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SOCIAL WORK; ESSAYS ON THE MEETING GROUND OF DOCTOR AND SOCIAL WORKER

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Содержание

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PREFACE

Most writers who disclaim thoroughness are prone to describe their work as an outline, a sketch, or an introduction. But the chapters of this book are more like spot-lights intended to make a few points clear and leaving many associated topics wholly in the dark. Possibly such isolated glimpses may serve better than a clear outline to suggest the interest of the whole topic. At any rate, that is my hope.

Part of the same material has been used in lectures given at the Sorbonne in the early months of 1918 and published by Crès & Cie. under the title of *Essais de Médecine Sociale*.

INTRODUCTION
HISTORICAL DEVELOPMENT OF SOCIAL ASSISTANCE IN MEDICAL WORK

I

The profession of the social worker, which is the subject of this book, has developed in the United States mostly within the past twenty-five years. Probably ten thousand persons are now so employed. It is known by various titles – social worker, school nurse, home and school visitor, welfare worker, hospital social worker, probation officer – varying according to the particular institution – the hospital, the court, the factory, the school – from which it has developed. But although the use of these visitors has been developed independently by each institution, and largely without consciousness of what was going on in the others, yet the same fundamental motive power has been at work in each case. Because this is so, we shall do well, at the outset of our study of home visiting, to get a clear conception of the common trunk out of which various types of home visitor have come like branches.

Why has such an army of new assistants been called into

existence? For this reason: In the school, in the court, in the hospital, in the factory, it has become more and more clear, in the last quarter of a century, that we are dealing with people in masses so great that the individual is lost sight of. The individual becomes reduced to a type, a case, a specimen of a class. These group features, this type of character, of course the individual possesses. He must be paid as "a hand," he must be enrolled in a school as "a pupil," admitted to the dispensary as "a patient," summoned before the court as "a prisoner." But in this necessary process of grouping there is always danger of dehumanization. There is always danger that the individual traits, which admittedly must be appreciated if we are to treat the individual according to his deserts, or to get the most out of him, will be lost sight of. We shall fail to make the necessary distinction between A and B.

It is the recognition of this danger which has led, in the institutions which I have mentioned, to the institution of the social worker. Above all of her duties it is the function of the social worker to discover and to provide for those individual needs which are otherwise in danger of being lost sight of. How are these needs found? In schools, hospitals, factories, courts, and in the home visiting carried out in connection with them, one can discern the two great branches of work which in the medical sphere we call *diagnosis and treatment.*

Thus, in the school, it is for the individualization of educational diagnosis and of educational treatment that the home

visitor exists. The educational authorities become aware that they need to understand certain children or all the children of a group more in detail – each child's needs, difficulties, sources of retardation. This *educational diagnosis* is made possible through the home visitor's study of the child in the home and out of school hours. There follows a greater individualization of *educational treatment*. The teacher is enabled, through the reports of the home visitor, to fit his educational resources more accurately to the particular needs of the scholar, so that they will do the most good.

In the juvenile courts the judge needs to understand more in detail the child's individual characteristics, the circumstances, the temptations, which preceded and accompanied the commission of the offence which now brings the culprit before him. This is *penological diagnosis*, and the court visitor or probation officer, sometimes simply called the social worker, makes a study of the law-breaker in his home and in relation to all the influences, physical or moral, which may help to explain the commission of the particular offence which has brought him into trouble. All this leads to the greater precision of *penological treatment*. Understanding more in detail why this particular boy has committed this particular theft, how he differs from other boys who have stolen, the judge is much more likely to choose wisely those measures of treatment which in the long run will do most to reëstablish the individual as a healthy member of society.

In the factory the object of the employer in setting a home

visitor or welfare worker at work is to create the maximum of satisfaction and good spirit among his employees, whereby each will do his best work and be as little likely as possible to change his employment. In the old days, when shops were small and the employer could know his employees personally, no intermediary such as a home visitor was necessary. The employer could keep human touch with his men. He could know not merely the amount of work done by each man, but something of the circumstances of his life, something of his personality, his adventures and misfortunes, so that help could be extended to him from time to time when special need occurred. It is only when the workshop has grown to the enormous size familiar in modern industrial plants that this relation of employer and employee has to be supplemented through the mediating offices of the home visitor.

It is this same process of evolution, the same heaping-up of groups till finally they become unmanageable, which has led to the employment of the social worker in other institutions. It is because the schoolmaster must teach so many that he can no longer know his pupils and their families individually that he has to employ the home visitor to keep him better in touch with them. It is because the judge tries so many prisoners that he cannot grasp and pursue all the detailed characteristics of those who come before him for judgment that he is compelled to get them at second-hand from a home visitor.

So finally when we approach the reasons for which the

medical home visitor has come in the better dispensaries of the United States to be an essential part of the institution, we find that the unmanageable increase in the number of patients to be treated by the doctor is one of the chief reasons why the home visitor has become necessary. In the old days and in country practice especially, it was doubtless possible for the doctor to follow the lives of his patients individually as acquaintances, and through many years, to watch the growth and development of families, to know their members as a friend and not merely in a professional capacity. He would meet them as a neighbor, in church, in town meetings, in agricultural fairs, in village sports and holidays. Thus he would touch the lives of his fellow citizens on many sides, and when he came to their aid in his narrower professional capacity he could supplement his diagnostic findings and his therapeutic resources out of the wealth of knowledge which years of association with them outside the sick-room had furnished him.

II

But in the evolution of the particular type of social worker who is the subject of this book, the home visitor connected with a dispensary, there are other forces besides those described above, other motives besides that common to the rise of all the types of home visitors in all the other institutions named. For in the dispensary, not only has the number of applicants greatly

increased, but it has increased because people realized that there was much more to be obtained by going to a dispensary than was formerly the case. The development of medical science and of the resources of diagnosis and treatment which can now be put at the service of the dispensary patient, has served to attract more patients there. But these new resources have also complicated the work of the physician in a dispensary, and made it more difficult for him to remember each patient and all the details about each patient as the physical, chemical, psychological, biological facts emerge in the complex ramifications of modern diagnosis and treatment.

In the old days the dispensary, as its name suggests, was a place to dispense, to give out medicine in bottles or boxes. The patient mentioned the name of his ailment, the corresponding remedy was given. It was a quick and simple business – no individual study, no prolonged labor was necessary. Moreover, one dealt only with a clearly defined class, the poor. There was no danger that the numbers applying for relief would swamp the institution or make it impossible for the dispenser to do his work properly.

But within the past quarter of a century the dispensary, especially in the United States, has received a new idea, an access of fresh life. Largely because it has become associated with universities and been used as an instrument of medical teaching, the influence of scientific medicine has begun to be felt there. This influence has enlarged and remodelled the dispensary in

two respects. First it has compelled the introduction of modern accurate methods of diagnosis, instruments of precision, *time-consuming processes of examination*, specialization of labor, and subdivision of function, for the skilful application of these methods. The dispensary physician is no longer content to treat a headache or a cough as an entity, to dispense this or that drug as the remedy for such a symptom. He must discover if possible the underlying disease, and, moreover, the individual constitution and life-history in the course of which the patient's complaint now rises for the moment to the surface like a fleck of white foam on an ocean wave. But how is the physician to gain this radical and detailed knowledge of his patient's life outside the dispensary and enveloping the particular complaints for which he now demands relief?

His difficulties are only increased when diagnosis is complete and he turns to the labors of treatment. For with the advance of modern medical science there are left now but few physicians who believe that disease can often be cured by a drug. It is recognized by the better element of the medical profession all over the world that only in seven or eight out of about one hundred and fifty diseases clearly distinguished in our textbooks of medicine, have we a drug with any genuine pretensions to cure. What is to take the place of drugs in dispensary treatment? In hospital patients we have the hospital régime, the unrivalled therapeutic values of rest in bed, the services of the nurses; but in dispensary practice all this is impossible. What is to take its

place?

For a good many years this question remained unanswered in American dispensaries, and as a result thereof there developed the pernicious habit of giving drugs no longer believed in by the physician, the custom of giving what we call *placebos*, remedies known to be without any genuine effect upon the disease, but believed to be justified because the patient must be given something and because we know not what else to do or how else to satisfy him.

III

It was at this very unfortunate and undignified stage in the development of our dispensary work in America that we received priceless help from France, help which I am all the more anxious to acknowledge to-day because it has not, I think, been fully appreciated in the past. We in America have not given to France the full expression of the gratitude which, for her services in the field of medicine, as in even more important phases of our national life, it is to-day particularly fitting that we should utter. The timely contribution made by France at this halting and unsatisfactory stage in the evolution of our dispensaries came through the work of the great Dr. Calmette, of Lille.

Calmette's introduction of the anti-tuberculosis dispensary as a focal centre of the fight against tuberculosis contained among other important provisions the institution of the *visite*

domiciliaire. The functions of the person making this visit were not precisely the same as those of the social worker whom I am describing in this book, but the latter may truly be said to have grown out of the former, nourished by some contributing elements from other sources. So far as I know, Calmette was the first to see that in the struggle of the dispensary against this particular disease, tuberculosis, it is essential to make contact with the home, and to treat the disease there as well as at the dispensary itself. In Calmette's view the function of the *visite domiciliaire* was an outgrowth of his bacteriological training and his bactericidal plan for treating tuberculosis. The home visitor was a part of the plan of antisepsis, a method of destroying the bacteria through disinfection and sterilization of the premises and of the patient's linen. In America the work of the home visitor in cases of tuberculosis has been concerned less with the disinfection and bactericidal procedures than with the positive measures of hygiene, such as the better housing of the patient, better nutrition, better provision for sunlight and fresh air, and above all instruction of the patient as to the nature of his disease and the methods to be pursued in combating it. But the great debt which we owe to Calmette was the linkage of the dispensary and the home by means of the home visitor. In America we have applied this principle, outside the field of tuberculosis, to all other diseases, and we have broadened the field of work assigned to the social worker. Nevertheless, the idea was primarily Calmette's.

There was another leading idea of Calmette's which we have followed first in relation to tuberculosis, later in dealing with other diseases. Like Calmette we have stopped wholesale drugging, and put our trust in those scientific hygienic procedures which carry out our knowledge of the nature of the disease which we are combating. Calmette's measures have the tone and the point of view of preventive medicine, and of that sound science which we have learned to associate with the Pasteur Institute and all that development of medicine which took its rise from Pasteur.

The focussing of interest upon a single disease which began, so far as I know, with Calmette's anti-tuberculosis dispensaries, has been fruitful in many ways. In the first place, it has enabled science once more to *conquer by dividing the field*, to help humanity by devoting itself to a single manageable task. Like others of Calmette's ideas, this isolation of a single disease for group treatment in dispensaries has been followed in fields with which he never concerned himself. Thus we have had special classes for cases of heart disease, for diabetes, for syphilis, for the digestive disturbances of infancy, and for poliomyelitis. A valuable measure of success has come in each of these diseases through the concentration of attention, at a special day and special hour by a special group of physicians and assistants, upon one disease at a time. We have even used class methods and taught the patients in groups as scholars are grouped and taught at school.

But there has come another signal advantage in the point of view adopted by Calmette in his dispensary campaign – the point of view, namely, of public health and public good. It has freed us from the limitations contained in the old idea that a dispensary is an institution concerned solely with the poor. Tuberculosis, of course, like every other infectious disease pays but little respect to distinctions of property. From the point of view of the State a tuberculous individual is as dangerous to others and a cured tuberculous patient is as valuable as a possible asset to the State, whether his income is above or below a certain figure, whether, in other words, he is inside or outside the imaginary group sometimes called the poor. From the institution of tuberculosis dispensaries with their home visitors in America, the poverty of the individual ceased to be a necessary badge for admission. Especially since many of our dispensaries have been instituted and maintained by the State, and therefore are paid for by all its citizens in their taxes, any one so unfortunate as to acquire tuberculosis, or be suspected of it, feels himself wholly justified in seeking help at a State-maintained tuberculosis dispensary. In this respect, as in many others, the campaign against tuberculosis has had a value far greater than its measure of success in checking that disease. It has introduced methods which were applicable outside the field of tuberculosis. One of these, as I have already said, was the utilization of the home visitor. A second was the disregarding of property lines. A third was the frank and confident reliance upon scientific measures and the relegation

of eclecticism and quackery to the hands of those who make no pretence at scientific education or honest dealings with the public.

IV

I must speak at this point of another great French contribution towards the occupation which in its fully developed state we now call social work. I mean that which at present receives ordinarily the name of the "Œuvre Grancher." Grancher proceeded upon the same sound bacteriological foundations which guided Calmette. Since children are especially susceptible to tuberculous infection (though they rarely show alarming signs of it till later years), he planned the *separation of children from the neighborhood of tuberculous parents* or other tuberculous persons as an essential measure for preventing contagion. I am not concerned now with the enormous benefit derived by the forces struggling against tuberculosis from this insight of Grancher's, nor with the part which it has played in such success as that fight has already attained in the United States and elsewhere. What interests me particularly in connection with the topic of this book, is that the procedures suggested by Grancher led the physicians who came in contact with the tuberculous individual in a dispensary to extend their interest to other persons who did not present themselves at the dispensary as patients. It is not obvious at first sight how great a transforming principle

is thereby introduced. Hitherto the doctor had been passive in his activities at the dispensary. He had concerned himself with such patients as chanced to appear there. He had never taken *the active or aggressive attitude*, searching for possible patients among those who had made no attempt to avail themselves of his services. Now he goes to find patients.

This is an epoch-making change. The physician becomes henceforth not merely a person who stands ready to treat disease when the accidental and incalculable forces of custom, hearsay, and natural propinquity bring the patient to him. He becomes now a person who actively wars against disease, who searches it out wherever it may be found. Thus he approaches for the first time the possibility of truly preventive action, the possibility of killing disease in its infancy or preventing its birth. For it is well known that preventive action in relation to disease is well-nigh impossible if we are forced or accustomed to wait until the disease has made such progress that the patient himself is aware of it and forced by its ravages to ask medical aid. Ordinarily the patient seeks the physician only when he has broken down. From the point of view of public health and public good, this is grievously late, far too late. It is as if one inspected an elevator only after it had fallen and killed or maimed its passengers, instead of inspecting it at regular intervals so as to prevent its breaking down.

In this series of aggressive steps in the campaign against tuberculosis whereby one seeks out possibly infected children,

brings them to a dispensary for examination, and separates them from their infected parents or house-mates, the social worker is the all-important executive. She finds the children, brings them or has them brought to the dispensary, and sees that financial aid or other assistance is given so as to carry out the isolation demanded by our bacteriological knowledge of the disease.

V

As far back as 1895 the reforms introduced by Calmette and Grancher in the field of tuberculosis had begun to modify and improve the treatment given in our dispensaries, not only to tuberculosis but to all other diseases. Especially it had favored the growth of home visiting, at first for the specific ends for which it was designed by Calmette and Grancher, but later for the prosecution of various related purposes which the very process of visiting brought to light. Not only in tuberculosis, but in other diseases, it was soon found that a knowledge of home conditions and of the family was essential for the treatment of the single patient who chanced to appear at the dispensary.

It was my good fortune during the ten years preceding 1905 to work as a member of the board of directors of a private charitable society caring for children deserted by their parents, orphaned, cruelly treated; also for children whose parents found them unmanageable or for children who had special difficulties in getting on at school. The work of this society brought to me

detailed knowledge of the life-histories of a good many children. I watched the careful studies made by the paid agents of the society into the character, disposition, antecedents, and record of the child, his physical condition, his inheritance, his school standing. I noticed during these years how the agents of this society, to whom the child was first brought by its parents or by others interested in it, utilized to the full the knowledge and resources of others outside its own field; how, for example, they enlisted the full coöperation of the child's school-teacher, secured facts and advice from the teacher, and agreed with her upon a plan of action to be carried out both by her and by the home visitor in concert. Moreover, I saw how physicians were consulted about the child, and how their advice and expert skill contributed something quite different from that obtained from the teacher or that gained by the home visitor herself. The priest or clergyman connected with the family was also asked for aid, and sometimes could give very great help, differing essentially in kind from that given by the teacher or by the doctor. If there were problems involving poverty on the part of the parents, other societies concerning themselves particularly with the problems of financial relief were asked to aid, in order that indirectly the help given to the parents might make itself felt in the better condition of the child. Sometimes free legal advice was obtained from the legal aid society formed for the purpose of giving such advice to those who were unable to pay for it.

As I watched the application of this method over a period of

a good many years and in the case of a great many children, I saw a good many failures in addition to some most encouraging successes. But what most of all impressed itself upon me was *the method*, the focussing of effort on the part of many experts upon the needs of a single child, the coöperation of many whose gifts and talents varied as widely as their interests, to the end that a single unfortunate child might receive benefit far beyond what the resources of any single individual, no matter how well intentioned, could secure.

I have said that the doctor was a member of the group whose efforts were focussed upon the needs of a single child, but he was never a very closely connected member of this group. A few charitably inclined physicians, personal friends of those directing the charities, were called upon again and again to help out in individual cases by examining a child, by giving advice over the telephone or otherwise. Through the free hospitals and dispensaries help was also obtained for the physical needs of persons who had come to the notice of the different charitable associations by reason of economic need or other misfortune. But the medical charities, the hospitals, dispensaries, convalescent homes, and the benevolence of individual physicians were not well connected with the group of charitable associations which I have been referring to above.

At this period, in 1893 and 1894, I had been working for some years as a dispensary physician, concerning myself chiefly with perfecting the methods of diagnosis in a dispensary, so that the

patient could obtain there a diagnosis as correct and scientifically founded as he could obtain from a private physician. But in the course of these efforts for a complete and exact diagnosis which should do justice to the actual needs of the patient, I found myself blocked. I needed information about the patient which I could not secure from him as I saw him in the dispensary – information about his home, about his lodgings, his work, his family, his worries, his nutrition. I had no time – no dispensary physician had time – for searching out this information through visiting the patient's home. Yet there was no one else to do it. My diagnoses, therefore, remained slipshod and superficial – unsatisfactory in many cases. Both in these cases and in the others where no diagnosis was possible from the physical examination alone, I found myself constantly baffled and discouraged when it came to treatment. Treatment in more than half of the cases that I studied during these years of dispensary work involved an understanding of the patient's economic situation and economic means, but still more of his mentality, his character, his previous mental and industrial history, all that had brought him to his present condition, in which sickness, fear, worry, and poverty were found inextricably mingled. Much of the treatment which I prescribed was obviously out of the patient's reach. I would tell a man that he needed a vacation, or a woman that she should send her children to the country, but it was quite obvious, if I stopped to reflect a moment, that they could not possibly carry out my prescription, yet no other filled the need. To give medicine was

often as irrational as it would be to give medicine to a tired horse dragging uphill a weight too great for him. What was needed was to unload the wagon or rest the horse; or, in human terms, to contrive methods for helping the individual to bear his own burdens in case they could not be lightened. Detailed individual study of the person, his history, circumstances, and character were frequently essential if one was to cure him of a headache, a stomach-ache, a back-ache, a cough, or any other apparently trivial ailment.

Facing my own failures day after day, seeing my diagnoses useless, not worth the time that I had spent in making them because I could not get the necessary treatment carried out, my work came to seem almost intolerable. I could not any longer face the patients when I had so little to give them. I felt like an impostor.

Then I saw that the need was for a home visitor or a social worker to complete my diagnosis through more careful study of the patient's malady and economic situation, to carry out my treatment through organizing the resources of the community, the charity of the benevolent, the forces of different agencies which I had previously seen working so harmoniously together outside the hospital. Thus I established in 1905 a full-time, paid social worker at the Massachusetts General Hospital, to coöperate with me and the other physicians in the dispensary, first in deepening and broadening our comprehensions of the patients and so improving our diagnoses, and second in helping to

meet their needs, economic, mental, or moral, either by her own efforts, or through calling to her aid the group of allies already organized in the city for the relief of the unfortunate wherever found. To bring the succor of these allies into the hospital and apply it to the needs of my patients as they were studied jointly by doctor and home visitor, was the hope of the new work which I established at that time.

In the thirteen years which have elapsed since this period, about two hundred other hospitals in the United States have started social work, some of them employing forty or fifty paid social workers for the needs of a single hospital. Unpaid volunteer work has always been associated with that of the paid workers in the better hospitals.

I should mention, in closing this chapter, three forms of medical-social work which had been undertaken previous to 1905, and which were more or less like the work which I have just described, though not identical with it:

(1) The after-care of the patients discharged as cured or convalescent from English hospitals for the insane (1880). The visitors employed in this work followed the patients in their homes and reported back to the institution which they had left. Their labors were directed chiefly to the prevention of relapses through the continuation in the home of the advice and régime advised by the hospital physician and previously carried out in the institution.

(2) The work of the Lady Almoners long existing in the

English hospitals had begun about the time that I started medical-social-service work in America, to change its character so as to be more like the latter. Originally the purpose of the Lady Almoners was to investigate the finances of hospital patients in order to prevent the hospital from being imposed upon by persons who were able to pay something, but who represented themselves as destitute and therefore fit subjects for the aid of a charitable hospital. Gradually, however, the Lady Almoners had begun to be interested in the patients as well as in the hospital funds, and had begun to labor for the patients' benefit as well as for the hospital's. This brought them near to the idea of hospital social service as practised in this country since 1905.

(3) The visiting nurses or public health nurses, employed by a Board of Health or by private agencies for the care of contagious diseases in the home and also for the nursing of the sick poor whatever their malady, have found it more and more difficult in late years to confine their work wholly to physical aid. They have been forced to take account of the patients' economic, mental, and moral difficulties, to extend their work beyond the field of nursing proper, and thus to approach very closely to the field of the social worker. It is my own belief that the frontier separating visiting nurse and medical social worker should be rubbed out as rapidly as possible, until the two groups are fused into one. The visiting nurse must study the economic and mental sides of the patients' needs, and the social worker must learn something of medicine and nursing. Then the two groups will be fused into

one, as indeed they are fast fusing at the present time.

PART I
Medical-Social Diagnosis

CHAPTER I
THE MEDICAL STANDING, DUTIES, AND EQUIPMENT OF THE SOCIAL ASSISTANT

I have said in the Introduction that *home visiting* may easily and properly spring up in connection with various institutions; for example, in connection with the schools, courts, or factories of the city as well as with the dispensaries. But it is essential in home visiting, no matter what institution it is connected with, that the social assistant should be distinctly recognized as *part of the machinery* of that institution, or, in other words, as one of the means by which that institution does its work. If she is connected with the schools, she should be a part of the school system alone, not responsible to a Board of Health or to any other outside agency.

So in the type of home visiting which now particularly concerns us, it is essential to make it clear from the outset that the social worker is a part of the medical organization. She is one

of the means for diagnosis and treatment. All that she does from the moment when she first scrapes acquaintance with the patient is to be connected with the condition of the patient's health. She is not to pursue independent sociological or statistical inquiries. She is not to be the agent of any other non-medical society. It is unfortunate even if her salary should be paid from any source other than the medical institution itself.

There are great advantages in this apparently formal and obvious point of connection. In the first place the *medical method of approach* to close relations, to friendly relations, with a group of people, is decidedly the easiest. Persons who may be suspicious or resentful of our approach if we appear primarily as investigators, or primarily as persons concerned with economic or moral control, will welcome the visitor if she appears as the arm, the cordially extended hand, of the medical institution where they have already found welcome and relief. I know well that charity organization workers, court workers and others may establish just as close a relation with their clients *in the end* as is possible for the medical social worker. But the start is harder and needs more experience. Because disease is the common enemy of mankind, all sorts and conditions of men are instinctively drawn together when it becomes necessary to resist the attacks of disease as the enemy of the human family. Members of a family may disagree about many matters, and may be far from congenial with one another in ordinary times and upon ordinary subjects, but will draw together into the closest kind

of unity if any one attacks the family, accuses or criticises the family. So human beings of widely different environment, taste, economic status, heredity, may find it quite easy to begin and to maintain friendly relations when that which brings them together is their common interest in the struggle against disease. It is, indeed, almost too easy to get friendly with people when they are suffering physically and we are endeavoring, however lamely, to bring them relief.

The medical avenue of approach, then, the plan and hope of establishing intimate relations with a person or a family while we are trying to give them medical assistance, offers incomparable advantages. These advantages become clearer still if we compare them with the special difficulties which arise if one tries to begin an acquaintanceship with financial inquiries or with moral investigations. People who will agree on everything else will quarrel on money matters. There is nothing that so easily leads to friction, suspicion, and unfriendliness, as the interview in which one is trying to make out whether people are speaking the truth, the whole truth, and nothing but the truth, in relation to their income and expenditure. This matter very naturally seems to people their own business. They quite naturally resent inquiries on such matters by strangers. They feel attacked and in defence they are apt to conceal or color the truth. And yet, if a friendly relation has first been established through the patient's recognition of our genuine desire to help his physical difficulties, the financial inquiries which make a necessary part

of the home visitor's work can much more easily follow. One has to understand what money is available in order to make the best plans for nutrition, for home hygiene, for rest and vacation – all of which naturally form part of our medical interest. I wish to make quite clear here my appreciation that good social workers never begin their relationships with a client by assuming a moral fault on his part and never push the economic questionnaire into the first interview. All I wish to point out is that it is perhaps easier for the medical social worker than for others to avoid these blunders.

At the outset of a relationship which aims to be friendly, investigations which start with the assumption that there has been some *moral fault* or weakness in those whom we wish to help are even worse than financial inquiries. The instant that the social worker finds herself in the position of a moral critic, it becomes next to impossible that a friendly relation not hitherto established, shall be built up from the beginning. Late in the course of a friendship established long before, moral help, even moral criticism, may be welcome. But it cannot often or easily be one of the topics of conversation, one of the points of investigation, in the early stages of what we hope to make a friendly relation.

Everything stands or falls with this. We cannot even teach hygiene, we cannot even make medical principles clear unless we have succeeded to some extent, perhaps without any merit on our part, perhaps through extraordinary good fortune, in acquiring a genuine liking for the person whom we want to help. Once that

is attained, we can work miracles. But if it is wholly lacking, we cannot count upon accomplishing the simplest interchange of accurate information; we cannot achieve the most elemental hygienic instruction.

But there is another signal advantage in the medical point of approach to a relationship which, as I have said, must be friendly in fact, not merely in name, if it is to succeed in any of its ulterior objects. When the social worker begins the difficult task of acquiring her influence in a family, she starts with a great deal in her favor if she appears in the home as *the agent of the physician*. He has prestige. By reason of his profession, by reason of the institution which he represents, by reason of confidence already established by him in the patients' friends and neighbors, the new family is ready to have confidence in him. He is not thought to have any axe to grind. He is assumed to be genuine in his desire of helpfulness. Therefore any one who appears in his name, as his assistant, has a great deal in her favor, especially when compared with the visitors of societies which might be supposed to begin with economic or moral suspicions about the family. If the visitor appears in the home with the prestige of a medical institution enhancing the value of her own personality, she has a very definite advantage.

Light on the severity of illness

I have said that it is essential to the success of a medical

visitor's work that she should be part of the medical machine, acknowledged as the doctor's agent, concerned wholly with helping to carry out his plans. But we must ask now, *what part*? And the answer is that the social worker is an assistant to the physician both *in diagnosis and in treatment*. I will begin with an account of what she is to do as his assistant in diagnosis.

She is to discover, so far as she can, *what* the disease is, *how much* the disease is, and *why* it is. I do not mean, of course, that she is to ape the doctor's scientific investigations, that she is to use instruments of precision, or to try to prescribe medicines. But she is to help the physician in some of the following ways:

He is often very much at a loss to be sure how bad the patient's symptoms really are, how much the patient suffers, how serious the case is. The social worker is often able to help in discovering why the patient really came to the dispensary, discovering, perhaps, that the reason is such as to show that the malady is really a trifling one. She may find, for instance, that the patient has come merely because her husband had to come, anyway, and she thought she would get the benefit of whatever there was to be had in the way of medical assistance at the dispensary, even though, unless her husband had been going, anyway, it would not have occurred to her to make the independent visit upon her own account. Or, again, the visit may be due chiefly to curiosity, especially if the dispensary has been newly established or has added some new features to its methods of diagnosis and treatment. These facts are passed along from

person to person; the person hearing of them may appear as a patient chiefly to see just what it is that her neighbors are getting when they go to the dispensary. I have known a patient to come merely because he was alarmed as a result of a recent conversation with a friend. His friend had been hearing about heart trouble and had mentioned some symptoms such as pain about the heart or cold extremities or dizziness. Any one sick or well on hearing such symptoms may easily remember that he has had them himself not long ago, or may even begin to feel them as a result of suggestion. Straightway, perhaps, he will betake himself to the dispensary, complaining of symptoms which never would have been noticed but for his talk with the friend.

Or, again, the patient may have some definite organic disease or some obstinate train of discomforts and physical inconveniences. But he has adapted himself to them tolerably; he has settled down to bear or forget them as best he may. He may know that his troubles are really incurable and yet not serious. He may have become as accustomed to them as he is to an uncomfortable lodging or to a modest income. Yet, as a result of some temporary fatigue, some newspaper paragraph, some fragment of gossip overheard, there may arise in him a crisis of alarm and worry about his familiar discomforts or inconveniences. Thereupon he may betake himself to a dispensary, and give the physician an account which may be very difficult to interpret, because the physician does not understand the train of events which appear acute and new in that they have

led the patient just now, rather than at any earlier time, to seek advice. After nearly twenty years' experience of dispensary work I should say that in no respect can a social worker give the doctor more welcome help than by discovering now and then reasons such as I have just suggested whereby the patient comes to the dispensary now rather than at any other time, and at a season not really connected in any special way with the nature of his disease.

Perhaps I can make this clearer by contrast with its opposite. A person who has just developed a scarlatinal rash, who has just coughed and raised a considerable quantity of blood, who has just lost the power to move half of his body, who has just begun to have swelling of the face, naturally consults a doctor at once. If he then comes to a dispensary for treatment, he has come at a time which is the right time, the reasonable time, considering the nature of his malady. Something new has happened. An attack has been made which should be foiled if possible at once. The clue for usefulness on the part of the doctor is thus fairly clear. If, on the other hand, a person has had more or less back-ache all his life, and has grown used to getting along and doing his work, even enjoying life in spite of it, he may suddenly come to a dispensary for that back-ache because he has seen in the newspaper the wholly false statement that pain in the back means kidney trouble. Yet when he comes to the dispensary *he may say nothing whatever about his having seen this newspaper advertisement*. Indeed, it is very unlikely that he will mention this at all. He will describe his back-ache as something

which demands immediate treatment, and the doctor may set in motion extensive and probably useless activities of investigation or treatment which never would have been undertaken had he known just what it was that brought the patient to the dispensary that day rather than months earlier or later.

So far I have spoken only of cases in which the visitor's studies in the home make it clear that the case is not as bad or not as manageable as it might have seemed if one had known only what the patient himself could reveal in the dispensary. But occasionally on reaching the patient's home the visitor may find reason to believe that the symptoms are much more serious, the disease much more urgent, than could have been realized from the story told and the facts obtained at the dispensary. The visitor may find in the home conditions of disorganization, dirt, disorder, serious malnutrition, discouragement on the part of other members of the family, arguing a much more serious condition of the patient than one would have realized from talking with him at the dispensary. As a result of such findings the doctor, who must spend his energies for the patients who need him most, will see that he had better give more time and more effort to the patient than he would otherwise have thought right.

Still, again, the visitor may find that the symptoms are neither more serious nor less serious than he would have supposed from the dispensary interview; yet the clinical picture is different from the doctor's because the patient has thrust into the foreground of the clinical picture something which further knowledge shows to

be really unimportant, while he has said almost nothing of some other feature of the trouble which is really much more serious. For example how much does the patient really eat, how does he do his work, are there complaints about him from his "boss," has he *always* had the cough which he has only just now begun to complain of? Such questions can be better answered after visits at the home and talks with the whole family.

Clearly the supplementary information thus secured by the social worker will count for nothing unless clearly explained to the doctor, and is taken up by him as part of the evidence on which he bases his diagnosis and his treatment. It is absolutely essential that the social worker should not merely make her visits and record them in her notebook, but should incorporate her findings in the medical record and deliver them not formally but effectively to the doctor's mind.

Such help is needed because she can often learn far more in the quiet of an interview at home than would be possible for the doctor despite all his medical skill. For at the dispensary he questions the patient when he is confused and forgetful, alarmed, perhaps, by the sights and sounds of the clinic, and so very unlikely to give a correct and well-balanced account.

Nests of contagious disease

So far I have been describing the work of the social worker as a process of finding out how much ails the patient and what his

symptoms signify. But it is also a part of the social worker's duty to find how much disease is present not only in the individual who appears in the clinic, but in his immediate environment, to discover *nests, foci or hotbeds of disease*. In the case of a disease like smallpox, this is obvious. If a patient presented himself at a dispensary with the pustules of smallpox upon his body, it would be criminal negligence on the part of the physician not to set on foot a search of that patient's home, his industrial environment, or, in the case of a child, his school environment, for evidence that others have been exposed to the same contagion and possibly already infected. This sort of duty cannot be abandoned merely because there is no health officer at hand. It is a crying need and must be attended to at once.

Now in a minor degree this is true of many other diseases as well as smallpox. We are beginning to realize that it is true of tuberculosis, so that when one case of advanced and therefore contagious tuberculosis is seen at the dispensary, machinery should automatically and invariably be set in motion to search out possible paths of contagion from that patient to others, just as if he had smallpox.

This principle which is well established in the case of dangerous contagious diseases like smallpox and diphtheria, and is beginning to be established in relation to tuberculosis, is even more important in dealing with syphilis. Every case of syphilis means more cases of syphilis, and the danger of still more each day that the contagious patient is at large. No physician has

done his duty unless, after seeing a case of syphilis, he attempts, through a social worker or otherwise, to get knowledge of others from whom this disease has been acquired, or to whom it may be freshly spread. At the Massachusetts General Hospital each patient with syphilis is asked to bring to the clinic for treatment the person who infected him. The method sounds impossible *but in fact it works*, and many cases are thus brought under treatment and prevented from infecting others.

With contagious skin diseases such as scabies or impetigo, the principle is obviously the same, though the dangers of disregarding it are not so great. With typhoid fever, which not very infrequently shows itself even at a dispensary, the duty of the social worker is not so much to search for other persons through whom it may have been contracted or to whom it may be spread, as to investigate the water-supply and the milk-supply of the patient and of others in his environment. One case of typhoid always means more cases, usually more cases acquired, not by contact with one another, but through their share in a contaminated water-supply or milk-supply. The social worker, therefore, should know how to search out contaminated water-supplies, or at least to put in motion such machinery of public health investigation in the city or town where the case arises as may lead to good detective work in the attempt to track down the source of the trouble. It has been well said that every case of typhoid is some one's fault. It has even been asserted that for every case of typhoid some one should be punished. Certainly

there are some grounds for such an assertion.

Hotbeds of industrial disease

Commoner and not less important than the contagious diseases that I have just mentioned are industrial diseases, or diseases aggravated by the conditions of industry. A physician may serve for many months in a dispensary without seeing a case of smallpox, of trichiniasis, or of typhoid fever, or feeling it his duty to set in motion the forces that I have just mentioned for rooting out the sources of contagion and preventing their further spread. But he cannot serve a month in any well-attended dispensary without seeing cases of industrial disease in the narrow sense, such as lead poisoning, or of independent disease aggravated by the conditions of industry, such as the functional neuroses of cigar-makers or of telephone operators. With such diseases, as with the infectious and contagious diseases, the presence of one case in the clinic should lead straight to the inference that there are others elsewhere, out of sight but no less important from the point of view of public good. This conclusion should lead in turn to the search through a social worker for the cases of disease which do not present themselves to any physician, which may be totally unknown even to the patient himself, yet which are important to the health of the nation.

Difficult though this field of industrial disease has shown itself to be, difficult though it is to separate out that portion

of the patients' complaints which can justly be referred to the conditions of his work, and to distinguish it from the portions which are due to the way he lives, to his inheritance, to his habits or to diseases like tuberculosis and syphilis which may have been acquired without any connection with his work, – nevertheless we must try to disentangle and to recognize the elements in this knotty problem. And we can hardly fail to see that the social worker is an essential and logical assistant in the processes of investigation which we must carry out. If we can ever unravel the tangled skein of causes and effects whereby the hours of work, the strain of work, the patients' heredity and his home conditions, all combine to produce the symptoms of disease, it will be through such intimate, prolonged, detailed studies as the social worker can carry out, especially if she becomes a friend of the family. The doctor in his hours of consultation at the dispensary certainly can never do it. The official agent of the Board of Health, perhaps feared, certainly not a natural confidant for the family, may easily miss the truth which the social worker unearths, provided always she succeeds in differentiating herself altogether from the impersonal and professional investigator, and gradually becomes in the mind of the family and in truth their friend.

I said above that the social worker should try to find out what disease, how much disease, and why this disease is present. The answers to these three questions cannot be kept separate. If one knows how much importance to attribute to a given symptom

and whether it is as bad as it seems or worse than it seems in the dispensary interview, one may be steered straight to a correct diagnosis. To know *how much* disease may thus mean knowing *what* disease is present. Furthermore, the understanding of these questions, even though it be only partial and unsatisfactory, leads us a considerable distance towards understanding why the disease has arisen. The search for sources for contagion is an example of a search for a *why* in disease. The search for psychical factors – groundless fears, misleading newspaper advertisements, distracting rumors – all this is also a search for the cause as well as for the nature of disease.

The social worker's investigations into the cause of disease may perhaps be still further exemplified. I once sent a social worker to my patient's home with the request that she try to find out what I had failed to find out, namely, why a young girl could not sleep. Physical examination of the girl had revealed no cause; the exploration of such parts of her mind as she would reveal to me had thrown no light upon the trouble. I was at a loss and asked for help through the more intimate knowledge of the patient sometimes to be gained through a social worker's studies. Such a search might easily have been fruitless – it often has been fruitless in my own experience. But in this case it was almost comically swift in reaching its goal. The visitor found that this girl was sleeping with two other girls of about her own age, in a bed hardly more than a metre wide. It needed only that she should acquire a separate bed for herself, which she was able

to do without any financial assistance. She then regained her power to sleep. How often have such cases been treated with drugs or perhaps with more complicated physio-therapeutic or psycho-therapeutic procedures, when some simple fact like the size of the bed, the temperature of the sleeping-room, or the mental activities of the evening immediately preceding bedtime, are really responsible for the whole trouble.

Medical outfit of the social worker

In order to carry out the particular procedures of diagnosis and treatment which belong within the province of the social worker, a certain amount of medical knowledge is needed. Because this is true, it has often been assumed that the social worker must be a trained nurse, prepared by months or years of experience in a hospital. But experience has shown that much of the knowledge possessed by nurses who have had this training cannot be used by the home visitor. On the other hand, the information which the social worker needs is often quite lacking even in well-trained nurses. Furthermore, it may be said with truth that the training of a nurse, as we know it in America at any rate, really unfits a woman in some respects for the work of a social worker, since it accustoms her to habitual obedience and subordination. These habits are very useful in their proper place, but they are antagonistic upon the whole to the temper and mental activity which is important in the social worker. I mean the temper of

aggression in relation to disease, and the mental attitude of the teacher and leader in relation to the patient. But of this point it will be more in place to speak when I come to consider the functions of the social worker as a teacher.

Let us return, then, to the question, What knowledge should the social worker possess in order to do her part in the "team-work" of the medical-social dispensary? Her knowledge should approximate that of the public health officer. Like him she should be, above all, familiar with what is known to medical science about *the causes of disease*. This is of great importance because it is especially in this field of medical science and medical ignorance that the public, the patients among whom the social worker will work, is most in need both of new knowledge and of the uprooting of old error and superstition. Medical science knows very little of the causes of many diseases. But our patients, especially the more ignorant of them, are very glib and confident in their assertions as to what has caused the particular disease from which they just now suffer. They tell us about their "torpid livers," their "congestive chills," their "ptomaine poisonings" and the like. Their supposed but unreal knowledge is extensive and detailed. Indeed, so stubborn are their beliefs upon such matters that they often present a firm wall of resistance which must be broken down by the social worker before any truth upon these matters can be introduced into their minds.

The social worker, then, should share such knowledge as the medical profession possesses about the causation of infectious

disease, about direct personal contagion, and also about the indirect *methods by which disease is conveyed* from person to person through insects or through instruments and utensils, such as the barber's razor, the family towel, or the public drinking-cup. She should be familiar with the small body of knowledge which we possess upon the transmission of disease by drinking-water, by milk, and other kinds of food. She should appreciate our still smaller body of knowledge about the relation of disease to climate, to weather, and to other physical agents such as the extreme heat and cold produced by some industrial processes, and the action of X-rays.

In addition to this definite and specific knowledge of causes, she should know the generally accepted views of the medical profession on the subject of *bodily resistance*, *immunity*, inheritance, the diseases and perversions of metabolism, and the other non-bacterial factors in the production of disease. Above all, she should realize the *multiplicity of causes* which science more and more clearly recognizes in their single result. She should learn both by precept and by experience that for a single fact such as disease or health there are always many causes, so that any one who points confidently to a single cause, such as cold, fatigue, bacteria, or worry as a sufficient explanation of a person's disease, is almost certain to be wrong. Obviously, this truth bears a close relation to what is to be said on the "historic and catastrophic points of view." Chapter III.

The importance of teaching the social worker all that is known

about the transmission and causation of disease is due to the following fact: whatever we succeed in accomplishing in our efforts at *preventive medicine*, whatever we do to nip disease in the bud or to check the spread of epidemics, is due to our knowledge of the causes of disease. The instructions of the doctor at the dispensary can accomplish but little in this field when compared with the detailed teaching of the social worker in the patient's house, in his workshop, in the schools and factories where disease is spread so much more frequently than in the dispensaries. If we hope to show people how they can avoid the disasters of illness, our teaching should be given in the very place where these disasters most often occur. There we can illustrate and demonstrate with the objects in sight what is to be done and to be avoided.

It is for this reason that the social worker is above all others the person who can convey life-saving information to the public in an effective way. A considerable amount of this precious knowledge is now possessed by the medical profession; but it is shut away useless, unavailable, in medical libraries and in doctors' minds. The social worker can fight disease by spreading the contagion of medical truth. She can multiply the foci from which truth can spread still more after she is gone, just as disease is redistributed again and again from new nests of infection.

The *prognosis of disease*, like its causation, is a subject on which the social worker should know almost as much as the doctor. This is possible because medical knowledge on this

subject is still so very limited. For the purposes of one who has to combat the poverty, sorrow, idleness, and corroding fears which disease produces, knowledge of prognosis is a most useful tool. For example: if one is to make plans for the care of a group of children during their mother's illness, one must have some idea how long that illness is going to last. If it affects the bread-winner of the family, how long will he or she be disabled, and how completely; what are the hopes of ultimate and complete recovery; will chronic invalidism follow; is it worth while in this particular disease to spend a great deal of money and time in trying to achieve a complete cure, or is cure so improbable and at best so incomplete that our resources can be expended more wisely in other directions?

A knowledge of prognosis will help the home visitor greatly in the solution of such problems. But it must be added that such knowledge as she already possesses about the prognosis of a disease, such as tuberculosis or heart trouble or kidney trouble, must always be supplemented by all the information that she can gain from the doctor as to the present prognosis in the case of the particular patient with whom the social worker has to deal. For the general prognosis of a disease is greatly modified by the particular circumstances in each individual case.

Physicians are not at all eager to impart their knowledge about prognosis, because this knowledge is so limited and so faulty. No scientific man likes to make definite statements upon so indefinite and hazy a matter as prognosis. Nevertheless, it is

essential for the patient's good that the doctor should be asked to give her as clear and definite a statement as is possible for him to make with the facts that he possesses. For it is only upon the basis of such a statement that an intelligent plan of social treatment can be constructed.

Besides acquiring all that she can learn of the causes and prognosis of disease, the social worker should be familiar with the symptoms of the more important and *common types of disease*. There are now several books written particularly with the object of conveying to social workers and others such knowledge as I have referred to, yet without any pretence of equipping the person either for nursing or for the practice of medicine. I will mention here a book by Dr. Roger I. Lee, Professor of Hygiene in Harvard University, "Health and Disease: Their Determining Factors" (Little, Brown & Co., Boston, 1917), and my own book, "The Layman's Handbook of Medicine" (Houghton Mifflin Co., Boston, 1916).

In order to understand such books, and to arrange her knowledge of disease in such form that it may be easily handled, the social worker must have a slight knowledge of anatomy and physiology, so that she can arrange the symptoms of disease in connection with the different systems of organs: circulatory, digestive, respiratory, urinary, nervous, and locomotive.

Finally, the social worker must know the *principles of hygiene*, in order that she may effectively combat medical quackery and the prevalent medical superstitions of the people. That portion of

hygiene which is both securely founded upon scientific evidence and useful in the preservation of health, makes up only a very small body of knowledge, so that it can be easily mastered by any intelligent person. Our knowledge upon such matters as diet, exercise, bathing, sleep, ventilation, when such knowledge is both scientific and practically useful, could be written upon a very few pages. It consists largely of negatives which contradict the current superstitions.

In my own work in this field I have found it essential that there should be no mystery and concealment, no obscurantism and mediæval Latin in the methods of treatment which the social worker explains or carries out under the doctor's directions. She must be able to deal with the patients frankly, openly, without concealment or prevarication. Otherwise she will not have moral force enough behind her statements to bring them home to the patient so as to secure any reform in his hygienic habits. Such reforms are difficult enough in any case. They are usually impossible unless they can be initiated by one rendered eloquent and convincing by the consciousness that she leans upon the truth and has nothing to conceal. If she has mental reservations, if she is trying to protect the authority of the physician in a statement which she does not believe to be wholly true, the force of her appeal will be so weakened that it will probably be ineffective.

Technical methods

There are some technical processes of diagnosis and treatment which are usually carried out by the visiting nurse, but which may well be performed after a brief training by the social worker who is not a nurse. Among these are:

(1) The accurate reading of the patient's temperature, pulse, and respiration, which she must often teach the patient to do for himself and to record accurately and clearly. This is of especial importance in tuberculosis, for in suspected cases of this disease one often needs daily measurements of the temperature as an aid in determining the diagnosis or in estimating the severity of the case and the fitness of the patient for work.

(2) The arrangement of a window tent or some other device for insuring the maximum of fresh air for the tuberculous patient both day and night. This device is also useful in pneumonia, typhoid fever, and other diseases, in case they are to be cared for at home and not in a hospital.

(3) The application of simple dressings to wounds, abscesses, and common skin diseases such as eczema, and impetigo.

(4) The care of the skin in bedridden patients. Our primary object here is the prevention of bedsores, those ulcerations which occur in very emaciated patients at the points where their weight presses a bone against the bedclothes.

(5) The simpler procedures for the preparation of milk for

sick children and of other foods commonly advised for patients who are confined to bed.

(6) The methods of emptying the lower bowel by means of an enema.

Into the details of these procedures this is not the place to enter, but I wish specially to assert that all of them may be learned within a few weeks by persons who have not studied medicine or had the full course for the training of a nurse. Any one who possesses these simple bits of skill can do all that is necessary for the physical care of the sick poor in their homes, unless continuous attendance upon the patient is necessary. Such attendance is not within the province of the social worker. But in the technical procedures just described it is all the more important that she be expert, because such skill makes her a welcome visitor and a trusted adviser outside the field of medicine. Because she has given relief by dressing a wound, curing a skin disease, or applying a poultice, she will be listened to with liking and with confidence when, later, she comes to give advice in economic, educational, or moral difficulties.

CHAPTER II
HISTORY-TAKING BY THE SOCIAL ASSISTANT

History-taking concerns the social assistant especially because history-taking is one of the things one does, if one is wise, in any matter in which one is trying to help a human being. Even if you were concerned to help not a stranger, but a member of your own family, still you would need a story or history of the person's life whether you wrote it down or not.

History and catastrophe

In our attempts to be of use to people in their misfortunes, there are two very common and quite opposite points of view (roughly the right and the wrong), which I call (*a*) the "historic" and (*b*) the "catastrophic," the accidental, or the emergency point of view.

Confronted with people's troubles, whether physical or mental or spiritual, we are tempted, and above all *they* are tempted to regard the sickness, the poverty, or the sorrow in the light of an emergency, an accident, and therefore as something to be treated at once and by means which have little to do with the past and the future. On the other hand, the standpoint of science and

philosophy, and of any one who has labored long in the field of social work with or without science or philosophy, is the point of view of history. This is the habit of mind which makes us believe that a supposed "accident" belongs in a long sequence, a long chain of events, so that it is impossible to understand or to help it without knowledge, as extensive as our time and our wisdom will allow, of that whole chain.

Consider a few examples which contrast these two points of view. When a boy is brought into court for stealing, it is almost always his attempt, and the attempt of those who defend him, to show that such a thing has never happened in his life before; he "just *happened* to steal." But as we inquire more closely into the facts, we almost always find that this is a fundamentally untrue statement of the case. For the offence which brought him into court is almost never the first offence. He has always stolen before. On the present occasion he was a member of a boy's gang; it was not in the least accidental that he got into that group of boys. As we search back in his history, and perhaps into his father's history, we find reasons why he is what he is now. Again, we are trying to help some wayward girl who has taken an immoral step. We are told what a wholly unforeseeable *accident* it was that got her into her trouble. But if we can get a good picture of her past, we find that we could have traced the tendency to weakness of this kind from the time she was born.

So it is in medical matters. *Emergencies are rare.* I remember being called out of a sound sleep one night to go "as quickly

as possible" to see a man who had discovered a lump upon his breast bone. He was quite sure that the swelling had appeared since the time when he went to bed. It was then one o'clock in the morning, and he had gone to bed at eleven. Well, I found a slight bony irregularity in his breast bone which doubtless had been there about forty-five years, as he was forty-six years old. He did not pretend that it hurt him, and did not undertake to show that he was ill in any other way. But this lump had come and naturally he wanted help at once.

Конец ознакомительного фрагмента.