

Hospital Social Service

PUBLISHED MONTHLY BY THE
HOSPITAL SOCIAL SERVICE ASSOCIATION OF NEW YORK CITY
INCORPORATED
200 MADISON AVENUE, NEW YORK, N. Y.

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SUBSCRIPTION PRICE

Domestic \$2.00 Canadian \$2.50 Foreign \$4.00 Single Copies, 35 cents

Advertising Rates may be had on application

HOSPITAL SOCIAL SERVICE

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AFTER-CARE IN TUBERCULOSIS—THE PHYSICIAN'S RESPONSIBILITY*

RALPH C. MATSON, M.D.

Portland, Ore.

Probably no tuberculosis problem is more complex than that of "after-care" which is the weak link in the chain of continuity of our sanatorium idea of carrying on treatment after discharge.

Efficient schemes have been made for early diagnosis, and tremendous strides have been made in treatment, offering even the advanced consumptive, since the perfection of methods of collapse therapy, new hope for recovery, so that the prognosis of tuberculosis is infinitely better now than even fifteen years ago. Yet we are not experiencing the real value of sanatorium care, and much unfair criticism has been directed toward it because the results of institutional treatment appear transitory except for those who remain until clinically well. However, this reflection upon sanatorium care is due largely to the absence of a definite system of responsibility for the care of the patient after discharge from the sanatorium and therefore much of the wonderfully creditable institutional work is quickly undone soon after the patient's discharge. The solitary reflection upon the tuberculosis movement is that a workable scheme for "after-care" still awaits development.

Statistics tell us that 50 per cent. of deaths after discharge from the sanatorium are due to relapses occurring in the first eighteen months after discharge and 50 per cent. of the disabling relapses occur in these first eighteen months.

Weisner¹ concludes from her statistical studies that the time of greatest hazard is the first five years following discharge from the sanatorium. She found 37 per cent. of discharged patients dead in the first year; 41 per cent. dead in the second year; 41 per cent. dead at

* Read before the 24th Annual Meeting of the National Tuberculosis Association, Portland, Ore., 1928.

the end of the third year, and 42 per cent. dead at the end of the fourth year. However, her figures show clearly that the first year is the most hazardous.

Why should not taxpayers raise the question as to the value of sanatorium or hospital care when the results of institutional treatment appear so temporary? The apparent failure of institutional treatment is due to two factors. First, the misconception the public and even some members of the profession have regarding the rôle of sanatorium or hospital care. Unfortunately, there is a general impression that a short sojourn of a few months at a sanatorium or tuberculosis hospital is sufficient to arrest a disease like pulmonary tuberculosis and that upon returning home, the patient, feeling and looking well, can at once resume his old occupation; and the patient often assumes he can resume his bad habits and ways of living, with the result that in a short time he again shows signs of advancing disease,—an advance which is invariably more rapid than the original one and frequently leads to a fatal issue. The second factor is the difficulty of the patient's adjustment from the sanatorium to outside living and working conditions.

The question of responsibility for after-care is a very complex one; and while it may be shifted from one agency to another, the physician cannot escape his obligation to follow up the program he has outlined. Of what lasting value, for instance, is pneumothorax, thoracoplasty and other collapse procedures, and heliotherapy if the patient is cast adrift upon his own resources after discharge from institutional care.

Every sanatorium physician is familiar with the example of a patient entering an institution and being placed at bed rest; later given graduated exercise, and after months of effort when the disease becomes quiescent or arrested (possibly with a pneumothorax or after some surgical procedure has been performed) he is forced to leave perhaps earlier than desired because he is the breadwinner. While under treatment, the patient has become dependent upon his attending physician for advice and encouragement. Upon his return home, he finds an environment quite different from his sanatorium routine; he feels like a drifting ship without an anchor. Leaving the well regulated, well directed, restful, open air life of the sanatorium, he goes home looking ruddy and robust and to his family and friends appears perfectly able to work. Sometimes, he is even accused of being lazy and of having no ambition.

The patient, himself, after months of bed rest and hour after hour in the reclining chair with carefully regulated exercises, develops an anxiety complex lest some overact may activate a latent lesion which will put him back where he was. This frame of mind makes it more difficult for him to adjust himself to markedly altered conditions.

At times, he returns to his wife and family who frequently harbor the fear of infection, and often he is the source of infection amongst badly nourished children. He is moreover frequently not employed, and not infrequently non-employable, which, in any event, means one more to feed, throwing an additional burden upon a struggling family,—all of which reacts unfavorably upon the patient.

It is therefore not an easy matter for the patient, emerging from a well regulated environment, to adjust himself psychically and physically to the new problems of home environment which may not only make social demands but industrial ones as well. The very consideration of these problems provokes worry and anxiety and makes it more difficult than ever for the patient to recover and too often they are responsible for his return to the sanatorium.

It is not surprising then that the time of greatest hazard for the discharged sanatorium patient is the first year. This important aspect of the tuberculosis problem may be summed up in "after-care" and the solution of it is an adequate system of follow-up which would undoubtedly increase the permanent successes fully 50 per cent.

The problem of the patient's rehabilitation is one of medicine, economics, sociology and psychology, in which there are three factors which influence the patient's chances for recovery upon return home. First, the patient himself, his mental and physical adjustment; second, medical supervision; third, employment.

Before the patient is discharged to his home, the physician should ascertain the existing environmental conditions, including condition of health of the patient's family and his economic resources. The physician should also learn the family's attitude toward the patient's proposed return.

The patient leaving the sanatorium has learned the meaning of the word "rest" and its importance. He has learned the value of a carefully regulated life. He no longer feels comfortable in a badly ventilated house. These facts should be explained to the patient's family.

The attending physician can accomplish much by his parting advice to the patient and by psychically preparing him for the situation

he will face upon return home. The physician must carefully outline every phase and every angle of home treatment. The physician should put the patient in the most favorable mental attitude for home care. I regard it as highly essential in preparing the patient's mind to give him an optimistic outlook and warning against the advice of well-meaning friends who plead climate, faith cures and quack nostrums. In numerous instances, I have seen all the good work of institutional care, including collapse therapy, quickly undone by a vicious quack nostrum exploited here in Portland under the name Pul-Bro-Tu.

The patient must be given detailed instructions regarding his exercise and work capacity. Full instructions must also be given regarding protection of other members of the family. The physician must also interest himself in the business and financial worries of the patient,—at times, even domestic ones.

The patient should be inspired to continue the fight and maintain at whatever personal cost a constant vigilance against any circumstance or habit which would act deleteriously on the progress of his convalescence. The physician must make the patient clearly understand the patient's personal responsibility and that sacrifice and self-discipline and careful attention to his hygienic life are necessary if he hopes to acquire sound lungs in a sound body.

The patient must have full understanding of his condition, but at the same time, gloomy introspection and self-analysis must be prevented.

For two years after arrestment the patient should live and work to make permanent the gains accomplished. During these two years he should be under the direction of a physician with training in the treatment and management of tuberculosis or a tuberculosis clinic.

The character of the follow-up of discharged sanatorium or hospital cases depends of course upon the type of case. Cases discharged as arrested or quiescent should have special medical supervision. With proper follow-up, probably half the relapses can be prevented. Cases which are progressive and may be definitely classified as incurable after prolonged observation, should have medical supervision and examination at intervals, but most of the follow-up work can be carried out by public health nurses. Should serious complications occur requiring constant nursing or emergency medical care, the patient should be persuaded to re-enter a sanatorium as the association

and over-strain of caring for such a patient may break down the resistance of other members of the family.

Patients temperamentally unsuited for sanatorium care should have careful medical supervision, and in many instances, after a short sojourn at home, the doctor, by exercising patience and tact, can persuade the patient to re-enter the sanatorium. Patients who are not amenable to sanatorium discipline and who are sources of disturbance to the morale of other patients as well as wanderers and discontents, lacking in definition and positiveness, may yield to a hard-boiled attitude on the part of the doctor in follow-up and be persuaded to re-enter sanatorium. But institutional care in these types of cases is of little value to either the patient or community. In the case of psychoneurotics too rigid a follow-up on the part of a doctor is undesirable.

One of the essentials of institutional care is to instruct and train the patient in the conduct of his future life so that after discharge he may continue his own treatment with understanding.

The patient must be made to understand his condition. At the same time, care should be taken that he does not become morbidly introspective. For this education and training the physician is responsible.

Undoubtedly, a very great factor in preventing relapses after discharge from the sanatorium is sympathetic guidance of the sanatorium or dispensary physician, either direct or through the family physician.

After consideration of numerous schemes for education of the patient and for purpose of maintaining close contact after discharge from the sanatorium, we adopted a clinical chart at the Portland Open Air Sanatorium which the patient is instructed to keep up at once upon admission. The chart is a monthly one, spaced for each day's record, and provides for graphically recording the pulse and temperature four times a day. Provision is made for recording the sputum quantity in twenty-four hours, measured in cubic centimeters, and its germ content. There is also, as part of each day's record, space for time in bed, time sitting up, time walking, time in the open air, hours of work, amount of extra nourishment, weight, bowel movements, and liberal space for daily notes. On the reverse side, provisions are made for exercise orders and the results of physical examination.

The records, instead of being kept in a chart room, are placed at the patient's bedside. Patients are carefully instructed in the method

of taking and graphically recording their temperature and pulse, as well as recording other data of importance. Thus every patient becomes quickly impressed with the value of rest and the necessity of strict discipline because any overact is shown on the chart.

We know of no better way to secure the patient's confidence and maintain his coöperation as well as prepare him for meeting the many problems of conduct upon return home than to entrust him with his own clinical chart. It is our experience that patients make a greater effort to secure good records if entrusted with their charts, and certainly they are prepared to carry on self-treatment at home more intelligently.

Upon discharge from the sanatorium, every patient is given a record upon which are written his orders for the following month. The patient, at the end of the month, presents himself with the record to the physician or to the dispensary, or, in case he is unable to come, the chart is mailed or brought in by some member of the family. The record is studied and criticised and a new one given with instructions written for the next month, and so on. This procedure is followed until the patient is classified as apparently well.

Admittedly, the method involves a great deal of work on the part of the physician. However, the results, we feel, fully justify the effort.

Objection to the plan may be made because of the belief that many patients are temperamentally unsuited to know so much about themselves and that patients doing badly react unfavorably with a record before them that all is not going to their advantage. According to our experience in the past fifteen years in the Portland Open Air Sanatorium, during which time 4,216 patients have been admitted, I can recall very few instances where permitting the patient to keep up his record and have full information regarding his case has had an unfavorable influence. On the contrary, we do experience splendid coöperation from the patient. Even patients doing badly make a greater effort to follow instructions and coöperate.

Obviously, the critically ill do not keep up their records, this being done by the nurse, or, upon return home, by a member of the family. It is striking, however, to note how quickly patients realize the unfavorable result of some indiscretion when everything is recorded.

The physician is responsible then, we feel, for intimate personal supervision of the patient until he is clinically well and then for such contact with the patient as the individual case appears to demand.

It is the physician who must assume responsibility for the patient's post-sanatorium guidance. Other agencies may secure employment, provide extra nourishment and other assistance, but the physician must decide upon the character of the work and prescribe the hours to be spent therein.

Constant education of course is required until the public realizes that our present anti-tuberculosis work rests upon a sound basis. Physicians must be educated to realize that post-sanatorium care is just as important as sanatorium care and that unless the after-care is carried out as painstakingly as the institutional care, sanatorium successes will not be as great as they should be. The community must be educated to realize that they can capitalize the investment which has been made in the patient only by providing adequate medical and nursing care during the period of post-sanatorium adjustment.

The community must also realize that the tuberculous patient is physically handicapped and that sheltered employment must be provided for him until his industrial readjustment takes place. Post-sanatorium follow-up work is admittedly shamefully deficient. Aside from the need of a system for responsibility of after-care, no program of after-care is complete, to repeat again, without provisions for sheltered employment until the patient is fully equipped to re-enter the industrial world without a handicap or without requiring preferential treatment.

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THE RELATIONSHIP OF THE DIETARY DEPARTMENT TO THE SOCIAL SERVICE DEPARTMENT IN THE HOSPITAL

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We are told that were it not for organization neither the United States Steel Corporation nor the Roman Catholic Church would be what it is nor where it is to-day. Organization in relation to Medical Work is a fairly new expression. It does not yet sound quite ethical to some ears. Even in allotting this subject the word was omitted. It reads "in the Hospital," not "in the Organization of the Hospital."

Any group of people in an organization strengthens that organization as they realize and appreciate the relationship of each one to the others. In other words one must become very familiar with his family tree and it will prove valuable to have a copy hung over the desk just to remind one how small his branch is in relation to the whole tree, yet how important it is in shaping it.

Dietary and Social Service Departments are related to each other through their relationship to the whole family tree; there can be no independent relationship.

A patient comes to the hospital for treatment. First there must be a diagnosis which may be accomplished only by many departments contributing their knowledge of conditions which furnish the symptoms and facts from which the diagnosis is made. Both the Dietary and Social Service Departments are branches of the tree called organization and they are dependent on the other departments or clinics, as they too must have all the symptoms and facts as well as the diagnosis.

Furthermore these two departments are small branches of the great tree of treatment for health, and when it comes to treatment at the present time they furnish the major part outside of surgery.

Because of this last fact the relationship of these two departments

must be well understood so that there may be perfect functioning. The Dietary Clinic is the wholesale food fact center while the Social Service Department is the retail end of the therapy.

Where does the Dietary Department get its stock? Some fifteen years ago the major part of the stock in trade was Home Economics, a knowledge of menu making and good cooking at reasonable costs. Then the stock increased and Calories became important, followed soon after by vitamins. Since then food facts have multiplied very rapidly and stock, or scientific information, concerning nutrition and food chemistry has advanced in leaps and bounds. The Dietitian who is in charge of this Department must be sure she has obtained the best stock in trade or facts from the various sources. She must be so scientifically educated that she knows where to go to get the best and how to present this best so that it will be available to the Social Service Department which retails the facts. How is this stock passed on from the wholesale department of Dietetics to the retail department of Social Service to be used in direct application for treatment? A prescription slip should be given to the Social Service Department whenever a patient is referred to it. This slip should contain the name of the patient, his location in the hospital or his home address if the case is an ambulatory one, also his age, nationality, and occupation. The diagnosis, full information as to dietary treatment, *and why* should be included. It may seem a little unprofessional to add the why as we have learned many times that orders are orders but it's the why that indicates relationship. It promotes understanding. It saves many mistakes. These prescription slips should be made in triplicate form, one to be filed in each of the Departments and one for the patient.

If the Social Service Department has a report blank to fill in after the first interview and again as the case progresses, this to be sent to the Dietary Department, it will help in promoting a mutual understanding and result in more satisfactory work.

It might be a help if a small reference book were available for the Social Service Worker, this book to cover food values, some technical knowledge of the chemical changes of foods, and the application of food as treatment. What does the Dietary Department do to promote business relations with the Social Service Department?

Dr. Walter H. Eddy in his new book on "Nutrition" states that "we suffer quite as much to-day from dogmatic statements of food faddists as from lack of scientific data." The Dietary Department's

duty is to weed out the dogmatic statements about food and to present to its colleagues information from the most accurate authorities among chemists and biologists. Therefore the dietitian must keep in touch with the laboratory experts not only for her own sake but for the help she may pass on to the members of the Social Service Department to whom she is closely related. This information should be given to the Social Service Department at regular conferences and it should also be handed out on any occasion which offers, to keep a close understanding between the departments which will promote service.

Does the Social Service Department always patronize the products from its own wholesaler? The only way to develop and improve the work of the Dietary and Social Service Departments in the hospital is by maintaining a close relationship and coöperation. This will give an opportunity to know each other well.

Eating has been considered a social function, but when its direction emanates from a doctor's prescription, it is dietotherapy. There should then be but one source from which the treatment comes, that is, from the physician in charge. His prescription, with the treatment specified, should be passed on to the Dietary Department which in turn should translate it into meals and refer it to the Social Service Department. No fads nor fancies from any other source should be added or subtracted as it is only a detriment to the patient and is not conducive to a helpful relationship. This then is the time to "separate fact from finery and avoid dogmatism" as Dr. Eddy warns us to do.

To promote the best relationship all round, the responsibility for the treatment of cases must be left in the hands of the physicians, and we two little branches must remember that we are to add only helpfulness in carrying out his plan of treatment and save our hobbies to try out on ourselves.

What will be the results in promoting repair or health for patients if there is a close relationship between each other and with the parent organization? If we function smoothly we may some day be considered *Clinics* instead of *Departments*. Both departments are old enough now to change their names. It seems strange that a Dietary Department in an Out Patient Department becomes a Food Clinic. If the definition of the word "clinic" is "bedside teaching" isn't the work *in* the hospital more liable to be bedside teaching? This is just food for thought. What's in a name?

There will also follow a more extended knowledge of the results of dietotherapy. When we report back we are really bringing to-

gether information which shows what certain treatment brings about. In time this will add considerably to our store of knowledge.

There can be no set rules in treatment so long as metabolism differs so much in human beings. It is still true to some extent "what is one man's meat may be another man's poison."

The next result is the confidence produced in the patient. If we swear *by* each other it gives confidence to the patient which in turn helps in applying treatment.

If it is true, and we must believe that it is, that today drugs are being less and less used, whereas food and psychology are being increasingly used, we have an opportunity for service that should inspire us to walk hand in hand for the good of the public. If health is a great asset and we have the power to help produce it can we have a greater goal?

Shall we sit down and commune together as the breezes blow our little branches, a part of the great tree?

THE VALUE OF HEALTHY FEET

HELEN KING

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A young woman was sent to my office one day for corrective exercises for posture and feet. She complained of pain in her feet and a general tiredness. Her feet were painful on pressure and also swollen. She had a painful back and felt irritable and discouraged. As she talked to me her whole posture was relaxed and she shifted her weight from one foot to the other.

This girl is only one in hundreds in the same condition. Why should intelligent women sacrifice their health for extreme styles and ill fitting shoes. The Chinese women whose feet were bound and deformed were no more ignorant than the women of today who deliberately wear too narrow and too short shoes into which their feet are forced with no chance for normal use and support.

Most of us start out in life with a good pair of feet and for the sake of those who do not know the mechanics of the foot, I will state briefly.

A normal foot is made up of two arches, the longitudinal or long arch extending from the big toe to the heel and the short arch or ball of the foot. The long arch is high and flexible and gives the spring and flexibility in walking. The short arch supports the body weight, actively and passively and gives to the foot the final spring in walking. An important factor in maintaining the flexibility and strength of this arch is the ability to spread and flex the toes. During walking the foot serves as a lever, the distal heads of the toes form the fulcrum and the calf muscles supply the power. The postures assumed are briefly these,—The long axis of the foot is approximately parallel to the direction of the locomotion, the weight is borne momentarily on the heel, then upon the outer border of the foot, lightly upon the ball and finishing on the toes, as the heel is raised.

Thus bearing in mind the mechanics of the foot, can you imag-

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ine the foot performing its functions freely and normally in some of the shoes that are commonly worn. The elevation of the heel throws the center of gravity forward so that a greater part of the weight of the body must be supported by the front or ball of the foot than it is designed or intended to bear. This means strain throughout the foot. Added to this is the strain caused by the distortion of the outer border of the foot by the curved shanks of the shoes. The bearing surface of the heel is small as a rule and the support or balance is unstable. The narrow pointed toe of the shoe so constricts the foot that there is little chance for spring on the ball of the foot. The toes are given no chance to spread and are deprived of most of their function in walking. The toes are frequently crowded back and flexed; there is much pressure irritation to the skin and in addition to this the use of the foot is so disturbed that normal gait is practically impossible.

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The feet of any child under the age of three years appears to be flat, but there is a perfectly good fatty pad under the arch and unless the following characteristics are present it is usually a normal foot: the inner malleolus is more prominent than the outer malleolus, the heel cord or tendo Achilles swings towards the inside while the heel bone or os calcis is everted. There is sometimes a condition of knock-knees accompanying this position, and the abnormal balance of this foot may cause foot strain, certainly in most cases, without corrective treatment, the muscles may become strained with painful results.

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This position is called pronation, which may be caused by malnutrition, forced early walking, weight-bearing following severe illness, too rapid growth, overweight, too short stockings or shoes or both. Less often are children's feet cramped by ill fitting shoes, than adults, for children's shoes and mocassins are made for comfort. It is when the child attains adolescence that low standards in shoes, extreme styles and improperly fitted shoes cause the first appearance of trouble.

The child with moderate pronation is seldom brought to the doctor because of pain. Rather is it the appearance of pronation noticed by the school physician, corrective teacher or school nurse that draws the parents' attention to the necessity for correction of the existing condition. Sometimes however, the child complains of fatigue and the inability to jump or run as well as his school mates.

While for adults it is more difficult to procure the correct shoe,

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for children it is simpler. There are many shoes on the market that fulfill the requirements of a correct shoe; the shoe for a child should have the following characteristics:

1. There must be sufficient space for the independent movement of the toes, hence there must be plenty of room at the front of the shoe.

2. The heel should be broad and low.

3. The shape of the sole should correspond to the shape of the foot, hence there should be a right and left shoe. The inner border of the shoe should be straight to follow the line of the big toe.

4. The shoe should be flat from end to end and from side to side. It is especially important to see that the forward part of the sole should not be rolled up, the flatness of the forepart of the shoe enables the toes to finish the step in walking.

5. There should be no stiff anklets, such as the so called corset shoe, which restricts the normal free action of the foot, and prevents muscle strengthening. Tennis shoes which are high may be worn by a normal foot for certain hours of recreation but should be replaced by oxfords or high lace shoes for ordinary use and activity.

Stockings should be longer than the foot to avoid constriction of the toes. Button or strap shoes for children are not considered as protective or do they give the support that a laced shoe gives.

The requirements for an adult's shoe are: a moderately high heel, a straight inner line and enough width and length at the forepart of the foot to prevent cramping or crowded toes. A flexible shank is preferable for a normal foot but if there is weakness of the arch muscles more support is necessary. Steel arch supports should never be worn without the advice and supervision of an orthopedic surgeon. Supports of any kind sold in stores are not made for the individual foot and can do more harm than good.

For evening and dancing a light weight pump or slipper may be worn; but what is correct for such occasions is not suitable for daily use.

If intelligent care of the the feet were carried out there would be small reason for foot troubles, neither would there be so many tired and nervous women and children with poor posture and back strain.

The very early appreciation of the necessity of healthy feet and the knowledge of the importance of hygiene and nutrition and correct clothing for the whole body can not be overemphasized and

are contributing factors to the usefulness and the health and happiness of our present and future generation.

Thanks to schools today and parental education along health lines, many children are being taken in time for early correction and prevention of poor posture and pronated feet. Still much time is wasted and harm done in allowing children to be taken to charlatans, the most popular being the chiropractor; in some states there is a law banning such quacks, which law we pray may be put into effect in all states eventually. Parents should consult an orthopedic surgeon for all deformities and defects such as lateral curvature of the spine and poor posture and foot troubles.

SOCIAL SERVICE IN THE TREATMENT OF TUBERCULOSIS

MARIE LURIE

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Tuberculosis presents many social implications. In its predisposing causes, in its course of sanatorium treatment, and in its necessary long time after-care, social problems are much in evidence. Our some 70,000 sanatorium beds are filled, for the most part, with young men and women, forced to leave their work during the most productive periods of their lives. Bad social conditions, in many instances, were predisposing factors of the first breakdown, and the resulting treatment in sanatoria left behind it countless social problems that reach out and touch the patient's immediate family, his friends, and his whole community.

Tuberculosis, with its chronicity, its insidious attack on the young, its community relationships, and its baffling long time duration, presents social problems that challenge the skill and patience of the best social worker in their solution.

Statistically, tuberculosis is decreasing—the actual number of deaths is less and the age limits are increasing, but the ravages of tuberculosis, the poor social conditions, which include bad housing, underprivileged children, crowded neighborhoods, inadequate income, low standards, and numerous other contributing factors, are still with us.

Hospital Social Service was called into being to meet the needs of the physician, and especially is this true in relation to tuberculosis. To effectively treat tuberculosis from the early stages of preventive work, through the necessary period of sanatorium treatment, on through the long stage of post-sanatorium care, it is essential that social as well as medical complications be recognized and given treatment, and to this end the Hospital Social Worker was created.

Social Service is of value not only to the individual patient whom it directly serves, but the sanatorium and the community are benefited by a good social program. To be effective, a social service program in the treatment of tuberculosis should have behind it a good medical background. The hospital social worker should recognize that the treatment of tuberculosis is of long time duration; that important as sanatorium care is, it is only one stage in the treatment. Equally important is the pre-sanatorium or preventive period with other members of the family, and a long period of post-sanatorium care for the discharged patient.

The worker starts out with the individual who has tuberculosis and attempts to carry out the doctor's recommendations for treatment by removing those obstacles which stand in the way of the patient following the medical recommendations. Meeting the obvious need for medical treatment is not always easy, but in most cases this can be effected, and with the patient as a starting point, the educational work directed toward members of his family, his friends, his employer, and other individuals in his small community, goes on.

Beginning with the patient, the social worker first attempts to remove or change those factors which contributed to his first breakdown. These may include improper food, vitamin deficiency, overwork, bad industrial adjustment, insufficient earnings, bad home conditions, and countless others. It is the social worker who sees the patient in relation to his family, his job, his employer, his friends, his church, and many other influences in the community, and she utilizes the resources of that community for the best interests of the patient and his family, helping to make effective his medical treatment while he is at the sanatorium, as well as during his long period of after care.

Routine contact examinations over a long period of time is the first step in the pre-sanatorium stage. Good physical and mental health, with its accompaniment of social adjustment in the individual's normal environment, is the goal of our preventive work, and it is to attain this standard that the skill and knowledge of the social worker is utilized.

In treating tuberculosis, all will agree, I am sure, that the disease cannot be treated without considering the social factors, which are perhaps 75% of the disease, both in predisposing causes, and in treatment.

But just exactly what is it that the hospital social worker does in a specific instance? Let us take the case of Sam Doe, who is a white man, age 40, married, father of five children between the ages of 2 and 14. He came into the dispensary because his brother, who had been living in his home, was recently diagnosed as having an active pulmonary tuberculosis. It was the social worker who convinced Mr. Doe that a contact examination might be of value.

Before he was examined the doctor was told by the social worker that patient's father had died of tuberculosis; that he had been in close contact with his brother, who was recently diagnosed as tuberculous; that the home conditions were poor. The patient owned and operated a small shop, where he renovated clothing. He used a hand iron, weighing twenty-five pounds, to press old suits which he bought at auction and after renovating them, sold them to a transient clientele. Insufficient income and worry over his inability to make a living for his family, had caused the patient a great deal of anxiety.

Sam Doe was given a careful examination and was diagnosed as a moderately advanced case of tuberculosis. Sanatorium care was recommended.

And then what? The doctor was very sympathetic and told the patient not to worry. All he would need was six months of sanatorium care and after that he would be all right.

It wasn't so easy for the patient to accept this recommendation. He didn't feel very sick and he saw no reason for stopping work. A six months' stay away from his family was out of the question. Who would support them? What would happen to the shop? What would become of ten-year-old David, who was a behavior problem? His wife could never stand the shock of knowing that he had to leave home, and he was afraid to tell her what was wrong with him because a brother of hers had died of this disease. And so on, were the many questions that came to his mind as he thought aloud.

The social worker's second job, after bringing to the doctor factors in the patient's background which helped the physician to make a diagnosis and aided in selecting proper treatment, was to interpret the diagnosis and medical recommendations to the patient and his family in terms of social adjustment.

In this case it was to relieve Mrs. Doe of her mistaken idea that a diagnosis of tuberculosis meant a hopelessly diseased individual,

and to plan with her how best the family could take care of themselves in the patient's absence.

In quick succession the social worker first secured sanatorium care for the patient and then helped him to get the benefits of this sanatorium care by giving him freedom from worry. In this particular case it was to supplement the family income by funds from a social agency. Help was obtained in disposing of the store. All the contacts were examined and defects, such as infected tonsils, poor eyesight, rachitic condition in the baby, and many other medical needs were taken care of. Ten-year-old David, the behavior problem, was given a thorough psychiatric examination, and he ceased to be a behavior problem when, upon the recommendation of the psychiatrist, he was placed in a pre-vocational school. Two of the other children were found to be 15% and 18% underweight and were sent to the Preventorium. Fourteen-year-old Pearl, who was doing excellent school work, was given a scholarship to enable her to continue her high school work. Patient's insurance policy was adjusted so that the premium would be waived until after he returned.

Frequent visits were made to the family throughout the patient's stay at the sanatorium and reports brought to him so that he was more contented and willing to stay until he was no longer in need of treatment. Home conditions were not suitable for his return and while he was still in the sanatorium these were changed. The family was moved into a five room flat in a better neighborhood, and a sleeping porch was equipped for the patient's return.

Many times during his stay at the sanatorium, which was extended from six to ten months, patient was impatient and wanted to leave. Very often during this period it was the worker who helped to sustain his morale and who stood by the family through many acute situations.

But even ten long months come to an end and when the patient was ready to leave the sanatorium, the physician was proud of the good recovery that the patient had made. He was classified as an arrested case and told that he could work, but not at his former job, as the operation of a twenty-five pound iron, coupled with the unsanitary conditions usually found in small tailoring shops, was not the best kind of work for him. The doctor recommended a light, easy job, and told the patient to take care of himself and keep well.

Getting back into industry after a long stay at a sanatorium is one of the most discouraging things a patient has to face. When

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

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

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

To effectively carry out a supervised system of post-sanatorium treatment, we have on our staff a full time employment worker, who adjusts the patient back into industry under conditions that will be most conducive to his staying well.

When Sam Doe was ready to leave the sanatorium, he was told that he could not lift a twenty-five pound iron and he could not work in a shop that was as unsanitary, small, crowded and poorly ventilated as his old shop had been. But the worker knew that Mr. Doe had a better chance to adjust in industry if he could use his former experience. With the doctor's recommendation that the patient could go back to pressing if conditions were favorable, this man was placed in one of our large tailoring industries, where his skill as a presser was utilized. A light, sanitary factory, where employees work an eight-hour day, sufficient time off for lunch, a living wage, a job that entails a minimum of mental as well as physical strain, are some of the conditions that make the patient happily adjusted.

Before the patient left the sanatorium, he was impressed with the necessity for long time medical supervision and because his earnings were insufficient to cover private physician's fees, he reported at frequent intervals to the sanatorium's out-patient department, where we were happy to see him doing well. During this period of medical

supervision, again it was the social worker who helped to make possible the doctor's recommendations for a two weeks' vacation, or for no overtime work when the factory was pressing him, or for a short period of financial help when two of the children were acutely ill with scarlet fever. The other members of the family, too, were being watched carefully, and after a five year period of social and medical supervision, the family was physically in good condition and economically independent. They were able to meet their own problems and make their own adjustments, and when the sanatorium was counting the number of patients who had not had a relapse during the first five years after their discharge, the social worker felt that she, too, had made a contribution to Sam Doe's staying well.

Let us leave Mr. Doe and his family and see how hospital social service is of value to the community. Doctors and nurses were in existence long before the profession of hospital social work was called into being, and I need not dwell on the change from the old time practitioner to the highly specialized modern physician. Doctors and nurses, because of their particular training, often do not have their senses attuned to social pathology, to the resources in the community, or to the methods and technique of making social adjustments.

Today, the profession of social work demands specialized training. Social workers on the job are keenly realizing how necessary this training is, and new schools for the training of hospital social workers have sprung up in all parts of the country, to take care of the needs of the profession. These schools are usually connected with universities or other recognized schools of education.

Social service is a community asset. In her program of preventive work, which includes contact examinations, preventorium care for underprivileged children, social adjustments in the home, the education of the mother regarding food needs, hygienic living, and so on, the social worker often prevents infection from becoming active disease. And in her program of post-sanatorium care, there is the economic value to the community in keeping men and women well. Recurrent illnesses take place during the most productive age of the individual and if the social worker, through temporary financial aid, industrial help, or other social adjustments, can prevent recurrences, there is great economic saving to the community. And if recurrences are prevented, there is also prevented further spread of the disease in the community.

Through industrial rehabilitation, there is a decided asset to the community, as there is no need of support, either through public or private agencies, and with this comes a saving of morale, which is far beyond a financial evaluation.

It is a community asset to educate employers to the fact that they can employ patients who have had tuberculosis. If an employer is aware that an arrested patient is not a menace; that as an employer there rests upon him an obligation to induct this patient into industry; and that small considerations on his part help greatly in keeping the patient well, then the community as a whole, benefits. If through this process of educating the employer, he works out the best possible plan to keep the patient well on the job, we are saving the community an added burden.

The following history illustrates how much can be accomplished if the interest and coöperation of the employer are secured. It is the case of Bertha, a young Jewish woman, whose background is typical of many of the newer immigrants. During the war she suffered untold hardships and privations, and came to this country through the help of an older sister, who had been in the United States prior to the war. Bertha went from a small provincial village to Hamburg, to embark for this country, but after her arrival there she was told that she was outside the quota and could not be admitted to the United States. She was advised to go to Cuba and told that by living there one year she could enter this country. She did this, but while she was in Cuba a new law was passed, which extended the period of residence there. After three years of hardships, including illness, financial deprivation and homesickness, our patient came to Chicago to join her sister.

Two weeks after her arrival here, she was told she had tuberculosis. When she entered the sanatorium she seemed a timid, cowed, shy animal, fearful of everything. She responded very slowly to the friendliness of the sanatorium, but little by little accustomed herself to our regime, learned to speak a few words of our language and improved physically.

When she was ready to leave the sanatorium, the employment worker, after one interview with her, asked how she could place a girl whom the vicissitudes of life had reduced to a state of abnormal fear regarding everything, a girl who was not familiar with English to any degree, who did not know directions in the city, who was shy and full of fear, who had never been employed at anything,

with the exception of sewing buttons on garments for a few months in Cuba, and who, because she had had tuberculosis, looked upon herself as a sick person.

Many employers were approached but it was difficult to enlist their interest. The business manager of the Amalgamated Clothing Workers Union was approached in an effort to place the patient. At first he said, "What could I gain by employing such a bunch of handicaps as are embodied in this girl? She probably could give very little industrial service in return, and added to all this, you ask me to surround her with convenience, comfort, congeniality, and to train her to do one job efficiently?" But his sympathy and interest were finally aroused and Bertha was placed by him in one of our large factories, where her little training in button sewing was utilized. The physical working conditions were excellent. The foreman of the shop had been informed by the business manager of the union that the patient was to be given special attention, and as a result, the best hand button sewer was placed next to the patient, in order to assist her in learning the most efficient, modern methods.

This patient is happy and is now earning \$15.00 weekly. The factory is never shut down for lack of work. It runs full force for nine months during the year and then part time work is given each worker. Work begins each morning at 8:00, and the workers are discharged at 4:30. The patient works on the second floor, to which she may ascend by elevator or stairs. She sits at her work.

A great deal of time and effort was expended in acquainting her employers with the patient's history and background, in an effort to make the placement a permanent one. For the first time in her life, this patient is working under good conditions and is happy. If she is kept so, we know that the danger of a relapse will be minimized, and from an economic standpoint, the expenditure for her previous sanatorium care will not have been completely wasted.

In the same way, with the social worker helping the family over a trying period, sustaining their morale, and helping them to help themselves, families are more often kept together, instead of thrown back on the community as broken homes, deserted wives needing financial support, or dependent children, becoming the burden of society.

In addition to the sum total of individuals who are helped, the community as a whole derives tangible benefit. Because the senses of the social worker are attuned not only for alleviation, but for pre-

vention, they help to reflect bad social factors in the community that are predisposing causes of the disease and with sufficient evidence, help to change, if not do away with these conditions. Community pressure is often responsible for changes in working conditions in factories and the bettering of standards in industrial concerns.

Now let us leave this big community and go back to the sanatorium. Why should a sanatorium have a social worker attached to its staff? All of you know how ineffective a short period of sanatorium care is. A frightful amount of time and money is expended each year because patients do not stay long enough to complete their treatment. Very often patients leave the sanatorium, not because they are tired of it, but because they are worried about conditions at home, and it is here that the social worker is of value. By removing the aggravating causes in the home; by relieving the patient of worry about his family, the social worker is able to persuade him to stay in the sanatorium. Her promise to take care of the situation in the home is no idle one. She proves to the patient that she can help his family and can, in some measure, remove the causes for his worry. In the same way it is the social worker who helps to lessen sanatorium care by removing the causes of worry and allowing the patient to get the full benefit of sanatorium treatment in the least possible time.

The physician in the institution can treat the patient better if, through the social worker, he knows the family background, some of the patient's reactions, the probable contributory causes of his breakdown, and the environment to which he must return. She brings to him not only a picture of the home situation, physical conditions of his house, whether or not there are adequate sleeping quarters, factors about sanitary conditions, ventilation, heat, light, and so forth, but through her help the physician sees a whole problem in its total environment, and is better able to make recommendations for the future. Recommendations for full time work may be modified to a four hour a day job, after the physician learns the particular type of work and the particular environment under which patient is working.

In her intensive program of post-sanatorium care, the medical social worker is a decided asset to the sanatorium. To do a good job, the sanatorium is anxious to keep its patients well. Sending a form letter to a patient, six or eight months after he has left, asking him if he feels well, whether he is working, and so on, is not the type of

after-care that a hospital social worker would call adequate. A good program of after care includes the knowledge that the patient has no social problems that need attention. If there are problems, they should be adjusted. Urging periodic medical examinations and seeing that they are carried out, does not insure the patient's remaining well, but if the social worker is in close touch with the patient and the doctor, and will help to carry out the physician's recommendation that the patient should have a short vacation, that he should do no overtime work, or, if it is a woman patient, that she be helped with the heavy work in the house and relieved of the care of her children for a short time, then medical recommendations are of value.

And may I at this point stress the very decided asset of putting post-sanatorium care where it belongs, not in a card index system, but in the hands of a professionally trained hospital social worker, who is aware that in this long period of after-care there are many social problems that stand in the way of effective medical treatment. And a form letter, perfunctorily filled out, is of very little value, either to the patient or to the sanatorium.

We have not as yet found an ideal method of after-care. Sheltered workshops, colony systems, with sheltered employment under ideal environments, are attempts to meet the problem for the individual whose medical condition makes a return to a normal environment impossible. But for the many thousands of individuals, who are discharged each year as arrested, with a full day's working capacity, these sheltered industries are neither practical nor feasible. Our responsibility is not ended when patients are discharged from the sanatorium, as arrested, able to work a full eight hour day. Each year we throw back into industry and normal environmental conditions, individuals who, because of their long period of enforced rest in the sanatorium environment, cannot easily adjust to the hectic, busy life of our industrial environment. There are many obstacles that stand in the way of a complete return to normalcy. Very often these obstacles are small, but the cumulative effect of a bad industrial adjustment, worry over finances, a domestic difficulty perhaps, may soon nullify the good effects of the long sanatorium period, and a relapse is the inevitable result.

It is the patient who is discharged in good condition, who quickly forgets the many "don'ts" learned at the sanatorium. It is so very easy to go back to the old habits, many of which were the predisposing causes of the first breakdown. In order to make sanatorium care

effective, there should be an intensive follow-up on each patient who leaves the sanatorium, and this work should be done by a trained social worker, whose senses are alert to recognize those things which stand in the way of a complete recovery. Strict medical supervision should be urged, but, equally important, is following the patient into his home, into his place of employment, seeing him in his community, carrying out a program of health education, not only for the patient, but for his family as well, teaching them all to build on the good foundation which the sanatorium has given.

PUBLIC SUPPORT OF NURSING SERVICES

MABEL E. FINCH

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We are erecting today, in Canada, a Temple of Happy Homes. Each citizen is a builder, designing and carefully chiselling the stone which he shall fit into place at eventide.

The foundation of this temple is the foundation of all satisfying life. It is health. "Health preservation rather than cure," has been carved in every stone of the base laid by our public health nurses.

Bed Rock

They did not found this structure on shifting sands. Down to bed rock they sank their shafts and started to work with the mothers. Full well they realized that trained mothers would mean more happy firesides watched over by the sheltering care of both parents; fewer little mounds on the hillside to mark the mistakes of ignorance. To them they therefore came with their skill and scientific knowledge, interpreting their message in terms of the home, in order that struggling humanity might have life and have it more abundantly.

It is in this sphere that the United Farm Women of Manitoba and many other rural women's organizations, have found the Public Health Nurses one of their greatest blessings. Willingly they have responded to invitations to address meetings, and there small groups of women have learned the sacredness of their task of bringing life into the world; the possibilities within their reach of alleviating suffering; the opportunity of preserving the life of their babes by proper care of their bodies, selecting the most nourishing foods, and securing early competent medical advice.

In rural districts the prospective mother is often hesitant about seeking consultation with trained workers but the personal chat with the nurse after the meeting or in the home soon wins her confidence. She wants to do what is best for herself and child but does not

know how. She is skilled in music, needlework and cooking and knows the ethics of business, but from early childhood she has been taught to believe the myth, "Women are born mothers," hence has not sought education in this field. As a result she finds herself enveloped in darkness, anxiety and worry. Then, with the nurse's sympathetic understanding and unfolding of words of wisdom, her chrysalis breaks and she becomes a new woman, a woman who is anxious to grasp and master every fact that will make her a capable and intelligent mother competent to look after the little life entrusted to her care.

Closely associated with the nurse's personal visits are the mothers' books and pre-natal letters. To those in outlying districts without the service of a doctor or a nurse, these monthly letters are the mother's only ray of hope and sunshine. A mother recently expressed her appreciation in these words, "One could not read them without wanting a baby of one's own." Thousands of pre-natal letters find their way every year into all parts of Manitoba through women's organizations and other agencies, yet many more would be sought and much health literature asked for, if the service were still more widely known. Is it any wonder, then, that from those who have learned its value, we find the request coming that the Nurses' Department establish a service through rural papers and magazines, so that there will appear regularly stories popularizing health, even as home economics is today made attractive in the press.

Women are gradually awakening to the fact that they have a vital part to play in the preservation of health; that a large measure of the responsibility is theirs for four maternal deaths per day in Canada, and as a result, fourteen little children left motherless daily. They are therefore using the knowledge acquired through the public health nurses' lectures and literature, not only for self-enlightenment, but to educate school boards and convert members of municipal councils to the support of a sound economic program, which will save the lives of thousands of infants by providing child welfare clinics and nursing services for all.

Foundation of Temple

When the baby appears a new bond unites the mother and the nurse through the loving care bestowed on her infant. One often hears it said: "Give me the first six years of a child's life and you

may have the rest." Possibly nowhere can this be claimed to be of greater value than in the child welfare work carried on by our public health nurses. The preservation of the health of the pre-school child forms the foundation of our temple. Mothers are only beginning to learn the value of the nurse's help during this period.

They are only beginning to realize that as the general health standard in the home is raised the more impossible is it for fatal diseases to make their entrance. To enable the child to escape contagious diseases to which his age is susceptible, to establish health habits, to see that he follows a diet suitable for a growing child, to detect symptoms of disease and see that he receives proper medical attention, all this is embodied in the service rendered by the public health nurse.

Though this is carried on during visits to the home, the most popular form is through child health conferences. Nothing arouses more interest in a community. Telephones become busy consulting as to preparations for the conference; children gather in groups at the school and church, counting the babies in the district that they think are one hundred per cent.; committees work diligently in order that no family in the community will be overlooked; and in the home itself the chief topic of conversation is,—the baby and the child beneath school age.

How gay the community hall looks on health conference day! The public health nurse has made it a veritable fairyland with her health nursery-rhymes and posters. School children are busily engaged in reading them, while mothers are examining the model layette, the proper equipment for the new arrival, first-aid supplies for the home, and all that goes to make up the splendid educational exhibit for the public.

Devoutly thankful are those parents whose children are one hundred per cent. Even more thankful are those who find disease detected before their child is maimed for life. At a recent conference the nurse noticed, in measuring a little one's limb, that one leg was smaller than the other. The slight difference had not been observed by the parents but was sufficient to receive the consultation of the child specialists who were present. The diagnosis proved to be tuberculosis. Proper treatment was prescribed. In time the limb was restored to normal. Instead of a crippled man, those parents realize that the future holds for their child the best life has to offer.

Needless to say, they are firm supporters of the public health nurse and child health conferences.

It is good for a community to so organize. It teaches unity, coöperation and the pooling of their resources in a determined effort to preserve child life and lower our high rate of infant mortality. Each year interest is spreading. Fathers may now be seen waiting outside the conference hall to see how their children are measuring up. We hope in the future to see such conferences organized so that fathers as well as mothers may be present while their children are being examined. Through the eye one learns to appreciate much more keenly than through the ear alone, and in this way the coöperation of the father will be secured and through him, the support of other men who will shortly have to mark the ballot for or against that municipality supporting the services of a public health nurse.

At best, however, health conferences provide an opportunity for only temporary educational work. To be permanent and to meet emergencies, as they arise, there must be a follow-up program. Child welfare stations are the solution of this problem. There the mother may bring her delicate child to be weighed and measured regularly and be advised regarding its diet. Wherever these stations are established they have become the mothers' consulting-room and the centre where many of the young girls love to meet to spend a few hours caring for the babies. The terrible anxiety that before rested on the parents' shoulders when the little one took sick, now is invariably dispelled through the nurse's health instruction. Manitoba looks forward to the time when child welfare stations shall be within driving distance of every home, as one of the first steps in the saving of infant life.

Walls

With physically fit children of pre-school age to form the foundation, it is not such a task to erect the walls of our temple of happy homes. In this task we find parents and teachers busily chiselling under the direction of the trained builders, the nurses. Children have now arrived at the school-age period and parents soon learn that the problem of the community is the problem of every home. One child takes diphtheria, soon there is an epidemic. Must they resort to the old method of closing the school, retarding education, losing economically, and not knowing how far-reaching the epidemic will be or when it will cease? No, with a public health nurse they attack the

problem scientifically. Her training enables her to quickly detect disease in its early stages and she reports to the public health officer. The child receives medical care before his life is in danger. Each day school is kept open so that a tab can be kept on every child. Daily they are examined and swabs taken. In a relatively short period the epidemic is checked and time from school is lost only by those who have become patients. There is such great appreciation of the service of the nurses in this field that municipalities which have abandoned them for economic reasons have found they have lost many more times the cost of the support of the nurses, in the cost of epidemics, and have been glad to call for their help again.

It is in her work in the school that the public health nurse in Manitoba is best known. Each year thousands of school children are inspected and thousands found with defects, many of which would otherwise never come to light before they had left their life impress. The value of follow-up work with these cases is too great to estimate. Democracy is gradually coming into its own and demanding that every child be given a fair start in life, with good health as the foundation.

Children love to coöperate, too, in the building of this health wall. To be a member of a health crusade is most appealing; to receive a diploma in a Little Mothers' League gladdens the heart of any teen-age girl. A capable mother who raised successfully ten beautiful children, most of them themselves now mothers, said: "When I watch the children trained in the Little Mothers' Leagues handling babies, I am ashamed of the foolish things I did with mine." We are gradually learning that motherhood requires trained workers.

Gates

As the builders toil steadily on, sculpturing and fitting into place their stones, we see that the gates of the temple stand open wide. These are the gates of service. All who are building may enter in and pass freely to and fro for they are contributing to the happiness of mankind. Let us pause a moment and watch those we see in the passage-way. There are mothers greeting the nurses who have made it possible for their children to grow up strong through the surgical care received at the tonsil and adenoid clinics. There is a family expressing appreciation to the nurse for the clothing that enabled their children to attend school in the winter. There is a father leading by his hand a chubby, robust son, thanking the nurse who

persuaded him to take his child to the chest clinic. His was a contact case and the care he received prevented him from following his mother to the sanatorium. There are bright, vivacious children clinging to the nurse's hand. Once they were under-nourished, lifeless, little ones but through her health instruction they had the gift of life restored.

We cannot refuse this gift to anyone, least of all to the children, yet today we are only touching the fringe of what lies within our reach. As we look around us on every hand we see numbers suffering through sickness, numbers whose anxiety and pain might be removed through proper health attention. Twenty thousand daily in Manitoba are unable to act as builders on our health wall, because sickness has claimed them. Mothers yet are left to struggle alone through the darkness of child-birth because no doctor or nurse is within calling distance. We need missionaries, women who realize the suffering and will not rest until adequate nursing and medical facilities are provided for all. May we not solicit for this campaign from our department of health, moving pictures that will tell the story of both health and disease? Many will learn through the eye who will not hear through the ear. Rural districts which are the hardest to reach on account of scattered settlement, will respond to a "movie" in the winter months, and obstacles that have long hindered the progress of health service will be overcome.

A few districts have caught the real spirit of democracy and are providing health facilities for all. Some of these have municipal doctors; others have public service nurses, nurses who do bedside nursing as well as the work of the regular public health nurse, but who serve a smaller area. No one can count their value in the saving of suffering and loss of life, but the poverty-stricken homes who before had no health assistance, today bless the sight of the smiling figure in white.

Architecture

We will have many more such districts when once the people understand. Understanding creates sympathy and sympathy begets vision. If we would build a beautiful and stately temple symbolic of happy homes, we must have vision. Too long we have taken the work of the public health nurse for granted, expecting her to restore health while we sat by and waited. Is it not time that we went to her as a unit saying, "We represent many organizations but only one

community. 'We believe that babies everywhere should be as well and kindly tended as we would have our own; that motherhood should be protected as we would have the mothers who are dearest to us; that childhood should be as joyous and free to come to its own as ours should be if we had our wish,' and we are here to support you by every means within our power in the promotion of your health program." Such a citizens' committee in every community would do much to forward the cause of health.

As the builders work on the temple a radiant light streams through the window, caressing the brow of each with its hallowed glow. The tiny panes of colored glass through which it streams, symbolize the courage, faith and devotion of those who have gone before, the pioneers of the nursing service. The light is the spirit of the present builders, radiant with the steadfast faith of the pioneers, cheering each other as they chisel, day by day. At night, as the stars come out silently, one by one, in the azure sky, the hands of the workers cease from labor and a quiet peace enters their souls. To them has come the message from their great co-worker, the Master Builder, who speaks as they rest on the old gray wall:

"Did the hand of the builder guess,
As he laid me stone by stone,
A heart in the granite lurked
Patient and fond as his own.

"Ah, when will ye understand,
Mortals who strive and plod,—
Who rests on this old gray wall
Lays a hand on the shoulder of God."

SOCIAL WORK AND PUBLIC HEALTH IN GERMANY*

PROFESSOR F. ROTT

Berlin, Germany

The International Conference of Social Work is principally concerned with general questions of welfare and particularly of economic welfare. Questions relating to social work in its bearing on public health are dealt with only in so far as they are immediately connected with general questions of welfare. In presenting the German General Report on questions to be discussed at the Plenary Meeting of Section V, our task is not only to describe the system of social service in behalf of public health throughout Germany but also to indicate its connection with economic welfare work and its position in the general scheme of national welfare work. We have the further task of describing the interplay of health work, preventive care and economic relief in public welfare work, and the collaboration between public and private welfare organizations.

The second part of the General Report gives information on conditions in Germany in regard to the various subjects to be discussed at the Section Meetings.

A.

1. RELATIONS BETWEEN SOCIAL WORK AND THE ORGANIZATION OF PUBLIC WELFARE AND PUBLIC HEALTH WORK.

There are three spheres of national social welfare work in Germany which can be fairly clearly distinguished:

- (a) Social and public health work,
- (b) Educational welfare work,
- (c) Economic welfare work.

*Read before the International Conference of Social Work, Paris, France, July, 1928.

This classification is, however, significant only as regards the differentiation and application of specialized methods of welfare work. Those who adopt this classification are not trying to divide suffering humanity into three classes any more than it is possible to define the boundaries of the afflictions and needs of society, to divide them into three classes or to classify them exactly. In practice the three spheres of work are not only carried on concurrently but they frequently overlap and interpenetrate. Health work is as closely allied to economic welfare work as educational welfare work. The relief of economic distress is as necessary for the success of health work as for educational work. Nevertheless health work has its own special significance inasmuch as it often prepares the ground for educational work, paving its way and often enough having to come to its assistance. And ill-health leads to economic disaster much oftener than economic disaster to ill-health. Thus health work is not only most intimately bound up with economic welfare work, but is often enough the preliminary condition for the success of welfare work and educational activities. In the long run, health work serves the purpose of preventing distressed persons from becoming a burden on the community economically. Economic measures are employed most effectively in health work side by side with medical treatment.

Social and public health work has greatly enlarged its sphere in Germany since the war. Health work has developed in that it is no longer confined to advising and caring for persons brought for the purpose by the agency of investigating welfare organizations but does constructive work from its own data and on its own initiative in order to increase its effectiveness and prevent sickness or relieve it as early as possible.

For this purpose the public health organizations systematically pass in review definite sections of the population or age categories. Their object in so doing is to make a record of persons who are sick or in danger of becoming so and to see that they receive advice or treatment. Three phases may be distinguished in health work:

Phase I: Ascertainment of cases of sickness or endangered health and selection of those in need of relief.

Phase II: Provision for those in need of relief, in the form of preventive advice, economic assistance or arrangements for any necessary treatment.

Phase III: Investigation of the results of the treatment or relief given.

Health work in its modern form covers a wider field than in the past, when it was essentially confined to the services described under Phase II.

The fundamental principle of present day health work is comprehensive health supervision. The change brought about in health work is due to the fusion of the public services for the treatment of sickness with those for health welfare work. This fusion finds its outward expression in the fact that health records are kept by the workers and organizations of preventive health welfare work and that hence the latter have taken over functions of the public services for the treatment of sickness, and that this *health service* has been centralized in one office, for the most part in the municipal health office, with a view to better supervision and organization, and has been placed under the guidance of officially appointed doctors. The relations of the municipal health office with the public and child welfare office vary according to local (sometimes also personal) conditions, being now closer, now more distant. But even where the health office is a branch of the welfare office, the effort of the health department to do independent and responsible work is unmistakable. Moreover the different branches of health work have constructed their whole system so as to take into account the educational and economic needs of those under their care.

Thus work for cripples consists of :

- (a) medico-orthopædic treatment,
- (b) school training for crippled children,
- (c) training of young cripples in some handicraft.

The single aim of these three measures is to equip the cripple to earn his livelihood.

Comparatively close relations exist between health work and general welfare work as organized by the welfare offices of the rural districts.

Health work as at present organized is carried on by four agencies which coöperate in the work :

- (1) the *State*, as legislator and source of administrative measures ;

- (2) the *Communes* or *Communal Associations*, as organizations legally competent for their locality;
- (3) the *Insurance Societies*, as corporations under public law,
- (4) the *private welfare organizations*, as associations under civil law.

As yet no legislation for public health work exists in Germany—apart from certain spheres of activity (Law for the Combating of Venereal Diseases and in Prussia, among other States, a Law for the Combating of Tuberculosis and a Law for the Welfare of Cripples)—and there has been no agitation for such legislation. The only support for health measures for those in need of assistance is contained in the *Reichsverordnung über die Fürsorgepflicht* (Reich Welfare Decree) of February 13, 1924, which partially incorporates the *Reichsjugendwohlfahrtsgesetz* (Reich Child Welfare Law) of February 9, 1922. The Reich Welfare Decree appoints as the ideal and material agencies for welfare work the District and State Welfare Association (in place of the former local and State poor relief associations). In addition to poor relief, these associations have to carry on public law relief work, including the health work connected with *the care of minors in need of assistance and maternity welfare work*.

In all cases the intervention of the welfare associations is conditional on the need for assistance. The obligation to give temporary relief *arises simultaneously* with the need for assistance, i.e. at the moment at which the need for assistance arises in a manner recognizable by the authorities, organizations, welfare offices, etc., of the District Welfare Association on whom the costs of the relief granted are provisionally incumbent. *Preventive measures* are not as a rule included among the tasks of the welfare associations. It is merely a question of relief granted by or on behalf of an association within the scope of its duties.

According to the rules laid down by the Reich regarding the prior conditions for public welfare work, its nature and its scope, the minimum assistance granted represents the indispensable necessities of life, in particular: shelter, food, clothing, the *necessary care in cases of illness*, and a suitable burial after death. The necessary assistance must be given to mothers before and after confinement. Minors in need of assistance must, under the provisions of the Reich Child Welfare Law, be provided with the necessities of

life, including education and vocational training and the *necessary care in cases of illness*. When judging of the need for relief, account must be taken of the necessity for timely, continuous and thorough remedies for derangements of the physical, mental and moral development of children and young people.

Thus the relief granted now extends beyond the bare minimum of existence recognized by the former poor law system. In general, however, it can be applied only when economic assistance is needed. When it is a case of *endangered health* and the economic position of the applicant has not reached the stage of distress, within the meaning of the Welfare Decree, relief cannot as a rule be granted. Thus no support is given by these provisions to systematic preventive health work and treatment.

The possibility of maintaining and, in certain circumstances, of extending the system of health work within the scope of the provision of the Welfare Decree is provided by the application of the clause contained in the last paragraph of § 1: "The State may transfer further welfare activities to the Welfare Associations." Thus it is left to the decision of the States or autonomous bodies how far they will provide the means for more extensive preventive health work. The executory regulations of the States determine whether the protection and care of infants, welfare work for cripples, anti-tuberculosis work, etc., shall be carried on systematically on the basis of existing legislation.

In point of fact, the agencies of social work, the public welfare organizations of the communes and communal associations and the private or voluntary welfare organizations have gone far beyond the limits laid down by the Reich Decree—and had done so even before it was promulgated. They do not confine themselves to health work in relief of distressed persons in the meaning of the Reich Welfare Decree but carry on systematic preventive work. But whereas in the time of greatest emergency the work was not confined to those in need of assistance, i.e. those who without public relief could not be cured or could not remain healthy, it is now evident that efforts are being made to confine the care given, on economic grounds, to those in need of assistance as defined above.

Moreover it was early recognized that there is a close and intimate connection between the various agencies of health work and that it is unpractical for them to be working along parallel lines. There is therefore a marked effort being made on all sides to link

up the communal authorities, the private welfare associations, the medical associations and the agents of social insurance into *joint associations or unions for the object or task in view*. § 5 of the Reich Welfare Decree regulates the coöperation of the public and private welfare organizations, in so far as the State or the Welfare Association can transfer certain of its duties to voluntary welfare associations and organizations, and the local offices in the meaning of the law (§3)—which are responsible for the conduct of the welfare work—have to form the liaison between the public and the voluntary welfare organizations. They have to aim at getting the public and the voluntary welfare organizations to supplement each other's activities and to collaborate in such a way that each will preserve its own independence. The new Prussian Law on Tuberculosis, which entrusts important coöperative work to the Centres for the treatment of pulmonary complaints, proposes, in its executory regulations, that joint associations be formed for this work. The Reich Minister of the Interior has also asked for such associations to be formed; in the Rhine Province there has long been one in existence and one has been formed recently in Hannover, among other places.

The Reich Law of July 28, 1925, on Health Work in connection with Reich Insurance, provides a basis for combining the measures of the agencies for sickness, disablement and employees' insurance in carrying out health work. It is a question here of the procedure with regard to the treatment of sickness under the Reich Insurance scheme and the general measures taken by the insurance agencies for preventing the occurrence of premature incapacity for work or disablement or for improving the general health of the insured population. Rules are now being drawn up by the Reich Ministry for the regulation of collaboration between the various agencies of Reich Insurance and their coöperation with the agencies of public and voluntary welfare, primarily in connection with tuberculosis and venereal diseases.

Health Insurance as regulated by the Reich Insurance Decree forms the basis for the social health service. It comprises economic and health measures on behalf of the insured persons in cases of illness and on behalf of insured women during pregnancy, confinement and nursing.

All wage earners are obliged to insure if their income is less than 3,600 RM. per annum. The funds are obtained by regular contri-

butions to the sick funds, one-third being borne by the employer and two-thirds by the employee.

Grants paid out of the sick funds on behalf of insured persons may be divided into the following categories:

(1) Sick benefit, (2) Maternity benefit, (3) Funeral benefit.

(1) *Sick benefit.* This consists of

- (a) medical treatment;
- (b) provision of medicine;
- (c) curative appliances (spectacles, trusses, etc.);
- (d) sickness grants in case of incapacity to work;
- (e) hospital treatment;
- (f) allowance for home treatment.

Sick benefit is in general granted for 26 weeks. By § 187 of the Reich Insurance Decree it may, however, be extended to one year. The amount of the grant during illness represents at least half the wages of the insured person. The grant is supposed to provide him with the sum necessary for his subsistence and for the diet prescribed by the doctor. If this grant is not sufficient, the insured person may receive a supplement for special costs of illness under § 193.

Uninsured members of the family of the insured person may also have the advantage of treatment by means of a "*family benefit.*"

Up to 1925, 89% of the local insurance societies
 70% " " insurance societies for rural districts
 87% " " factory insurance societies
 78% " " insurance societies of the trade unions
 had introduced family benefit.

The following statistics give information regarding sick benefit:

In the year 1925, 9.5 million cases of sickness combined with inability to work were reported. The percentage of cases was:

51.9 for the local sickness insurance societies
 31.2 " " sickness insurance societies for rural districts
 61.9 " " factory sickness insurance societies
 52.4 " " sickness insurance societies of the trade unions

I. e. 50 cases per society, on an average.

(2) *Maternity benefit* comprises the next group of grants by the sick fund, namely:

- (a) medical treatment;
- (b) services of a midwife;
- (c) medicine;

- (d) appliances;
- (e) contribution to costs of confinement;
- (f) maternity allowance;
- (g) nursing allowance.

In 1925 there were 11.3 million men insured in Germany with the sickness insurance societies and 7 million women. In the case of 840,000 births, i.e. two-thirds of the whole number, maternity benefit was granted in 1925 under the health insurance scheme to the insured person herself or to a woman insured under the family insurance system.

Under the Reich Insurance Decree in its present form the following payments are provided for in respect of maternity benefit:

Sickness insurance societies grant maternity benefit to all women members of the society who, in the last two years, have been insured against illness for at least ten months on end before confinement and, in the last year, for at least six months before confinement. This benefit is extended, in the form of family maternity benefit, to the wives of insured person and to the daughters, stepdaughters or fosterdaughters of the insured person, if they are living in his house and are habitually domiciled in Germany, and if the condition of duration of insurance applying to insured women has been fulfilled by the member of the insurance society through whom they are claiming the benefit of family relief. The regulation benefits in such cases are as follows:

(1) The services of a midwife for the confinement or for pregnancy troubles, medicine and medical appliances, and medical treatment if required;

(2) A single contribution of 10 RM. to costs of confinement or treatment for pregnancy troubles. If no confinement takes place, the contribution to costs on account of pregnancy troubles is 6 RM.;

(3) A maternity allowance to the amount of the sick benefit, but at least 50 Reichspfennigs a day for 4 weeks before and 6 consecutive weeks after confinement (the same amount under the family benefit system). The payment of maternity allowance before the confinement may be extended by two more weeks to six weeks if the woman has no paid work during this period and the doctor certifies that the confinement will probably take place within 6 weeks. The maternity allowance for the period before confinement is sometimes payable immediately and not only at the date of the confinement. (Under the law of July 16, 1927, concerning Occupation before and after Confinement, the woman may not be employed for six weeks after the confinement. For 6 weeks before and 6 weeks after confinement, notice of dismissal is invalid or prohibited, unless it is given for some important reason unconnected with the pregnancy or confinement).

(4) As long as the mother is nursing her child, a nursing allowance amounting to half the sick benefit, but to at least 25 Rpf. a day (the same sum for family maternity benefit), until the expiry of the 12th week after the confinement. The management of the insurance society may fix a maximum for the daily nursing allowance. The statutes or the supreme authority in the State may decree that the societies, when paying the nursing allowance, must point out the value of regular attendance at consultation centres for mothers, infant welfare centres or similar institutions. Women employed in industry are entitled to time off during working hours for nursing.

Instead of the maternity allowance, the insurance society may provide insured women or those insured under the family insurance scheme with treatment and attendance in a maternity hospital or similar institution, or with an allowance for attendance at home, with their consent.

(3) *Funeral benefit* comprises the third group of payments by the sickness insurance societies. In general, it amounts to one-twentieth of the basic wage.

The *organization of public and private preventive health work* has become indispensable as a *supplementary measure* to the treatment of those already ill. The sphere of preventive advice and economic relief to those in need of assistance is the so-called *outdoor relief*, of which the welfare office is the most characteristic expression. At the consultation, the person requiring assistance obtains advice and preventive treatment, food and dietary, clothes and other objects of daily necessity. The welfare office also provides for any necessary remedial treatment or for the services of a special welfare institution. The work is followed up by welfare organizations which investigate the home circumstances of the patient and see that the instructions given at the consultation are carried out. By this means also careless and indifferent patients are rounded up and induced to go to the welfare office.

Rural welfare organizations have the same tasks to perform as urban welfare organizations, but in the country welfare work is in the hands of the woman worker. Obviously the latter cannot be expected to do the same specialized work as the welfare offices. This makes her rôle of intermediary all the more important. Recently efforts have been made to give more scope to the public health activities of the public health nurse and the midwife as helper and confidential assistant of the social worker.

Institutional relief, i.e. the care of patients in hospitals and nurs-

ing homes comes into play if the outdoor relief given is insufficient for the recovery of the person requiring treatment or assistance.

It is becoming more and more an accepted principle of health work that recourse must be had to institutional treatment only when absolutely necessary. Institutional treatment costs more than outdoor relief. Unnecessary recourse to institutions adds to the public burden.

In health work preventive treatment comes first and foremost. It is important to note the threat of illness in the early stages. The combating of individual cases of sickness is undertaken not only in the interests of the patient but also, in conformity with the principles of social welfare, in the interests of the community, whose health is menaced and whose resources are seriously encumbered by the presence of the sick person.

According to Gottstein's system of classifying those whose health is endangered, two large groups are most clearly distinguished by health workers:

- (1) those whose health is more particularly exposed to various risks by reason of their *age, social status* or *occupation*;
- (2) those who, through the menace of a definite *social disease*, are a danger to or a burden on themselves or their immediate or remote surroundings.

The first group is served principally by maternity, infant and child welfare organizations, by school hygiene and welfare work, by hygienic conditions, by health work in industry, and the second group by cripple welfare work, including welfare work for the blind and for deaf mutes, for those suffering from tuberculosis, venereal disease, for inebriates, the feeble-minded, epileptics and the mentally diseased. All these branches of welfare work have the closest relations to each other and call for a mutual exchange of opinions while preserving their independent methods of work.

2. HEALTH DEMONSTRATIONS AND SOCIAL PROGRESS.

Health propaganda, as Professor Adam, the General Secretary of the Reich Committee for Health Propaganda, says, is a movement which arose almost simultaneously in all civilized countries. It is a recent movement and is still being extended. It has not yet achieved its definitive form. Every country must pass through the experimental stage; an international conference on the subject therefore

seems highly desirable so that the different countries may profit by each other's experiences.

Health propaganda is rightly regarded as one of the most important measures for preventing sickness and the resulting economic distress. The progress made in the cultural and social sphere in the last ten years is rightly regarded as principally due to successful propaganda work. Propaganda in connection with the various spheres of health work is indispensable, whether for child welfare, the prevention of crippling diseases, for combating tuberculosis or preventing the damage to health and wealth resulting from drunkenness or venereal disease. Health propaganda is ever the chief weapon in preventive health work.

Health propaganda in Germany has no official character. It is carried on side by side with the activities of the authorities, the insurance societies, the associations for different branches of social hygiene, the medical profession, the Red Cross, above all by the Reich Committee for Health Propaganda, on which all these bodies are represented. It merely lays down the lines along which the organizations under it are to work. One of its main principles is that instruction must be on a scientific basis.

The organizations under the guidance of the Reich Committee are:

- (a) the state committees, which decide on the organization of propaganda within their State;
- (b) the local committees, which carry on the actual instruction;
- (c) the provincial committees. These exist only in Prussia, as, owing to the size of that State, the organization cannot be conducted uniformly from a single office;
- (d) the so-called district centres, which are principally concerned with instruction in country districts and in the small towns. They were instituted because the smaller communities were unable to form special committees owing to their smallness.

The means of imparting instruction are many and varied: lectures by doctors, press articles, the influence of the drama, in particular of the cinema, of wireless, of the insurance societies, of the authorities, of the activities of other institutions with like aims, etc.

The Reich Committee considers its main task is to create a public opinion with regard to health matters. Just as nowadays no one is satisfied to allow filth to accumulate in the streets, so a public opin-

ion must be engendered in favour of abolishing unhygienic conditions and taking measures advantageous to public health. The population must be trained to a feeling of responsibility in regard to what individuals must do or leave undone in matters of hygiene. It must be led on from consciousness to conscience, from comprehension to a sense of responsibility.

Another essential task of health propaganda is to influence the schools in its favour. There is a deficiency in the educational system from this point of view which it is the task of the schools to make good.

Valuable support is given to the efforts of health propaganda by the Press. The Press must be induced to show the same interest in questions of health as it now does in questions of sport. Every newspaper must have its Health Column as well as its Sports Column.

It is particularly important that the cinema public should be reached, since it is just the cinema which is visited by sections of the populace which show little or no interest in questions of health. The form taken by instruction through the film must, of course, be of a kind that will captivate the interest of such a public. Another important ally in the campaign for national health is provided by wireless.

The so-called Reich Health Week recently held in Germany was intended less for intensive instruction than for propaganda purposes and for the formation of associations for the instruction of the population in matters of health. Organizations were formed in over 3,000 places during the Reich Health Week. Of these three thousand associations, more than half have survived and have been transformed into local committees for health propaganda which in their turn are now systematically instructing the people on health questions. For reasons of organization, the Reich Health Week turned its attention chiefly to the large towns, leaving the country for the most part untouched. To make good this deficiency and above all to create the necessary associations in the country, the so-called "Health Campaign in the Country" was instituted, which, so far as can be judged, was as successful as the Reich Health Week.

3. THE CONTRIBUTION OF SOCIAL AGENCIES TO HEALTH WORK.

Soon after the political revolution in Germany it became evident that the task of public welfare work could not be fulfilled by purely

material assistance: annuities, relief grants, etc., but that in welfare work psychological factors must also be taken into consideration if those who stood in need of assistance were to be helped in such a way as to enable them to become active once more and to help themselves as much as possible. To supply this combined material and moral relief has ever been the mission of the voluntary charitable organizations. It proved to be absolutely essential that public welfare work should be supplemented by private welfare work. On the other hand there was need for a thorough reorganization of the existing forms of private welfare work. Emergency associations were formed which comprised all the institutions and organizations of private welfare work which were in any way engaged in this kind of work. This group is known as the *Union of Private Welfare*. It consists of seven important main associations:

- Inner Mission of the Protestant Church,
- Caritas of the Catholic Church,
- German Red Cross,
- Central Committee of the German Jewish Relief Association,
- Fifth Welfare Association,
- Central Board of the Association for the Relief of Christian Workmen,
- Central Board of Workmen's Welfare.

The first six of these associations formed themselves in 1925 into the German League of Voluntary Welfare Work.

The most important task of voluntary welfare work is the care and cure of all ills with which it comes into contact, particularly the serious and incurable cases. It is especially interested in the educational aspect of this task. A good definition is supplied by the third Executory Decree to the Law of December 4, 1926, on the Redemption of the Public Loans: "Welfare work is systematic care for the suffering and those exposed to danger, exercised for the good of the community and not for the sake of gain. This care may extend to their physical, moral or material welfare and may be aimed at prevention or cure." Voluntary welfare work is work "practised voluntarily by its agents, without any legal compulsion."

Dr. Harmsen, the reporter on health questions to the Inner Mission, states, with regard to the share of voluntary welfare work in the total health work done in Germany in 1927, as follows: Voluntary Welfare Work comprises about 10,000 homes or institutions, in

which half a million people are treated or looked after entirely. Besides these there are 7,000 day or night homes, in which about 400,000 persons, chiefly children, are looked after in the daytime or at night. Further there are 15,000 institutions for the treatment, support or other relief of persons in need of assistance. The personnel of the head office numbers over 100,000 male and female workers; in addition, there are large numbers of honorary workers in the 30,000 branch associations. If all the institutions were to be collected in a single welfare city, the size of it would be about that of Frankfurt-on-Main.

According to the usual classification, three types of work are to be distinguished: (a) institutional relief, (b) semi-institutional relief, (c) outdoor relief.

(a) *Institutional relief* includes the general and special hospitals. In 1925, 35,659 days' work was done in 1,485 institutions having 143,172 beds. If we compare these voluntarily run institutions with those under public control we find that about two-thirds of all the hospitals are under public administration and one-third under the voluntary system.

Under the category of institutional treatment come also the maternity homes (maternity hospitals, lying-in hospitals, nursing homes). According to statistics for 1925 there are more than 568 institutions of this kind with 21,479 beds at the disposal of voluntary organizations.

There are 1,017 convalescent homes for adults and children with 63,083 beds.

Among the institutions for physically defective persons are 119 institutions for epileptics and the feebleminded, with 31,557 beds, 134 institutions for cripples, blind, deaf mutes and blind deaf mutes, 2,139 almshouses and infirmaries with 54,256 beds.

For the treatment of venereal diseases there are 5,462 institutions with 325,969 beds.

(b) *Semi-institutional relief* is provided in 149 day convalescent homes with 15,775 places, and 7,657 crèches, kindergartens and children's shelters, with 456,630 places.

(c) *Outdoor relief*: The centres for the treatment of patients and the public health nursing centres are important agencies of voluntary health work. There are 10,157 of these in Germany. Moreover there are 5,800 consultation centres for alcoholics, consumptives, and expectant and nursing mothers. Voluntary welfare work in-

cludes also all associations such as the maternity and nursing associations, the so-called welfare services, railway station missions, associations for distressed persons and various associations which have as their mission the relief of their fellow-men.

B.

1. HOSPITAL AND DISPENSARY SOCIAL WORK.

According to Hedwig Landsberg, Head of the German Association for Hospital Social Service, social work for inmates of hospitals and their families was first instituted in Germany in the middle of the nineties at the Charité Hospital in Berlin. Nearly twenty years passed before this example was imitated and in 1913-14, in the towns of Frankfort-on-Main, Berlin and Munich a social service was introduced in the various hospitals. In the following decade it was instituted in Breslau, Stettin, Hamburg, Düsseldorf, Leipzig, Dresden, Nuremberg, Brunswick, Altona and Kiel. To-day social work is carried on in the hospitals of more than 70 towns. In recent years both the communal administrations and the agencies of voluntary health work have turned their attention more and more to this subject and have decided in ever increasing numbers to introduce social work of this kind.

In the early years it was exclusively persons interested in social work belonging to voluntary welfare organizations who took the initiative in introducing hospital social welfare work, as it was called until lately. This may be due to the fact that at first sight the activities of the woman hospital social worker appear to be rather of the nature of pure charity because it is the individual service rendered to the individual patient which first strikes the eye. Only gradually was it realized that the service rendered to the individual patient is not without significance for the community. Ninety per cent of cases of poverty are due to the illness of the head of the family. The social service in the hospital was therefore taken over in some places by the municipality, when, in the difficult years after the war, voluntary organizations were in many cases unable to keep up the institutions which they had founded. Similarly where it has been introduced since 1919, this has chiefly been under the auspices of the communal health work. This seems all the more justified in that the saving of money effected by the activities of the hospital social worker benefits the public finances almost exclusively.

The fact that the work developed in the manner described above is the reason why social work in hospitals was not organized on uniform lines throughout Germany but takes a variety of forms.

One of the most controversial questions is whether the hospital social worker should be a member of the hospital staff or whether she should carry on the social service in the hospital on behalf of some office outside the institution. Similarly the question whether this social service is to be regarded as a branch of health work or of economic welfare work has not been settled alike in the various towns. Moreover the denominational associations hold the view that only hospital social workers whose convictions are the same as those of the patient are fitted to look after him.

On the basis of these very varied views, social work in hospitals is carried out in Germany:

(a) by hospital sisters (e.g. in Berlin—to some extent,—in Düsseldorf, Goerlitz, Jena, Nuremberg, Stettin, Stuttgart);

(b) on behalf of the Health Office (e.g. in Leipzig);

(c) on behalf of the Welfare or Relief Office (e.g.) in Brunswick, Danzig, Dresden, Frankfort-on-Main, Berlin-Wilmersdorf);

(d) on behalf of the Child Welfare Office (e. g. in Mannheim, Berlin-Spandau);

(e) in the form of family relief, which in some towns comes under the Health Office, in others under the Welfare Office (e.g. in Altona, Berlin-Charlottenburg, Gelsenkirchen, Kiel, Lübeck);

(f) on behalf of the denominational organizations (e. g. in Berlin, Breslau, Elberfeld, Frankfort-on-Main, Hanover, Hildesheim);

(g) on behalf of inter-denominational welfare associations (e. g. in the Berlin University clinics, in Breslau, Hamburg (Red Cross), Munich).

The sphere of labour of the German hospital social worker is, generally speaking, the same as that of her colleagues in other countries.

Social work in hospitals supplements the work of doctors, nurses and the hospital administration in the direction of welfare (Goldmann).

Social work begins with the *patient in person*. He receives advice and assistance in all economic difficulties, and all the small obligations with which he cannot be troubled owing to his illness are taken over on his behalf. Into this category comes the work of as-

uring the continued payment of the sick benefit and allowances, which the social worker must, if necessary, collect from the post office, of writing letters, sending in forms, etc., establishing and maintaining contact with dependents, and so on. As the patient recovers, the question of where he is to go and what he is to do on leaving hospital becomes an important part of the social work. For it is often a case of beginning life over again, either because a new occupation must be found for him owing to his diminished physical powers as a result of his illness, or because he finds himself in altered circumstances on leaving hospital. Thus the social worker is obliged to get into communication with the labour exchange or employment agency and, if the patient has nowhere to go, to inform the Housing Office or the poor-law or other competent authorities. In not a few cases the patient has not recovered his full powers of work when he is discharged from hospital. A period at a convalescent home or settlement will have to follow the hospital treatment if complete recovery is to be ensured. It is the business of the social worker to prepare and arrange for this additional treatment.

Besides this work on behalf of the patient himself who has been received into the hospital, that of looking after his *family which is often left in the greatest distress* is one of the most urgent duties of the hospital social worker. In order to make it possible for the household to be carried on, she often has to arrange for relief from the welfare office or some other public or private welfare organization, especially when the family has become greatly impoverished by the long illness of the breadwinner and had already been obliged to dispose of any clothing or furniture that it could do without. In many places the welfare worker has at her disposal a special fund for cases in which speedy help is required; in others she is able to procure by other means pecuniary assistance, provisions or free meals, linen, beds and furniture. In cases in which the housewife is ill, the social worker will apply to the association for household relief for a woman to run the house properly; children who have no one to look after them, or helpless dependents, must be provided for in suitable homes or institutions. It is also part of the social worker's duty to have an unhygienic or overcrowded dwelling exchanged for suitable accommodation by the Housing Office, thus opening up further possibilities for the complete recovery of the discharged patient.

Advice and assistance of the same kind are given also to patients

who are having dispensary treatment at the hospital and are prevented by the treatment from carrying on their work.

Children receive instruction only at the children's sanatorium at Berlin-Buch and Frankfort-on-Main.

In 1926, the number of cases under treatment was as follows:

Altona	in 2 hospitals	399	cases	
Berlin	32 "	15,423	"	
Bochum	? "	299	"	
Breslau	6 "	424	"	
Danzig	? "	345	"	
Dresden	? "	2,814	"	
Düsseldorf	1 "	1,030	"	
Elberfeld	? "	891	"	
Frankfort-on-Main	15 "	5,328	"	
Gelsenkirchen	6 "	475	"	
Görlitz	? "	77	"	
Hamburg	5 "	4,093	"	
Jena	5 "	931	"	
Kiel	? "	2,211	"	
Leipzig	2 "	575	"	
Lübeck	? "	115	"	
Lüneburg	? "	6	"	
Mannheim	? "	1,098	"	(children)
Munich	1 "	130	"	
Nürnberg	1 "	963	"	
Stettin	1 "	1,886	"	
Stuttgart	1 "	1,620	"	

2. PSYCHIATRIC SOCIAL WORK (INCLUDING THE WORK IN COURTS AND PRISONS).

The so-called psychiatric work is still only just beginning to develop in Germany. According to Dr. Kleefisch, head physician at the Franz-Sales asylum in Essen, "mental deficiency" is merely a generic term. Idiocy, to a great extent, is a malady which affects the whole body. A home for the feeble-minded is a clinical chaos of human beings suffering from the most varied forms of disease, from acute or chronic, functional or organic disorders of the nervous system, of the brain, of the organs of the senses, of the powers of speech and locomotion, variously afflicted also with numerous other infirmities and illnesses due to predisposition to illness, insufficient care of themselves and lifelong overcrowding.

Scientific psychiatry is engaged in establishing a system of classifying diseases and drawing up tables of cases of feeble-minded children, epileptics and the causes of abnormal mentality.

The statistics of the special schools give an important indication of the *number of mentally deficient*, i.e. those who are incapable of assimilating the teaching of normal primary schools; according to the statistics, the number of such scholars at the special schools is from 2 per cent. to 3 per cent. of the total number. Moreover, the worst cases of feeble-minded children do not attend school at all. The number of idiots and bad cases of imbecility in Germany can be reckoned at about 300,000. Of these about 30,000 are in private and public institutes and about 2,000 receive school and vocational instruction.

The law of July 11, 1891, deals with public welfare work in connection with the feeble-minded, idiots and epileptics. Cases of feeble-mindedness receive shelter, treatment and care in an institute. Patients are received in an institute:

- (1) for *treatment* which cannot be carried out in their own family, in a strange family, or for experimental purposes or vocational training;
- (2) *owing to inadequate care at home*,
 - (a) if the necessary permanent supervision cannot be insured by the family;
 - (b) if incontinent, crippled or serious epileptic cases cannot be provided with the necessary attention or assistance during attacks.
- (3) *if the patient is a danger to the community*,
 - (a) through a tendency to senseless destruction,
 - (b) through the difficulty, frequency and danger of the epileptics fits for the patient himself and those around him;
 - (c) through a tendency to indecent practices;
 - (d) through a tendency to vagrancy and illegal practices connected therewith.

It is calculated that in Germany there are from 1 to 2 epileptics in every 1,000 inhabitants. Naturally, only a small percentage of these sick people need treatment in an epileptic home. The question of family care arises in the case of many.

The societies chiefly concerned with welfare work relating to the

feeble-minded are the Roman Catholic Caritas and the Protestant Inner Mission. The *German Catholic Relief Association* at present maintain 55 institutions with 14,000 beds. There are 40 *Inner Mission Institutes* for idiots and epileptics also with 14,000 beds.

Welfare work for young psychopaths is concerned with (1) *supervision*, which aims at the prevention of physical, mental or moral neglect and is carried out by an educational worker (helper); (2) *training* in a suitable private family, or in an institution under public supervision and at the public charge.

According to Ruth v. d. Leyen, the superintendent of the German Association for welfare work in connection with young psychopaths, there are today in Germany:

- (1) Public organizations for giving advice, supervising and finding homes for psychopathic children and young people;
- (2) Private (benevolent, denominational) organizations;
- (3) Self-supporting private homes for remedial treatment, sanatoria for children and young people.

Category 1 includes psychiatric *observation stations and consultation centres* affiliated to various University clinics. They receive abnormal mental cases which cannot be diagnosed by means of clinical examination and keep them in an environment (other than hospitals) suitable for children under medical supervision and treatment, as well as under an educational influence until the nature and causes of the physical abnormality have been established and further advice concerning curative treatment can be obtained.

Many of those centres are run in connection with social welfare organizations for the purpose of investigation. Other States organizations are those institutions for the care of psychopathic children which, like that in Baden, are superintended by a "State psychiatrist" and are under State supervision. In Prussia, these institutions are divided among the provinces. The object is to create an "observation and distribution centre" (sometimes called "reception and distribution home") in each province and state, whose aim is to examine, physically and mentally, and to observe all children who are handed over for protective education in order to place them in a family, institution, home for remedial treatment, service, training or work according to their peculiarities, abilities and possible existing mental abnormalities. With the organization of the child welfare offices (under the German law of July 9, 1922, relating to child

welfare work) advisory centres have been established at various child welfare offices for remedial training conducted on the lines of psychiatry or instruction in remedial treatment, supplemented, if necessary, by psychiatric research.

The above-mentioned organizations—with very few exceptions—are for the observation and placing of mentally deficient children in general; the remedial training of psychopathic children cannot be carried out according to remedial instructional ideas unless they are in special institutes.

If it is necessary to remove the child from its home for a course of concentrated remedial training away from its usual surroundings, this is effected through and under the supervision of the office for the placing of feeble-minded children, known as the "Central Office for Remedial Training." When the training is completed, the child is sent back to its parents and remains under the supervision of the said Central Office. During the last 8 or 10 years the private organizations for advice and provision in regard to psychiatric cases have increased.

There are no special schools in Germany (e. g. special schools for feeble-minded children). There is, moreover, no demand for them. If the children are able to remain at home, they are also able to attend the public schools. If they are sent to homes for remedial training, the training can there be carried out by suitable persons until the children are able to attend school.

Social work in police courts, according to Herr Michel, Municipal Counsellor (Frankfort-on-Main), represents coöperation between the legal authorities and the welfare associations. In order to carry out the educative idea, which even now is served by conditional exemption from punishment and which the penal methods of the future will place in the foreground, the penal system requires special organs, since the system now at its disposal, viz. the police, owing to its composition and its other functions cannot be taken into consideration as an organ for welfare work and education. Welfare organizations, therefore, which are constantly concerned with physical and moral welfare, are all the more suitable since they so often have to deal with human beings who are in the charge of both the judicial and welfare authorities. The first thing to be investigated is their mode of living, environment, social status and mental condition. Before deciding as to conditional exemption from punishment, or when deciding definitively to remit punishment after the period of

probation, the results of such investigations are taken into consideration. Wherever this system of coöperation between the judicial and welfare authorities in this sphere has been tried in an exceptionally satisfactory manner, as for example, in Bielefeld, Halle, etc.,—in those two cities 5,727 cases were dealt with during the years 1923 and 1924—it has been recognized that the welfare institutions must be asked to collaborate in the preliminary proceedings, in an advisory capacity. The official welfare organizations are called upon together with the voluntary organizations for the performance of the resulting tasks.

The practical execution of social work in police courts for adults is carried out, in Halle for example, as follows. The office is in the court building itself. In all cases of criminal proceedings pending before the police court or assizes in which sentence to imprisonment or detention in a reformatory is anticipated, a copy of the charge or complaint is sent to the office with the request that a questionnaire be filled in. The court welfare workers collect the necessary information and enter it in the questionnaire which is then returned to the court. The head and his assistant workers can, in principle, be present at the court proceedings. The difficulty of the investigations has resulted in the honorary members originally appointed being gradually replaced in difficult cases by regular officials. In the event of exemption from punishment, the welfare measures are directed from this office in conjunction, however, with the organizations concerned (those dealing with alcoholics, psychopaths, epileptics, etc.). They must be found work and live in morally strengthening surroundings which often necessitates separation from their family as well as other welfare measures.

Police court welfare work for adults is still developing. The first office, according to Bozi (Berlin) was established in 1921; according to a census taken in 1925 there were about 27 police court social workers, i.e. in one-third of the circuits.

(For social work in connection with children's courts, see German special report for the International Child Welfare Congress).

Social work in prisons—in the outward sense of the word—according to Dr. Grünhut, Professor at the University of Jena, means all the *welfare measures* which in cases of detention or imprisonment are carried out *during and after such a period*. There is a difficulty in connection with a wider interpretation of this conception in that discussions relating to the organization of the duties concomitant with

social assistance and welfare work are not based on any clear definition of the object of such work. Welfare work is sometimes subjective, as for example, measures of relief, and sometimes objective, for general purposes, in the special case of prison welfare work, such as endeavours towards the rehabilitation of the offender. The fact that, notwithstanding this abstract definition, criminal and prison welfare work are often combined for purposes of organization and practical reasons is bound up with the recognition by modern criminology of the fact that punishment by imprisonment is an evil not only for the culprit but also for State and community, but that nevertheless this form of punishment, like all others, entails the duty of overcoming not only the evils caused by the act, but also those which the act has brought to light.

The work in Prussia was outwardly based on existing legislation relating to welfare work in connection with discharged prisoners made public through the circular decree of June 13, 1895. Inwardly, the work was to a great extent inspired by ideals of Christian charity as applied to social work.

Moreover, under the regulations of June 7, 1923, for the execution of sentences of imprisonment, the care of discharged criminals and, in particular, the finding of suitable homes and work is the duty of all officials and, first and foremost, of all welfare workers when these are at hand. To help the associations and organizations which devote themselves to the care of discharged prisoners, these workers must keep in constant touch with and assist them as much as possible (§ 226). After the post-war and inflation period had passed, some of these associations were given a new lease of life by State subsidies. The newly founded German Reich Association for court, prison and discharged prisoners' welfare work is striving to obtain the inclusion of all associations united by similar ideals in a head organization for all welfare work in connection with prisoners and discharged prisoners.

In particular, various methods have been adopted for the division between State and Associations. In Prussia, the Wittlich a. d. M. reformatory at first had a travelling welfare worker for young people discharged from that institution. The appointment by the head office of social workers for the prison departments and larger prisons was first decided upon by the Landtag on February 1, 1926. In Berlin, there is an advisory and welfare centre set up jointly by the central association of public and voluntary welfare workers and the asso-

ciation for the reformation of criminals. In *Hamburg*, prison welfare work is to a great extent carried out by the *Social Section* of the prison department itself. In *Thüringen*, social workers appointed by the head office coöperate in the prisons with local groups of the Thüringen prison welfare association and its workers. *Saxony* was the first German State to declare, through the Saxon social welfare law of March 28, 1925, that the care of discharged prisoners was the duty of public social welfare, thereby making the State responsible for the organization and cost thereof.

The primary and most urgent duty of prison welfare work to-day is to provide work and maintenance. Nowadays, the finding of work has to be left to the official labour exchanges, which in large towns often have special sections for those whose working capacity has been endangered or reduced. Before the discharge of a prisoner, the prison authorities generally apply to the competent labour office or to a central labour exchange. This is done through the intermediary of prison welfare workers. These workers must also assist the department in finding suitable work, in furnishing particulars, and in influencing the employer, the unions and the public in favour of the employment of discharged prisoners. In the way of economic assistance, prison welfare gives preference to payment in kind instead of bare support: food, shelter, railway expenses, rent, tools, etc.

Prison welfare is supplemented by the system of family relief for members of the prisoner's family which is still only in the early stages of development.

Prison welfare work is in a state of transition both in regard to practical methods and matters of organization.

For some years past endeavours have been made to introduce a law for the supervision of so-called "asocial" persons (supervision law). For those who are not entirely normal, but who are yet responsible within the meaning of the penal code, a long period of detention—veritable supervision—in completion of the sentence and as a measure of welfare work in connection with discharged prisoners may be definitely taken into consideration in addition to a temporary period in a training institution (coming towards the close, but not after the term of punishment).

3. SOCIAL WORK AND SCHOOL HYGIENE.

According to Dr. Hoffa, municipal children's doctor in Barmen, school hygiene in the strict sense of the word includes all measures which serve to combat the increasing dangers to health outside the school. The crowding of a large number of children into a small space and the instruction itself involve disadvantages and dangers: a vitiated atmosphere, increased possibility of contagion, injury to the eyes and limbs. School hygiene proper includes mental hygiene (the question of overworking) and the recognition of abnormal mentality and deficient intellect. These are acknowledged facts and need not be discussed here.

School health work is part of general child health work which covers the period from infancy until the time when the child leaves school. To a certain extent it makes use of the school in order to reach all children of various ages requiring attention and extends from the school to the family and home within the scope of organized family relief.

Although in theory it is comparatively easy to make a distinction between school hygiene and welfare work for school children, in practice these constantly overlap and are inseparable. Hygiene and welfare work are alike concerned with the same object, i.e. the school-child, and the individual workers, school doctors, female social workers and school nurses are the same in either case.

Some of the welfare organizations, such as *shelters, children's day nurseries and similar institutions*, emphasize the educational side, while others, such as *holiday camps, recreation grounds and hostels*, lay stress upon the health aspect. The close relation between the two spheres of interest and their connection with social economic problems is recognizable at every turn.

Children's shelters, according to an old and widespread definition, are institutions which receive children who are not looked after out of school hours and offer them a substitute for home care and educational influence. They are thus included in the child welfare organizations which lay particular stress on the educational aspect. In each child welfare organization, however, due consideration is given to the three aspects of welfare: social conditions, health and education. The system of shelters entails the coöperation of doctors interested in biological and social hygiene.

The particular disadvantages which have to be combated by the

shelters are mainly due to the employment of married women in industry and to the increasing housing shortage in large towns. In addition, there are many other kinds of economic and moral requirements which naturally play an important rôle: poverty, sickness, orphanhood, insufficient sense of responsibility or moral degeneracy on the part of the parents. They suffer from insufficient and irregular nourishment and above all from insufficient sleep. In the shelters the child is in healthy and comfortable surroundings and receives devoted supervision and training, guidance in work and play, in so far as is necessary, improved food and physical care and exercise.

Convalescent care and treatment in homes and sanatoria assist the supplementary school welfare work, in particular, health work. Convalescent care includes all the measures which are provided by the public authorities or private welfare organizations for the elimination of the after-effects of illness and for counteracting constitutional defects and hereditary or acquired tendencies to illness. The duties of the sanatoria include treatment of existing disease, in particular, tuberculosis, and also other constitutional or acquired illnesses, such as nervous diseases, skin diseases and syphilis, digestive disorders, deformity, after-effects of rickets and hereditary malformation. Some of these duties have recently been assigned to the cripple welfare association.

Those measures which are necessary for the maintenance of the child's physical health, such as gymnastics, sports, games and walks, do not come under convalescent care, but under general health. It is difficult to draw a hard and fast line as between health and sickness, fitness and unfitness. The difference between treatment in sanatoria and hospitals lies mainly in the fact that the former is characterized by its limitation to certain special categories of illness, as, for example, tuberculosis, and by the use of special curative measures and climatic factors. Hence, convalescent treatment consists in preventive measures against illness and the building up of the constitution, and the task of the sanatoria is the treatment of sickness. In the fight against infant tuberculosis, therefore, children threatened or already infected with tuberculosis are sent to convalescent homes, while those who have already contracted the disease are sent to sanatoria. It is necessary, on economic grounds, to make as definite a distinction as possible. The very limited funds must be sent to the proper institutions. The selection of the children must not be left to chance,

but must be made systematically from the medical, economic and educational standpoint. Such selection is possible only through an organized system of welfare for children of all ages. In regard to the selection of school children, we rely respectively on the assistance of the teachers, school nurses and social workers, but above all on the intelligent coöperation of the school doctors. The school doctor must be a fully qualified children's doctor. He must also have a knowledge of the social environment of the children under his charge and, lastly, must earnestly endeavour to discover the constitutional tendencies of the child.

There are no hard and fast lines in the organization of convalescent treatment so that it is able to adjust itself to changing economic conditions. The simple forms which were customary in Germany before the war are no longer adequate. During the war, since about 1917, it became more and more general to send children away from the large towns and industrial districts. The principal reason was the increasing shortage of food in the towns and under-nourishment in the fullest sense of the word. The question of under-nourishment being settled within a certain time after the conclusion of the war, prominence was given to other forms of ill-health: the various effects of the war, injury to health through many years of mal-nutrition and through the cent treatment so that it is able to adjust itself to changing economic shortage of other necessities (shortage of clothing and houses, lack of sleep and supervision). The calamitous increase in prices and the famine in the occupied zone resulting from the Ruhr conflict in January, 1923, made it necessary again to send large numbers of children out of the Rhineland and Westphalia to relieve the food problem. Through the devotion of the rural population in nearly all parts of unoccupied Germany, and with the help of "The Fresh Air Association for Town Children" central organization in Berlin, this extensive transfer of children was accomplished without a hitch to the great benefit of the children.

In the meantime, economic and political conditions in Germany have once more become sufficiently settled and established to render such extensive transfers unnecessary. It is now possible to return to individual welfare work in respect of each child in need of convalescent treatment.

Any child who cannot obtain the necessary treatment through the means and resources of its own family is to be regarded as a subject for convalescent treatment from the standpoint of social

welfare work (*Rott*). Convalescent treatment carried on by means of public funds must be restricted to such children.

The following categories of children may be indicated as in particular need of treatment:

(a) All children who are suffering from actual undernourishment owing to shortage of food, or who, through living in congested surroundings, through insufficient clothing or other forms of neglect, have deteriorated in health and normal development. The following reasons must also be taken into account:

(b) Need for convalescent treatment after exhausting illnesses;

(c) Pallor and mal-nutrition, known as school anaemia. This school anaemia is generally not caused by actual poverty of blood, but is a symptom of increased nervous irritability. The pallor of such children is only due to quick changes of colour;

(d) Actual poverty of blood and lack of muscular strength (permanent pallor, weak pulse when standing);

(e) Constitutional skin diseases (eczema), frequently recurrent catarrh of the respiratory organs, ulceration of the ears, inflammation of the eyes;

(f) Debility and hypoplasia (defective development) if combined with bad social conditions;

(g) Pronounced disproportion between physical height and weight during the growing age;

(h) Symptoms of rickets, especially when late in developing;

(i) Danger of tuberculosis and tubercular infection.

The need of convalescent treatment by school children is often due to mal-nutrition. *There is very often a close connection between convalescent treatment and the provision of good food.* One sometimes takes the place of the other. The investigations of the school doctors often result in selecting at the same time children for both kinds of treatment. The good results obtained during convalescent treatment are often followed up by the supply of good food at school.

Convalescent treatment is divided as follows:

1. *Local treatment:*

(a) Local light and air baths (verandahs, day colonies, half-day colonies, forest centres for treatment);

(b) Local brine baths;

(c) Forest schools.

2. *Convalescent treatment away from home:*

(a) Individual care in families in the country;

(b) Special rural colonies, holiday colonies, holiday homes (in the lowlands, the hills, the mountains, at brine baths, at the seaside).

4. THE DISTRIBUTION OF ECONOMIC BURDENS OF ILLNESS.

(See Special German Report.)

5. HEALTH WORK IN INDUSTRY.

According to Dr. Martineck, a permanent official at the Reich Ministry of Labour, the Reich Industrial Decree (Reichsgewerbeordnung) provides the elements for industrial welfare (health work in industry). It contains general welfare provisions, according to which industrial employers are obliged, in all premises in which the workmen have to be accommodated for their work, to install and maintain the working appliances, machinery and tools, to regulate the work through the use of certain methods, through the choice of suitable workmen, through the equipment of such workmen, etc., in such a way as to ensure them against danger to their lives and health. It will suffice to mention: good light, sufficient cubic space and ventilation, the removal of dust arising from the work, of steam, fumes and rubbish. There are special provisions relating to the personal health of the workmen. In addition to the general protective provisions, it is also the legal obligation of the employer to institute special measures for the protection of young workers under 18 years of age against danger to health and morals. The employment of juvenile labour (under 18 years of age) and of female labour may be strictly prohibited in particularly dangerous work or made contingent upon special conditions. This legislation supplies the so-called general regulations on the basis of which special regulations can be laid down by the competent authorities (Reich, States or police authorities) for particular branches of industry. The law specially defines the authorities which are competent to draw up such regulations.

In addition to the Reich Industrial Decree, as legal basis for the execution of the protective measures, there are also certain Decrees regulating the *working day*—among which is the special decree of February 13, 1924, concerning the working day in nursing institu-

tions—the *Law for the protection of children*, and the *Law relating to work at home*, for the protection of such workers.

The special provisions relating to labour dispersed throughout the various laws and decrees will be comprised in a *law for the protection of labour* and supplemented on the ground of practical experience and knowledge—taking account also of the Washington Agreement.

The protection of labour in mines is regulated by special mine laws enacted by the individual States.

The employers' associations for workmen's insurance are an important addition to protection of labour by the State. This protection is provided for in the legislation concerning protection against accidents set forth and recently extended in the *Reich Insurance Decree*. According to that decree, the employers' associations are responsible for the enacting and execution of regulations for protection against accidents; they shall provide for effectual *first aid* to persons injured through an accident and, moreover, shall adapt their protective measures, in so far as is economically possible, to the latest technical and hygienic improvements. They must assign duties to their members in respect of first aid to the injured and must also see that the insured persons themselves carry out their obligations. Thus, for example, the employer can be compelled to keep in readiness suitable ambulances and the necessary medical appliances and material for the first dressing and to make arrangements with hospitals for the rapid and appropriate care of the injured person. Further, arrangements shall be made for instructing insured persons, masters and employers, verbally and by means of pamphlets and pictures as to the nature and value of protection against accidents; for teaching the principles of safeguarding against accidents in schools of every kind, and for holding classes for industrial welfare workers, etc.

At the instigation of the Reich Labour Minister, a Committee of the States for safeguarding against accidents has been set up by the Reich Ministry of Labour for the examination of questions relating to health work in industry throughout Germany; this Committee is supposed *inter alia* to utilise the experience of industrial inspectors in the various States for establishing the regulations of the industrial associations for safeguarding against accident, on the one hand, and, on the other, for safeguarding the interests of the workmen.

Whereas the existing regulations apply almost entirely to the

employer, the *Industrial Council's Law of February 4, 1920*, expressly provides also for coöperation on the part of the employee. According to § 66, the representatives of the employers shall turn their attention to measures against accident and injury to health in industrial concerns, and shall support the industrial inspectors and other authorities concerned with these measures by encouragement, advice and information.

For the advancement of protection against accident, the German Commonwealth has created a "*Permanent exhibition for workmen's welfare*" in Berlin-Charlottenburg which has now been brought up to date. Here all the latest, proved appliances for the protection of life and health in industrial concerns are shown with easily understood descriptions for purposes of explanation and instruction; some of them are shown in operation. There is also a collection of foreign pictures on the same subject; films are also on loan, some of which are shown at the exhibition.

A special monthly supplement has been added to the "*Reichsarbeitsblatt*," the official gazette of the Reich Ministry of Labour, concerning protection of industrial workers; pictures relating to safeguarding against accident are published in connection therewith.

The regulation for the supervision of measures for the protection of labour in the individual States is left to these States which employ special *industrial inspectors* for that purpose. The execution of the protective regulations against accident is supervised to a certain extent by the technical inspectors of the industrial associations; the approval of the Reich Insurance Department is required for the appointment of these officials. The State industrial inspectors and the mining authorities have to draw up annual reports, which are submitted to the Reichstag and to the Reichsrat by the Reich Ministry of Labour. The Reich Ministry of Labour, with the coöperation of the individual States, may submit certain additional questions concerning important urgent problems relating to measures for the protection of labour. The Reichsrat has arranged for as uniform a system of State industrial supervision as possible and for the effectual execution of the basic principles of protection in the several States.

This work is carried out at present by about 650 officials (Government industrial counsellors, industrial counsellors, industrial assessors, industrial lawyers) and assistants, including women officials who deal in particular with the protection of women, young people

and children in the factory and women working at home. The employers' representatives must take part in the investigation of accidents.

In certain circumstances, the police also participate in protection in the factory. In accordance with the national mining law, the mining industry is supervised by special State officials, known as mine police.

The coöperation of the doctor in industrial supervision was provided for by the legislation on protection of labour at the very outset. The technical industrial inspectors had to confer with the permanent doctor on medical questions. In addition, doctors paid by the employer, as part time factory doctors, were early engaged to examine the workmen employed in dangerous work both at the time of their engagement and periodically, as provided for in the decrees of the German Government. Such examinations are, for example, compulsory for the admission of young people to the glass works, for workers in lead and zinc mines, in lead colour works, in accumulator factories and in works for the manufacture of nitro and amido combinations.

Special industrial doctors were instituted comparatively late in the day. In Württemberg in 1905, the industrial health counsellor of the Medical College was appointed industrial inspector in addition to his other work. Baden was the first German State to appoint, in 1906, a doctor as industrial inspector. The position of State industrial doctor in Bavaria was created in 1909. Saxony followed in 1921 and in the same year Prussia appointed five industrial doctors (industrial medical advisors) with headquarters in Düsseldorf, Arnsberg, Wiesbaden, Breslau and Erfurt (now Berlin). The Prussian service order of 1922 declared the industrial medical advisors to be industrial inspectors within the meaning of § 139 b) of the RGO; they have, however, no authority to issue orders or punishment. Their sphere of work includes advice and assistance to officials of the general industrial and mines supervision, in questions of health in industry, research into pathological conditions in the organism of the workmen brought about by their occupations, their prevention and elimination, development of the general field of work relating to health in industry. The number of industrial medical advisors should certainly be increased in order to cope with their ever-increasing duties. In Saxony, steps have already been taken to this end.

It is proposed that the need for industrial doctors should be recognized by the above-mentioned law relating to industrial protection.

The Decree of the Reich Ministry of Labour of May 12, 1925, relating to the extension of accident insurance to occupational diseases constitutes an important advance in industrial protection. It includes the following diseases under insurance against accidental poisoning through lead or its combinations, through phosphorous, through mercury or its combinations, through arsenic or its combinations, through benzol or its homologues, through nitro and amido combinations of the aromatic series, through carbonic disulphide, cancer of the skin through lamp-black, paraffin, tar, anthracene, pitch and allied substances, cataract among glass makers, illness through Roentgen rays and other radio-active energy (radio-active substances), miners suffering from worms as well as Schneeberg disease (emphysema of the lungs in the Schneeberg mining district of Saxony). An extension of this decree is being prepared by means of a series of inquiries in connection with industrial doctors and technical inspectors. These enquiries have been subsidized by the Reich Ministry of Labour.

From the standpoint of health protection, the most important provision of this decree is that whereby not only the employer, but also the attendant physician, must immediately notify cases of sickness connected with the specified poisonous substances and consequent injury to the insurance office, which is obliged to allow all such cases to be examined by a "suitable" physician, that is, by one who is specially qualified in occupational diseases. In order to facilitate this work, the Reich Minister of Labour has published instructions setting forth the various morbid conditions which, according to recognized scientific principles and experience, generally, or in certain circumstances, come under the category of occupational diseases. These instructions are not final since they allow of indemnity even for conditions which are not specified and constitute an important basis for future developments in this domain. Under another provision of this decree, whereby the insurance office has to transmit a copy of the notification to the insurance societies and to the official doctor, knowledge of the frequency, immediate circumstances and symptoms of the diseases in question in the industries concerned will be increased and will lead to improved protective health measures in the respective industries, either by an improvement in the existing arrangements, or by the timely withdrawal of the worker concerned from the in-

dustry which is injurious to his health and the timely application of suitable medical treatment. This provision will perhaps lead to the institution of permanent medical supervision in other industries.

Finally, the decree contains a clause providing for *industrial relief* to insured persons running the risk of contracting any of the above-mentioned occupational diseases; insurance societies may grant to insured persons whose health is endangered, in addition to any annuity on account of loss of capacity to earn a living, a temporary annuity up to one-half of the total annuity so long as he is not occupied in the particular industry which is dangerous to his health.

In the first insurance year (July, 1925, to the end of July, 1926) 3,847 cases of occupational diseases were notified under this decree to the societies insuring against accident; 165 cases were compensated by means of annuities or sick benefit. Seventy-two per cent. of the notifications and ninety per cent. of the compensations related to cases of lead poisoning. The expenditure in respect of compensation for occupational diseases incurred by the societies insuring against accident amounted to 120,000 Reichsmarks.

WHERE SHALL WE PLACE THE EMPHASIS IN HOSPITAL SOCIAL SERVICE WORK*

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There are so many places where emphasis should be put in hospital social work that it is hard to know just where to begin. I am approaching the subject from the viewpoint of a person who is not at the present time actively engaged in hospital social service, but is trying to supervise the work of several groups in a number of western states, widely scattered geographically. Conditions surrounding hospital social work in the west, where most of us are located, are rather different from conditions on the Atlantic seaboard. Nevertheless, the problems are much the same and places for emphasis do not differ greatly.

1. I believe that more emphasis should be placed on securing for the jobs of hospital social work, persons who are not only well trained, who can qualify as members of the American Association of Hospital Social Work, but who have some of those qualities mentioned in yesterday's discussion by Miss Burleigh, qualities of courage, humility, adaptability and emotional poise. Social Workers should certainly be able to adjust their own lives, if they expect to help other less fortunate people to make similar adjustments. Real character and interesting personalities should always be sought. Our workers should be the intellectual equal of the doctors with whom they work and need the very best in the way of equipment for understanding the social implications of disease, a knowledge and admiration for medical science and practice and, a flexible and sympathetic understanding of their patients. Too often, I am afraid the reason for our failures lies in the poor quality of the workers, themselves.

* Read before the meetings of the American Association of Hospital Social Workers, held in connection with the American Hospital Association, San Francisco, Calif., August, 1928.

I believe it is hardly possible to lay too much emphasis on this matter. Many a time the heads of hospitals have made it very clear to me that they believe in the principles of hospital social work but are not satisfied with the personnel of their particular social service departments. Generally speaking, it is my experience, that hospital social work is successful where high types of persons are employed, having the attitudes which I have just mentioned.

In parts of the country where there are no training schools for Medical Social Work, the problem of maintaining standards and securing qualified workers is acute. Persons are being used who are unsuitable and, who do not have the broad basis of fundamentals necessary for good work. Often times a worker is used as sort of a glorified clerk, whose sole function is that of making financial investigations. I do not think the answer lies in expending large sums of money, in going long distances to established schools of social work; that is too much like filling a bucket with a spoon. But, I believe that the demand from these uncharted territories must be so clamorous that certain universities will heed the call and establish departments which will conform to the requirements of the Association of Schools of Professional Work. I wonder if we shall ever get to this point which, apparently has been reached by the nursing profession. That is perhaps not a good simile, for their need is not only for fewer but for better training schools.

2. A second place for emphasis is in interpreting our work to the hospital administration itself. We talk a great deal about interpreting the patient to himself and to the community agency, but I think we do not say enough about interpreting our work to doctors, nurses and boards of directors or trustees. Perhaps, we are assuming that they all understand this work of ours, which we consider so vitally absorbing and important to the successful running of hospitals. But do they really understand? I am afraid that if a census were taken, the number of doctors who have a clear understanding of the functions of our departments would be much smaller than we like to think. I am sure there are many doctors in some parts of the country, at least, who think of social service entirely as that department of the hospital, whose sole duty is the determination whether or not the patient can pay for his treatment. It is a great pity that the bigger and fundamental side of our work, case work with patients, is not nearly so well known or appreciated. Our committee on Functions has very definitely confirmed the fact that this *is* our primary func-

tion. There are many ways of demonstrating our work. Our first and main method should be through the doctor. If we are a vital and integral part of our hospitals, we are every day making a visible demonstration through our daily work. I am a strong believer in concrete examples. In making our reports, why not make them vitally readable? Last year at Des Moines, Leon Whipple of the Survey told us that more good in the way of changing popular opinions about social work had come from slogans and articles written in the style of Eleanor Wembridge and Dr. Van Waters than by any quantity of technical articles. It is hardly necessary to state that there is a place for the latter, but it would not be a bad idea to try out the former with some of our boards of directors and superintendents. I know a head worker, who had been feeling quite confident that the work of her department was understood and appreciated by the hospital officials, certainly it was being used to a great extent. She was brought up with a start one day by a question from the superintendent which showed his lack of knowledge. Consequently, she planned a definite attack to break down misunderstanding and lack of knowledge. To further better understanding, medical schools should incorporate in their curricula some chance for the students to get a wider understanding of the social side of the patient's life, as well as of the functions of the Social Service Department. It is too much to hope that the American Association of Hospital Social Workers will make this one of their objectives?

3. My next point is the need for emphasizing diagnosis. The hospital's first concern is the medical diagnosis, and on the accuracy and completeness of the diagnosis depends, in a great measure, the success of medical and social treatment. There is a great desire on the parts of both the physician and social worker to discover cause. Just as the patient is first in the mind of the physician, so must he be in social work. "A medical social diagnosis should be something more than a social diagnosis added to a medical diagnosis. It should signify the condition resulting from inter-action of the health and social situation. The findings of a social worker regarding social relationships, behavior and physical environment are the contributions which a physician, responsible for the care of a patient, must relate to other findings. The hospital worker cannot alone determine a medical social diagnosis. Social findings have significance for medicine proper only in the light of other findings which the social worker, as a social worker has no skill to discover or to evaluate. On

the other hand many medical findings are useless to medicine proper unless they are interpreted in terms of a sick person's capacity and needs. The social worker needs to learn, not only the effect of disease, but the general physical conditions, other disabilities or liabilities and their compensating assets." These last sentences were taken from the report of case study of 1000 cases from 60 or 70 hospitals, tabulated by Dr. Bryant and evaluated by the committee on functions of our own organization. The following example is given. In medicine the diagnosis is in terms of classifications. To understand the essentials of any particular medical case, we need not only this classifying diagnosis, as tuberculosis, pneumonia, etc., but also a description of its effects upon the particular patient. In social work the diagnosis is usually in descriptive terms as to a particular situation.

4. My fourth point is the importance of the Social Service Department being a real and integral part of the hospital. Dr. McEachern said the other afternoon most of the things I have in mind on this particular point, and I think Miss Baker has referred to it also. Our work is one of the factors contributing to the treatment of the patient, and as such must be closely correlated with all the other departments. Dr. McEachern pointed out that one of the best ways, is by a conference between the different departments of the hospital. There must, of course, be a close understanding on the part of the administration. Offices should be easily accessible to the patient and the doctor, and the medical history should contain, if not a complete social history, at least a social summary.

Where funds for the support of the social work in the hospital come from the outside, such as is the case in San Francisco, where certain hospital Social Service Departments are supported by the Community Chest, great care should be exercised that professional policies are not dictated by these outside agencies. There can be very little professional progress where the reverse is true.

5. My last point is the need for closer tying up with the community agencies. The medical social worker and the family case worker must cooperate in the most cordial way in a spirit of mutual confidence based on a deep respect for each other's technique. The aims of both are the same—alleviating distress, securing health, and helping the client to realize to the utmost all the possibilities within him. There are many aspects to the situation, for we have not only

our first responsibility to the patient but to the hospital, and to the community which supplies the funds making our work available.

Miss Gordon Hamilton pointed out in a paper read before our section in Memphis, in May, 1928, that there are now two trends in Social Work— "the converging of agencies to produce greater efficiency, and the fact that social work is becoming more truly social and a professional entity, with social case work as a basis for all types. The approach to the problem is a little different in each group, but there are common objectives for all social work. In 1920, a worker was trained in the art of investigation and since then, various ideas have been emphasized, but her function today is diagnosis and interpretation."

THE SCHOOL'S SHARE IN THE PROGRAM OF CHILD DEVELOPMENT AND PARENT EDUCATION*

ANNA E. RICHARDSON

*Field Worker in
Child Development and Parental Education*

The school of today is committed to the ideal of giving to each child who comes within its guardianship the chance for maximum development within the range of opportunities which it is able to provide.

If this commitment is to go beyond the stage of carefully selected tenets of faith and is to become the motivating force of a functioning program then the school must bend its efforts far more than ever before to know something of the full round of the child's activity out of school as well as in school. It must know something of his physical condition, food habits, rest and play, something of the home from which he comes—the home that has nurtured him and which is so largely responsible for shaping the behavior that he manifests at school. The school will no longer be content in doing what it can for the child during school hours alone, it must try to affect for the better the home from which he comes.

This means that the school's share in the program of parent education must start with its first contact with the child or the child's home, for as early as possible the school and the home should set up a partnership whose purpose is to furnish the best possible opportunities for the child to develop to the "optimum," his potential capacities. The school must not supplant the home in the handling of problems of child care, but it must supplement its work, often times guide and direct it.

Excellent coöperation has been developed between the home and

*Read before the Iowa State Conference of Child Development and Parental Education, June, 1928.

the school by gifted teachers in a number of instances. These, however, are still exceptional, for in the schools as a whole we are just beginning to recognize that they cannot wisely select those experiences which they can best offer the child unless they know far more about the child and his home than they now do.

The nursery school's emphasis upon parental coöperation as a requisite for the school's intelligently doing its part for the development of the child and upon a program which must include child and parent, has much that is significant for those of us who believe that the school and the home should work more closely together in a program for well rounded growth.

The National Congress of Parents and Teachers offers a splendid avenue of approach to this problem. The association has able leadership, it is already interested, and it is earnest in its purpose to serve the best interest of the child through understanding and sympathetic coöperation of teacher and parent. The school has not yet done its full share in promoting this objective. In a letter from the president of the Congress of Parents and Teachers dealing with the question, she said, "We can bring the guests to the table, but you, the teacher-specialists must furnish us the food." Many schools have used the parent-teacher groups to further the work of the school but a well worked out program which will help parents to better see and do their part in a coöperative project between school and home for the education of the child is yet to be worked out.

The next important aspect of the school's share in the program of parent education which should be discussed, is the school's responsibility for giving to its girls and boys training for "worthy home membership." We have accepted this objective as one of the cardinal principles of education, but we have done little to promote a functioning program which will achieve it. Are we ready to pledge ourselves to a program of curricular and extra-curricular activities which will give to every girl and boy an appreciation of the significance of the right kind of home life and a desire to perpetuate it? Which will build up attitudes of home loyalties and will influence the part that they play as members of a family?

Many children in the public schools come with no ideal of the kind of home which should be preserved, or of the kind of home which is worth struggling for or working for. Is the school of today ready to furnish this ideal to the boys and girls under its charge? Are we ready to give our young people help in their own adjustment

problems, training which will enable them to better understand the basis for successful human relationships?

Are these questions of importance for boys and girls of high school age? Are they interested in them?

Statistics show that there are 700,000 persons who were married below sixteen years of age, and statistics further show that marriages of students completing the seventh and eighth grades produce more children than marriages from high school or college graduates. These facts and the interest of high school students clearly indicate that not only should our public schools assume responsibility for developing ideals of homemaking but that they should also furnish training in the social and biological sciences underlying the maintenance of a home, in the skills which must be practiced in the home, and in the problems of child care and management.

A program which will encourage girls and boys to assume their share in the home today and challenge them to strive for the maintenance of worth while homes in the future, demands the coöperation and coördination of a number of the subject-matter departments and of the extra curricular activities as well. Life's situations are seldom solved in terms of chemistry, mathematics, or biology, alone. Knowledge of these should help us to understand and interpret life's problems but they will only do so, if taught so that the child gets relationships and learns to use subject matter as tools.

Child care and other problems of home and family life cannot be adequately taught as one subject or by one department alone. It is an important part of homemaking and can well be organized by the home economics department but it should have the assistance of all available specialists; the school nurse, physician, psychiatrist, as well as the help of the health and physical education department, social and biological sciences, and the departments of music, literature and arts.

A recent survey reports courses in child care offered as a part of the home economics program in a number of schools and indicates that they are using many agencies to assist in providing for their pupils observation of and experience in handling young children. This is being secured through coöperation with kindergartens, primary grades, day nurseries, health and behavior clinics, children's hospitals, orphanages, child placing homes, playgrounds and nursery schools. The girls are given opportunity for directed observations and after some experience are permitted to assist with the care of

the children. The class discussion is based upon the questions which contact with the children provoke. It is thus well motivated and grows out of very genuine interest on the part of the student.

A skilfully directed course in child development offers the opportunity to help young people to understand themselves and their relationship to others as probably no other course is able to do. The study of the child quickly becomes the study of "the human" and the span of development between the child and the adolescent is soon bridged by the high school girl and boy and the instruction thus helps solve immediate personal problems as well as lays the foundation for later understanding parenthood.

In conclusion I can only say a few words about the parental program. Interest in adult education is growing steadily and parent education is an increasingly important part of this movement. Several cities now employ a specialist in parent education, who gives her whole time to such work. We have become accustomed to spending public school funds for the training of auto mechanics, bricklayers, milliners, and for the teaching of history, geography and English. Can we question the wisdom of spending public funds for training in homemaking and parenthood? It is a program which meets vital needs, which promotes in a most effective manner the maintenance of the best principles of the institution of the home—it well deserves the support of our educators.

BOOKS AS MEDICINE

ALICE WILDEY

Chicago, Ill.

Carefully dodging the wet mops which porters swept across the floor oblivious to all other movement, we followed in the wake of the small book cart carrying one hundred and fifty books to the patients to whom Cook County, Illinois, gives medical aid free of charge.

Ordinarily the County Hospital would be the last place in the world that the Public Library of any city would think of servicing. The patients are from poverty-stricken homes, many of them foreigners, most of them comparatively uneducated. The world of books has never been their world; their pleasures have been of another realm. A book suggests boyhood experiences with the compulsory school law to them. Obviously, one would conclude, the County Hospital would not be a fertile field for library work.

Or else it would be exceptionally fertile! Some one thought a step beyond and caught the vision. These men and women were necessarily deprived of their own kind of recreation. Was there not a great opportunity here to bring into their lives knowledge of a new pleasure?

In 1921 the Chicago Public Library set aside a number of its books to constitute henceforth the library for the County Hospital, these books to be supplemented continually from the main library. Trained library workers soon replaced volunteers, and established the regular book tour of the hospital which takes place every week. For time has justified that first vision! Now the county hospital library, serving approximately 1,000 beds, circulates on an average of 385 books a week!

In the halls patients pushed forward eagerly in their wheel chairs to look over the books and choose one for themselves. The same interest was manifest in the wards themselves, particularly in those in which the patients were well on the way to recovery. These had

had time to become acquainted with the librarians; they chatted gaily over this book and that, and called to friends across the room to recommend such and such a story.

Again, one sees what appears to be an insurmountable wall of apathy. The request "Do you want a book this morning?" is met with a shake of the head and not so much as a glance at the speaker. A patient is never pressed, never urged. Yet with admirable tact the librarians have learned to try to find the cause of the lack of interest, and thus a remedy. This man does not understand that the book service is free. This woman can not read English; then would she not like a book in her own language? Many times, she would. And so it has gone until now it has become the fashion at the County Hospital to take out a book when the little cart makes its rounds. One man, observing this, chose a book with a bright red cover at his first opportunity. "Do you want to take that one?" the librarian questioned. "Yes, I like this one," he replied just as the librarian noticed that he was holding it upside down. He was evidently illiterate, yet the book was checked out to him without comment. He wanted a part in one of the leading activities of his ward!

The men at the County Hospital wish novels of mystery and adventure. Zane Grey, Curwood, Oppenheim, Seltzer are their favorites. The negroes are particularly interested in Bible stories. The women, especially those in the maternity ward, ask for love stories. Once in a while some highly educated person who has lost everything will be found at County, and will want books of a better class, but he is the exception.

Individual cases reveal much about human nature. There is pathetic irony in the story of the man who suffered with tuberculosis of the spine for six years in the County Hospital, and read all the travel books he could lay his hands on. Another, an easterner who had always been eager to see the west, kept the staff busy supplying him with stories of desert and mountain country. Another became interested in characterology, and books had to be searched out for him. Not only that, but nurses and librarians were cajoled into submitting to analysis at every opportunity.

Sometimes patients unite to read to one who is unable to read. One boy of sixteen, the size of a six-year-old and thought to be dying, was amused in this way by almost the entire ward for many months. He recovered, and started to try to learn to read himself.

The work of the librarians has proved of tremendous value as

social service. Their ambition for the patients knows no limit. They have started the illiterate learning the alphabet and kept them supplied with books in the simplest English; they have done the same for foreigners in many cases.

"If only we could carry our work *through!*" they exclaim. "A full-time librarian could do wonders!"

They carry their enthusiasm into the wards with them. All about them doctors and nurses are dressing wounds and bandaging fractured limbs. Many faces are tired and listless and discouraged. "Give me a book with an *end*," we heard one man cry in the depths of depression. The librarians go quietly, and with a smile. It has come about that listless eyes have learned to light at their approach. If, perchance, they are a day or two later than usual in making their rounds, they are met with reproaches from patients who have been ill-at-ease for fear they would not come, and with an excess of enthusiasm and appreciation of the work they are doing.

How large a part the librarians play in the lives of the patients is shown by the personal requests which come to them. They are asked for a glass of water, or to lower a curtain blind, or to call a member of the patient's family by telephone and deliver a message. The librarians fill the need for a personal friend. The women feel this particularly, and keep them visiting with them as long as possible.

It is not only in the County Hospital that the value of books for patients has been discovered. Practically every private hospital in Chicago maintains a book service in connection with the Chicago Public Library. The library always gives a hospital patient preference over other patrons in reserving a book, and so patients have their requests for even the latest books filled promptly. Many of them comment on the wonderful service, and leave the books which friends bring them so that they will have them still to read when they get home, preferring to use the library books during their time in the hospital. The demand has been so great, in fact, that daily circulation service is maintained in most of the private hospitals. Many patients say they find a chance to catch up on reading they have wished to do for months and never had time for.

The better class of books is requested in the private hospitals. Biography is popular—Ludwig's "Bismarck," for instance, has been near the top of the list. Bromfield, Feuchtwanger, Cabell, Lewis, Erskine, are all in demand.

One hospital we visited with a bed capacity of 275 patients circulated on an average of approximately nine hundred books a month.

Hospital boards, some of them at first dubious concerning the value of the Chicago Public Library offer of servicing the hospitals with books, are themselves becoming enthusiastic. They have observed the response of patients; they have seen how books can make a patient forgetful of suffering, and how they can provide a new mental attitude in patients for whom the world has become colorless. They have seen, in other words, the therapeutic value of books. Medical science, as well as the lives of patients, has thus become richer because of a library's desire to serve.

EDITORIAL

Have You a Health Conscience

If a normal individual were to commit a crime, it is likely that his conscience would trouble him to such an extent that he would seek in some way to make amends. But each day many crimes against health are committed and the "health criminals" are, in a way, infinitely worse than those who have broken the laws laid down by legislative bodies.

The crimes against good health are legion in number. There are two types,—those that injure the individual himself and those that serve to bring harm to one's fellow men.

There are five health laws, as follows:

1. Eat a well balanced diet.
2. Get plenty of rest and sleep.
3. Exercise moderately and regularly.
4. Get an abundance of fresh air and sunshine.
5. Have regular habits of elimination.

An ideal state will exist when one's conscience begins to bother him each time one of these laws is broken. Under ordinary circumstances, most of us give little thought to health. It is only when sickness occurs that we begin to think about it. If the time comes when there is a universal "awareness of health," the health laws will then be closely followed.

The second type of crime against health is, perhaps, worse than the first, for not only may some other one person suffer from the effects, but possibly a large group of people.

There are two factors which make for good health,—the building up of resistance, and the avoidance of contact with infection. The first is an individual matter. It is brought about by following the health laws given above. The second is a community problem. The person who is ill owes it to himself, as well as to others, to stay at home in bed, until he is well. Colds are infectious and are passed

on from one person to another, yet how many people do we see each day going about their daily tasks, not caring how many others may suffer from their negligence.

Germs are carried from person to person through droplets of moisture expelled in coughing and sneezing. Not to cover the mouth during coughing and sneezing is not only a crime against politeness but against good health as well.

There are certain parts of the body subject to the harboring of infections. Decayed teeth, infected tonsils and nasal sinuses serve as spots from which bacterial poisons are absorbed into the body. It is a crime against well-being to let such infections continue. They are quickly detected and easily removed.

Thus, there are two types of health conscience. The first and better presupposes an "awareness of health"—a knowledge of what to do to keep healthy, and then a steadfast desire to do the right thing. The second kind of conscience is the kind that bothers one after he has committed a health crime, and when results cannot be sidestepped. It is to be hoped the time will come when the public will be so educated in their duty as regards health that no one's conscience will ever have to trouble him. Heaven speed that day!

HERMAN N. BUNDESEN, M.D.

NEWS NOTES

A recent issue of Illinois Health News published by the Illinois State Department of Health was devoted to School Health. School medical inspectors, nurses and teachers will find this pamphlet useful as a guide in their work.

In a recent report the Metropolitan Life Insurance Company attributes the low death rate among infants insured by the Company by individual wage-earning parents to the care given to expectant mothers and follow-up work of the visiting nurses.

The extent to which editors of newspapers published in the United States in languages other than English put to use material sent to them by the Foreign Language Information Service is best indicated by a summary of a report for the first six months of 1928. Clippings received from more than 800 newspapers in 16 languages to which the Service sent material would make about 18 printed volumes of standard form and 1,000 pages each. During these 6 months the Service sent out 289 articles covering a wide range of subjects—American law and institutions, American industries, American history, geography, literature, art, health, agriculture and home economics. These articles were printed 13,478 times and represent a mass of reading material of 9,400,000 words. Newspapers in 41 states (no foreign language newspapers are published in the other seven) used the material and it is estimated that approximately 9,000,000 readers were reached.—*The Interpreter*.

A gift of \$50,000 was made to the Cuban Sanitation Department by President Machado to be used in extension work at the Carlos Finlay Institute, which is named for the discoverer of the origin of tropical malaria in the mosquito. The object of the donation is to start a movement in Cuba to perpetuate the memory of Cuba's leading scientist who made possible the later excellent work of Dr. Gorgas in the Panama Canal Zone.—*New York World*.

A splendid course of lectures on public health, open to the public, was given during the past few months under the auspices of the Westchester County Organization for Public Health Nursing.

The Nursery Play School established as an experiment last winter at Drexel Institute, Philadelphia, is to be continued permanently, and a member of the staff of the Vassar College Nursery School has been appointed director.

Virginia has recently started a traveling mental-hygiene clinic to serve the schools and medical and social agencies throughout the state, and to examine and treat delinquent children. Its staff will include a psychiatrist, a psychologist, and two psychiatric social workers. The Commonwealth Fund has contributed approximately \$40,000 for the clinic.—*World's Children*.

Something said to be entirely unique in the coal-mining industry has been started by the Rocky Mountain Fuel Company of Colorado. It is replacing the old company doctor with a department of medicine, health, and sanitation, which will not only treat injured men but give confinement care to wives of employees and specialized service and information on the health and development of children. The commission controlling this medical department will consist of representatives from both the miners and the company.—*World's Children*.

Health News reports that a health centre has been organized in the Harrietstown Town Hall at Saranac Lake. All health activities will be housed under one roof.

A recent issue of Chicago's Health was devoted to the menace of automobile exhaust gas or as it was termed "the invisible death." Instructions regarding the danger of inhalation and absorption were given, also careful instructions to motorists in regard to driving and method of controlling the gas supply of their engines. Attention was called to the fact that the effect of motor gases is positively destructive to the tissues of young and growing children who frequently show signs of impaired health which can be attributed (although seldom suspected) to the poisonous effect of gas laden air breathed dur-

ing their so-called Sunday outings on roads crowded with cars, moving at the rate of 5 or 10 miles an hour with frequent stops.

The Laura Spelman Rockefeller Foundation has contributed funds to establish a Division of Child Development and Parental Education. Dr. Ruth Andrus, formerly Chief of the Institute for Child Welfare Research, Teachers College, Columbia University, has been appointed Director of the Division.

The 56th meeting of the National Conference of Social Work will be held in San Francisco, California, June 26th to July 3rd.

The celebrated Mayo Clinic at Rochester, Minn., gives a tuberculin test as a part of the routine examination of every child registered. Of 1,000 children 6 months to 15 years of age, coming from communities of less than 25,000 population in 35 states, Porto Rico, Mexico, and Canada, who showed no evidence of active tubercular lesions, 169 gave positive reactions to the tuberculin test. 2/5 of these children were underweight, and a small proportion were overweight. The percentage of girls reacting positively was considerably higher than that of the boys, and the 3 cases found among children under 2 years of age were of girls. Known contact with the disease was reported for less than 1/10 of the 169 children, but family history of the disease was found for nearly 1/5—a finding similar to that of comparable studies.—*World's Children*.

Through provisions made in the will of the late Mrs. John Innis Kane the Sarah Schermerhorn Convalescent Home of the Episcopal City Mission Society, will erect a new \$100,000 building to care for convalescent children. Funds were also provided for endowment purposes. The new addition will increase the Home's capacity by 62 beds.

Plans have been filed for the new psychopathic building of Bellevue Hospital, New York.

The State Legislature of New York, has granted a budget sufficient to care for 35 blind babies and young children in the institution maintained by the International Sunshine Society with Headquarters at 96 Fifth Avenue, New York City. Mr. Edwin Gould has just

finished building two large playrooms 20 by 20 as additions to the Edwin Gould Kindergarten Annex, making exceptional schoolroom facilities for these little folks. The State Board of Education has sent to the Sunshine Arthur Home and Kindergarten since its opening 95 children. They are taken in generally as was babies and they can graduate at 8 years for the State or City School for the Blind if they are physically strong and mentally bright. As children leave or graduate their crib is immediately given to some child on the waiting list. If this item reaches the eye of any mother who has a blind baby or a young blind child too young for the State Schools, she should communicate immediately with Mrs. John Alden, Sunshine Headquarters, 96 Fifth Avenue, New York City, and she will help in every way possible to get the little one properly appointed by the State Board of Education. Anybody knowing of a wee blind budy should feel it her duty to tell the mother that now New York State and City gives special care to these little ones.

The New York State Department of Health has revised and re-printed the list of motion pictures owned by the Department. A copy of the catalogue may be obtained by applying to the Supervisor of Exhibits, State Department of Health, Albany, N. Y.

Victoria and Queensland have instituted traveling dental clinics for service in rural districts of Australia. In Victoria, free dental service is provided for school children until they reach the age of twelve. The portable dental offices have been found so satisfactory that their introduction into cities and towns has been suggested. In Queensland the treatment of adults at reasonable charges is also included in the service, though the dental service to school children is usually free. It is reported that both adults and children often travel long distances for treatment and that the Queensland van traversed nearly 3,000 miles during a period of eight months in 1927. The Queensland Radio Station every Thursday broadcasts the location and immediate itinerary of this van.—*World's Children*.

A Medical Information Bureau has been established by the New York Academy of Medicine and the Medical Society of the County of New York. The purpose of the Bureau is to give out

to the public correct information on medical and public health matters and to create a better understanding between the laity and organized medicine.

It has been announced that the activities of the Julius Rosenwald Fund, Chicago, Ill., will be extended to include the support of medical services for people of moderate means. Michael M. Davis, jr., has been appointed to the executive staff of the Fund as Director for Medical Services.

The Bureau of Tuberculosis, Department of Public Health, 901 Griffith-McKenzie Building, Fresno, Calif., has issued a pamphlet entitled "Planning and Serving Food in Sanatoria and Preventoria."

The American Red Cross has completed plans for establishing and maintaining health and nursing activities in the remote provinces of the Philippine Islands, where at present no medical aid is available.

Social Hygiene News reports that in Kansas City the churches are taking an active part in social hygiene work. The Kansas City Social Hygiene Society in coöperation with the churches are holding classes to aid parents in instructing their children in sex matters.

World's Children reports that since the beginning of 1927 the Virginia State Board of Health has immunized 250,000 children against diphtheria and that in 1927 the State showed the lowest death rate from the disease in its history. The Board of Health is also carrying on a general health campaign among school children, largely through arousing interest in winning the "five-point" certificate which is issued to every child who comes up to the Board's standard in regard to teeth, weight, sight, hearing, tonsils and adenoids. The State employs 10 dentists, who use a portable equipment and give necessary treatment at nominal rates in the rural schools. Teachers are required to qualify themselves to examine the children for remediable defects.

According to the Statistical Bulletin of the Metropolitan Life Insurance Company the general health conditions in the United States and Canada were more than satisfactory during the first 9 months of the year 1928. A new minimum in deaths from tuberculosis was established. There was also a decrease in the death rate for conditions associated with maternity. Typhoid fever shows a lower mortality and the communicable diseases of childhood, with the exception of measles is below the average. Influenza and pneumonia and deaths from alcoholism have not decreased. The cancer death-rate shows no improvement among white policy-holders and has increased among the colored. Mortality from diabetes shows an increased tendency among American and Canadian wage-earners. Accidents and homicides show a decrease.

In Wisconsin employers are required to pay double or triple compensation to children injured while illegally employed, according to the nature of the violation of the law involved. In 1927 extra compensation payments ranged from less than \$20 to nearly \$5,800, and the aggregate amount of such compensation under claim cases settled during the year was more than \$16,000.—*World's Children*.

The Save the Children Fund in coöperation with the Greek Patriotic Institution is waging a vigorous campaign against trachoma which is so prevalent among Greek children.

The Utopia Children's House, 170 West 130th Street and Columbus Hill Neighborhood Centre in the Henrietta School Building, 224 West 63rd Street, New York City, are now open. Both centres which are administered by the Children's Aid Society and committees appointed from the neighborhoods of the centres, both of which are in densely populated Negro districts, will provide social and recreational facilities for children. This much needed form of welfare work was made possible by John D. Rockefeller, jr., who through the Welfare Council gave a large sum of money to establish and maintain the centres.

A recent issue of the News Letter of the Division of Child Hygiene, Minnesota Department of Health was devoted to frontier nursing service among the Chippewa Indians. Public health nurses will find this edition particularly interesting.

The new Jewish Home for Incurables, Rutland Road and Utica Avenue, Brooklyn, N. Y., has been dedicated.

The American Social Hygiene Association has upon invitation of Yale University prepared an exhibit to be shown in the new building of the School of Public Health.

The National Society for the Prevention of Blindness estimates that about 15 per cent. of the 100,000 blind men and women in the United States is the result of eye hazards of industrial occupations. Last year this society brought the essential facts concerning eye hygiene, prevention of injuries to the eyes and importance of good lighting before three million workers in hazardous occupations.—*The Kablegram*.

The name of the Bureau of Immigrant Education of the State Department of Education has been changed to the Bureau of Adult Education.

The Italian Hospital, New York City, has laid plans for a new 12-story building at 106th Street and Lexington Avenue.

A resourceful lieutenant of police at San Jose, Calif., is writing plays and spinning Mother Goose rhymes to teach the children of that city how to take care of themselves in the dangers of modern city life. Enthusiastic children and the author himself take part in the plays, which are given in the San Jose Theatres. One play shows what may happen to a child who rides with a stranger, and another depicts the results of jay walking, including realistic hospital scenes. The Mother Goose jingles have been illustrated with drawings made by the school children, and these have been turned into stereopticon slides for exhibition in the schools. The same police lieutenant 3 years ago organized a school traffic reserve of about 275 boys from 18 schools, and there has never been an accident at their crossings during their periods of duty.—*World's Children*.

The City of St. Louis has provided 10 dental clinics and an extraction clinic for children. A dentist will be in attendance for four hours each day. The Red Cross is coöperating by donating the equipment for 8 of the clinics.

Information about the means of entry into trades, the training given in workshops, and the outlook for future employment is given in *A Guide to Employment for London Boys and Girls* recently issued by the London Advisory Council for Juvenile Employment. The occupations covered are, as a rule, only those open in London to workers under the age of 18, emphasis being placed upon those offering definite prospects of permanence and advancement. The material was collected by officials of the Ministry of Labor with the aid of many business firms and members of trade organizations.—*World's Children*.

Three medals for "distinguished social service to the City of New York" were awarded at the joint dinner of Better Times and New York City Conference of Social Work, in December. Medals were awarded to Mary R. Mason of the State Charities Aid Association, Dr. John Lovejoy Elliott and to the late William Hamlin Childs—Mr. Childs died between the consideration of the award and the actual award. The medal was received by his son Richard S. Childs.

THINK IT OVER

"If children capable of becoming strong, well-poised men and women are being born to take up the problems of tomorrow we need have no fear of the future. But if the quality of life shall fail, neither universities nor symphony orchestras, nor cathedrals, nor philanthropic endowments, nor economic prosperity, nor battleships, nor armies, nor anything else can save a nation."

THURMAN B. RICE
Health Pilot, October, 1928

BOOK REVIEW

"Being Well-Born." By Michael F. Guyer. Indianapolis: The Bobbs-Merrill Company, 1927. 490 p.

Being Well-Born is a subject worthy of serious thought to the present day thinking public. Dr. Guyer has realized this and has presented a book with a scientific approach and with a view to illuminate some of the mysteries that surround the subject of heredity.

Eleven years ago this book made its first appearance as one of the "Childhood and Youth Series." It was kindly received and well spoken of, as "a book for the layman but not written down to the 'popular' level, as a work for the general reader, the parent, teacher or social worker, as a text book for classes in applied eugenics."

The extent to which Dr. Guyer has revised and expanded the first edition may be seen in the fact that the original first four chapters have become fourteen. The space devoted to the physical basis of inheritance and on genetics proper has been greatly increased, also separate chapters on embryology, the mechanics of development, immigration, and population have been added. Much of the new material is more technical than that included in the first edition. However, the same simplicity of style and presentation is employed so that the book may continue to be read by the layman as well as becoming a text book for the student.

The book gives much recent information in the experimental fields, which bears upon hereditary. "My gifts have come to me from down the years," Dr. Guyer has emphasized as being more than a bit of poetry. Knowledge of Heredity is derived from first, the study of embryology, second, through experimental breeding of plants and animals and, third, through the statistical treatment of observation or measurements. These three methods are explained at length and used as a basis for any statements and conclusions drawn in regard to inheritance. The phenomena of reversion is explained as being of three types; (1) recombination of character—or rather of the factors of character—which became separated in some way in previous generations; (2) removal of super-imposed or obscuring factors; and (3) arrested development. An elaborated and detailed discussion of embryo formation, the mechanics of development including the influence of the internal secretions and vitamins is dealt with. Illustrations are used in a forcible way to emphasize the results of these influencing factors. The Mendelian Law is traced through simple experiments, new combinations, crossing of individuals, and finally the complex Mendelian phenomena of inbreeding, cross breeding, and outbreeding is treated. All this is valuable information for the student genetics.

Perhaps from the psychological and sociological point of view the latter half of the book holds the greater interest. Mental qualities are inheritable as truly as physical, Dr. Guyer emphasizes. The Mendelian principles apply to the traits of man, we are beginning

to observe he states. "After making due allowance for environmental influences," Dr. Guyer goes on to say, "It has been shown that such mental and temperamental attributes, such as ability, memory for numbers, vivacity, conscientiousness, industry, efficiency, attentiveness, perseverance, and temper, are like physical features, based on hereditary endowment." Also he states "because of outstanding similarities in mental traits in many family strains, one is compelled to believe in the inheritance of a considerable degree of specialization in the underlying structure."

The psychologist with the behaviorist point of view will scarcely concede these statements as facts, as they tend to conflict with the ideas, that, personality is the sum total of habit systems plus many conditionings—that emotional behavior is learned not inherited—that we learn to think by learning to do.

Human heredity on the physical basis includes, eyes and hair color, digital malformations, baldness, stature, longevity, multiple births, cousin marriages, predisposition to diseases of tuberculosis, cancer, insanity and hereditary feeble-mindedness, according to experiments recorded.

The chapters in the latter part of the book which deal with the problem of; "Are Somatic Modifications Inherited?" lays due stress upon environmental influences. The question is stated as—"Can such enhanced or suppressed development, or can new or modified characters produced in an individual by external agencies be so reflected on the germ-cell of the individual that they tend to reappear as such in its offspring without requiring the same external factors for their production?" The authors believe the questions to be still unanswered until further experiments which are in progress are worked out.

The chapter on Prenatal Influences dispel any illusions or myths which frequently are believed and handed down from one generation to another concerning "maternal impressions." The prenatal influence of, lead poisoning, alcoholism, and venereal diseases are stressed. "Parents can do nothing toward modifying favorably such qualities as are predetermined in their germ plasm. Nevertheless, they must come to realize that bad environment can wreck good germ plasm," is the conclusion drawn.

The plea for race betterment through heredity made in the final chapter is strong. Mental and nervous diseases, crime and delinquency and immigration, are factors discussed in relation to their

bearing upon race betterment and social evolution. "The fate of future generations is ours to determine Dr. Guyer states and we are false to our trusteeship if we évade the responsibility clearly laid before us."

The book is a comprehensive study of the subject "Being Well-Born" based upon scientific and biological background. It is filled with information valuable for the classroom and the individual.

OLIVE MAE HOOVER
New York State Department
of Mental Hygiene

"The Story of May Day." By Katherine Glover. Published by the American Child Health Association, 370 Seventh Avenue, New York City.

This beautifully edited and charmingly illustrated book recounts the story of May Day, the one day in the year when the nation responds to the call for child health and happiness. May Day is one of the few good things attributed to the World War. "In 1923 the high tide of war's glory had receded. We were busy picking up the wreckage and counting the cost. Almost for the first time in our history the American people checked up loss against profit, not only material but human loss." Thoughts turned naturally, or who can say perhaps providentially, to the spiritual, mental and physical needs of childhood. A few inspired leaders worked out a plan. Several existing organizations—scientific and educational—pooled their experience and approached the problem of child welfare by creating the American Child Health Association, an association which has helped make the lives of millions of children healthier and happier. In Europe dire necessity demanded conservation of child life. In America there was no such urge. The general public had to be educated up to the ideals and aims of the Association. Ada de Acosta Breckinridge through the Grace of God was inspired by a vision of a joyous healthy army of children who could be enlisted in a health crusade and act as publicity agents in their own cause through happiness and play. The pagan festival of Spring was rededicated to childhood. No need to say how the idea "went over the top." Every city, every town, every village has its May Day celebration with plays, pageants, dances and tableaux emphasizing child health and happiness, given by children. The story of May Day is a magic tale of vision, lofty purpose and wonderful achievement in

behalf of American Childhood. Considerable space is devoted to documents, scrap-book clippings and the story of May Day by pictures and by States.

“Health Record for Women.” By J. Theron Hunter, M. D. Baltimore: Williams & Wilkins Company, 1928.

The purpose of his book is to encourage women to keep complete and accurate records of their health from the age of puberty, through adolescence, and during adult life. The purpose is admirable but we fear there are not many young girls or women to whom the idea will appeal. To those who like detail and record keeping the book will be a source of interest and valuable to a physician called in time of illness. The book contains a family history outline weight record, and charts for recording colds, sore throats, operations, accidents, tumors, blood pressure, etc., and the various diseases or abnormalities which may be one's lot in life. Each chart is explained so that any deviation from normal health can be recognized and medical aid obtained.

NEW PUBLICATIONS

Report of the Social Service Department of the Mount Sinai Hospital, New York City.

The report of Mrs. Alfred A. Cook, President of the Social Service Auxiliary gives a detailed and concise report of the Social Service Department since its establishment in 1906 with one worker, its expansion and development up to the present time, with a staff of 43 and a budget of over \$78,000.

The activities of the department are best described in the President's own words: “The activities of the department are many and varied, but underlying them all is the fundamental principle to do whatever is possible to aid the doctor and patient so that the patient reaps the full benefit of the medical care which the hospital offers. The following are some of the services:

Making hospital care possible by removing personal difficulties.

Interviewing patients in the wards and out-patient department to ascertain their social needs, and presenting such information to the physician that may have particular relationship to the patient and his care.

Procuring temporary shelter for children whose mothers are ill in the hospital.

Interpretation of disease and treatment to patients, families or others interested.

Educating patients and their families in hygiene.

Lessening the incidence of re-admission of patients through instruction and careful supervision.

Coöperating with other philanthropic agencies; using their facilities and giving them such service as the hospital offers.

Advising patients in many personal and family problems.

Arranging for convalescent care in the patient's home or outside of the home.

Adjusting or securing proper employment.

Arranging permanent care for the chronic sick.

Country outings for children during the summer months.

Providing temporary financial assistance.

Providing special nourishment.

Procuring medical appliances.

These, along broad lines, are the types of service rendered, varied by the special needs of the different department."

Miss Lissauer, Head Worker, outlines the aims and policies of the department and gives a clear picture of the workings of a social service department in a large hospital. One of the outstanding features of the work brought out in this report is the fact that the department not only attempts but does have close personal contact with the internes, early in their hospital career, interpreting social service to them and implanting the thought—oftentimes the first—that the patient is not merely a case but an individual, who has a place in the scheme of things and that his illness and hospitalization bears a direct relationship to his family, to industry and the community. The nurses too receive instruction—the aims and policies of social service are explained to nurse probationers, selected groups spend several weeks in the department acting as student social workers. A course of lectures on social work is given to the entire student body yearly.

The resumé of departmental reports is full of interest and makes it possible to visualize the immense volume of work accomplished and the abstracts from a few typical cases show how constructive is the work and how varied the services rendered.

ABSTRACTS

"Mental Hygiene of Childhood." John F. W. Meager. *Long Island Med. Jour.*, 1928; XXII, 641.

Mental health depends greatly on the training children receive during the earliest years. From a mental hygiene point of view the pre-school years are the most neglected, due mainly to parental lack of knowledge regarding mental hygiene of childhood. All children can be placed in one of the following groups (1) supernormal; (2) normal or average; (3) subnormal or feeble-minded; (4) psychopathic, unstable or psychotic. Character which depends so largely on early training is the expression of what we really are. Unbalanced character traits favor an unbalanced personality make-up. The author emphasizes the fact that children very early in life show evidence of emotional reaction to life. These reactions require careful study and wise guidance in order that the child may grow to adulthood in harmony with life and capable of adjusting himself to circumstances and environment. Physical ill-health will interfere with a normal attitude toward life therefore physical health and mental health go hand in hand. Under the headings intellect, intellectually superior children and intellectually inferior children, the author describes the three types and offers excellent advice in regard to home and school training. The author has carefully studied delinquency, its basic causes and evil results if delinquent tendencies are not wisely handled. Home, church and school are the places where the child obtains his fundamental early training. It is the home that makes or mars the child and it is the home influence that lays the foundation of character. Parents should be the child's best models. In all contact with children we should try to see the child's viewpoint and understand his reaction. The author has covered the subjects of character, mental and physical health, intellect, delinquency, training, physical status of children, mental and moral treatment, social factors to be considered and education briefly but amply for clear understanding. Parents, teachers and all who are entrusted with the care of children will profit much by reading this interesting article.

"Medical Inspection in Schools." Ethel R. Harrington. *Ill-Health News*, 1928; XIV, 309.

Many people are under the impression that school health is an

entirely new idea. As a matter of fact France, nearly a century ago inaugurated the system of health supervision in French schools. Boston was the first city in the United States to employ school physicians. Other American cities followed. By school medical inspection is understood the health supervision and examining of children in order (1) to detect contagious or infectious diseases; (2) to discover remediable physical defects which may be responsible for ill-health or poor work in school; (3) to determine wherein faulty health habits may account for lowered vitality in many of the school children. When examinations have been made it is essential to see that the defects are corrected. School medical inspection which offers a contact with the home through the child, presents an excellent opportunity for community health instruction. The author speaking from a wide experience considers the rural schools, because of their comparative isolation, far behind urban districts in matters pertaining to health supervision. In order to get good results school authorities, parents and teachers must cooperate. A medical staff working with people who do not understand has little chance for success which consists of (1) convincing parents and teachers of the value of the work so that they follow the advice given; (2) improving the physical condition of the children through correction of physical defects; (3) obtaining the best conditions possible for children with defects which can be remedied. Teachers through training can be entrusted to note apparent defects, such as defective vision, defective hearing and to weigh and measure children, etc. The ideal plan for school medical work is to employ both medical inspectors and trained nurses. The nurse assists the medical inspector with physical examinations, does routine class inspection and cares for the health of the children in general. Her follow-up visits in the homes where she stresses the importance of carrying out the doctor's orders in regard to treatment or correction of physical defects, not only show good results but she constantly acts in the capacity of friend and health missionary in her district. An efficient school medical service fulfills the purpose for which it was introduced, namely, "Protection of the child against the hazards of school life, the protection of the school investment, and lastly the building of a better informed and more virile citizenry."

"Social Service and the Nurse." A. Noufflard. *World's Health*, 1928; LX, 348.

This short but interesting article is a direct challenge to nurses to enter the field of medical social service. The author defines the work and emphasizes the importance of the nurse's training and medical background as a preparation for this branch of health work. The Board of Management of the organization known as "Le Service Social à l'Hôpital" in Paris, of which the author is director, is of the opinion that if a social worker is to be equal to the task entrusted to her by the doctor or surgeon, she must have the necessary medical knowledge to understand the full value of the treatment prescribed, therefore, nursing studies are an essential part of the training. All workers attached to "Le Service Social à l'Hôpital" hold a state hospital nurse's or visiting nurse's diploma. In the matter of home visits the nurse's ability to recognize disease and symptoms of disease is considered of the utmost importance. The author leaves no doubt in one's mind that medical social work is a field of work for which the socially trained nurse is particularly adapted by nature of her hospital training and medical background.

"The Heritage Craft Schools." Mrs. C. W. Kimmins. *Sunlight*, 1928; I, 12.

This article gives an interesting account of the Heritage Craft Schools and Hospitals established in Chailey, England, as a private experiment with eight crippled boys, some 25 years ago. The Colony, for such it has become, is situated in the County of Sussex and now accommodates three hundred boys and girls. For treatment and training the boys go bare-headed in shirts and shorts, with military capes for bad weather. At stated intervals the children wearing loin cloths recline on stretchers in the sun. In order that while making the most of the sunshine no school hours are wasted a master reads or talks to the boys. Children confined to the Boys' Hospital spend much of their time on sun-drenched balconies overlooking beautiful country. School work and crafts are carried on while the patients take sun treatment. At the Llangattox School of Arts and Crafts for Crippled Girls half a mile away, the same well-ordered routine exists. There is also a nursery building for babies and very young children. The buildings are all especially adapted for the care and to the needs of cripples, and the children work and play under ideal conditions. Everything which would

have an influence on the children's treatment, health and comfort has been provided. In order to give children who are not necessarily hospital patients the benefit of the schools and hospitals, a plan has been worked out whereby children may attend both schools and hospitals as paying out-patients. These children receive local and constitutional physical treatment, including electricity, massage exercise and both artificial and natural sunlight, as well as manipulative treatment. Schools and Hospitals are under the direction of Surgeon-Commander Murray Lenick, R. N., an authority on the value of sunlight, artificial and natural.

"The Importance of the Day Nursery in Relation to the Child Welfare Movement." Viscountess Erleigh. *Rev. Internat. de l'Enfant*, 1928; VI, 384.

The day nursery has a very definite place in child welfare work as it provides for a class of young children who would otherwise be neglected. Women with young children, who for various reasons work outside the home find a haven in the day nursery and go to work knowing that their children will be cared for and properly fed during the day. Working women have no opportunity or time to attend welfare centres, therefore, the only health supervision which includes health instruction for themselves and babies is obtained at the day nursery. The modern day nursery in addition to caring for the physical needs of children is an educational centre in the widest sense of the term. Children of pre-school age are trained in correct habits, their physical and mental health guarded and they are influenced by an environment especially planned for their physical, mental and spiritual development. It would be impossible to estimate what this influence, during the most formative period of life means to a child in later years. One reason given for the fact that this branch of welfare work has not expanded to a greater degree is the high cost maintenance and the prevailing idea that the number of young children cared for must necessarily be restricted. The discovery that risks of infection are enormously minimized by open-air regime and that young children benefit by this regime proves that the number need not be restricted. The author notes that in one nursery school in Deptford, London over 300 children between the ages of 2 and 5 years are accommodated and the school has a marvelous health record. In the Sun Babies Day Nursery of which the author is chairman provision is made for 100 children from one

month to four years. Not only the children cared for in a nursery benefit but other children of the neighborhood, as the mothers of the nursery children do much indirect health work among their neighbors. Many young girls take the prescribed course in caring for children in the nursery and while being fitted to earn a livelihood are at the same time being prepared for motherhood. The author predicts the day when day nursery and nursery school will be combined and their true value recognized. Teachers now complain that they spend the first years when a child enters school in correcting bad habits, curing physical defects and instilling elementary ideas in order and decency. The mischief is done during the unsupervised period of early childhood, that period between infant welfare station and entrance to school. The author also believes that it is only a matter of time when psychological or behavior clinics will become part of the routine of every well-conducted nursery.

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