic are drawn from a closed membership—that is the clinics are open only to members of the International Ladies Garment Workers' Union and the members of their immediate family. These are men and women who do not care to go to a free dispensary and who cannot afford the high fees of specialists. Furthermore, the memberships come pretty much from one or two ethnic groups, largely Jewish and Italian, this obviates the problem of the ordinary clinic pertaining to differences in racial psychology and languages, factors in some ways a great advantage in carrying on the health work. The general medical clinic is held every day from 11
a.m. to 2 p.m. during lunch hour when workers in the neighboring
district can be examined. Three physicians and a surgeon are on
duty, the latter handling minor surgical cases. The patient enters
the clinic, presents his union card, has a short social history taken,
and is then sent in to see the physician. If something requires the
attention of a specialist, he is referred to that clinic and an appoint-
ment made. The eye clinic is held twice a week in the evening, an
optician is in attendance so that glasses are secured at cost price.
Because of the nature of their work and the constant glare of electric
light in the shop, workers suffer to a very large extent from astig-
matism and eye-strain. An important part of the specialist's work is
to educate the patient on the care of the eyes. Other special clinics
which are held during the evening sessions are: heart, gastro-
intestinal, nerves, skin, diseases of women, pediatric, orthopedic, and
X-ray. The medical service aims to be self-paying so that every
patient secures for the minimum fee of $1, the treatment of a special-
ist for whose services he would ordinarily pay from $3 to $15.
During the year 1921 there were over 15,000 examinations made in
the medical clinic. Every worker desirous of becoming a member of
the International Ladies Garment Workers' Union because of sick
benefits must first pass a physical examination. The various locals
of the Union pay for this examination and thus assure themselves
of a comparatively healthy membership. In the last year the Union
Health Center has examined 5,113 applicants. Applicants suffering
from tuberculosis are not given the health card entitling them to the
Union card, but, if the case is an incipient one, a temporary card is
given and the patient is asked to come back for periodic examinations.
An advanced case is referred, of course, to other agencies for treat-
ment and care. When a member of the Union is found suffering
from tuberculosis he is examined by the lung specialist at the Union
Health Center; his local is informed of the result and the patient is
sent away or placed under the care of the Health Center physician as
the situation demands, and the Union pays him a tuberculosis benefit.
A most interesting form of the preventive work is the life extension
examination, consisting of a thorough physical examination; given
for the minimum fee of five dollars which entitles the patient to addi-
tional re-examinations within stated periods during the year. The
dental clinics of the Health Center are exceedingly well equipped,
with a chief dentist in charge, a dental assistant, and six dentists in
attendance during clinic hours. The dental work is paid for accord-
Abstracts

ing to the amount to be done. As yet the clinic has not been able to charge much less than the average rates for it is the desire of the Health Center to become completely self-paying after the initial expenses of the building are deducted. Approximately 2,612 patients were treated in the dental clinic during the year 1921. In prevention, the use of leaflets, charts and pictures have shown results; but most valuable of all has been a health study class held once a week under the supervision of one of the physicians connected with the Health Center, and a weekly public health lecture, usually illustrated by moving pictures or lantern slides. It will be of interest to the public to know some of the lectures which have been most popular with the workers: "Cancer; Its Cause and Cure," illustrated by moving pictures. "Errors of Jewish Diet;" "Psycho-analysis;" "The Human Spine and Its Diseases." This sort of health education in addition to the articles on health written in the Union papers, the health talks given in the shops and also at the Union meetings, results in an intensive health propaganda among the workers of the industry. There is no doubt that the Union Health Center will grow; it is already overcrowded and is compelled to spread out in order to house electric baking, massage and other appliances for the treatment of rheumatism, flat feet and other forms of orthopedic cases. In New York City alone the International Ladies Garment Workers' Union has a membership of 90,000 so that the Union Health Center can still grow to become the health department for this large membership.

"Syphilis as an Economic Factor in Industry," J. M. Quirk. Internat. Jour. of Surgery, 1922, XXXV, 175. The author gives a general discussion of the history and prevalence of syphilis. It attacks every organ of the body and simulates every disease. Its lesions are often insidious and patients, therefore, report for all kinds of injuries which are traced by the medical men to syphilis. In its late manifestations it comprises a grave economic charge in industrial care of health. Diseased bone in some slight injury may snap during employment and further involvement results. If the syphilitic dies from a slight injury the industry meets the loss in a measure. Other examples are cited. A neuro-syphilitic loses muscular co-ordination or mental concentration, an accident occurs and industry suffers. The need of the problem is plainly one for education and treatment. Health talks to employees will do much more for education than pamphlets which may be discarded unread. The author recommends in addition, prophylaxis and prophylactic education.
EMPLOYMENT BUREAU

In order to be of greater service to our readers, Hospital Social Service will conduct an employment bureau for Hospital Social Workers. Until further notice, a list of positions open will be carried free. Copy should be received at the Editorial Office by the tenth of the month. In answering keyed advertisements, please mail replies separately to Editorial Office in New York. In replying, give professional training, salary requirements, previous positions held and three or more references. Position wanted announcements will also be carried. The charge will be $2.00 per insertion. Copy should reach the New York Office by the tenth of the month.

POSITION OPEN—The position of social service worker is vacant at Alameda County Hospital, San Leandro, California. The position requires a worker with competent medical social training. Salary $125—maintenance if desired. Apply to: Dr. R. G. Broderick, Almeda County Hospital, San Leandro, California.
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