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HOSPITAL SOCIAL SERVICE

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HOSPITAL AND DISPENSARY SOCIAL WORK*

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I.—INTRODUCTORY REMARKS

The *patient* approaches the hospital with certain hopes and desires. He desires the cure of his illness. He hopes that, as a means to this, he and his illness will be understood; that he will receive kindly and expert attention; that there will be no preventable errors, no useless waste or overlapping of energies in the attempt to relieve him.

The *doctors, nurses, and management* of the hospital, on their side, also cherish certain hopes; that their labors will not be in vain, that their time will not be unnecessarily wasted, that a reasonable proportion of success shall crown their efforts and that the services of the hospital shall be given to those who are most in need of them.

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

A third group of desires and hopes which converge at the hospital express the somewhat vague purpose of *society* represented in the activities of public health and public welfare. These agencies and the persons responsible for them have come to consider the hospital as one link in the chain of efforts directed towards the prevention of disease, the curbing of epidemics, and the better understanding of disease, both through research and through the instruction of medical students.

But about thirty years ago it began to be clear that these three currents of hopes were not reaching their goal. Out-patients in many instances were not getting the relief which they came for, because the physician's orders,—for rest, vacation, better diet, change of work, peace of mind,—could not be carried out by the patient without instruction, guidance, financial help and encouragement which he knew not where to find. The physicians working at hospitals were coming to see that their directions for the treatment of tuberculosis, heart disease, childrens' gastrointestinal disturbances, diabetes, syphilis, gonorrhoea, for the neuroses, the psychoses, and so forth, were rarely carried out; and in view of this they were becoming more careless in diagnosis. For of what use is accurate diagnosis, if no rational treatment follows?

The interrelations of "mind, body and estate" in the production of disease and still more in its continuation began to be more clearly realized about a generation ago. But the over-burdened out-patient physician had no time to visit the patient's home, to look into his economic situation, to enter into his state of mind, to comprehend or to influence that many-sided psychic, domestic and industrial environment which is often a large part of what ails the patient, and is moreover a necessary avenue to his cure.

Clearly the physician and the patient needed another helper to supplement and interpret the physician's directions and to pass them on to the patient, to his family and to the charitable agencies outside the hospital.

New hopes for the cure and alleviation of diseases once regarded as incurable sprang up with the new century. New hopes, too, for a more humane and comprehending service by the hospital, for a return to that welcoming hospitality which its name and its ancient use imply.

Because of these hopes of the patient, of those who work in hospitals, and of the public, the new activity known as Hospital Social

Service has come into being. It is because so many of us want these hopes fulfilled and not disappointed, that the hospital social worker is appointed to her responsibilities and given her means of subsistence. She is doing her work in many countries of the world because certain citizens of those countries do not want these hopes frustrated. It is true that for the present many of these hopes cannot be fulfilled. Our ignorance of disease and of its control, our ignorance of human nature and its possibilities, still dash many patients' hopes, and block the desires of those who would help them. But so far as possible we want these new energies of desire and hope to be expended so that none of their force shall be spent in vain.

Of course in some form these desires are as old as humanity, and the attempt at their fulfilment is at least as old as the Christian era. But hospitals in anything like their present form are not nearly as old as that. For though, as the name itself suggests, a hospital was originally a place for *hospitality* to those in sickness and sorrow, to those who often have made long journeys in the hope of cure, yet in recent centuries the hospital has often presented a forbidding aspect. Patients have dreaded to go there and have put off the day as long as they could. In part this has inevitably been connected with the horror of disease itself and of the suffering which its treatment may cause. In part, however, this menacing and heartless aspect of the hospital is something avoidable, an abuse which we want to banish and are better able to banish today than ever before. As a means to this end hospital social service was born, and we hope that many other means to the same end will yet come into use. For even at the best, there is still much needless suffering, disappointment, bewilderment and fear mingled with the benefits for which patients seek a hospital.

II.—HISTORY

I take as a starting point of this movement the introduction of the first full time paid social worker into a hospital with the object of assisting the doctors and nurses to understand and to treat disease. We cannot fix the earliest time or determine the place at which priests, compassionate women, and other voluntary helpers of the sick have visited hospitals with the hope of furthering the patient's recovery, of cheering him in his sufferings, or of interpreting to him the meaning of his illness. Certainly such activities have gone on here and there for hundreds of years. We can set no beginning to them. But

for hospital social service as a paid, full-time job we can set a very definite beginning.

In 1895 in the Royal Free Hospital in London, at the initiative of Mr. C. S. Loch of the Charity Organization Society, the first "Lady Almoner" was permitted to work. It is true that King's College Hospital in London in 1876, St. Bartholomew's in 1883, and the London Hospital in 1884 had appointed "Inquiry Officers" in order to prevent the "*abuse of hospital charity*" by those able to pay physicians. But in this endeavor there was apparently no thought of improving the hospital's service to the patient. That came only in 1895 when Miss Stewart began work at the Royal Free Hospital. The tasks assigned to her were in the main three: (1) To check the "*abuse*" of hospital charity in the sense just referred to. (2) To transfer to the care of the State such patients as could best be helped by public authorities or in public institutions. (3) To make the treatment of disease in needy patients more effective by coöperation with the social agencies outside the hospital. It is this last purpose which in the development of hospital social service has come to overshadow the other duties originally assigned to the Lady Almoners. (See section on *Present Functions*.)

In England as in other countries where hospital social service has started since 1895 the hospital authorities have shown at the outset no enthusiasm about it except insofar as they hoped that it would check "hospital abuse." The first Lady Almoner at the Royal Free Hospital was introduced as an experiment and at the initiative of the Charity Organization Society. Of her salary, 100 pounds a year, 75 pounds was paid by the Charity Organization Society and only 25 pounds by the hospital. This onesided arrangement continued until 1903, when at the initiative of the Charity Organization Society the hospital consented to assume one-half instead of one-fourth of the financial burden. Even as late as 1919 an almoner in one of the great London hospitals records that "it had been uphill work to induce the hospital authorities to view the Lady Almoner in any light other than as a preventer of hospital abuse," or to realize that she could help in the understanding, the cure, and the prevention of the disease.

When, ten years later, similar work was initiated at the Massachusetts General Hospital in Boston we met the same sort of opposition. We were permitted to make the experiment but we were regarded quite naturally as a good deal of a nuisance. It is to the everlasting credit of the women who have done this work in England,

in America, and in the countries of Europe where it has taken root, that they have persisted in the face of many discouragements, persisted in seeing certain facts and needs to which doctors and hospital authorities were blind, and have gradually shed upon these facts and needs a light so powerful that now anyone can see them.

As time has gone on the likeness between the work as it began in England and as it sprang up independently in America ten years later has increased. Though in England the worker is still known as an "Almoner," her work has come to be designated by the term first used in America, "*Hospital Social Service*" and her task soon became known as that of the "*Social Service Department*." In England the work of warding off well-to-do patients from a hospital intended only for the poor has come to occupy a smaller and smaller place relatively to the rest of the almoner's work. In America the hospital social worker did not have this function in the beginning, and is only now beginning to assume it in a few hospitals.

In America, as in England, the work took its origin in the Out-Patient Department. But our social workers soon extended their activities into the wards and in 1909 a young Englishman visiting his American relatives heard of our work and on his return to England started similar work under the "Cicely Northcote Trust." It was in that same year that Mr. C. S. Loch, in an open letter to the Almoners of the London hospitals urged certain changes which tended to bring the work more nearly into line with that going on in American hospitals. He urged that the Almoners should not take up the duties of registrars or do any of the clerical work connected with the admission of patients, and still more wisely pronounced that "*the almoner is not to scurry*," a rule which I am afraid both in England and elsewhere has since been honored more in the breach than in the observance.

From its original starting point in the Royal Free Hospital in 1895 the work of the Lady Almoners, now generally known as "social work in hospitals," spread to most of the other London hospitals. In 1910 Mr. Loch, speaking at the first annual conference of the British Hospital Association, said, "The hospital almoners system is now adopted in some fifteen hospitals in London and in some others outside London." In 1916 it was introduced at Glasgow in the Royal Maternity and Women's Hospital. Meantime it had spread to many of the other provincial cities of England and had taken root in Ireland. It is difficult today to say

exactly how many hospitals in the British Isles are using hospital social workers, because many quite different activities are carried on under the name of the Hospital Almoner or of Hospital Social Work. But in the yearbook of the Association of Hospital Almoners for 1927 the almoners connected with 19 London hospitals and 17 other institutions in England, Scotland, and Ireland are listed. In a number of other hospitals I believe that a service more or less resembling that of the Lady Almoner is maintained.

In the United States it is equally difficult to say how far the movement has spread since its beginning in 1905. It was taken up at Bellevue Hospital in New York in 1906, and twenty years later Miss Wadley reviewing her twenty years of service at Bellevue said that hospital social work was going on in 850 hospitals in the United States, a claim which I believe to be greatly excessive, though far less exaggerated than the generous beliefs of some of our German colleagues, who have stated that it is installed in all of the 6000 hospitals in the United States and working on the same plan in all! Miss Waters—then Secretary of the American Association of Hospital Workers—writing in 1925 in *The Modern Hospital* stated that by the Census Bureau 574 social service departments had been recorded up to the end of 1924. Unfortunately we have no exact figures since 1924. In that year there were 420 hospitals registered¹ as having social service work installed in them within the boundaries of the United States and one in the Hawaiian Islands. In Canada ten more were listed.

Within the twenty-two years since this work began in the United States the most important date is 1913, when the first book on social work in hospitals² was published. This book, which is still the only important and comprehensive book upon the subject, was written by Miss Ida M. Cannon, whose experience as director of social work at the Massachusetts General Hospital dates back to 1906 and who, I think, is now entitled to speak with greater authority than anyone in the world since she has enjoyed continuous service in the same hospital and as the head of this work for twenty-one years.

It is noteworthy that in the same year when this book was published hospital social work began upon the Continent of Europe, almost simultaneously in France, in Germany, in Holland, and in Austria. In *France* the work took its origin from the visit of Dr. Charles W. du Bouchet to Boston in 1913 and from the subsequent translation of some of my reports on the work done at the Massa-

chusetts General Hospital, a translation made by Dr. Nageotte-Wilbouchewitch, and published in the *Bulletin de la Société de Pédiatrie de Paris*, November, 1913. A pamphlet published in 1914³ describes the work initiated by Mme. Georges Getting in Professor Marfan's wards in March, 1914, at the hospital for sick children in Paris. Its purpose is described as the endeavor "to see that the patient understands the doctor's directions, carries out his prescriptions, actually receives the care desired by him, and has a home environment in which these measures can be successfully carried out."

Since that time the work in Paris has spread, not as a rule to cover the whole needs of any single hospital, but to certain clinics in which outstanding problems are presented. Beginning with the work in the children's clinics it spread in 1917, with the help of the American Red Cross, into the wards for tuberculosis and in 1919 into the maternity wards. In 1922 the work was reorganized by the state. Still more recently it has extended into certain wards for surgical patients and for medical cases. In 1927 this service had extended into 47 different clinics of 28 Paris hospitals, and was employing 59 full-time and 10 part-time workers. It has also been established in Lyons and Marseilles. Since 1921 the social work done in all the different Paris clinics has been unified in an association known as *Le Service Social à l'hôpital*, managed by a volunteer committee of which Mme. Georges Getting is the head, and assisted by a contribution from the Ministry of Hygiene.

In *Germany* the work started in the year 1913, almost simultaneously in Berlin and in Frankfort a. Main, and as a result of a journey to the United States made that year by Prof. Else Strauss. To Dr. Alice Salomon is due the credit for having initiated it in several of the Berlin hospitals. From that beginning it has now spread into 77 hospitals in various parts of Germany.* The work is now united under the *Deutsche Vereinigung für den Fürsorgedienst im Krankenhaus*, with headquarters in Berlin and with Hedwig Landsberg and Anni Tüllman as general secretaries. The first meeting of this association was held in July, 1927. Both in Germany and in France the connection of the work with the Government is much

* In these figures and in those relating to the work in France, in England, and in America, it is almost impossible to be accurate, both because new hospitals are taking up social work from month to month, and because it is so difficult to state whether a given piece of work is yet worthy to be called "*hospital social service*" in the sense in which the term is here employed.

closer than in the United States. Thus the various governmental bureaus in 1927 supplied 550,000 out of a total of 900,000 francs needed for the maintenance of social work in Paris hospitals, and in many of the German cities the work is carried on largely or wholly at the public expense.

The first work of which I have any record in *Canada* was begun in 1910 at the Winnipeg General Hospital at the instance of the hospital staff. At the present time work is carried on in ten hospitals situated in Montreal, Toronto, Winnipeg, Hamilton, and Vancouver. In the seven hospitals of which I have detailed records, 32 full-time workers are employed in addition to stenographers and interpreters. About half of these workers have had social training.

Holland. The Wilhelmina Hospital in Amsterdam was the first to begin hospital social service, in September, 1913, modelling the work done upon that of the Cicely Northcote Trust at St. Thomas's Hospital in London. By 1927 the work had spread into eight other cities besides Amsterdam and included activities carried on in fifteen different hospitals.

Belgium. In the Neurological Center at Brussels a social worker was introduced in 1925 by private individuals. A year earlier (1924) the socialist mutual benefit societies of the districts of Brussels and Louvain established a half-time worker.

Austria. Dr. Karner, describing the work in Vienna in 1926, says, "A separate hospital social service does not yet exist, but those leaving a hospital are given special attention by the public charities. So far the work is concerned chiefly with the care of babies and young children, extending from them to the mother and to some extent to the rest of the family." This work started in 1913 with one worker for unmarried mothers and their children. By 1928 there were seven full-time workers and this service had become an essential part of the obstetrical clinic. Up to 1922 it was chiefly an out-patient service, "rarely and cautiously allowed to extend into the wards." But now the worker is in the hospital all day, sees all records, and has a convenient office. She is paid and supervised by the Vienna Department of Social Welfare.

Hungary. In 1926 the Hungarian Red Cross at Budapest began social work in the hospitals of that city. At the present time work is carried on in seven out of the 16 hospitals of the city, by one full-time worker and 26 volunteers. The workers are not trained and the expense is borne from private sources, although in 1928 the work

was recognized by the State and made part of the Municipal Health Service. Economic and industrial problems are naturally in the foreground, but the workers also act as intermediaries for the transfer of patients to various special hospitals and to the care of general social agencies.

In addition to the work just described three Roman Catholic sisters are doing similar work in one of the city hospitals of Budapest. They work in close cooperation with the Red Cross workers.

Sweden. In Stockholm and Gottenberg social work has more or less direct connection with the general hospitals. In Stockholm since 1920 a trained nurse employed by the Board of Health visits the different general hospitals and sees patients at fixed hours in consultation with the doctors and hospital nurses. The financial and other needs of the patients are cared for in this way. The social worker acts as an intermediary with the various special medical institutions and with the state pension boards. For temporary financial assistance the social worker also distributes special hospital funds. Her office is at the Board of Health.

In addition to this work carried out directly in connection with hospitals, there is in Sweden a great deal of follow-up work done mostly by nurses for the benefit of patients who have left hospitals for the mentally diseased, for the tuberculous, for cripples, for cancer, for chronic arthritis, venereal diseases, children's diseases, and leprosy.

Denmark. In 1922 social work was started in two of the hospitals in Copenhagen, chiefly, at the start, for cases of mental disease. At the present time one worker gives her whole time to the work of single clinics in each of six large hospitals.

Switzerland. I am informed by Dr. Marguerite Wagner of Geneva that in no part of Switzerland is there any agency corresponding exactly to hospital social service, although through the Red Cross and through religious organizations a good deal of useful work, more or less connected with hospitals, is carried out.

Concerning social work in the hospitals of *Italy, Poland, Czechoslovakia, Jugoslavia, Norway*, and the rest of Europe I have no knowledge.

Australia. In the Melbourne Hospital and in the Royal Prince Alfred Hospital in Sidney, social work has been installed, in the former since May, 1924, but according to a report presented to the Victorian Government in November, 1927, "practically nothing has

been done." In New Zealand, according to the same authority, the value of social work in hospitals is becoming recognized.

China. In two hospitals of China, both of them founded by American initiative, social work has been going on since 1921. The most important of these is the Pekin Union Medical College and Hospital, in which Miss Ida Pruit, a very thoroughly trained worker, has labored since 1921. She now has seven assistants, two of them college women socially trained in America.

It does not appear that the movement has taken any strong root as yet in *Japan*, or indeed in any countries except Europe and North America.

III.—NAME AND DEFINITION

The purpose of social work in hospitals is to obtain such understanding of the patient and of his concerns as will enable us to supplement the efforts of the physicians and nurses, both in the comprehension and in the treatment of his illness.

From this definition it follows that the chief work of the social worker is to understand the patient and to make him understand what he especially needs to know in order that he may be properly cared for and if possible recover his health. Ideas, then, are the material in which the social worker chiefly deals. She is to gather ideas about the patient and to convey ideas to him. Her business is to understand him and to make him understand, so far as this is necessary to fulfil the hopes and desires with which he sought the hospital. What she aims to understand is especially (a) the patient's state of mind, (b) his economic, domestic, and industrial situation, and (c) these same facts as regards his family and those most closely connected with him in his school, his work, his recreations, and his religious life. When she aims to enlighten and assist the patient it is chiefly (a) by explaining to him the nature and the future of his own disease, (b) by explaining what is to be done for its palliation or its cure, and (c) as to what individuals or agencies outside the hospital can help him either by care or by cure.

It is much easier to state these purposes than to give them a fit name. All names hitherto proposed seem to me unsatisfactory. The word "social," which I have perhaps done as much as anyone to connect with this work, seems to me in several respects misleading; for in the first place the work is concerned primarily with individuals and *social* is a term often contrasted with *individual*. Moreover, the ideas

called up by the word *social* are often entirely misleading when one is thinking of the work which we are now discussing. If we think of "social hygiene," the problems of venereal disease are suggested. "Social democracy" calls up political theories with which we have here no concern. Finally, in English the word *social* is often, perhaps chiefly, connected with afternoon tea and similar functions. For all these reasons I object to the term. Yet when I consider the alternatives proposed for it I am no better satisfied. For instance, in Germany Dr. Alter of Dusseldorf, in his most valuable and interesting writings in the *Zeitschrift für das gesamte Krankenhauswesen*, January 3, 1927, and elsewhere, has proposed the term *Fürsorgedienst im Krankenhaus*. We all agree that this work should be connected with the *hospital* and that it is a *service*, but when we come to define this service by the word "*Fürsorge*" or "*Fürsorgelich*" we have a term that is as much too wide as the word *social* is too narrow. For the doctor and the nurse also give "*sorge*" or care, and it is one of our chief objects to distinguish the *particular* hospital service which I am now describing from other services given in hospitals.

The English word "*almoner*" naturally connects itself with the giving of *alms*, which we are all agreed has little or no part in this work. The English themselves have had to supplement this word by phrases like "*social service*," "*social work*," and "*the social service department*," all of which now appear in their reports.

One of the ideas which we most want to convey in the name which we give to this work is that whereas all or nearly all the others who deal with the patient are concerned with rendering him some *particular* service (bodily, mental, spiritual, recreational, occupational, educational), our task is concerned with *whatever the patient may need* to further his recovery, either in one of the special departments of service just mentioned or in any other. In other words it is a service to the *total personality* of the patient insofar as this service is needed to promote his health. This suggests that we might call it "*personal service in the hospital*," a service devoted to the restoration of the patient's total personality. But unfortunately the term "*personal service*" has become associated with such occupations as those of the manicure and the bootblack, and cannot, I fear, be easily rescued.

"*Welfare work*" is in some ways a better term than any of those yet discussed, since surely we are concerned with the patient's welfare and with whatever may be necessary to maintain or secure it. But this

word has now, especially in Germany, a very definite and fixed association with activities outside the hospital and not connected in any strict sense with illness. Moreover, we could say that the doctor and the nurse also work for the patient's "welfare" in the ordinary, non-technical sense.

In view of all these difficulties I think we should come back to the word *social* as on the whole best characterizing the work which here concerns us. For many writers have rightly insisted that this work is essentially one of "linking" the patient to all available sources of help. This is the original meaning of the word "*social*"—*that which connects* or joins. Suppose we say that the purpose of social work in hospitals is to link the patient with all available sources of help: (a) in God, (b) in himself, (c) in the world around him. It is true then that this work is primarily and essentially a work of linkage, a *social* or intermediary work, or, as I like best to say, a work of *interpretation*,—a term to the discussion of which I shall return later.* After noting these advantages upon the side of etymology, we may also acknowledge that, for good or for evil, the word "*social*" has now taken very firm root in at least three of the four countries in which this work is extensively developed. Furthermore, it can be taken to emphasize another essential feature for its prosecution, namely what we in America call "team-work." Unless the work is social in the sense that many persons work together in close, yes, if possible in affectionate relations with each other, it will never be successful. Unless the patient himself, the doctor, the nurse, the social worker, and the manifold agencies of helpfulness outside the hospital can be linked together in helpful coöperation, we do not attain the objects for which we are striving. For reasons, then, connected with etymology, with usage, and with the form which the work actually takes when it is successful, I believe we should continue to call this work *social*.

The word *hospital* should always be a part of our title. For though similar work may be done in many other places, the peculiar traditions of hospital work, the peculiar complexity of the interrelations centering there, and the special knowledge needed by anyone who is to work there without giving rise to all sorts of trouble and without making herself a great nuisance, differentiate her work both in the training required for it, the taste and character proper to it, and the results to be obtained by it.

* Further discussion of this point will be found in the section on *Organization*.

IV.—REASONS FOR THE RECENT ORIGIN OF HOSPITAL SOCIAL WORK

The need of hospital social service is so basic and so obvious that when one has once perceived it one wonders why we have got along for so many years without it. It is not, I believe, that superior wisdom has only in our time appeared upon the earth, but rather for the following reasons.

1. A change in the conception of medical diagnosis and of medical treatment.

Although physicians have for centuries cherished the ideal of "*getting to the bottom*" of the patient's troubles, of avoiding superficiality and plunging as deep as they could towards the basic causes of his illness, yet they have been inclined, both by their temperament as a profession and by the nature of their training, to focus attention upon the *bodily* manifestations of disease and to ignore partially or wholly the intelligence, the emotions, and the will of the patient, together with the effects made upon him by his relationships to his family, his friends, his work, his recreation, his religion or lack of religion, and the other influences entering his life. There is nothing new in the recognition that a patient may suffer from disturbances of his stomach, his intestines, his heart, and other portions of his anatomy all because of wounds of the spirit, fevers of the mind, moral degenerations, fatigue, sorrow, remorse, worry. There is nothing new, I say, in this knowledge. But even yet it has penetrated into the practice of only comparatively few physicians. Though our medical textbooks tell us all these facts we forget them because our senses present us such impressive evidence of bodily disease and because on the whole our medical training centers our attention there and nowhere else.

This forgetfulness is especially characteristic of hospital work because there one sees the patient torn out of his natural setting and bereft often of considerable portions of his wits. Why should we be made vividly aware of the influence of his mind, his work, and his family life when very little evidence of any one of these appears at the bedside? It is strictly true to say that only a fragment of the patient's personality appears clearly at the hospital. He has left a large portion of himself at home or elsewhere. But his disease he brings with him. That we see. The rest we forget.

Especially is this true under the conditions of hurry which are unfortunately only too common in hospital work, and above all in hospital out-patient departments or "polyclinics." We are prone enough under any conditions to neglect what is not before our eyes or on the surface, to ignore the psychological and social aspects of the patient's case. But we are more than ever in danger of making this blunder when we are in a hurry, when patients are seen in masses and in an atmosphere of distraction and confusion. The old-fashioned country physician, the general practitioner of the village, who saw his patients in their home or at their work, who knew them, their families, their neighbors, who had been associated with them in all the neighborly offices of town life, was less likely to forget the man, less apt to focus blindly upon his disease. But such practitioners, I fear, are now growing rare; at any rate in hospital work it is impossible for the physician to enjoy such comprehensive understanding of his patients.

All this, as I have said, has long been true. But for various reasons it began to penetrate to the minds of those concerned in hospital work, that is, the doctors, nurses, and hospital superintendents, only a little more than thirty years ago. It was at about that time that we began to realize that only in a small minority of the patients who come to a hospital for treatment, especially of those seen as out-patients, could drugs or surgery produce any important improvement. In the great majority of cases the out-patient will not be better unless his hygienic conditions, the conditions of his work, diet, sleep, and his mental and emotional activities can be changed. But these changes in turn are often impossible unless his economic, domestic or spiritual conditions can be improved. In my own case certainly it was the sense of my failure, of the uselessness of my work as a hospital physician, that led me to seek aid from social workers. The treatment needed by most of my patients could not be carried out without their help. But unless something could be done in the way of treatment it was hardly worth while to spend time and strength (as I was doing) on the niceties of diagnosis. To work hard in an out-patient clinic day after day with the sense that most of one's work is wholly useless because the patient can not possibly get the treatment demanded by the diagnosis, must lead one either to careless and slipshod technique or to a demand for reform. So long as we could believe that we were doing all that could be done for the patient when we handed him a prescription for medicine or bandaged a vari-

cose ulcer, one could take some satisfaction in one's work. But the advance of medical knowledge banished these beliefs and left us often quite hopeless.

2. Another change in our point of view was brought about by the development of campaigns against tuberculosis.

I have often thought and said that from the point of view of public health *tuberculosis was a blessing* because it taught us new ways of attacking disease, new aggressiveness, new hopefulness, and above all, a new attitude towards our patients. This new attitude consisted in *taking the patient into partnership* in our campaign against his disease. We recognized in tuberculosis earlier than in other diseases that the disease cannot be effectively fought unless the patient himself understands it and does his part in the contest against it. In earlier years the doctor and the nurse were supposed to do everything, the patient almost nothing. That is, he was to do as he was told, to open his mouth and shut his eyes. It was not for him to presume that he could understand the complex mysteries of his disease, and even if he could, we arrogantly assumed that he was not capable of keeping his balance in the face of the ever-present threat of death. That burden, we thought, must be borne by someone else. It was the doctor's business, or the nurse's, not the patient's. I cannot say that we physicians have as yet wholly conquered this fallacious idea, any more than we have conquered our stupid forgetfulness of the patient's mental and social life. There are still those who preach that the patient should not be told the truth about himself, so far as we know it, but should be treated like a child by others who know better than he does what is good for him and what he can bear. This autocratic and domineering attitude, though assumed often from excellent motives, has been made possible by a self-deception like that by which the ostrich was said to suppose himself concealed when he had hidden his head in the sand. The doctor has often been able to deceive himself into thinking that he can do all that needs to be done and think all that needs to be thought for his patient, even when everyone else except the doctor sees clearly how absurd this attitude is.

Modern public health work, beginning with the campaign against tuberculosis, has been centered about the conviction that the patient must understand all that we can teach him about his own troubles and about the ways to combat them. It is true that he may get to worrying about himself and his disease. That is a chance which we must take, and experience has shown that it does very much less harm than

we used to suppose. The campaign against tuberculosis, begun in America largely by the laity, soon brought to light the fact that after the doctor had finished his expert work of diagnosis there is relatively little as to the treatment of the disease which cannot be understood and carried out by intelligent laymen, among whom no one is so much concerned or so constantly in a position to do the right thing (if properly taught) as the patient himself. Ever since the beginning of the campaign against tuberculosis doctors have begun to *teach medicine to their patients*. At first this sounded revolutionary and many physicians have not even yet begun it. But they are being compelled to move in this direction by the increased enlightenment of the patients themselves, who hear from each other what the more enlightened physicians have begun to do in the way of educating their patients medically. I know now many a diabetic patient who knows more about diabetes than the average physician. He has been forced to learn it for his own benefit and because it concerns himself more than it concerns anyone else in the world. So it is with venereal diseases, with many orthopedic troubles, nervous troubles, diseases of the heart,—in fact with almost all diseases which last more than a few days. Medical knowledge is becoming public property. It is no longer the exclusive possession of doctors and nurses, and on this rest our best hopes for the preventive activities of public health work in hospitals and elsewhere.

3. Just as that fortified citadel, the physician's exclusive possession of medical knowledge, has been broken down through public health work, so another closed fortress, the hospital, with its own peculiar standards and customs, has now been penetrated. Formerly the medical staffs were absolute monarchs there. The hospital superintendent, at any rate in America, was very much under the thumb of the physicians and surgeons of the hospital. His business was to give them a chance to carry out their work according to their own ideas. He owed no primary allegiance to the public. If people did not like hospital customs they could go elsewhere. The physician and the surgeon were kings, each in his own sphere, and they wanted above all things not to be interfered with. Like the other reforms which I have described, the change whereby the hospital physician has become a servant of the public instead of an independent sovereign, is still far from complete, especially in private hospitals and those without university connections. There is still often very little recognition of the fact that hospitals exist primarily to serve

the public rather than the physicians who work there. But the process of enlightenment has begun and one important evidence of it is the establishment of social service departments. For one of the chief functions of such a department is to connect the hospital with all the social forces, and helpful agencies outside its walls.

I suppose that this has come about as part of a more general recognition of the connection between economic life and every other human interest. Hospitals exist still very largely for the treatment of the poor, and the connection between poverty and disease is now recognized better than ever before. But if we are concerned with the patient's economic life when we are trying to improve his health, we cannot escape the need to know something about his work and his home. And if we are concerned with the patient's mental, emotional, spiritual life whenever we are concerned with his disease, we cannot escape the need to know something about his social relationships both in his home and outside it, about his enjoyments and recreations, his habits, his fears, even his beliefs or his despairs about religion.

V.—PRESENT FUNCTIONS OF HOSPITAL SOCIAL WORK

Wherever social work exists in hospitals it is concerned with trying to accomplish the three things so well stated by Dr. Alter (*loc. cit.*) as *Vorsorge*, *Fürsorge*, and *Nachsorge*,—prevention, hospital treatment, later treatment. It is also concerned I think, though in a minor degree, with diagnosis, insofar as a knowledge of the patient's social and mental life is essential to the understanding and evaluation of his symptoms.

But though these are the great tasks of social work in all hospitals, both in the out-patient department and in the wards, there are and ought to be the greatest differences in different countries and in different parts of the same country, depending upon the psychological and economic conditions of the time and place, and also upon the development (or lack of development) of social work outside the hospital. Whenever or wherever poverty is extreme, the task of social service will be concerned with attempts to improve the economic conditions of the patient, either directly, in case there are in the community no social organizations concerned with this work, or indirectly by cooperating with any that may exist. Where patients are excessively ignorant and uneducated, the task of educating them in a knowledge

of their disease and of the methods of combatting it, cannot be carried out extensively. On the other hand, with a relatively intelligent group of patients, hygienic education will constitute an important part of the social worker's task, always provided that she can depend upon accuracy in the diagnoses and prognoses given by the physician.

All her work for hygienic instruction and toward an adequate provision for the patient's future is useless or harmful if the diagnosis and prognosis furnished her by the physician are seriously inaccurate or are given her in a brief and largely unintelligible form, as is often the case. When medical diagnosis and prognosis are seriously inaccurate, or where the understandings between physician and social worker are not close and friendly, the worker often sees her plans fall to pieces like a house of cards.

At best she can attend to such economic necessities or such mental troubles as she independently discovers, but she can do relatively little to forward the patient's recovery by enlisting him and other allies as partners, in a well-planned struggle against his disease. She can do relatively little also to guide his present and future life, since she does not possess the essential medical data of prognosis.

Therefore the sort of work which the social worker undertakes in a hospital must depend very largely on what the hospital and the community outside it are willing to contribute to support this work. For example, in Berlin, where there are but seven full-time workers for the seven university clinics, or one worker for each clinic,* the task of each worker must be very different from that of a worker at the Massachusetts General Hospital, with nineteen full-time workers for that hospital alone. In Paris and in some German cities where the development of general social agencies is very much less extended than in London or New York, the hospital social worker must make many home visits, must attend to matters of material relief, the placing of children in foster homes, and other matters ordinarily attended to by family agencies or children's agencies. In England and in American hospital social workers make few home visits, because the agencies outside the hospital cooperate in this.

Another factor which helps determine what the social worker shall do within the hospital is the interest and intelligence (a) of the medical and surgical staff, and (b) of the hospital management. If

* The *Charité* is not included.

these gentlemen are not interested or not in sympathy with social work, all sorts of expedients have to be adopted to arouse them. Many a social worker is now doing in hospitals jobs which she knows are no part of her proper work, because she wants to be obliging and so, gradually, to win the interest of the staff and of the management. Thus we find social workers doing clerical work, arranging for the donors of blood when transfusions are needed, putting drops into the eyes of patients waiting for the oculist, carrying messages or escorting patients from one part of the hospital to another. Moreover, when social work is done by nurses they are prone to relapse into assisting the physicians or the patient in ways proper rather to a nurse than to a social worker. I assume as a matter of course, that in emergencies or times of special pressure the social worker or anyone else should do whatever seems most needed to help the institution through a crisis. Nothing is more contrary to the spirit of social work than the unwillingness of any worker to do, *in an emergency*, something obviously needed, though outside the field of her own special work. But in this as in any other field there is danger that exceptions and emergencies shall become the rule, so that a person is permanently dislocated from her proper usefulness.

England. According to the statement of purposes published year by year in the reports of English hospitals, the original function of the almoners, namely to turn away from the hospital patients who did not belong there, was for a considerable period put first as late as 1919. In 1924 it was put second and now (1925) it is mentioned only at the end of a list in which the earlier items are as follows:

"1. To gain a knowledge of the patient's home conditions for the use of the medical and surgical staff.

"2. To cooperate with the other social agencies of the city.

"3. To do whatever will enable patients to carry out the doctor's treatment more thoroughly" (e. g., furnish surgical appliances such as trusses or flat-foot plates, help to arrange for the patient's treatment during convalescence, help him to change his occupation, or even to emigrate to another country).

"4. To arrange for the after-care of patients discharged from the wards.

"5. To be familiar with powers of state and municipal authorities which bear upon the health or social conditions of the patient, and to act in close cooperation with these authorities.

"6. To administer the relief funds of the hospital.

"7. To discuss with the patients and to collect if required by the hospital the patients' contributions towards their treatment.*

"8. To check the misuse of the hospital, (a) by those able to pay, (b) by those who already have medical attendance under the sickness insurance legislation, (c) by those more suitable for treatment in public institutions such as almshouses."

In addition to this stated in 1925, I find in earlier English reports (1922) that the social worker in English hospitals is also supposed:

9. To urge upon the patient the necessity of joining the permanent clubs and friendly societies registered under the act of Parliament, and to avail himself of the services of the panel doctors under the system of sickness insurance.

10. To further the use of hospital Out-Patient Departments as consulting centers. (The report further explains that this last purpose is to be accomplished by seeing that the patient reports to his own physician after the consultation at the hospital, and does not continue there as a patient. Something of this kind has also been attempted in America, but in the "pay clinics" rather than in the ordinary free clinics.)

In other reports it is added that it is the business of the social worker to encourage the regular attendance of patients at the Out-Patient clinics, to act as a link between the doctor and the patient, and to attend to the technicalities of hospital administration in connection with the state ministries of pensions, of health, and of education. Of late years it is clear that in English hospitals the social worker is paying more and more attention to the psychological problems of patients as contrasted with economic or purely hygienic problems. Thus it is stated that she is supposed to do what she can to remedy "maladjustments" in family life, difficult adolescence, troubles arising from jealousy, fear, remorse, or loneliness. Here of course she acts in closest coöperation with the physicians of the neurological and psychiatric departments. Again, she arranges for the loan of books, dolls, and games to children who need to be kept contented

* In theory all the English hospitals of which we are now speaking are free to all patients, but in practice the patient is invited to make a voluntary contribution towards his treatment, and ordinarily does so. In America most "free" hospitals make regular charges to patients but remit these in cases of special need.

in bed during a long period of convalescence. Also, as a part of her duties towards public health, the almoner now tries to arrange for bringing to the hospital for examination members of the family or others who are in contact with a contagious disease such as tuberculosis, syphilis, or gonorrhoea. In the early days of hospital social work in England, as in the same stage of the work in other countries, the worker was called upon to make a great many visits to the patient's home. As the work has developed the task of making these visits has been more and more transferred to outside agencies, district and visiting nurses, etc.

Germany. In 1926 the National Conference of Social Workers and others interested in this type of work adopted an interesting and comprehensive code of "Guiding Principles" for social work in hospitals. The duties of the social worker as there listed include:

1. Religious ministrations to the patient.
2. Secular services as follows:
 - (a) Inquiry into the social and psychological factors which may have played a part in causing his illness.
 - (b) The distraction and redirection of the patient's attention, through the provision of reading matter, physical training, and occupational therapy.
 - (c) Attention to the condition of the patient's family during his absence in the hospital.
 - (d) Provision that the patient may not lose his job during his illness, nor be deprived of any of his civil rights.
 - (e) Arranging for examination of any who may have been in contact with the patient in case he is afflicted with tuberculosis or venereal disease.
 - (f) Arrangements to insure the permanence of the patient's recovery after leaving the hospital (financial aid, nursing, transfer to other institutions or agencies, aid in securing work or in changing work).

It will be seen that these measures fall into the admirable divisions suggested by Dr. Alter: *Vorsorge, Fürsorge, Nachsorge*.

In this statement of the functions of hospital social work in Germany one of the striking points is the concentration of attention upon ward patients and the extent to which out-patients are ignored, though it is true that in some of the most recent writings

by German social workers, more attention to out-patients has repeatedly been urged. In England and in America attention to out-patients forms the staple of social work in most hospitals and engages the attention of most of the workers, while our activities in the hospital wards, although very important from the point of view of shortening the stay of the average patient in the wards, still remains a relatively subordinate part of our work.

In Fraulein Landsberg's survey of social work in the hospitals of thirty-five German cities during 1926 she notes that all the hospitals agree on the following list of services actually provided by the social worker :

1. Helping the patient to get medicines and surgical apparatus.
2. Arranging for out-patient treatment.
3. Arranging for convalescence.
4. Material relief.
5. The improvement of home conditions.
6. The improvement of work conditions.
7. Coöperation with all available private and public agencies.

In the hospitals of Berlin she says the most important tasks of the social worker are :

1. Arranging for the early transfer of ward patients to their homes or to other institutions and agencies.
2. The providing of surgical appliances and apparatus.
3. Material and financial relief.
4. Arranging for home nursing.

The number of home visits made by the Berlin hospital social workers is still very considerable.

Dr. Alter, who seems to be accepted as one of the best interpreters of this work in Germany, interprets its task as one primarily for the mind (*Seele*) of the patient and so concerned with the patient's mental and spiritual development. He insists that the worker should be a person "of deep and warm motherliness" (*innerliche, herzliche Mütterlichkeit*). In this I should like to express my strong agreement with Dr. Alte. He also well says that the problems for the social worker in hospitals are "as numerous as are human sufferings and human wishes, since the object of all the work is the patient himself."

So far as I can judge from the reports and articles available to

me, I think the contact between the social worker and the hospital physician is less intimate in Germany (and also in France) than it is in England and in America.

So far I have been speaking of the positive functions of hospital social work in Germany. On the negative side we find emphasis in the rules established for social workers in Dresden. "She must avoid meddling in any way in the routine of medical treatment and in particular she must neither make nor listen to any criticisms upon the treatment given the patient in the hospital." One sees here traces of the friction which I imagine must have taken place in the earlier stages of social work in Germany as it certainly did in my own experience with social work in America. Hospital authorities and physicians are used to a certain routine and find any innovation a disturbing factor. The workers on their side do not realize the difficulties under which hospital doctors and administrators pursue their callings, and are apt therefore either to criticize or to sympathize with the patients in their criticisms in a way that may upset the discipline and morale of the hospital. On the other hand I feel sure that in Germany as in other countries wherever social work has been established for some time in a hospital, the hospital management and the physicians welcome all suggestions and criticisms brought to them by any social worker who has a due sense of the difficulties and limitations under which hospital work must be done.

France. A recent statement of purposes (1927) is as follows:

1. To discover the social and psychological factors in the patient's illness.
2. To remove mental and economic obstacles to his recovery.
3. To see that the doctor's instructions are carried out and that the patient comes regularly for advice and treatment.
4. To secure for the patient's benefit the coöperation of any charitable or social organizations outside the hospital.
5. To follow patients discharged from the hospital as long as they need help.
6. To help the patient and his family back to a self-supporting position.
7. To help in the prevention of disease and the preservation of health.

In Paris, since social work has been introduced into certain wards of twenty-eight hospitals but not into the whole system of any

hospital so far as I am aware, its connection with the hospital management is perhaps less close than in some other countries. Moreover, as I have already pointed out, owing to the comparatively slight development of strong social agencies outside the hospital, the hospital workers in Paris are compelled to do a great deal of family work, children's work, and financial relief, which in other countries is taken care of by agencies not connected with the hospital. For these purposes the fifty-nine Parisian workers made in 1927 a total of 12,120 home visits and 11,294 other visits.

In their care of patients in the *tuberculosis wards* of the various hospitals the social worker tries to ease the mind of the ward patient as to the condition of his family and of his children by placing the children temporarily in foster homes, or by doing what she can to see that they are properly cared for at home. She also endeavors to secure medical supervision for all members of the family who have been exposed to infection, to place children in preventoria, foster homes, etc., when this is advisable, to secure suitable work and medical supervision for convalescent patients. Another peculiar function of the French workers in connection with their tuberculosis patients is to visit the patient's employers and endeavor to obtain from them or from other sources money* to cover the expenses of the patient's treatment and convalescence. In 1927, 1737 tuberculous patients were placed in sanatoria or other institutions. After the patient's discharge from the hospital wards it is also the social worker's business to arrange for a continuation of his treatment in a dispensary, and for work not beyond his strength.

In the children's clinics the worker is present at the time of the doctor's visit and tries to see that his prescriptions and his directions are understood by the patient and are carried out. She tries to help and teach the child's mother so that she may properly care for her sick child, and if necessary places the other children temporarily in foster homes (2728 children so placed in 1927), tries to find a job for the father, and in general assumes responsibility for the family. Beyond this she tries to make herself useful as a general assistant to the doctor in his crushing out-patient task ("*écrasante*"), giving him concisely the chief points in the patient's histories.

In the *maternity wards* the workers

*In 1927 the social workers themselves raised 97,200 francs for tuberculous persons and 94,444 francs for other patients.

- (a) See all applicants at the prenatal clinics and try to provide for their chief needs, medical, hygienic, domestic and economic.
- (b) Try to make sure that they report regularly for examination before their confinement, and carry out the doctor's advice.
- (c) Encourage them to nurse their babies and not to give them up to the care of others, showing them in detail how a budget for their support may be arranged even by an unmarried mother.
- (d) In the case of married mothers the worker arranges for the care of the other children during the lying-in period, and,
- (e) Visits the patient at home so as to arrange for economic and hygienic help.

The social worker's "widest sphere of action is that relating to unmarried mothers. In 1927, 196 mothers were placed with their children." "Perhaps the greatest difficulty faced by the Parisian workers is to find decent lodging for the many families now living in one or two dark and overcrowded rooms."

In the *surgical wards* the chief tasks are:

- (1) To convince patients of the need of immediate operation.
- (2) To secure patients aftercare on discharge.

In the *medical wards* the worker tries:

- (1) To arrange institutional care for chronic cases.
- (2) To make provision for the destitute after their recovery.

In the *clinics for venereal diseases* her purposes are:

- (1) To combat the prejudice which leads patients to conceal their malady and to discontinue treatment.
- (2) To teach them how to prevent the spread of their disease.
- (3) To persuade them to bring in for treatment others with whom they have been in contact.
- (4) To refer to local physicians (sending prescriptions and drugs) patients who leave Paris.

United States. I think I can best describe what hospital social workers are now doing in the United States by analyzing a pamphlet entitled *Functions of Medical Social Service*, written by Louise S.

Bryant,⁵ Ph. D., and recently published under the auspices of the Committee on Functions established by the American Association of Hospital Social Workers. In this pamphlet the records of 1000 cases submitted from 60 hospitals in 24 cities of the United States and one Canadian city have been studied. Most of the hospitals contributed 15 cases each, a few contributed only five, a few sent 20, 30, 50, or even 75 cases. These represent both public and private hospitals, those under the United States Government, those for chronic patients exclusively, Jewish hospitals, children's hospitals, dispensaries, two psychopathic hospitals, and many other varieties including the famous Mayo Clinic at Rochester, Minnesota.

In the total 1000 cases there were :

Men	238
Women	440
Children	322

This analysis shows the following outstanding functions of the hospital social worker in America :

1. To contribute for the use of the physician, both in his diagnosis and in the understanding of the patient's health problem, data from the patient's own social history*, from acquaintance with his family life and other relationships, and from his economic and industrial history.

2. To explain and interpret the patient's physical and mental conditions as found by the hospital physician to the patient himself and to his family and friends, so far as that is desirable.

3. To contribute these same physical and mental data concerning the patient to the proper agency outside the hospital. These outside agencies are grouped as follows :

- (a) Health agencies.
- (b) Social agencies.†
- (c) Industrial agencies.
- (d) Educational agencies.
- (e) Recreational agencies.

* The social history includes an account of the patient's inheritance, development, behavior, education, present interests, recreations, companions, and the traits of his personality.

† This refers to what are ordinarily known as family agencies, children's agencies, and those for general welfare.

(f) Legal and governmental agencies.

(g) Religious agencies.

4. Through an investigation of the patient's present social and economic history, and of his character and health as revealed in his industrial history, to contribute to his medical and social rehabilitation.

5. To utilize for the patient's treatment any resources discovered in himself, in his family and friends, or in any of the outside agencies above listed.

6. To improve the physical conditions or the management of his household so far as they bear upon the patient's mental and physical health.

7. To build up family loyalty and affection and so far as possible to stimulate a better relation between the patient and his friends.

8. To promote proper recreation for the patient.

9. To improve so far as possible the physical condition of the patient's work or his own management of his work.

10. To explain to the patient the nature, extent, and probable future of his disability and of the limitations imposed upon him by it.

11. To perceive, safeguard, and develop in the patient's character those elements of strength which may contribute to his mental and physical health.

12. To arrange for such financial or material aid to the patient or his family as may be essential for building up his health or for securing proper care without destroying his independence.

13. To procure such hygienic instructions and medical examinations for the patient's family as are called for both in the interest of the patient and of public health. Therefore,

It is moreover a proper task for hospital social workers to utilize the knowledge and experience obtained in carrying out the tasks just listed for the improvement of existing agencies or local conditions as regards industry, education, recreation and public health. Therefore,

14. Where proper resources in any of these directions are lacking the hospital social worker may do good public service by calling attention to this lack, on the evidence of her own experience. She has seen where the resources of the community fail to meet the needs of the patients whom she has tried to help. She is in a position,

therefore, effectively to urge upon the community the need of better agencies or resources for the sick. In this way the need of sanatoria for the tuberculous, of psychopathic hospitals or wards, of better provision for the feeble-minded and the syphilitic may be published. Moreover,

15. Her experience may induce her to take the lead in bringing about a better coördination and coöperation among existing social agencies and health agencies.

16. In addition she should assist in the collection of cases for group-study and discussion (for example, cases of industrial disease, unmarried mothers, children with heart disease), and thus should prepare the way for further study and research.

Analyzing further the particular problems dealt with by the workers in the thousand cases here analyzed, we find that they may be grouped as follows:

I. *Problems directly related to the patient's illness:*

1. "Personality-problems" (that is, concerned with the patient's conflicts, worries, fears, inefficiencies, forgetfulness, envy, etc.)	407
2. Problems of specific hygiene (that is, the hygienic management of the particular organ diseased in his case)	286
3. Problems of general hygiene	154
4. Industrial problems (physical handicap or poor adjustment to a particular job)	126
5. Problems of procuring institutional care	124
6. Problems of physical, moral, or social hygiene.....	47
Total	1144

II. *Problems indirectly related to the patient's illness:*

1. Economic insufficiency	491
2. Family or domestic problems (widowhood, desertion, marital difficulties)	456
3. Illegitimacy	75
4. Mental disease in other members of the family.....	56
5. Prostitution	36
Total	1114

It will be evident that we have been listing here problems, not patients. We have picked out here a total of 2258 outstanding problems related to the needs of 1000 patients.

The diseases from which these thousand patients suffered fell into the following divisions:

1. Internal medicine (including diseases of adults and of children)	511 cases
2. Nervous and mental diseases	282 "
3. Obstetrical and gynecological (including 99 cases of pregnancy, 75 of which were in unmarried women)	120 "
4. Orthopedic cases and accidents	57 "
5. Diseases of the organs of special sense.....	28 "
6. No diagnosis	2 "
	<hr/>
Total	1000 "

Among the 511 cases falling within the field of internal medicine there were:

1. Tuberculosis	123 cases
2. Cardiac disease	100 "
3. Venereal disease	79 "
4. Diseases of metabolism (chiefly diabetes, rickets, and malnutrition).....	59 "
5. Gastro-intestinal disease	36 "
6. Cancer and other new-growths	27 "
7. Non-tuberculous lung disease	25 "
8. Arthritis	22 "
9. Nephritis	22 "
10. Malignancy	18 "
	<hr/>
Total	511 "

Out of these thousand cases, 467 had been under the care of the social worker for periods of six months or less up to the time of the report, 210 from six months to one year, and the remainder from one year to more than five years.

In from one-third to one-half of these thousand cases the data contributed by the social worker seemed to her to contribute to the medical *diagnosis*. What the judgment of the physician may have

been on this point we do not know. The worker's service in *explaining or interpreting* the patient's physical or mental condition to him or to his family seemed to the worker to be of some value in from eighty to ninety per cent. of all the cases (roughly 900) in which it was attempted. A similar service as interpreter to a health agency or a social agency seemed to be of importance in about three-fourths of the cases. Explanations given to industrial, educational, recreational, religious or legal agencies seemed of value in perhaps one-fifth.

Valuable contributions by the medical social worker to the patient's medical and social *treatment* came out of the study of the patient's personal history in 953 cases, out of the study of economic factors in 892 cases, and of factors concerned with the patient's work conditions or manner of work in 576 cases.

Resources utilized by the medical social worker with more or less success:

1.	Resources within the patient.....	utilized in 770 cases
2.	“ “ his family	“ “ 786 “
3.	“ in his friends	“ “ 383 “
4.	“ “ health agencies	“ “ 702 “
5.	“ “ general social agencies...	“ “ 660 “
6.	“ “ educational agencies	“ “ 280 “
7.	“ “ industrial agencies	“ “ 250 “
8.	“ “ recreational agencies	“ “ 224 “
9.	“ “ religious agencies	“ “ 213 “
10.	“ “ legal and governmental..	“ “ 205 “

If now I may add from my own experience of hospital social work, chiefly within a single hospital, some impressions as to what it does and ought to do, I should emphasize first of all the task of the social worker as an *interpreter*. The patient finds himself facing a new and often a terrible situation. To enter the hospital is often for him the most momentous event of his life, and he needs all the help that can be given him to understand it. When we say, then, that one of the most important tasks of the social worker is to cheer, encourage, and reassure the patient, to let him see that warmheartedness and good will are at the center of all the apparently impersonal and heartless technical procedures which he sees around him, we are saying that *the social worker must interpret the hospital to the patient*, must explain that “its bark is worse than its bite,” and that behind these apparently immovable faces, plans for the alleviation of his suf-

ferings and for the reconstruction of his life are forming. Nurses and doctors of course should also do this work of interpretation, but they rarely remember to. Interpretation is therefore especially the business of the social worker who wants the patient to understand things as they really are and not as they seem, in order that his mind may not be terrified by fictions of his imagination.

Most of the people whom the patient sees moving about him seem to be frantically in a hurry and utterly unaware of any particular individual. It is therefore particularly important that the medical social worker should seem to be undistracted, at leisure, and wholly at the service of the patient so long as she is in his company. Because most of the doctors, nurses, and others whom the patient sees about him appear as wholly cool, unemotional beings, it is especially important that the social worker should express in a perfectly sincere and natural way some warmth of good feeling. She should be a person who can easily smile, who is naturally attracted to anybody in trouble, and who shows it. This can easily be distinguished from sentimentalism and from hypocrisy, and of course it is above all necessary that the worker should never pretend any feeling which she does not possess. Sincerity is above all things desirable in these trying times of the patient's life.

Because doctors and nurses so often speak in technical terms, unintelligible to the patient, and seem inexplicably reserved about matters that chiefly concern him, about the nature of his trouble and the future to be expected, it is especially the office of the social worker to explain in plain and truthful language all that the patient wants to know about his disease. She must be able to judge, through her unusual sympathy and sensitiveness, when patients want information for which they dare not ask, and when they are quite content to remain in ignorance. When an operation, a special method of treatment or a special technical procedure, such as a metabolism test, a lumbar puncture, an X-ray examination, a cystoscopy, is advised, it is generally for the social worker to explain what these things mean, how much and how little suffering they involve, how important they are.

Much more difficult but not less important is the task of the worker to explain as well as she can the answer to a question which takes the foremost place as a disturbing element in many patients' minds. I mean the question, "How does it happen that *I* am afflicted with this terrible illness? How can it be that in an orderly world

such disaster can come to me?" Of course the patient rarely if ever asks this question, but it is almost always in his mind, and unless answered it militates strongly against his recovery. The manner of the answer given by the social worker will depend of course upon her own religious, philosophic, or even political beliefs. If she has, as I think she always should have, a religious belief, she must attempt with Milton "to justify the ways of God to man," to explain the place of evil and suffering in the training and education of man's soul, and especially in a world where "we are members one of another." But even if religion means nothing to the worker she must still try to foster in the patient a contented or stoical attitude by giving him some idea of how his trouble has come about and what is likely to be its outcome. Her beliefs as to biology, economics, and hygiene will have here their place of usefulness.

Besides these difficult but all-important tasks of interpreting to the patient the hospital routine and the meaning of his illness, the social worker has the much simpler but still very important task of interpreting to the patient what the doctor has said as to the diagnosis and prognosis of his disease, and sometimes of interpreting the patient's more or less incoherent or scanty replies to the doctor himself. Especially in countries like America where patients of many races and speaking many languages are assembled in a single hospital, the simpler problems of literal linguistic interpretation may be of great importance both in diagnosis and in treatment.

So far I have been describing the duties of the social worker as one who interprets the hospital world to the patient. But she has also the task of interpreting this hospital world and the manifold events which go on there to the patient's family or friends. Sometimes she has even to interpret the behavior of the patient, when he is apathetic, delirious, frightened or hysterical, to members of his family who may not be accustomed to illness and its effect upon the mind.

Beyond the patient's immediate circle, his family or his friends, the social worker has to interpret to the social agencies outside the hospital or to other interested persons, what it is that his illness means, and what measures, financial, hygienic, psychological, are proper for its care. Not infrequently also she must interpret to the hospital physicians or to the hospital management conditions existing in the patient's home or community, which have a vital bearing upon his disease or upon its treatment. The doctor may be ready to send a

cardiac patient home at once, but may change his mind when the social worker explains that the conditions in his home are such as to militate strongly against his recovery.

The intelligent social worker soon learns that in her task of explaining the patient's condition to persons outside the hospital, the actual diagnosis as it is written down in the medical record is often of very little value. Occasionally, of course, that diagnosis is one which should not be revealed without the patient's consent or to any but those who have a right to it from the point of view of public health. More often, however, the difficulty is of quite another nature. It is that the diagnosis itself reveals very little as to the real nature of the illness. For example, all that stands upon the medical record as a diagnosis may be the words, "Ulcer of the duodenum," a phrase which may be perfectly true and accurate so far as it goes. But in one patient this may mean only a slight inconvenience and in another a chronic and crippling disease. What the patient, his family and those who are trying to help him after he leaves the hospital need most to know is that about which physicians are ordinarily most reticent, namely *the prognosis of this disease (a) in the average case and (b) in this particular individual*. Is he going to be partially or wholly disabled? Disabled for a week, a month, or a year? Disabled in his physical endurance or in his mental capacity and balance? None of this necessary information is ordinarily revealed in the diagnosis, and as a rule no prognosis and no statement of the kind, degree, and duration of disability is included in the medical record or in any statement that is vouchsafed by the physician. All this, therefore, the social worker must try to extract from the doctor yet without annoying him or interfering unduly with his other duties. Then, after she has mastered all the knowledge that he can communicate to her, she must then translate this into terms comprehensible to non-medical persons.

It is quite clear that if the social worker is to succeed in the tasks which I have just been describing, she must know a good deal about the psychology of hospital physicians and hospital nurses, what they see and what they ignore, what they habitually express and what they ordinarily forget to express, what seems to them important and why, what will irritate or anger them, what is the right moment to engage their attention, how they may be induced to concentrate their minds upon a particular problem of importance to the patient but outside their ordinary medical routine. Further, the worker should come

gradually to understand what the physician himself often knows little enough about, namely, in what matters he is really an expert and a leader; in what matters he is only an amateur; when his diagnostic or therapeutic knowledge approaches infallibility; when it must of necessity rest on much weaker foundations. Ideally, I suppose, it would be the part of the doctor himself to make this clear, but it is certain that he rarely does so, and perhaps it is expecting too much of him.

Another function of hospital social workers, of which almost all of them are aware but which most of them are tactful enough not to mention, is that of gradually teaching the doctors and nurses what they need to know regarding the social and psychological aspects of disease. I hope the time is long past when the hospital physician thought of himself as an omniscient autocrat, too wise to receive instruction from anyone on matters that concerned sick people. We physicians know well enough today that we must learn from the physicist much about X-rays, about light and other forms of radiant energy; that we must learn from the chemist much about our drugs, body-fluids, and about diet, that we must learn from the psychiatrist many things which intimately concern our patients within the field of mental life. Is it not abundantly clear that we have also much to learn from the social workers about the influence of domestic, industrial, psychological, economic, recreational, and religious factors which enter into and modify the course of our patients' maladies? We are very far from being omniscient in this or in any other field, and if we have true spirit of science and a decent portion of humility, we shall be always ready to welcome facts and interpretations concerning our patient's welfare from those in a position to furnish them to us. Physicians are usually ready to teach, and ought to teach medical students, nurses, social workers, the family of the patient, the patient himself. But we should be equally ready to learn from any and all of these persons. Only so far and so fast as we do this can hospital social work accomplish the objects for which it came into being. There is no sense and no justification for any doctor to treat a social worker as an ignorant subordinate. Subordinate she is and should be in all matters of direct medical technique, but not in her own proper sphere. Therefore the doctor and social worker should meet in the wards and out-patient departments of hospitals as colleagues and consultants, each contributing his quota to the patient's welfare, each teaching the other what he needs to know.

Too often medical social work has been a virtual though unacknowledged failure because the hospital physician did not know enough about it to make use of it for the patient's benefit, just as in a good many of the more backward hospitals they do not know how properly to make use of the laboratories or even of the X-ray department, which therefore do not properly function in the hospital economy. Personally I think it is a mistake to introduce social work into any ward or out-patient clinic where the physicians are ignorant about it or indifferent to it. Their coöperation is a necessity. Without it social workers may do more harm than good.

Still more obvious is it that social work in the sense here described is impossible where the quality of medical diagnosis and treatment is not what it should be. Unless the social worker can trust the doctor's diagnosis and extract from him reasonably definite prognosis, she can make for the patient no plan that can be depended upon to produce good rather than evil results. At the Massachusetts General Hospital we have never attempted to introduce social workers into any medical or surgical ward or into any part of the out-patient department unless they were actually asked for by the physicians. Parts of our hospital therefore are virtually unsupplied with this kind of service, and I think should remain so until the physicians of these departments are sufficiently educated on the social side of medicine to do their part in the essentially coöperative efforts of medical-social work. And even in the portions of a hospital where the physicians or surgeons ask for coöperation from social workers, what they can accomplish will be limited by the degree of close and intimate coöperation which they succeed in establishing with the physicians and nurses of that department. A formal, superficial contact will not do. Doctor and social worker must come to understand each other almost as the members of a family or of a string quartet or of an athletic team understand each other, instinctively, rapidly, accurately, confidently.

VI.—ORGANIZATION AND RELATION TO THE HOSPITAL

In all the countries as to which I have data, social work has been begun at the initiative not of the hospital management itself but of outside persons specially interested in social work and keenly aware of the need for it in a hospital. Sometimes these individuals have

been connected with social agencies already in existence outside the hospital, sometimes they have been physicians working in a hospital and aware of its deficiencies, or socially-minded individuals especially conversant with the needs of hospital patients. As a rule the organization of social work in a hospital has been undertaken as a matter of experiment, *permitted but not specially encouraged* by the hospital authorities. This is quite natural since any innovation is disturbing to hospital routine and is likely soon to involve the hospital in new expenses. Quite often the work has been undertaken first by volunteers without pay, but before long it is found more convenient for all concerned that the workers should be paid. Usually financial support comes first from private sources outside the hospital, but almost inevitably as the years go on it becomes clear that this sort of double responsibility, (a) to the hospital authorities and (b) to agencies or individuals outside the hospital, is an unsatisfactory form of organization. Hence the hospital comes sooner or later, to finance, at first a part, finally, the whole of the social work done in the hospital. When this stage is reached social work may be recognized as a department of the hospital itself, like the X-ray department, the laboratories, or the nursing service.

The march of events just described has been observed so often and in so many different places that I think it may be considered as almost inevitable. One recalls how by a similar train of events other social agencies or experiments, at first maintained by private initiative, have been in the end taken over by the public authorities and made part of municipal or national machinery. It seems to be the natural function of private individuals or agencies to carry new ventures through their experimental stage and to demonstrate their value. When this is made clear to all they become part of a system of public welfare work.

But there are advantages as well as disadvantages in the private control of hospital social work by agencies unconnected with the hospital. In the first place it saves the hospital money. In the second place it arouses and maintains the interest of intelligent and philanthropic individuals in the affairs of the hospital and tends to shield it from the abuses and from the neglect prone to spring up in any institution through which there flows no current of outside interest and inquiry. Moreover a social worker supervised and maintained by agents outside the hospital is freer to try new and progressive experiments, to initiate reforms, to make suggestions. She is less cramped

by the traditions and customs of the hospital, which are sure to contain elements that can be improved.

On the other hand, since the central necessity for good social work in a hospital is close coöperation with the physicians, nurses, and management of the institution, it is much better on the whole that the social worker should in the end become an integral part of the institution, paid out of its funds and subject to the authority of its superintendent. If she is the right sort of person she will succeed sooner or later in achieving a process of mutual education whereby she both learns and teaches in all her relations with the other members of the hospital family.

But if the worker is to get all the help which her patients in the hospital need from individuals and agencies outside the hospital she must spend time and effort in keeping herself in intimate relation with these. If she knows them only in a formal way she will not be able to coöperate with them easily and fruitfully. The nearer her relations, both with the hospital personnel and with that of the outside agencies, approach the intimacy of the members of a family, the more effective is her work. In the most successful instances the relation is a genuinely affectionate one. I know well enough that this is often not accomplished. Yet nothing else will achieve the best results. And this intimacy need not impair the strictness and clearness of official relationships. Indeed it should promote this quality, which amounts, after all, to the strict observance of all our promises and understandings,—a strictness which ought to be at its best when based on affectionate comprehension.

Between social workers and nurses there is often a certain amount of friction and misunderstanding. The nurses are rather prone to think that anyone but a nurse and a doctor has no business near a sick patient. And especially if she hears the social worker giving instructions as to hygiene or as to the causes and treatment of disease, she is apt to feel that a person without medical training is interfering in work which properly belongs to doctors and nurses. But with time and good will on both sides this difficulty, can be reduced to a minimum or altogether abolished. It is many years since we have had any such trouble at the Massachusetts General Hospital.

VII.—SELECTION OF PATIENTS AND LIMITATION OF INTAKE

In certain clinics the social worker is supposed to see every patient, and to do or get done whatever is most urgently needed. For special groups of patients, such as the tuberculous or the unmarried mothers, this is obviously the best arrangement. As soon as a diagnosis of tuberculosis or of pregnancy in an unmarried woman is made the social worker is then brought into contact with the patient, the doctor's directions are explained, and the main responsibility for treatment is then transferred to the social worker. But in general medical and surgical clinics, especially in the larger hospitals, some process of selection is usually carried out. The social worker assumes responsibility, not for all patients but for those who are specially sent to her by the physicians, internes or nurses connected with the clinic. In other cases she visits a hospital ward in which her coöperation has been asked by the physicians or surgeons in charge, and there assumes social responsibility not only for those directly referred to her but for any other cases which by reason of her special knowledge and experience she knows are particularly in need of her care. Thus cases of malignant disease or of chronic arthritis, when admitted to the wards of a hospital intended primarily for acute, that is brief, diseases, should automatically fall into the province of the social worker because within a few days, or at most a few weeks, arrangements will have to be made for their care at home or for their transfer to other institutions.

Whichever of these methods we adopt, whether the social worker is given the opportunity to select patients for herself after coming in contact with all those in the clinic in which she works, or whether she confines herself to those specially referred to her by others, the main point always to be kept in mind and to be insisted upon by those in control of the social worker's activity is the *limitation of intake*. Social work in a hospital is never done. We never get to the end of it or do all that we see is needed and would like to do. We must make some selection. It is certainly reasonable, then, that the social worker should not take or allow others to force upon her a volume of work which leads inevitably to the habitual exhaustion of her energies or to superficiality in the attempt to accomplish an impossible task.

All this seems so clear as to need no argument, but it is nevertheless very difficult to enforce. We can set a limit to the number of new cases which any worker is allowed to take up during a given week or month, or to the total number of cases "old and new" for which she is allowed to be responsible at any one time. But the difficulty with any such regulation is that one can never tell in advance whether a case will involve only a few hours' work or will extend over many days and weeks. Something can be done through the distinction later referred to between intensive cases and "short service" cases. We can say that the worker shall not take more than a certain number of cases of each of these varieties within a certain period. Even with these precautions, however, it is very hard to prevent the worker from becoming overwhelmed both by the number of cases thrust upon her and by the especially fatiguing demands upon her sympathy involved in this sort of work. If she is sympathetic enough to respond properly to the patient's needs, it is difficult to prevent her becoming exhausted or discouraged by the bulk of human misery thrust upon her. If, on the other hand, she takes her work easily and is not troubled by it, she is apt to be or to become superficial and callous.

I believe, however, that these difficulties can be overcome by a proper supervision and scrutiny of records. From these the supervisor can form an estimate of the load carried by each worker, and if beyond this the supervisor is daily in touch with all the workers, she will be able to obtain an additional check on the judgments formed from study of the records. In any case one may say without fear of contradiction that if social work is to be kept at a high standard of usefulness, opportunity must be given to each worker to follow up a few cases with sufficient thoroughness to feel that in these she has done her best and has both learned and taught as much as she can. There must be time for each worker to study in this thorough way at least a small group of cases each month and each year that she continues in the work. All of us have to do a good deal of routine work which employs only a small fraction of our powers. But we all need the stimulus and the opportunity to do *now and then* our best, so that looking back after a lapse of months or years we can say that we have accomplished something.⁶

VIII.—PERSONNEL AND ITS TRAINING

We are all agreed that the most important qualities for successful social work in hospitals are those which are inborn. Natural aptitude, fitness, and inclination are of primary importance. The central necessity is that the worker should feel a special impulse to help anyone who is in any sort of trouble, should be able easily to enter into pleasant and friendly relations with strangers of all sorts, should easily be able to understand and to make herself understood. She should have a genius for sympathy and for catching people's meaning even when very imperfectly expressed. She should have good health, mental and physical, be a person of regular and steady habits, reliable, intelligent, and above all warm-hearted. Without these qualities no training is sufficient to produce a good social worker. But if they are present training can do much, both to develop them and to add new powers.

The best system of training with which I am acquainted is that now demanded and supervised by the Institute of Hospital Almoners in London. This is divided into three parts: (1) a period of university study in which the economic, historic, and social background needed by anyone who is to undertake social work can be brought to light; (2) a period of training in the office of a general charitable agency (Charity Organization Society); (3) a period of apprenticeship in a hospital under the supervision of a trained social worker (almoner). In England it has been possible to hold up this high standard, and to arrange with most of the hospitals that they shall accept no workers who have not received this training. But in America, where the demand for social workers far exceeds the supply, where new social service departments are being opened almost every month in one or another city, schools for social workers have thus far found it impossible to supply fully trained workers for all the available positions. The American Association of Hospital Social Workers is now trying to work out and to establish standards. But at present a great many positions are filled by persons who have had no adequate social training at all.

In 66 or 1/6 of the 430 social service departments listed by this Association in 1924, the head worker bears after her name upon the list the letters R. N. ("Registered Nurse"). In the remaining 364 she has had no such designation, and if she has had nurse's training probably considers it less important than the social training which

she has also received. Thirty of the 66 registered nurses just referred to belong to hospitals within New York City, in which, following the example of Bellevue Hospital, it has until recently been the custom to consider that the training of a nurse was in itself nearly or quite sufficient to qualify one for social work. This point of view, however, has never been held in other parts of the country and is beginning to be abandoned even in New York. There are now schools for social work in New York, Boston, Chicago, Cleveland, St. Louis, New Orleans, Baltimore, and Smith College. These schools ordinarily require that the candidate shall study for at least one year, and some of them have now extended this to two years. All these schools train candidates for general social work as well as for hospital social work, but maintain special courses and give special hospital opportunities for those intending to enter hospital social work.

Either in these schools, in connection with university work such as the almoners receive in London, or as part of a hospital apprenticeship, the social worker must absorb a good deal of medical knowledge. It is useless to try to confine this to anatomy, physiology, and hygiene, though these branches should certainly be taught. In addition to these the social worker, like the nurse, should know a good deal about disease itself and about its treatment. She should know more about the factors of its causation and about the methods of preventive medicine and preventive hygiene than is ordinarily acquired by nurses, trained as they are at the bedside in the care and treatment of the sick. I know no way in which we can establish logical boundaries, up to which but not beyond which the medical knowledge of the social worker should extend. So far as I see her medical attainments must depend largely upon the institution in which she works and the physicians with whom she is associated. She must know enough to do what is expected of her by those with whom she works, and to safeguard, so far as she can the physical and mental needs of the patient. No one has ever been able to state how much medicine a nurse should learn. A certain fraction of medical knowledge she is supposed to absorb along with her more special training in the art of nursing. The fraction of medical knowledge which the social worker must master is at least as large as that needed by the nurse, but includes, as I have already tried to suggest, more knowledge on the side of causation and prevention of disease. Beyond this, when she is associated with physicians who are treating some one group of diseases such as tuberculosis, syphilis, children's

diseases, nervous diseases, skin diseases, diseases of the heart, diabetes, fractures, orthopedic troubles, she will need to acquire much more detailed knowledge of these diseases and of their treatment. At the end of five or ten years' service she will undoubtedly have learned, if she is intelligent, almost as much about medicine as some doctors know, and she will have to use some circumspection and tact in order that her possession of this knowledge may not give offense to doctors or nurses, who naturally think of themselves as entitled to a monopoly of such knowledge. At the same time the social worker must above all things guard herself from the temptation to make a medical diagnosis or to be responsible for treatment. In medical matters she must invariably depend upon the doctor, and confine herself to communicating and explaining directions for which he must assume all responsibility.

We have not yet established in America so thorough a system for the training of apprentices in hospitals as is the custom in London. Personally I believe that this is as important for the medical-social worker as an internship is in the training of a physician. But in order that it should be satisfactory, the training of apprentices in a hospital should be carried out by persons not already burdened with case work and other hospital duties. In other words, the teacher of apprentices must be paid to teach and feel free to devote her time to this. If she tries both to serve patients and to teach apprentices, she is bound to neglect either one duty or the other.

If hospital social workers are to be free to devote themselves to the work for which they have been trained and for which they are especially fit, they should not be burdened either with administrative duties connected with the management of the hospital or with clerical duties connected with the writing of records. Associated with the Social Service Department there should be a force of clerks to whom the workers may dictate their records at stated intervals, and who maintain the card catalogue system and other necessary indices.

When the same staff of physicians is in charge of a particular group of patients (orthopedic, pediatric, neurological, etc.,) both in the wards and in the Out-Patient Department, it is convenient to have social work both in the wards and in the Out-Patient Department done by the same group of social workers. Otherwise it is better to have one group of workers for the wards and another for the Out-Patient Department, each supervised by a head worker who is herself subordinate to the chief of social service for the whole hospital.

Volunteer workers, when properly supervised by paid workers, can contribute a great deal to the effectiveness of social work in hospitals. They can free the paid workers from many of their simpler tasks and at the same time can be preparing themselves as apprentices in case they may desire later to take up the work as professionals. They help to maintain interest in hospital affairs among the community outside and so to obtain for the hospital some portion of its necessary financial support.

As to salaries I have very little information except in America. There the new workers receive ordinarily about \$1200 a year, and are advanced as their competence and length of service increase to a maximum of approximately \$1800 a year. Head workers receive from \$1800 to \$4000 a year, clerical workers from \$780 to \$1020 a year. In some hospitals the workers are given their midday meal either in addition to such salaries as I have mentioned or as a part of them.

IX.—SPECIALTIES WITHIN MEDICAL SOCIAL WORK

I regard specialization both in social work and in all other professions as an evil but a necessary evil. As no one can be a competent practitioner both of medicine and of surgery, so I take it there must always be the differentiation between social workers who are concerned primarily with the sick (hospital social workers, public health workers) and those who are attached to the regular welfare organizations (Charity Organization workers, Family Welfare workers, etc.). Even this degree of specialization however seems to me in many respects undesirable. Certainly the hospital social worker needs all the skill and experience in case work *that is the center of expertness* in outside agencies. On the other hand, sickness is so frequent a factor in *all* social work (outside hospitals as well as within them), that no worker connected with a social agency outside a hospital can carry on her task properly unless she has a considerable familiarity with many kinds of sickness. Nevertheless, as I have said, I think that degree of specialization which separates in some degree hospital workers from those outside is necessary.

There is a strong tendency at present to go beyond this and to train special workers for psychiatric social work, for pediatric social work, for orthopedic, for neurological social work, etc. Especially where work is done in an out-patient clinic there is a strong tendency

for one worker to settle down in one special department, to become familiar with the terms, traditions, and personnel of this department and to make herself almost indispensable there. When this happens any proposition to move the worker into another department in order to broaden her acquaintance with other types of work, is apt to be resisted both by the worker herself and by the physicians who have come to value her services. Nevertheless I think that, for the good of the worker herself, for the maintenance of her interest, energy, and freshness of mind and so of the fruitfulness of her work, this degree of specialization should be discouraged. For the same reason I am opposed to the organization of a special class of workers, known as psychiatric social workers. Every social worker, outside a hospital as well as in it, deals primarily with the mind and character of those within her care. She cannot know too much about the mind, both in health and in disease. Any training, therefore, which is proper for a psychiatric social worker is equally proper and necessary for all social workers, since this is the very heart of all social work. To designate any special group of workers as "psychiatric" tends to give the impression that other social workers do not need psychiatric training and psychiatric knowledge. If the competence of the psychiatric worker goes beyond what all social workers need, she is apt to begin to practise psychiatry independently and without a physician's guidance. This I regard as undesirable. I think there is at least as much reason for the separation of special pediatric social workers as for those associated with nervous and mental diseases, and if once we encourage this degree of specialism we shall tend to still finer subdivisions until workers will be concentrating upon a single disease, such as tuberculosis, diabetes, poliomyelitis, or syphilis. One sees the same undesirable tendencies within the field of medicine and of nursing. There are physicians who devote themselves wholly to a single disease, and nurses who feel themselves competent only to nurse tuberculous patients, children, or maternity cases. The subject is too large for thorough discussion here, but I wish to record my opinion as opposed to this degree of specialization either in medicine, in nursing, or in social work. In all these fields the rule should be, "specialize as much as you must but as little as you can." The smaller and narrower the individual the more he must specialize, but always with dangers both to himself and to those he serves.

X.—RECORDS

The purposes of written records in social work are as follows:

- (1) To aid the memory of the worker.
- (2) To develop and clarify her reflections upon the problems encountered in her work.
- (3) To make such a picture of the case and its management as will be available for other workers either within the hospital or outside it, in case a transference is necessary.
- (4) To provide material for teaching and research.

I think it can be stated without fear of refutation that the value of case-work, either in medicine or in social work, is in proportion to the quality of the records maintained. When records are brief, formal, and dull, when they contain little beyond the data necessary to identify the patient and his disease, we are safe in concluding that the work which they represent is often superficial and slipshod. I am well aware that there are here and there skilful and accomplished physicians and equally expert and successful social workers whose records amount to very little. But these are rare exceptions. In the great majority of instances nothing that requires so much memory, so much reflection, so much system, so much originality, as is needed in social work can be done without the aid of a good deal of writing. But since the social worker is called upon to aid certain patients who need from her only very simple services of advice, direction to other agencies, etc., while, on the other hand, some of her tasks keep her in close and intimate contact with difficult personal problems over a period of months or years, it has generally been found expedient to have two kinds of records, identified in America as those for (a) "intensive work" and (b) "short service cases." Under these very unsatisfactory terms one can probably recognize two sorts of work familiar to all who are interested in this subject. The "short service" records and the sheets or cards on which they are written ordinarily contain chiefly the data necessary to identify the patient and to record a few brief facts or precedures. The records of a more "intensively" studied case on the other hand, may mount up as time goes on to something like a small book.

Almost every hospital and many individual workers within a hospital have their own methods and subdivisions for the keeping of "intensive" records. I shall not try to go into this here. The main essentials as I see it for good records are something as follows:

(1) They should be written or dictated within a short time after the events to which they refer.

(2) At stated intervals, say every three months or every six months, they should be summarized. The worker should then record briefly what she thinks about the situation and about the prospects. In these summaries and in the final notes or "social diagnoses" with which she should finish any case which she regards as "closed" it is, I think, essential to record the patient's strong points as well as his weak points, physical and mental.

(3) At regular intervals records should be read, criticised, and discussed by all the workers belonging to the staff of the institution in which they are made, or by a small group or special committee of that staff. Such a discussion of records makes a useful basis for regular staff meetings.

(4) It is essential to record both facts and impressions. Neither alone is sufficient. Impressions unsupported by facts are as undesirable as facts uninterpreted by expressions of opinion.

(5) Any record system which contains only records of the short service type bears witness to a superficiality in the treatment of some of the patients which will surely lead sooner or later to mental ossification or discouragement of the workers.

XI.—TEACHING BY HOSPITAL SOCIAL WORKERS

I have already alluded to the mutual, continuous and informal teaching of physicians, nurses and social workers which is the almost inevitable function of all three groups, but about which they say as a rule very little. The same is true to a great extent of the instruction given by the latter to their assistants and subordinates. Besides this continuous and informal teaching, social workers may be called upon to give a more specific and recognized instruction, (a) to patients, (b) to nurses, (c) to apprentices, (d) to medical students. Although I believe that the profession of the nurse and of the social worker should remain separate occupations, yet I am sure that it is profitable for each to know as much of the other as time and strength permit. Accordingly short courses on the social bearings and results of disease are often given by social workers to nurses, and also in a few institutions to medical students. By far the most important part of the social worker's duties as teacher, however, consist (as already said) in the instruction that she should pass along from the

physician to the patient, not only as concerns hygiene, but on the details of his treatment and the nature of his disease insofar as the patient himself is able and willing to become a partner in the management of this portion of his own affairs. Printed circulars are of value here *provided* they are given after a verbal explanation and never as a substitute for it. Demonstration of the preparation of food, of the use of surgical appliances, and of external remedies (as in diseases of the skin), may also be given by a social worker, though often more conveniently carried out by a nurse or a dietitian.

XII.—AID TO BE GIVEN BY SOCIAL WORKERS IN HOSPITAL MANAGEMENT

So far I have dealt wholly with the social worker's duties in her direct relation to patients, the duties ordinarily known as "case work." But there is a considerable tendency, especially where the work has been newly undertaken in any hospital, to draw the social worker into other sorts of usefulness, as an assistant either to the physician or to the administrative officers of the institution. There are so many things to be done in a hospital and so little time in which to do them, that persons who seem to have any time to spare are apt to be utilized as assistants by anybody who finds them at hand. Thus a great deal of quite unspecialized work, as messengers, librarians, technicians, nurses, clerks, is apt to be thrown upon the social worker unless she is able and determined to protect herself and to stick to her own proper work.

But in contrast with such abuses as this there has arisen of late years, especially in England and in America, a tendency to give the social worker responsibility either in the admission of patients or in the general management of out-patient clinics. It is quite clear that the special knowledge and training of the social worker is of value in deciding whether a patient's circumstances are such that he ought or ought not to be admitted as a patient of a "free" hospital, and also in directing him to other sources of helpfulness in case he is not to be received in the institution where she works. The admitting officer needs to be to a certain extent a bureau of information and of social discrimination, needs moreover the sort of familiarity with disease and with hospital management which a social worker is expected to possess. In several American hospitals social workers are now acting as admitting officers for a part or for the whole of their time. The ad-

vantage of assigning this work to a social worker is that she has in this way a better opportunity of seeing, at any rate cursorily, all the patients in the institution, and so of *distinguishing those most in need of social assistance*. On the other hand it must be admitted that such brief and for the most part formal contacts with great numbers of human beings, continued day after day without any opportunity to enter into more intimate and friendly relationship, tends to make the worker more of a machine than a human being. Such work can hardly be long continued without narrowing or discouraging the worker. To guard against this it has been proposed* that part, at least, of this worker's time should be devoted to case-work. Whether this combination of duties will prove in the long run satisfactory only time can show.

In the *general management* of an out-patient clinic, the proper coördination of the physicians, nurses, technicians, clerical workers, and social workers who are busy there, and in periodic reviews and surveys of their work and its efficiency, there are great advantages in having a person with that wide and unspecialized outlook over all human interests which is or should be characteristic of a social worker. It is greatly to the credit of Mr. Michael M. Davis of New York that he was the first to have carried out, largely through social workers, a series of *surveys* either of a whole clinic or of one group of patients within it, with a view to finding out how efficient had been the hospital service given them, how many of them had returned after their first visit for the treatment or further observation which alone makes profitable the expenditure of time and expert work given at the first visit, how many patients have understood the directions given to them, have carried out its directions, and have benefited by them. Such surveys as this are of the greatest value, and have so far not been carried out with anything like the frequency which they deserve. In such investigations the social worker is of great value, and since these are not continuous or daily duties, they need not exhaust or mechanize the worker as the routine of admitting patients would tend to do.

* By Miss Janet Thornton.

XIII.—COMMITTEES FOR SUPERVISION AND MANAGEMENT

Although the hospital social worker should always be responsible finally to the head of her institution and not to any body or agency outside the institution, I believe that one can get the best work done only when the head worker and to some extent the subordinate workers in each institution can also get friendly supervision and advice from some sort of advisory committee. Such committees are often regarded as a bother. They have often brought the social service department into existence and serve to maintain it by the collection of the necessary money. Sometimes they also act as volunteers or assistants to the paid workers. In any of these capacities they are apt to be very much in the way and are often regarded by hospital social workers as a necessary evil. The best kind of supervisory committee is one chosen by the hospital social workers themselves, and representing especially, (a) expert and experienced persons unconnected with the hospital but well trained in social work outside it, and (b), those physicians of the hospital who are most interested in social work. The management of the hospital itself should of course also be represented on such a committee.

Before a group like this the head worker or her assistants brings up from time to time questions of policy, new plans of work, discusses the fitness, salaries, qualifications of particular workers, the best methods of organization, and the extension of the work into new departments of the hospital. If the social service department is to make a report annually or at some other interval, this committee should be responsible for the report and should digest in preparation for it, the reports and views both of the head worker and of any others whom she may designate. It is rarely profitable, I believe, to bring up before such a supervisory committee the problems of any particular patient. These are better attended to in staff conferences of the workers themselves. But questions of general policy can sometimes be very profitably discussed before such a group.

XIV.—THE FUTURE OF HOSPITAL SOCIAL WORK

1. The development or regressions of this work in the years to come will depend primarily, I think, on the sort of persons who are drawn into hospitals as physicians, nurses and social workers. Medical and social work can be standardized in a very limited degree.

It can always be built up, extended or pulled down by the character of those who go into it. In America the calibre of hospital superintendents is steadily improving and their conception of the hospital as a public servant is clearing. This bodes well for the future of social work here.

2. Another favorable sign is the increasingly frequent connection of large hospitals with universities. The university-spirit is one of devotion to the interests of man as a whole and therefore strengthens the hands of all who—like social workers—are thinking and working for the “mind, body and estate” of man and not for any of these elements alone.

3. At present an omen unfavorable to the best development of our work is the small salary of the worker. We cannot demand of her a long and expensive education and at the same time limit her salary to an amount on which few can save any money for the future or keep themselves properly alive to the sources of refreshment and cultivation around them.

4. I believe that a large remuneration to the trained hospital social worker should be paid by the hospital itself. But I hope that an additional source of income will gradually be open to her as her usefulness becomes more generally recognized,—I mean paid service to well-to-do patients under the guidance of their physicians. For social work is needed by persons of all economic levels,—not by the poor alone. In the wards of the Massachusetts General Hospital our social workers do almost as much for the well-to-do patients as for the poor. Obviously this must be so if *social* work is, as I have said, a work of establishing new and better *connections* between the patient and the proper sources of his strength, physical, mental and moral. Rich people need this service when they are sick almost if not quite as much as poor people. Most physicians who are intelligent and disinterested perceive this need of social (i.e., connection-making) work for their well-to-do patients and try to do it themselves. They try to guide their patients into better hygienic habits, better habits of thought, emotion and will, better occupations, recreations and affections. If they felt competent they would try also to deepen and direct their patients' religious life.

But in all these fields the physician is usually untrained, an amateur. He needs “social” help as much in his private practice as in his hospital work and occasionally, even now, he knows this and borrows some of the time of a hospital social worker for the benefit

of his private patients. I hope to see this practice greatly extended. Time should then be allowed for it as it is now in the case of hospital radiologists who serve hospital patients on salary from the hospital but are allowed also their own hours for private practice paid by the private patient.

5. Should social workers become more intimately responsible for the administration, management and policy of the hospital than is now the case? Why should not a hospital superintendent be a social worker? Many hospital problems are essentially those of housekeeping, of nursing and of tactful relations with all sorts of persons, both inside and outside the institution. In these three fields of effort women are, I believe, naturally superior to men. On the other hand the specifically medical, financial and official relations (municipal, national) which also concern the hospital superintendent and his assistants, are such as have hitherto been chiefly the work of men. Until women have become more generally recognized as expert in these last three functions I think the management of large hospitals will remain in the hands of men.

6. Will men in future go into social work more frequently than they do now?

I doubt it. Women, I believe, are by nature better fitted for the work of establishing and maintaining the best social relationships. Social work is their field and I believe will remain so because the basic qualities of each sex are not in my opinion subject to great changes, though this I realize is a matter of speculation and controversy.

7. As medical science and social-economic organization progress many of the social worker's present tasks will be lightened. Even now, the bulk of her labors for the tuberculous has begun in the United States to diminish as that disease is gradually exterminated. Wherever the prevention or the cure of a disease is perfected (as in smallpox, malaria, diphtheria, typhoid fever, rickets, syphilis) there will be less burden for the social worker in hospitals. If for example the cure or prevention of hypertension should be discovered (which now seems not at all improbable) a large slice of hospital social work would become unnecessary. As institutional care for chronic disease is perfected, as old age is better provided for, as general education and common-sense increase, as unemployment is diminished, social work will be relieved of heavy burdens. Whether new needs will spring up as fast as the old ones are abolished, only time can show.

Nothing is more characteristic of our age than the increase and improvement of the *means of communication* through locomotion, telephones, radio, newspapers, books, magazines, schools, colleges, and through associations industrial, national and international. The "*socii*" or bonds which join place to place and man to man are being multiplied and strengthened year by year. Surely we may believe that the profession which bends its strength to *social work* is now only at the dawn of its usefulness.

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EDITORIAL

THE SPIRIT WITHIN THE WHEELS

Religion and Social Service

"For the spirit of the living creature was in the wheels."

EZEKIEL 1:20.

With the progress of the centuries life has ever tended to become more varied and more complex and man's work more specialized. In primitive Christianity social welfare work was part and parcel of the Church's ministry. It is surely significant that the first collections taken up in the apostolic church were not for church building, church expenses, the salaries of church officials or even for church extension through missionary work, but for the care of the widow and the orphan. In the Middle Ages the care of the orphan, the aged, the crippled, the blind, the sick, the poor and the traveler, the formation of labor guilds, all were under the aegis of the Church. Excellent in many ways as was the Reformation's emphasis on the individual, it is to be feared that it often meant a failure to realize that the Church had a social message and mission as well as the message and mission to individual souls. Social work was not indeed universally forgotten, but for some centuries it was, at least, largely overlooked. The nineteenth century witnessed a remarkable arousing of the social conscience and a development of social consciousness. Much of this was within, but much without the definite sphere of the Christian Church. In our own generation we have witnessed the truly marvelous development of social work along modern and scientific lines. This has involved the recognition that true social service is not merely relief work; that all our best knowledge of the sciences must find a place in it; that social work has become the newest profession, involving carefully trained workers, specialized types of work and the establishment of a vast network of social machinery in which the armies of professional and voluntary workers are engaged.

No thoughtful observer of modern life, in any of its aspects, would venture to suggest that it is possible or desirable to return to the simplicity of the ages that are past, or would belittle the value and importance of the best and most up-to-date modern machinery.

But, and there are always buts to be considered, the most complex and valuable machinery is useless without the motive power that puts life within the wheels. In some cases it is fairly obvious that the absence of this power is responsible for the comparative ineffectiveness of some of the most elaborate and expensive of our modern social welfare machinery. The chief of a large institution for mental deficientes asked by a visitor, "What is your greatest problem?" replied, "To get workers who do not regard their job as merely a means of wage-earning but as a vocation to help their fellows." The spiritual as well as the material has a real place in the therapeutics of society as well as of the individual.

Within the wheels of modern social service there must be the spirit, and that the spirit of the living creature, the spirit of personal contact and personal service; the spirit of commonsense and open-mindedness; the spirit of practical sympathy; the spirit of hard work; the spirit of adventure, the spirit of optimism; the spirit of love even unto sacrifice; in short the Spirit of Christ.

History reveals the fact that social welfare work throughout the ages has had its origin in the creative spirit of the religion of Christ, and of that ethical monotheism of the Hebrews, which was the bud, the perfect flower and fruitage of which is Christianity. Experience shows that the spirit which created social service is essential to its life and perpetuation.

The Church of to-day, if it is to be true to the social message and mission left to it by Him who "came not to be ministered unto but to minister," and who "went about doing good," needs Social Service. If its ministry to the sons of men is to be effective, it must combine the ancient spirit of sacrificial service for them with the approved results of modern scientific study and the careful use of modern methods. That is why it is surely desirable that every theological student should have some practical and theoretical training in social welfare work.

And Social Service of to-day needs the Church fully as much as the Church needs Social Service. It needs the Church to understand and to interpret its work, but above all it needs that inspiration that

the Church can give to its thinkers, its workers and its supporters. The Spirit of the Living Creature must be in the wheels.

C. W. VERNON,
General Secretary of the Council for Social
Service of the Church of England in
Canada.

Report of the San Francisco Meeting of the California Conference of Social Work

A small group of medical social workers representing their profession in eastern and middle western sections joined with the group on the Pacific Coast at their meeting held with the American Hospital Association in San Francisco, California. Miss Edith M. Baker, First Vice-President, was the official representative of the American Association of Hospital Social Workers. Other members of the Executive Committee present were Ruth Wadman of Washington, D. C., Marie Lurie of Chicago, Ethel B. Webster of St. Paul, and Helen Beckley, the Executive Secretary of the Association. Medical Social workers in San Francisco and the other Bay cities and from Red Cross departments of Hospital Social Work in the Army and Naval Hospitals were present at the meetings. Miss N. Florence Cummings, Director of Social Work at Stanford University Hospital, was Chairman of the Committee on Local Arrangements. The opening session was a joint meeting with the Social Service Section of the American Hospital Association.

Dr. Burlingham, President-elect of the American Hospital Association, opened the meeting, tracing the history of the development of social service departments in hospitals and cordially extending a welcome to all interested in social work in hospitals to join with the American Hospital Association in their present program. The general subject for discussion was "The Social Service Department as a part of Hospital Organization." Edith M. Baker spoke from the standpoint of function and Interdepartmental Relationship. Bertha M. Wood spoke on the relation of a Dietetic Department to the Social Service Department of a hospital. She presented some practical suggestions for a better interdepartmental relationship by the wider use of refer-slips and regular conferences between workers. She stressed

the growing importance of dietotherapy and urged its wider use by all hospital departments. Dr. M. T. MacEachern read a paper on "Fundamental Consideration in Developing Social Work in Hospitals" emphasizing the function of social work in medical institutions and minimum standards for a department. Under the latter subject he discussed in detail the following points:

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| 1. Organization | 3. Records | 5. Personnel |
| 2. Facilities | 4. Functions | 6. Conferences |

He said in conclusion that social work should play an important role in the challenge of the right care of the patient—man, woman, or child regardless of race, creed, or color. Edith Burleigh of Los Angeles and Marguerite Spiers of Berkeley discussed the papers.

At a joint meeting with the Small Hospital Section, Mrs. Charles W. Webb's paper on "Popularizing your Hospital through its Social Service Department" was read by Miss Beckley. The definition of the term "popular" was given as "to make intelligible to all groups of people." The community groups upon which the hospital depends for its understanding are (1) the professional group (2) the employers group (3) the self-supporting but non-employing group (4) the dependent group. Mrs. Webb pointed out that the social service department, because of its community activity, is the natural channel for interpreting the hospital to the above groups.

Miss Baker read papers at the Administration and Nursing Sections on "What Has the Social Worker to Bring to the Welfare of the Patient." By presenting the social history, the social worker brings to the physician, the nurse, the dietitian, and other professional people in the hospital a description and report of the patient in his extra-hospital relationship. By interpreting to the patient and his family some of the recommended treatment and by providing social treatment for the condition presented, she makes a contribution to the general welfare of the patient. "Social Service Content in Nursing Education" was the subject of a paper read by Miss Baker in the Nursing Section. She reported on the results of a study made by Miss Agnes Schroeder of Western Reserve University and gave in detail the outline of the course used at the Washington University School of Nursing. She pointed out that it is now a practice which is rather widespread to include courses in social work to nurses in training, not for the purpose of training social workers but to give

the nurse a better understanding of the patient in his social relationships.

Miss Marguerite Spiers, Director of Social Work, Berkeley Health Center, read a paper at the Dietetic Section on the "Social Worker and Dietetics."

Marie Lurie, Director of Social Work, Jewish Tuberculosis Service, Chicago, read a paper on "Social Service in the Treatment of Tuberculosis" at the Tuberculosis Section. She emphasized the importance of recognition of the social factors in the treatment of tuberculosis. She told of the social case work methods used by the Jewish Tuberculosis Service of Chicago and gave examples of the results obtained. That tuberculosis is a disease of far reaching social consequences has long been recognized. The importance of social case work as a part of treatment has been developing as a part of the plan of treatment.

Miss Cummings of Stanford Clinic, Miss Lovell, Director of Social Work of Lettermann Hospital, Mrs. Webster of Wilder Dispensary, and Miss Lurie participated in round table discussions on the regular program of the American Association of Hospital Social Workers. The value of social work and its participation in outpatient operation were the subjects under discussion at these meetings.

Three special round tables for Medical Social Workers were held. Edith Burleigh of the Child Guidance Clinic, Los Angeles, lead a very stimulating discussion on "The Psychiatric Approach to Social Case Work." This round table was arranged by the American Association of Psychiatric Social Workers. There were about 40 at the meeting and many participated in the discussion. Miss Burleigh offered an excellent outline as a basis for discussion. She presented a definition of terms used, the setting of the scene for the first interview, attributes of the worker, the workers' technique, the psychology of the situation, and the art of case work.

A small and very interesting round table on "Statistical Reports" was lead by Miss Lurie. Representatives from widely scattered geographical areas made the discussion stimulating. Certain definite recommendations to the Records Committee of the American Association of Hospital Social Workers were made.

Evelyn Phelps, Supervisor of Hospital Social Service, Pacific Branch American Red Cross, led a third Round Table on the subject, "Where shall we place the Emphasis in Hospital Social Work." This meeting was attended by more than thirty, many of whom took

an active part in the discussion of the several points made. Miss Phelps brought out points of personnel selection, the importance of interpretation of social work to others in the hospital organization, and significance of regular reports. Forms of records were discussed and the value of social reports on medical records was brought out.

The local committee arranged a dinner for those practicing or interested in medical social work. This was held on the opening evening of the Conference. The general program included a number of local speakers, members of the Executive Committees of the American Association of Hospital Social Workers, and the general plans of the Association were given by Miss Beckley.

A tea at the Burlingame Country Club was given by Miss Helen Chesebrough, Vice-Chairman San Mateo Country Chapter of the American Red Cross. Guests were given the opportunity of seeing some of the very beautiful gardens in Burlingame.

Miss Marguerite Spiers of Berkeley entertained the members of the Executive Committee at luncheon at the Womans Faculty Club at Berkeley on Friday, August 10th. An inspection trip through the Alameda County Hospital and the Health Centers followed.

Ruth E. Lewis, Assistant Director of Social Service at Washington University, St. Louis, Mo., was elected Chairman of the Social Section for next year. Helen Beckley was elected Secretary.

NEWS NOTES

The Westchester County Organization for Public Health Nursing is planning a course consisting of 10 lectures in public health work for the early autumn.

The United Nursing Service Club, Inc., 34 Cavendish Square, London, England, cordially extends its privileges to any past or present member of the American Army Nurse Corps, provided she carries with her either a letter of introduction from Major Julia Stimson, Superintendent of the Army Nurse Corps, or a letter from an active member of the Club. The rates for rooms and meals are moderate.—*Jour. Am. Nursing.*

The City Admission Office of the Burke Foundation has been moved to 164 East 124th Street, New York City.

The Royal Society of Hygiene of Milan, Italy, has announced a prize competition, open to the physicians of Italy, for the best handbook on the hygiene of children between the ages of 7 and 15 years. A prize of 5,000 lire will be given to the winner. This book is to form a part of a series on maternity and child hygiene.—*Pediatrics, Naples.*

The name of the Ohio Society for the Prevention and Cure of Tuberculosis has been changed to the Ohio Public Health Association.

A special course in public health will be given at Johns Hopkins University early next year. The course is especially planned for public health officers and physicians who wish to qualify for public health work.

Twenty-five countries were represented by official delegations in London at the Festival of Youth which was organized by the League of Nations Union.

The League of Red Cross Societies, through their Information Bulletin, are issuing from time to time sketches of the lives of "Heroes of Medicine." The series has so far consisted of short interesting life histories of Joseph Lister, Paul Ehrlich, William Osler, Oliver Wendell Holmes and Ignatz Phillip Semmelweiss.

The Argentine Red Cross has extended its medical program to include dentistry. A dental clinic has been opened at Red Cross headquarters.

Yale University has announced a gift of \$1,000,000 from Abram E. Fitkin to be used as a fund for the study of children's diseases.

A playground for colored children was conducted by Holy Trinity Church, New York City, during the summer.

The League for American Citizenship, New York City, has opened 6 new branches for the education of aliens who desire citizenship.

The Hebrew Orphan Asylum has acquired property at 331 W. 89th Street, New York, and will establish a home club for young girls who are old enough to leave the orphanage.

Colonies for the care of mental hygiene patients who are physically in good condition have recently been established by Middletown, Harlem Valley and Binghamton State Hospitals. Each colony is located on a farm and the patients will occupy a large farm house.—*N. Y. State Psych. Quart.*

The General Hospital of Miraflores, in La Paz, Argentina has a fully equipped ward for the care of tubercular patients.

Miss Nellie A. Glead, formerly Director of Social Service of the Mount Sinai Hospital, Philadelphia, has accepted the position of Superintendent of the Northern Liberties Hospital, Philadelphia, Pa.

The Society for the Welfare of Mothers and Babies in Egypt is a private organization just created in Cairo with the aid of funds

raised through a bazaar organized by the wife of the High Commissioner. Its purpose is to institute preventive and prenatal work in the dispensaries which hitherto have practically confined themselves to work with sick children. A trained and experienced midwife is to supervise the training of Egyptian girls as district nurses and health visitors and direct their work in the dispensaries affiliated with the society. The child-welfare movement has developed rapidly in Egypt during recent years. Cairo has a number of child-welfare centres maintained by various missions and the Egyptian Government, the oldest being the Mohamed Ali Dispensary, which has been in existence for 17 years. The Societe de Puericulture maintains a free clinic in Cairo where babies are weighed and examined by a medical officer and lessons in mothercraft are given in French and Arabic. The Society has also established a dairy which provides pure milk and prepares food for babies according to the physician's formulas.—*World's Children.*

As the result of the findings of a study of neglected and delinquent Negro children in New York City, conducted last Fall by a joint committee representing some 30 or more social agencies in co-operation with the Women's City Club and the Urban League, John D. Rockefeller, Jr., has given \$72,000 to establish recreation centres for Negro children in Harlem and West 63rd Street.

The importance of the work of the Council on Adult Education for the Foreign Born can be sensed when one reads that New York City has an estimated non-English speaking population of about one quarter million. It is also estimated that at least 250,000 are unable to read or write in any language—self-confessed illiterates at the last census.

The number of cities reporting to the Playground and Recreation Association of America that they maintain community-recreation programs under leadership increased from 505 in 1922 to 815 in 1927. During the same period the number of paid leaders reported was nearly doubled. Training institutes for employed leaders were reported for 1927 by 146 cities, and the total expenditures reported by 658 cities for that year amounted to more than \$32,000,000.—*World's Children.*

Smith College, Northampton, Mass., recently conferred the degree of Doctor of Science upon Miss Edna L. Foley, Superintendent of the Visiting Nurse Association of Chicago, Ill., for her outstanding work in the field of public health nursing.

The Vassar Brothers Hospital, Poughkeepsie, N. Y., is endeavoring to reduce the maternal death rate in the territory it serves, and calls attention to the record of low infant and maternal mortality rates recently made in Tioga County, N. Y., as a result of an intensive effort by Sheppard-Towner nurses to give adequate prenatal care to expectant mothers. The hospital has set apart one floor for maternity work, and it is offering to semi-private maternity patients who have had adequate prenatal care a special flat rate of \$65, covering all charges. Ward patients are offered a still lower rate on the same basis.

Copenhagen has 8 infant welfare stations in the poorer sections of the city to promote breast feeding. Both married and unmarried mothers are admitted, but only when the babies are breast-fed or partly breast-fed. The babies are examined at the station every week or two and the mothers are given necessary instructions. The neediest mothers receive milk and dinners for themselves and clothing for the baby, and the nurses visit the homes from time to time. Since 1908 these stations have cared for nearly 10,000 children, of whom only 2% died while under care. Copenhagen also has several day nurseries in charge of trained children's nurses and supervised by physicians in the employ of the city. The city has adopted regulations to which all such nurseries established within its limits must comply. Well-organized day nurseries are also to be found in a number of other towns.—*World's Children*.

A recent issue of campaign notes of the American Society for the Control of Cancer reported the fact that many persons suffering from cancer are refusing radium treatment and gives as a reason the wide newspaper publicity given to a number of persons who were poisoned through the use of a radium compound in painting watch dials. The Society is making every effort to dispel this mistaken idea.

The Central Bureau of Infant Hygiene of the National Department of Health and Charity in Havana, Cuba is giving a series of

free weekly lectures on child care and welfare for poor mothers. Great interest is evinced by the women who are anxious to know how to guard the health and care for their children.

The purpose of the Eugene Field Foundation for the relief of crippled children recently created in St. Louis, Mo., with representatives from all parts of the State, is to secure hospital care and education for all the indigent crippled children in Missouri.

A perfect set of teeth is among the rarest phenomena. The Metropolitan Life Insurance Company Statistical Bulletin substantiates this statement by the fact that among nearly 20,000 Home Office Employees of the Company in the past 12 years, only 2 sets of perfect teeth have been found.

Ontario has found its "traveling schools" for remote sections of the Province so successful that the Minister of Education has arranged for 2 more, which are to operate between Fort William and Superior Junction. Night classes for adults will form part of their program. British Columbia is opening primary schools in every community offering as many as 10 pupils and for older pupils living in places remote from high schools it is planning education through high school correspondence courses.—*World's Children*.

The City of Fargo, N. D. in 1927 attained a score of 827 points out of a possible 1,000, on the basis of the American Public Health Association appraisal form for city health work. This record is an improvement of 150 per cent. over 1922, the year before the child health demonstration was inaugurated.

The first colored paid probationer in Atlanta, Ga., has just been appointed by the County Commissioner. The new official is a woman, a graduate of the Atlanta School of Social Work.

Hospital News, published by the New York Post-Graduate Medical School and Hospital call attention to the fact that besides the Army and Navy Nurse Corps the United States Government employs more than 2,300 nurses in the U. S. Public Health Service, the U. S. Veterans' Bureau, Indian Service and other fields under U. S. Civil Service law.

As a tribute to the late Dr. Schlapp the Mental Hygiene Clinic of the New York Post Graduate Medical School and Hospital, will in the future be known as the Max G. Schlapp Medical Hygiene Clinic.

The First International Congress of Mental Hygiene will be held in Washington, D. C., in 1930.

Miss Sara Ostro, formerly with the Jewish Welfare Society of Philadelphia and Medical Social Worker at Mount Sinai Hospital, Philadelphia, Pa., has been engaged as Financial Investigator at the Jewish Hospital, Brooklyn, N. Y.

Miss Jane C. Allen, General Director of the National Organization for Public Health Nursing has resigned.

Dr. Edgar O. Crossman has been reappointed Medical Director of the United States Veterans' Bureau.

A higher cancer death rate seems to be one of the penalties for overweight. Persons from 5 to 15 per cent. in excess of normal tabular standards of weight show a cancer mortality about 9 per cent. in excess of the rate among normal weights. For persons who are 15 to 25 per cent. overweight, the cancer death rate is 24 per cent. in excess of the rate among persons of normal or standard weight. The highest cancer death rate prevails among those excessively overweight. Overweight, 25 per cent. or more above the standard for height and age, carries with it an excess of 29 per cent. in cancer deaths. These facts were disclosed in an investigation of the cancer mortality records made available through the courtesy of the *Union Central Life Insurance Company*. They cover risks admitted to that Company between 1887 and 1908, with the observations carried to the end of 1921.—*Met. Life Ins. Co. Bul.*

The bureau of physical welfare of the Cleveland Board of Education reports that examination of nearly 73,000 school children from the kindergarten and early school grades showed that at least 7 out of every 10 had physical defects. Nearly 1/6 were suffering from malnutrition, largely because of wrong choice of food rather than poverty; 32,000 children had defective teeth, 7,000 had goiter, 1,000

had heart disease, and 2,000 had defective hearing. Nearly 20,000 children of 14 to 18 years who applied for work permits showed, in general, a still larger percentage of defects. Since many of the physical defects can be prevented or controlled the department of health education believes that the necessity for more health work in the schools is clearly demonstrated.—*World's Children*.

HOW TO PRESERVE CHILDREN

Take 2 or more children of the runabout age. If they are bright eyed, rosy-cheeked youngsters, so much the better.

Tuck them into bed early—and leave for 12 hours of quiet, restful sleep. Windows wide open. In the morning, dress them lightly and set at a table in the brightest, cheeriest corner of the breakfast room.

To each child, add the following: one small cup of orange juice; one steaming dish of delicious nut-brown "whole-wheat" cereal, several slices of crisp whole-wheat toast, one glass of milk.

Remove the child to a grassy lot. Add a kite, some toys and mix thoroughly.

Cover all over with a blue sky and leave in the sun until brown.—*Weekly Bulletin, New Mexico Bureau of Public Health*.

BOOK REVIEW

"Health Habits," "The Playroad to Health," "The Way to Keep Well," and "The Human Body and Its Care," by S. Weir Newmayer, M.D., Supervisor of Medical Inspection, and Edwin C. Broome, Ph.D., Superintendent of Schools, Philadelphia, Pa. American Book Company, New York, 1928.

All four books belong to the Health and Happiness Series and are published as an aid to teachers in inculcating in children good health habits. The text of "Health Habits" and "The Playroad to Health" consists of delightful stories for young children, each emphasizing some phase of health or hygiene. Children listening to or reading these stories will unconsciously absorb much that will stimulate them to acquire good health habits.

"The Way to Keep Well" and "The Human Body and Its Care"

are equally attractive and instructive but are adapted to older children—indeed many an adult might read these books from cover to cover and profit thereby. The lessons and stories are illustrated by drawings which will appeal to growing girls and boys. The authors are to be congratulated in getting health lessons over to children in such a delightful, understanding way. While the books are primarily intended for the classroom, parents will find in them a wealth of health knowledge that will guide them in the care of their children.

NEW PUBLICATIONS

Conserving the Sight of School Children—A Program for Public Schools. A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, published by the National Society for the Prevention of Blindness; second edition; revised; 60 pages, illustrated. Available at cost, National Education Association, 1201 Sixteenth Street, N. W., Washington, D. C., American Medical Association, 535 North Dearborn Street, Chicago, Ill., or National Society for the Prevention of Blindness, 370 Seventh Avenue, New York, N. Y. Price 35 cents net.

This report, prepared under the editorship of Dr. Thomas D. Wood, Chairman of the Joint Committee, has the purpose of supplying teachers, school officials and others concerned with vision problems as related to education, with information, advice and practical directions which will promote the conservation of vision of school children. The present edition includes an illustration of the Symbol E. Chart, and a Letter Chart, both drawn scientifically to Snellen scale, for use from a 20 foot distance. All directions for the use of these charts in testing the vision are in line with the most modern approved practice of those now adequately safeguarding the eye health of school children. The new pages and illustrations discussing the technique of using the symbol chart with little children, by adapting it to a game of play, are most convincing evidence of its practical utility for use with young children as well as for older groups. The new chapter on Lighting the Schoolroom is sound in teaching and easily understood by nurses and teachers.

This booklet might well be in the hands of all doctors, nurses and teachers concerned with testing the vision of school children or with promoting eye hygiene.

The new Directory of Heart Associations, Committees, Convalescent Homes and Cardiac Clinics in the United States, issued by the American Heart Association, 370 Seventh Avenue, New York City, is ready for distribution. Price 25 cents a copy.

ABSTRACTS

"Medical, General and Social Considerations With Some Historical Reminiscences." G. L. Bellis. *Occup. Ther. and Rehab.*, 1928; VII, 89. The author does not attempt to deal with the scientific phases of occupational therapy either in a general or special way but draws conclusions from his own experience and goes on to say that occupational therapy must be sold to hospitals and sanatoriums not only on a scientific but a practical basis. Muirdale Sanatorium, a Milwaukee County institution for the tuberculous, was one of the first to introduce occupational therapy as an integral part of its medical program. In the case of tuberculosis the patient faces months and even years of hospital care and mind and body must have occupation. The author aptly remarks that although physicians prescribe absolute rest it can never be carried out without the aid of an anaesthetic and then only for a short time. Prior to the introduction of occupational therapy the patient was advised to exercise self control—in short, to do the things he should do and leave undone the things which he should not do—excellent advice but hard to follow. Occupational therapy has done away with enforced idleness. At Muirdale Sanatorium the patients are encouraged to be self-reliant—self, and perhaps family—supporting by occupational therapy. Schoolrooms with carefully graded courses in academic and commercial subjects, classes in Americanization, social customs, etc., are provided for patients whose education has been neglected or limited. After 12 years' experience the author sets down the advantages of occupational therapy to the patients and the institution: (a) promotes recovery from tuberculosis by substituting directed and supervised physical activities for the undirected and unsupervised physical activities destructive to the benefits to be gained through sanatorium treatment: (b) promotes recovery from tuberculosis by substituting the normal mental activities of an industrious life for the abnormal mental activities of an idle life, a pathogenic psychosis extremely common to all individuals, sick or well, deprived of useful occupation: (c) enables the child undergoing treatment to continue school work under

the most hygienic conditions possible, and enables the convalescent adult to become educationally better qualified to "carry on" in his former vocation or to take up a line entirely new and more adapted to his requirements: (d) increases the length of stay at the sanatorium by adding to sanatorium life a something that is extremely attractive and that relieves the monotony of cure-taking: (e) establishes morale, simplifies the problem of administration, especially in the matter of discipline, and promotes in no small degree a most wholesome institutional atmosphere.

"Occupational Therapy at the Austin Riggs Foundation." L. K. Lunt. *Occup. Ther. and Rehab.*, 1928; VII, 99. The general idea is that occupational therapy came in with the World War, but this important work, although not termed occupational therapy, was introduced as a curative factor in the Austin Riggs Foundation some 20 years ago, when Dr. Riggs was inspired to use work as a therapeutic remedy with patients suffering from functional nervous disorders. The first cases were sent in 1910 to an expert Italian cabinet-maker for instruction. Two years later three looms were set up in a village store and patients were taught weaving by an instructor. Miss Edith Tracy had a kiln in town and some patients were sent to her to learn pottery. The work grew and now the occupational therapy department is firmly established with fully equipped shops. Only two branches of occupational therapy, carpentry and weaving, are carried on as it was Dr. Riggs' belief that it was better to excel in these branches than to do less work in several fields. While apparently simple work these two branches offer a wide field of possibilities and patients derive a source of joy from their work. There is no suggestion of working to fill in time. The work is seriously undertaken and most beneficial results have been obtained. Some patients naturally do not take to the idea of carpentry or weaving, but as they are not forced to do it they usually decide that they are missing something and become the most ardent converts to occupational therapy. Speaking from his broad experience the author considers occupational therapy a most important factor in caring not only for patients with nervous disorders, but for all patients in all hospitals.

Conservation of Vision—The Public Health Nurse's Part. J. R. Royer. *Pac. Coast Jour. of Nursing*, 1928; XXIV, 396. When one considers all that loss of vision means in individual suffering and

economic loss it is alarming to be told in cold figures that there are 100,000 blind persons in the United States. In Missouri 6,000 persons have applied for pensions because of loss of sight. The outstanding causes of blindness are ophthalmia neonatorum, focal infection, syphilis, trachoma and the eye hazards of industry. The public health nurse in her capacity of friendly health visitor is in a position to urge conservation of vision upon all classes of people. To the men and women in industry she can emphasize the importance of protective measures. In the homes the nurse can insist that physical conditions which lead to blindness be treated. In the schools class inspection makes it possible to detect symptoms of eye strain or eye defects before it is too late to remedy conditions. Faulty lighting in schools and homes also come to her attention. In short the public health nurse who goes everywhere in industry, homes and schools is in a strategic position and she can be a mighty force in sight conservation work.

Tuberculosis in Children—A. Calmette. *World's Health*, 1928; IX, 167. This interesting article briefly describes the method of administering Bacille Calmette-Guerin vaccine to new born infants as a preventive measure against tuberculosis. Between July 1, 1924 and December 1, 1927 over 52,000 French children were vaccinated and in no case was there any complication that could be traced to the vaccine. According to statistics unvaccinated infants brought up in contact with tuberculosis parents die in the alarming proportion of 1 in 4. The deathrate among vaccinated infants reared under the same circumstances is less than one per cent. In France the B. C. G. vaccine is supplied free of charge by the Pasteur Institute to all maternity hospitals, dispensaries, social organizations, doctors and midwives. The author believes that the early vaccination against tuberculosis will help most effectively to stamp out the disease.

"Infant Welfare and Motherhood Protection in India." E. S. Chesser. *Rev. Internat. de l'Enfant*, 1928; V, 67. The author calls attention to the significant fact that it is not only the British people in India who realize the importance of child welfare and maternity work, but Indian women of the educated upper classes are greatly interested and advocate and encourage the campaign for bringing health visitors and midwives in touch with the village people. The great mass of native women are too illiterate to profit from anything

but the most simple information in health matters. Maternity centres have been established and excellent results have been obtained, and the need for many such centres is apparent when told that an infant mortality of 700 to 800 deaths per 1000 is common in the bazaar areas of the large towns. Excellent results are reported through the careful supervision and instruction of the dhai, or native midwife. These women, who know nothing about the theory or practice of hygiene, are being trained in personal hygiene and surgical cleanliness for their patients. Indian women are afraid of hospital wards, so the authorities in British India and in the advanced Indian States have adopted a family ward system in the hospitals. This family ward consists of two large rooms which comprise a suite containing an Indian bathroom and tiny kitchen, where friends of the patient remain, cooking their own and the patient's food. The Indian mothers are keen to learn and the workers who teach the native midwives also give instruction in infant and child care. National Baby Week celebrations in the large towns has proven good propaganda and will naturally spread to the villages. As a result of the earnest efforts of this pioneer health work the lot of the future mothers of India will be happier and maternal and infant mortality will be sharply reduced.