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身を向ける。）『私おいとまするわ。』

ジェリー（扉の右手の椅子へ腰掛け寄り）『待って、ジャニー。君斯んなにして歸っちゃ不可ない。ね、ジャニー。僕達は互に愛し合ってゝ居るんだ。』

ジャニー（ひどく疲れて、ジェリーから顔を反らし）『判って居ます、けれど私は結婚出来ないんです。どうぞ、行かせて下載。』（椅子の方へ又振向る。）

伯母ビー（立ち上り、ジャニーの左手へ腰掛さ）『今り不可ないね。ねえ、ジャニさん。（ジャニを長椅子の上手側に連れて行って其處に掛けさせ、自分は後を廻って下手側に腰を下す。）『さあ、訳を話して下載。ねえジャニさん。』

ジャニー『私頭の中がこんがらかってゝ了ってるんです。ジェリー！わ、私恐い。』

ジェリー『恐いことなんかよ。ねえジャニー。僕達がついて居る。』（腕を廻して彼女を抱かうとする。）

ジャニー（彼から顔を反らし、身体を引いて椅子に掛ける）『誰がついて居ても駄目なんです。とても、とても、恐しい事。』

伯母ビー『ねえ。初めから話して下載。』

ジャニー『ええ。お話しして見るわ。けれど――（一度口を切ると後は口を衝いてしゃべり立てる。）うちのボスと来たらけち、あの通り

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でせう。何か新らしい事だの、実驗ぶつて言ふと、商責に関係があらうが無からうが、何時も夢中になつて。でも此の間レントゲンの檢査を受けろつてモメを貰つた時には、私別に気に止めもしなかつたのよ。何だか X線の機械だの一杯もつて来て、お醫者さんや何か大勢来て、大騒ぎして、私達みんな一緒になつて二階へ行かされたんですの、會社の人は誰もかも、人夫の人達も。(少し語調を緩め)所が、昨日になつて、ニリーって言ふ……會計課の娘と私と呼び出されて、何とか言ふ處へ行けつて言はれて、もう一度レントゲンを撮らされたんです。色々と質問されて、細い檢査を受けたんですの。そして今日もう一度来いと言はれたんですけれど、……私……私……(恐怖の中に)お醫者さんから肺病ぶつて言はれたんです……。

伯爵ビン『まーあ。何うしませう。』

ジェリー『ば……ばかな。そりゃ、ジャン。……何か間違いぶ。』

ジャン(冷く、然し絶望的に)『いいえ。間違じやないんです。お醫者さんが詳しく説明をして呉れました。』(あきらめた様に)だからお判りになつたでせう。私結婚も出来ない……勤めも駄目……何もかも駄目なんです。』

ジェリー『けれど、そ……そんな馬鹿な話つてあるものか。』ジャン。居未だそんなに若いんじやないか。』

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伯母さん『何もそんなに駄洒落だってことないでせう。何度か日当りの佳い、空気の善い所へ行って……今迄素晴しい仕事に就いて居たんだって言って置けば、誰もほんとの事疑ひはしないよ。』

ジェリー（傷けられた様に大倉然と）『伯母さん。君の言ふこと何かとても恥かしい事の様に聞こえるじゃないか。』

伯母さん『でも、余り人に聞かせ度い事じゃないでせう。』

ジェリー（左手の方歩き初めて）『それでも、何んだって斯んな事が僕達の間に起こらなければならなかったんだ。』（振返って）ジャニに面を向ける）

ジャニ『ジェリー！』（彼等は互に手を差し出し、近付かうとして、不圖気が付き、身を引く。）

ジェリー（窓の方へ大股に歩み）『ひどい。あんまりひどい。（くるりと身を返して）ねえ、ジャニ、何んとか其方法は無いのかしら、誰かに會ふ……とか。』

ジャニ『方法なんて何も無いわ。ジェリー。何もかも、もうおしまいです。』

ジェリー『いやだ。僕はそんなのいやだ。』（左手へ大股に歩み去る）

ジャニ（優しく）『判ってるわ。あなたの気持。』

ジェリー（ジャニの方を向いて）『ケれど、一体君は何うするんだ。何うして暮すんだ。』

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ジャー（苦しげに）『私？お醫者さんが説明して呉れたわ。私、療養所へ這入って、順良なしくして居なければならないのです。そして、何時か、しなびてお婆さんになって出て来るでせう。わ…わたし、死んだ方がましし。』

（ジェリーは椅子Cに掛ける。）

伯母ビー『そんな風にお仰言るもんじゃないわ。ジャーさん。そんな捨て鉢は罰当りと言ふものよ。そんなに万事窮すと言ふ訳じゃないじゃありませんか。よく眠って、ミルクや卵や、美味しいものを食べて、十分に運動の熱れる所へ行きさえすりゃいいんじゃありませんか。良くなりますよ。見たところ、少しも肺病の徴候なんか無いじゃありませんか。直ぐに良くなる事請合いだわ。…けれど、無論、結婚は出来ないわね、子供に遺傳する恐れ不可ないから。』

ジャー『けれどお醫者さんが言って居たわ。ある日光ぶの新鮮な空気だのって皆んなが言ふだらうけれど、其んな事余り気にしなくてもいいって。』

伯母ビー『此の頃のお醫者さんと来たら、科学一点張りですものね。昔の人は皆經驗で言って居るんだから。それだのに本当に良いと思ふ療法でも此の頃のお醫者さんには気に入らないらしいのね。何んでもかでも難かしそうな理屈を付けて。そして。新らしいことでなくと嘉者さ試驗台に使ふのよ。貴女達斯んなに身やかした今の場

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合だってそうじゃありませんか。貴女（あなた）にない位い丈夫さうに見えるのに。」

ジェリー（起き上り）「いや、ジャニが脅えるのに不思議はないよ。（左を向き）僕だって同様だ。」

ジャニ（驚いて）「まあ、ジェリー。私もう貴方に感染（うつ）してしまってゐるとお仰言るの。」

伯母ビニ「馬鹿くしい。家（うち）の血統には肺病なんか傳染りません。」

ジャニ「でも診て貰った方が良いわ。ねえ。きっと約束してね。」

（次の會話の間、ジェリーは左下手と中央上手の間を往ったり戻ったりする。）

ジェリー「僕が言ったのは、そんな意味じゃない。」

ジャニ「それでも診察なさるでせう。」

ジェリー「うん。する。」

ジャニ「本当よ。ジェリー。」

ジェリー「OK. OK.（歩みを止めて、椅子Cの上手に止り、ジャニに面す。）僕が今脅帆だって言ったのは僕達二人の間の事だ。僕達二人の間は何うなるんだ。」

ジャニ「私は結婚出来ません。ねえジェリー。けれど少くも私は奇麗に解消出来ます。貴方が偶然私と恋愛に落ちた理由で貴方を束縛する気持は持ってゐません から。」

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ジェリー『けれどそんな事只口で言ふ丈で君が僕を愛する気持を無くする事は出来やしないじゃないか。』

ジャン『ええ。出来ません。けれど貴方を貴方の撰ぶ首を離して差し上げる事は出来ません。だ……だれか好い人を見付けて下さい……。』（口ごもって泣く。）

ジェリー（彼女の傍へ進み寄やる世無げに彼女を見下す。）『だけど僕は誰も他に恋しくない。僕は君が入り用なんだ。初めから、僕には君が恋しいんだ。（振り返って窓の方へ進み）それだのに、それだのに、何て事だ。……こんな事になって了ふとは。』

ジャン（ジェリーを見上げて）『けれど、斯んな事になって了ったんですもの。』（彼等は互に見詰め合ふ……緊張……其の時扉にノックがあり一同驚く。）

伯母ビン（びっくりして）『誰でせう。』

ジェリー『ああ、フレッド君だよ。すっかり忘れて居た。』（ULの方へ進みかける。）（次のノック。ジェリーが聲を掛ける。）『あ、今行く。』（ULから外へ出る。）

ジャン（立ち上って）『私裏口から帰るわ。』（手で涙を拭い帽子と外套を取りに椅子の方へ進む。）

ジェリー（部屋の外で）『さあ、言入り給へ。よく来たね。』

フレッド（部屋の外で）『やあ、久し振りだね。（二人はULから言入って来る。フレッドはジェリーの肩越しに口を利く。）何んだか三十の上

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を出た様子が少しも無いね。(後ろ向きに背中でジャニに突き当りそうになる。)あっ、失礼。』

ジェリー(フレッドの左手で)『あ、ジャニ。フレッド、エリオット君だ。よく君に話しした通り。ジャニさんと言ふ、僕の---(二人ためらい)---いやジャニ、ビックフォード、嬢だ。』

フレッドとジャニ『初めまして---。』

ジャニ『ジェリーさんから色々と伺って居ります。』

フレッド(伯母ビニを見て)『いよ---う。此り此は、僕の最初のガール、フレニード。』

伯母ビニ(起ち上り)『まあ、フレッド。』

フレッド、(長椅子の所へ行き)『少し年をとって居ない。(ビニに腕を廻して接吻する)何うです、お伯母さん。お達者で。』

(次の會話の間、ジェリーはジャニに歸る様にと、しきりに無言で合圖する。)

伯母ビニ『相変らずお上手やさんね。どれ一寸見せて。(彼を自分の身体から離して手を執って眺め)少し肥えた様ね。(ジャニに向って)とても可愛い小柄ぶっぷりに、斯んなに物凄くなってゐって。』

ジェリー(立って一寸ジャニの肩に手を掛け、そしてフレッドの傍へ進み)『まあ、外套でも脱ぎ(外套を脱がせて、椅子の上の他の外套などの上に置く。強いて快活を装ひ)まあ掛けて

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巣にして呉れ給え。何か上げやうか。』

フレッド『いやく。有難ふ。（長椅子の上手側に腰を下す。ジャニリ窓の上手の椅子の方に進み腰を下す。）此の前會った時から八年になるが、そんなに見えないね。（ビニ伯母リ長椅子の下手側に腰掛ける。）君、今何してんだい。やっぱり、例の貿易新聞をやってるのかい。』

ジェリー（椅子Cの上手へ進み）『いや、僕リ廣告の方へ這入ったんだ。ヘニチュム、アンド、グロップ會社さ。一九四〇年に入社したんだが、軍隊から出て又其處へ歸ったんだ。』

フレッド『軍隊ぢゃ、それは良かった。軍隊ぢゃ何處に居たんだい。』

ジェリー『ヤニキー部隊だ。とてもも良かった。居リ一体何うしてたんだ。』

フレッド『いや、僕は歸されたんだよ。』

ジェリー（敬禮して）『あれ！そうかね。』

伯母ビニ『ねえ、フレッドさん。フローレンスさんは何うなさったの』

フレッド『フローレンス？』

伯母ヒニ『もちろん、フローレンス、エバーハードさんよ。』

フレッド『あゝ、フローレンス、エバーハード。さあ何うして居るか。もう何年か消息を聞いて居ないんでね。』

ジェリー『伯母さんと来たら、今日居が来ると言ったらね、きっとフローレンス嬢と結婚して、もう子供の七人もあるに違いないと言ってゝ。』

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フレッド『へえ。そりゃ僕り結婚して、子供も三人あるがね。ローレンスじゃない。カーサス市のアリス、ウォースと言ふ人と結婚したんだ。』

伯母ビー『お子供さんは、どっち？』

フレッド『男の子二人と、女の赤坊。』

伯母ビー『寫眞持っていらっしゃる。』

フレッド『伯母さんと来たら、僕だったら並のお父さんになれないとでも思ふんだね。（ジェリーは長椅子の後に進む。フレッドはポケットを探り寫眞を取り出す。）ほら、此、此がピート、此がグビッド、そしてマーガレット。』

伯母ビー（寫眞をとり）『まあ、可愛らしいお子さん達だこと。ねえフレッドさん、素晴らしいわ。そしてまあ奇麗な奥さんだこと。ねえジェリー。とても素的じゃないこと。』

（寫眞をジェリーに見せる）

ジェリー（寫眞を見乍ら）『うん、素的だ。（二寸緊張して）フレッド、君は幸せ者だね。（フレッドは素早く彼を見る）』

伯母ビー（起ち上り、ジャニの方へ進み）『ねえ、ジャニさん、御覧なさい。何て可愛いお子でせう。』

（ジェリーは椅子この方に進みジャニを見る。）

ジャニ（寫眞をとり）『ほんとに素晴らしいこと。（語調を強めて）それに皆さんとてもお丈夫で頑丈さうなこと。』

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フレッド『ええ、もう馬の様に頑固で、まるで野性ですよ。』

伯母ビー（寫眞を取って長椅子に戻り掛ける）『ほんとに美しい御家庭だこと。（寫眞をフレッドに返す。）けれどローレンスエバーハードさんも奇麗な娘さんだったわね。』

ジェリー『どうも伯母さんはローレンス嬢を袖にすると気に入らない らしい。』

フレッド『おやおや。ローレンスは僕が大學を出ない中に結婚してしまったんだよ。』

ジェリー（煙草を取り出し一本をフレッドに差し出して）『煙草はいかがだ。』

フレッド（一本をとって）『有難う』

ジェリー（煙草をジャンに出す序に）『君あ、今、何してるんだ。何度に出るんだ。やっぱりジャクソン市に住んでいるのか。』（窓下の椅子をジャンの左手に引張り寄せ腰を下す。）（ジャンは煙草を取ろうとして止める。）

フレッド『うん、あすこだ。アル、エックラッドと言う男と一緒に其處で小さいラジオ放送局を經營してるんだ。』

伯母ビー『まあ、そう。可笑しいのね。私は又、並通の人が放送局を持ってなんて、事、出来ないんだって思って居たわ。』

フレッド『何是』

伯母ビー『でも放送局なんて何か大會社組織か、ネットワークかそんなんでないと不可ないんぢゃと思って居るんですもの。』

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フレッド『そんな事無いよ。言はば僕達は二人で株主の汗涉も無しに、自分の電波で輿論を作って居るって事になる。時に依ると廣告主の汗涉……つまり中ノ人が出るすぎて困る事もあるがね。而し兎も角食って飲んで大いにけしやぐ事は出来る次第さ。』

（一同輕く笑ふ）（一寸沈黙。）

ジェリー（絶望的な口調）『そうだ。何か御馳走しなくちゃ。』

フレッド『いやく。有難ふ。』

（又一寸沈黙）

ジェリー『まあいいじやないか。君を見て居ると健康そのものだ。』

フレッド『一寸妙な感じを受けた面持）『そりゃ、此の頃の僕は生れて且て無い位元気だが、君だってそうじやないか。一寸疲れてる様子は様子だが。多分激烈な都會生活のせいだよ。』

ジェリー（笑ふ）『そうかも知れない』

（一寸沈黙）

ジャン（思い切った口調で）『ジェリーさんかゝ色々とお伺ひしてますわ。何時もとても愉快でしたって。』

フレッド『そうでしたよ。此の頃は一緒になる機會が無くて残念です。』

ジャン『ほんとに。ケれどジェリーさんも此かゝはあまり此處に縛

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りつけられてばかりは居りませんから、稀にはお宅の方へもお伺い出来ると思ひますわ。』

フレッド『君はさぞ忙しかったんだろうな。戰地の模樣なんか何うだったい。』

ジェリー『うん。皆んなが知ってる程度の事さ。』

フレッド『そうか。而し僕も余り出る機會は無いんだよ。』

ジェリー『何かお仕事の御旅行ですの。お泊りになれると宜しいんですのにね。』

フレッド『去年の旅行の時に僕はそうしたいと思ったんですが、會憎此方へ寄れなかったんです。一昨年はジェリーは海外に行って居たでせうし、何しろ居所が判って居ませんでしたからね。』

ジェリー『そうゞ。その時分にや向ふに居た。』

ジェリー『それじゃ、毎年いらっしゃるんですのね。』

フレッド『そうし度いと思って居ます。まあ言はば同窓會の樣なものでしてね。仲間じゃ出来るだけ一ずいくやろうってことにして居るんです。』

ジェリー『何の仲間だい。何んで斯んな東部で集るんだい。』

学校の告示じゃ何時も「我等の楽しかりし昔の校庭へ」と書いてあったじゃないか。』

フレッド『いや、此は大学のじゃないんだ。レーキ、ヴィユウ會と言ふ

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特別な集りなんだ。つまり、皆んな同じ月に退院した連中で、長い年月仲良く一緒に暮して来たんだから、昔の場所へ集って年に一度はお祝をしやうと決めたんだ。』

ジェリー『何ぶい、そのレーキ・ヴューってのは。』

フレッド（微笑って）『何ぶって、僕が三年の年月を送った療養所じゃないか。』

ジャニとジェリー（急に元気づいて）『療養所？』故郷

フレッド『そうさ。なーんだ知らなかったのかい。君が国を出て一寸したから僕は其処へ入ったんだ。』

ジェリー『そりゃ、知らなかった。』

伯母ビー『まあ、驚いた。』

ジャニ（熱心に）『何う…何うなさったんです。』

フレッド『結核だったんです。』

三人『結核ー。』

フレッド（当惑して）『そうですよ。（考へ直して）だけど心配しなくても大丈夫ですよ。今は感染りはしないから。』

ジェリー（慌てて）『いや、そんな事心配してるのと違ふ。』

ジャニ『それで、お療りになったんですの。』

フレッド『ええ。すっかり。そりゃ無論、ピアノを動かしたり、ジョールイスの向ふを張って拳闘（ボックシング）なんて訳にはゆかないけれど、そんな必要は無いでしょう。僕は机に坐って仕事をする人が希

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望でしたからね。』

ジャー『何の位い、お掛りになりましたでしょう。』

フレッド『三年掛かったんですが、丈し此はその人の場合場合依って違ふんです。詰り何の程度進んで居るか、何病気が発見されたか、何れだけ言い付けを守ったかと言った事情に依るんですよ。或る者は早いでせうし、或る者は長く掛かる。而し勿論手術みたいなものは必要がないんです。――ただ完全な休養食ですね、――実際僕の休養を取ったんです。』

ジャー『それと奥さんは何うなさいましたの。』

フレッド『家内が何うしたって――？』

ジャー『いえ、奥さんは何うなさかって言ふんですの。随分御心配なさったでせうね。』

フレッド『あ、あ、やっぱり。その時僕は丁度結婚して居なかったんですから。私は今のアリスに其のレーキ、ヴューで逢ったんですよ。あすこの図書館長をして居たんです。彼女の人達にや散々親切にして貰った揚句、何うも出し抜いた形で一寸具合が悪かったですが、万事よろしにまかせますよ。』

ジャー『それじゃ、御承知の上で進んで御結婚なさったんですね。それにお子さんをお出来になって。』

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フレッド（不安そうな様子に力作る）『そうですとも。そんな事別に不思議はありませんよ。所でそろそろ出掛けないと遅くなりそうです。汽車に乗らんなりませんから。』

ジャニ（起ち上り）『いえ、いいえ。何うぞもう少し。とても面白いお話ですから。』

フレッド（起ち上り）『いやいや。僕にしたって自分の事ばかり喋舌る事中にや、手を焼きますからね。』

ジェリー（起ち上り）『まあ、まあ、ねえフレッド。（椅子Cの上手に進み）ぼ…僕達のこと、とても妙だと思ふだらうけれど（椅子をとり下手に動かし）僕達、実際のこと、君が来て吳れたことをとても喜んでゐるんだから――。』（二寸言葉を止めてジャニを振返る。）

フレッド（益々当惑して）『そりゃ僕だって君に會って素晴らしく嬉しいんだが、而し僕は歸らなくちゃ。』

ジャニ（ジェリーに向ってうなづく）『お話しなさいよ。』

ジェリー『うん。君、君此度へ這入って来た時、僕達何か変な様子だと思ったろう。』

フレッド（下手を向き、さりげなく）『僕？――うん――一寸おかしいとは思ったけど。』

ジェリー『ジャニと僕はね婚約者だったんだ――いや、婚約者なんだ。』

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次

ヘレット（ジョーの方に振向く）『チョッと目を使ふ。』

ジョー『奴がだんだん近寄って来る。』

ヘレット（再び振向く）『ヤ…ヤ此奴は気の毒なことだ。』

ジョー『奴が今やっと其の必要を感じたんだ。』

ヘレット（長椅子の上手寄りに腰を下す）『おゝ ジョー。僕は斯んな単純な田舎者だ。1・2・3と利口な事を言って喜ぶなんて間抜けだ。』

ジョー『だゝ人々を風に説明しなくちゃ奴だ。』

ヘレット『OK・OK・ヤ此で何うだ。』

ジョー（椅子の左手に腰掛）『ヤ此が私のチャンスだ。絶対に結婚出来ないと思ふんでしたんだ。ずっと其此は私の為に作られた私達です。…と申しますから、私、今日、肺病になって3年経ったんです。』（ヘレットを期待する様に眺める）

ヘレット（ほっとした様に）『なあーんだ。ヤ此で判った。（真顔に）ヤ此は確かなんですか。』

ジョー『ええ。確かです。（椅子に掛ける）確かにかかって居るんです。』

ヘレット『ヤ此ぢゃ喜びは沿たかも不可ない。』

（ジョーはジョーの左手に寄る）

ジョー『でも喜び過ぎると悪いかもしれない。』

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フレッド『貴女が言はれた通り言ひ付けを守りさえすれば。』

伯母ビー『それは先刻私が言った事よ。十分な日光と良い空気。良い食物と暖い乾燥した場所での運動――。』

フレッド『伯母さん。君は好い人、僕は大好きだ。けれど君には何も判ってやしない。』

伯母ビー『まあ、フレッド。』

フレッド『君の言ふ事は丸で時代遅れだ。一度寝たきと思ふ時に多勢仲間を寝室に呼んで来て、騒がせて、それで気持良く寝付けると思ふのと同じことだ。てんで見当違いだ。唯一つの答は療養所へ入る事だよ。日光だの食物だの病気に丁度良い運動だのは療養所が提供して呉れる。時にとっちゃ余分な日光が一番悪いことだってよるんだから。』

伯母ビー『まあ』

フレッド『そして運動、此も不可ない。一番大事なのは完全な休養だ――床について。つまり肺を使はない様にして休ませてやるんだ。それがせめて一杯なんだから。そうでないと、徹底的に休ませる為に一つの肺を破さなければならない様なことにたったりする。而し、何れにせよ、始終身体を診て呉れるお医者さんが沢山居る場所に居るくらい不可ない。段々良くなるに従って、先づ頭を使ふことなどを始める。

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つまり讀書会とか何会とかだね。次が手、最後に身体と言ふ順序だね。簡單なことから始めて丈夫になるにつれて段々活潑な事に及ぼす。要するに醫者がもう良いだらうと思ふにつれて、思ふ時期に、やうやきや不可ないんだ。」

ジェリー（息もつかず）『そうすれば、元元通りに良くなるんだね。』

フレッド（微笑する）『いや、そうはゆかない。兎に角急いちゃ不可ないんだ。そして、しては不ならん事も色々ある。而し君達が結婚しては不可ない、子供を持っちゃ不可ないなんて理由は絶対にない。……けれど斯ふ言った事は皆お醫者んが指図する事だよ。』

ジャニー（ジェリーを見上げ）『ジェリー——！』

ジェリー『ジャニー！』

伯母ビー（衝かれた様に）『でも子供の血統に、肺病を遺すのは良くないでせう。』

フレッド『馬鹿な。伯母さん。失礼だけど、子供は決して結核を遺傳なんかしやしないんだ。それが又昔のお伽話の一つなんだ。つまり家庭で、誰かが肺病にかかると、誰か家族のものに感染す、殊に子供に感染す。そこで或る家族に肺病が傳ひるなんて言ふんだね。黴菌を傳達するんであって、生れつき遺傳するのでは絶対にない。』

伯母ビー『でも、貴方はそう思っていらっしゃるかも知れないけど、

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それは私が聞いてることと違いますわ。』

フレッド『いや、伯母さん。僕はよく知ってるんだ。間違いけない。僕は詳しく知って居る。』

ジャー（調子を上げて）『エリオットさん。私今迄に誰かとお會ひして今程位嬉しいと思った事ありません。ほんとうに。』

フレッド『僕もお役に立ってほんとに良かったと信じた所ですが、真直面なところ、貴女達お二人にとって此からは相当に長い長い苦の道ですよ。決して楽な道ばかり無いので す。幾週も〳〵、幾月も〳〵、あすこで寝て暮さなければならない。況んば私がやった様に何か勉強でも始めたとしても中々楽じゃないです。実際、僕なんか、此の放送局の経營なんて仕事、彼奴に居る間に色々研究したんですからね。而し忍耐力を持って我慢りさえすりゃ――』

ジェリー（調子を上げて）『一年や二年が何だ。五年でも、……僕達にしたら永久の事だと覺悟して居るところなんだから。』

ジャー『ジェリー。私もう何でも無いと言ふ気になりましたわ。』

フレッド（早口に）『まあ〳〵君達。君達僕の言ふことだけ當テにしちゃ不可ないよ。今迄話したのは、僕の場合に就いてなんだから。明日にでもお聞者さんに會って、色々聞いて御覧なさい。僕の場合とジャーさんの場合とは又自ら違ふんだから。』

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ジャー『ええ。そりゃ判ってますわ。だけど少くとも私には或る希望が持てます。私達は何もビクビクする必要はなくなりました。』

フレッド『そうです。貴女達は決して恐がる必要はない。又誰にしたって恐がる必要りるんです。けれど世間の人は何たる馬鹿でせう。一寸、一年に一遍で善いから、醫者に診て貰って身体の中に何が起って居るか検べて貰いさえすりゃ、後でひどい苦みをせずに済むのです。いや、それば(イノチ)りじゃない、生命を捨てずとも済むのです。ところが中々そうしない。愚図々してて居て、結局身体が倦くなる、咳が出る、咳血をする、万事手遅れと言ふ事になるんです。……さあ今日の講習り此で終いっと。何がえらい喉が渇いた。』

ジェリー『うん。何か出さなくちゃ。』

伯母ビー『それより、コーヒーでもお飲みになりたいでせう』

フレッド『いや、兩方とも貰ふいます。(伯母ビーは扉の方へ立つ。)伯母さん。生姜(ショウガ)パーはありませんか。』

伯母ビー『合憎生姜パーはありませんけど、夕食の用意に鬼丸の様なオ菓子が作ってありますわ。……あゝジェリーさんジャーさん、丸つきり夕食の事を忘れてアーって何うしませう。チキーなんか書の二時頃かゝ煮つぱなしよ。』

フレッド『多分老いぼれの鶏(ニワトリ)で、丁度軟くなり始めたって所だよ。』

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伯母ビ『まあ、何時私が考へはれの鶏なんか買って。』

ジェリー『フレッド、汽車の時間は何時だい。』

フレッド『九時五十二分だ。』

ジェリー『未だ八時だ。』

伯母ビ『黒くなった方ビスケットも沢山ありますし、サラダも用意出来てありますよ。』

フレッド『それに鬼瓦のオ菓子。結構。（立ち上る）』

ジャ『野菜のお好きな方御座いません。』

ジェリー『そうだ、何も待つことは無いじゃないか。行かう。』

フレッド（伯母ビに腕を差し出しつゝ奥へ進む）『さあ、伯母上。』（伯母はフレッドの腕をとり、二人は中央から出て行く。）

ジェリー（ジャに腕を差し出し）『さあ、お嬢さん。』

ジャ（ジェリーの腕をとり、その上に頭をもたせ掛け彼を見て微笑する。）『私、幸せだわ。』（起ち上り、二人感気揚々と前の二人の後に従ふ。）

―幕―

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March - 28 - 1:30

March 31 — Thurs —

Shivakar — Theatre —

A.M — P.M

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News paper { Mainichi
Asahi
Kobe

P. T. a

Medical Association
" College

Comp. { Mitsubishi . Kawasaki
Daimaru — Department store
Sogō
Mitsukoshi "

Mayor { Kobe
Ashiya
Nishinomiya
Amagasaki

Baron Fujita

Hospital

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NO DOOR IS SHUT

by

ESTHER M. HAWLEY

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By Esther M. Hawley
American Theatre Wing War
Service, Inc.
730 Fifth Ave., New York 19, N.Y.

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~~Memo to: Mr. Pantz~~
~~Mr. Tinson~~ -
~~From: E. Cash~~

"No Door is Shut" - to be presented and sponsored by the Hyogo Branch of the Japanese Nurses and Midwives Association.

A group discussion is needed to formulate plans for the production of the play. The objectives in the presentation of the play are three-fold.

1. To present ot the general public in an interesting way basic TB health teachings.

2. To give to the Hyogo Branch of the Japanese Nurses and Midwives association some publicity through rendering a public service and thus stimulate their interest and efforts in improving and strengthening their association.

3. To include on our committee local Japanese health personnel so that they might in the future plan their own health education programs and learn to become an integral part of all health education presentations.

Some of the problems surroudning the presentation are:

1. What group of actors are best qualified and best suited for our purposes?

   1. Need actors who can give time and who will not be engaged in too many other professional activities. Therefore would professional group or a student group be better?

   2. Keep cost of production as low as possible. Since we cannot charge any admission fee cost must be raised through contributions or attempting to find a sponsor.

   3. Suggestion has been made that it might be possible to use the dramatic student group - from the Kan-sai Gakuin University Advantages - A. Cost Low
      B. Interest school group in health.

   A professional group will prove an expensive measure.

II. Need technical advisors:

   1. After plan organized - sanctioned by Legal Section to see that it conforms with copyright regulations.

   2. Need two technicians - one from M.G. office to see that pley comforms to ideas we want to convey. (I suggest Mr. Murata who is interested - and would like to be a part of this. He also translated play for us.) The other should be the theatrical director of the play group selected.

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III. Funds to be raised from Japanese Finance Committee - consist of both Japanese and Americans. One representative from the Nurses Association on this Committee.

1. Could have a pre-view of the play - with aim:

a. Get money through voluntary contribution.

b. Get public reaction to the play.

Pre-view if held - should be by letter invitation to wealthy Japanese and also press.

If sanctioned get name to-day. Nurses Association should write invitation.

2. Find individual sponsor.

IV. What will our (M.G.) role be after play is organized?

1. Stimulation

2. Guidance

V. Is it better to present play as an

1. American play?

2. Japanese play?

VI. We need cards with about three questions to evaluate the method. Formulate questions to-day.

COMMITTEE

Col. [illegible] -

Capt. Dickerson - M.G. Public Health Section

Mr. Paul)
Mr. Tieck) - M.G. Information Office.

Mr. Murata - M.G. Technical Advisor - (Legal Section)

Miss Colletti)
) - M.G. Education Section
Miss Adachi) Miss Colletti's interpreter, who is in TB. problem

Mr. Matsumoto - Ken - Information Office

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Dr. Tamaki - Chief, Ken Public Health Office

Dr. Watanabe - Director - Model Health Center

Miss Senga - Ken Chief Nursing Affairs

Mrs. Kuwahara - President Hyogo Branch Nurses Association.

_____ - Japanese Technical advisor - (Play group director)

_____ - Sponsor if decide or can find one?

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2-74

The Child-Health Conference

Suggestions for Organization and Procedure

UNITED STATES DEPARTMENT OF LABOR
CHILDREN'S BUREAU
Publication No. 261

DECLASSIFIED E.O. 12065 SECTION 3-402/NNDG NO. 775013

UNITED STATES DEPARTMENT OF LABOR

FRANCES PERKINS, Secretary

CHILDREN'S BUREAU • KATHARINE F. LENROOT, Chief

✦

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THE CHILD-HEALTH CONFERENCE

INTRODUCTION

Functions of Conference

The purposes of the child-health conference are to educate parents in better methods of child care and to provide or stimulate the provision of continuous health supervision for all children of the community from birth through school age. Being part of a broad public-health education program, the service of the child-health conference, particularly in rural areas, should be available to all parents whose children are not under the supervision of a private physician. *Its function is to keep the well child well and to promote his best possible state of health.*

The plan for the accomplishment of these purposes includes: (1) Review of the child's physical and mental health record and examination of the individual child by a physician at regular intervals; (2) the physician's conference with the mother, at which he discusses with her all aspects of the child's health and development, advising her regarding the child's special needs, including the correction of any abnormal conditions, the solution of behavior problems, and the performance of accepted immunization procedures; (3) service at the conference by the public-health nurse, and when feasible, although not necessarily at every conference, by nutritionist and dentist; and (4) follow-up service by the public-health nurse and, as needed, by other specialists such as the nutritionist, social worker, and child psychiatrist, when these workers are available.

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B. A district, county, city, or town having a health department with a part-time health officer and a public-health nurse, where a local voluntary agency or group of individuals takes the initiative in organizing and conducting the conference.

C. A district, county, city, or town having no organized health department but having a public-health nurse, where a local voluntary agency or group assumes responsibility for the conference.

A county or a community without a public-health nurse should not attempt to organize a child-health conference. Conferences without public-health-nursing follow-up service are of doubtful value.

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In communities where there are pediatricians or physicians giving special attention to pediatrics, their advice will be particularly helpful in the planning and their services should be obtained, if possible, to conduct the medical conferences.

B. In a district, county, city, or town having a health department with a part-time health officer and a public-health nurse, where a local voluntary agency or group of individuals takes the initiative in organizing and conducting the conference.

The realization of the need for the conference in such communities usually originates within the community. Whatever the origin of the initial action, the official county or local health department should be consulted early in the planning, and in turn the health department should give all possible assistance. Where the promotion is done by local groups, the public-health nurse usually provides leadership in organizing the conference, with the local health officer and local physicians represented on the organizing committee. The State department of health should be consulted regarding the assistance it can give.

When the health officer and local physicians are thoroughly familiar with the proposal and have agreed to give their support, a meeting of local groups representing the community to be served by the conference may be called for the purpose of discussing the need for the proposed conference, its functions, and the local resources and facilities available for its maintenance and operation. The nonofficial or voluntary agencies, including the local medical and dental associations, nursing groups, voluntary health and welfare groups, parent-teacher associations, men and women's civic and service clubs, churches, and other organized groups of citizens are invited to participate in the organization meeting. The local board of education should be represented. Local boards that are responsible for the expenditure of public funds for health and welfare are urged to attend, and the economy of providing services for health education and prevention of disease should be called to their attention. A careful inventory is taken of the assistance that can be given by each group represented.

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CORRECTION

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Community Responsibility for Child Health

While it is well recognized that the health of the individual child is the responsibility of his parents, parents must have an understanding of the fundamentals of child health in order to discharge that responsibility. In addition to the necessary knowledge they must have access to facilities for the protection and promotion of child health. Many parents have no way to acquire the needed knowledge of child care, nor have they access to the necessary health facilities except by means of provisions made through organized community resources.

The organization policy for the child-health conference should be to bring together in a cooperative community undertaking the public and private health, education, and welfare agencies that are interested in child health so as to eliminate duplication of expense and to develop unity of service.

Relation of Child-Health Conference to Local and State Health Departments

A child-health conference in a district, county, city, or town having a public-health department is developed as part of the local public-health program under the supervision of the local health officer. The State health department can assist also with organization and supervision through the professional staff of its maternal and child-health division and by provision of literature and exhibit material. The local health department or, if there is none, the local organizing group will obtain full information on the assistance that is available from the State department of health and take advantage of all it has to offer.

Local Situations Affecting the Organization of a Conference

In both rural and urban areas the various community situations that need to be considered when establishing a child-health conference are:

A. A district, county, city, or town having a well-developed health department with a full-time health officer, which assumes full administrative responsibility for the conference.

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B. A district, county, city, or town having a health department with a part-time health officer and a public-health nurse, where a local voluntary agency or group of individuals takes the initiative in organizing and conducting the conference.

C. A district, county, city, or town having no organized health department but having a public-health nurse, where a local voluntary agency or group assumes responsibility for the conference.

A county or a community without a public-health nurse should not attempt to organize a child-health conference. Conferences without public-health-nursing follow-up service are of doubtful value.

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ORGANIZING THE CONFERENCE

With conditions differing as they do in communities throughout the country, it would be impossible to offer suggestions for the organization of child-health conferences that would meet the requirements of all situations. It is the purpose of this outline to present the fundamental principles of the organization of a conference with suggestions for working them out in certain situations. The details of organization procedures in each locality will need to be developed according to the local requirements.

A. In a district, county, city, or town having a well-developed health department with a full-time health officer, which assumes full administrative responsibility for the conference.

A child-health conference in such a community is organized by the health department and conducted under its supervision. As it is a combined public-health, medical, and community undertaking, the cooperation of local physicians and the support of intelligent, interested, and representative community groups and individuals is necessary. To gain such support for their programs many health departments have developed community health councils which serve the needs of child-health conferences as a part of the whole health program. (See appendix A, p. 38.)

Where child-health conferences are being established for the first time, the health officer will probably wish first to discuss the proposition fully with the local physicians and gain their support for the undertaking. Where there is a community health council the matter would then be taken up with that group for the purpose of discussing the need for the proposed conference, its functions, and the local resources and facilities available for its maintenance and operation. In some cases it may be wise to have a subcommittee of the health council appointed to study the matter and assist the health officer with the details of organization and conduct of the conference.

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In communities where there are pediatricians or physicians giving special attention to pediatrics, their advice will be particularly helpful in the planning and their services should be obtained, if possible, to conduct the medical conferences.

B. In a district, county, city, or town having a health department with a part-time health officer and a public-health nurse, where a local voluntary agency or group of individuals takes the initiative in organizing and conducting the conference.

The realization of the need for the conference in such communities usually originates within the community. Whatever the origin of the initial action, the official county or local health department should be consulted early in the planning, and in turn the health department should give all possible assistance. Where the promotion is done by local groups, the public-health nurse usually provides leadership in organizing the conference, with the local health officer and local physicians represented on the organizing committee. The State department of health should be consulted regarding the assistance it can give.

When the health officer and local physicians are thoroughly familiar with the proposal and have agreed to give their support, a meeting of local groups representing the community to be served by the conference may be called for the purpose of discussing the need for the proposed conference, its functions, and the local resources and facilities available for its maintenance and operation. The nonofficial or voluntary agencies, including the local medical and dental associations, nursing groups, voluntary health and welfare groups, parent-teacher associations, men and women's civic and service clubs, churches, and other organized groups of citizens are invited to participate in the organization meeting. The local board of education should be represented. Local boards that are responsible for the expenditure of public funds for health and welfare are urged to attend, and the economy of providing services for health education and prevention of disease should be called to their attention. A careful inventory is taken of the assistance that can be given by each group represented.

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If the group agrees on the desirability of proceeding with the establishment of a conference, an organizing committee is appointed.

C. In a district, county, city, or town having no organized health department but having a public-health nurse, where a local voluntary agency or group assumes responsibility for the conference.

The procedure here would be similar to that described under *B*, except that there would be no health officer to assist. It is emphasized that where conferences are being organized by voluntary agencies, there is need for medical counsel all along the way.

Before the service is undertaken a local conference committee should be appointed by the sponsoring agency and the cooperation of local physicians should be assured.

For a discussion of the organization and functions of the local conference committee see appendix A, p. 38.

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THE CONFERENCE CENTER

In planning for a child-health conference, early consideration should be given to the conference center. In a county or community having an established health center or having available the office of the public-health department, the conference would naturally be held there if it is conveniently located for the majority of mothers who will bring their children. In larger communities a location convenient to families of low income is important. Communities of more than 10,000 population will need more than one conference center to give adequate service.

Certain minimum requirements for the conference are mandatory in even the smallest rural community; in the following pages *these requirements will be italicized*. Beyond this there can be such expansion as funds will allow for meeting further needs and providing additional conveniences.

In small communities a *centrally located place* is best for the conference center. Where possible, rooms on the ground floor are obtained, with facilities for *light*, *ventilation*, *heat*, running water or *convenient water supply*, and with windows and doors well screened in warm weather. *Safe drinking water and paper cups*, and a *toilet* which is in sanitary condition are essential. There should be no hazard to the safety of small children in or about the building. In a town where mothers will walk to the center, a protected space for baby carriages is needed.

Division of Space in Conference Center

Many types of quarters are used for conference centers, such as hospitals, schools, libraries, and clubrooms. Space and facilities for the conference will vary with the community to be served. When the attendance is too large to allow adequate service in small quarters, this difficulty can be met by holding conferences on two successive days or in two successive weeks, adhering in either event to a definite regular day and hour.

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It is desirable to have three rooms: one for a reception and waiting room; one for undressing, weighing, and measuring; and one for the physician's consultations. Where only two rooms are available, one of these may be divided by screens or a curtain. Similarly when a single large room must be used, some *privacy* for history taking, for weighing, and for the examination can be provided by means of screens or curtains. A quiet corner of the waiting room is selected for history taking, arranged so that the mother sits at one side of the nurse's table with her back to the waiting group; a screen will provide further privacy. This same corner can be used for the nurse's conference with the mother.

The rooms used for undressing and examination should be provided with *heat* and, if possible, with running water, and the room in which immunizations are done must have *means for sterilizing equipment*.

Preparation of Conference Center

Well before the time for the conference to open, the rooms are made ready for use. In cold weather the waiting room is kept at a temperature of 70° to 72° F. and the weighing and measuring room and the consultation room at about 74° to 76° F. It is important to arrange ventilation throughout so as to avoid drafts. The nurse will make a final inspection of each room and of all equipment to be sure that everything is in its place and ready for use.

The conference rooms are made as inviting and attractive as possible. Clean light-colored walls, bright-patterned curtains, and suitable posters (see appendix B, p. 42) help to accomplish this. Needless to say the rooms are kept clean and in good order at all times.

Reception and Waiting Room

Room is needed to seat comfortably as many adults and small children as are expected to be present at one time, with space also for a desk and two tables.

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Equipment (Essentials are in *italic*)

A desk or writing table for use in taking histories; blotter, pen, ink, pencils, paper clips, and scratch pad.

Record file for conference cases. This may be only a box or other small compartment for keeping records.

Infant and preschool record forms.

Telephone.

A table for exhibit material.

Chairs or benches.

Several small chairs, a low table, and large washable toys for children.

Hooks on the wall for wraps.

Clock, wall thermometer, and wastebasket.

A blackboard for teaching purposes.

Educational Material.

Exhibits.

Excellent use can be made of good exhibit material, and this phase of the conference service is worth considerable thought. The material could be made up by local groups under the direction of the public-health nurse. It might include demonstration material pertaining to both mothers and children.

For the baby.—A layette, utensils used in preparing milk formulas, approved infant garments, bath equipment, a miniature baby bed, display of foods for children of various ages.

For the child of preschool age.—Proper clothing, toys, especially home-made toys, and appropriate picture books.

For the mother.—Approved garments for the expectant mother, obstetric supplies, a miniature obstetric bed, and display of foods for the expectant mother.

To be most effective, an exhibit is limited to a single subject, a new exhibit being shown, if possible, at each conference session. For example, one exhibit might include the utensils used in preparation of milk formulas; another exhibit might be clothing appropriate to the season, such as winter clothing for the baby and the child of preschool age, out-of-door play suits, and clothing for the baby's out-of-door nap in cold weather; or foods needed for an adequate diet during pregnancy or during the preschool age.

All exhibit materials should be clearly labeled and kept fresh and clean. It is important to make all exhibits *practical* for the group to be served. Some State health departments have exhibits for loan.

Posters.—The best obtainable posters on maternal and child-health subjects should be procured. (For suggestions see appendix B, p. 42.)

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Literature.

A supply of *all the literature pertaining to maternal and child health* distributed by the State department of health should be available. The Children's Bureau, U. S. Department of Labor, Washington, D. C., will supply lists of its publications, some of which can be obtained without charge. These publications are not to be placed where they can be taken indiscriminately; they are given out by the nurse to provide information on specific questions. It is important to have literature printed in the language spoken by groups attending the conference.

Play Space for Children.

When a very large room is available, a good play space for little children can be made in the center or in one corner of the room by placing chairs or benches together facing outward. These seats can be used by the mothers if desired. The play space may contain a low table, small chairs, and toys. Noisy toys are best avoided. Where a trained play supervisor is available she could be helpful in demonstrating the proper handling of children.

Weighing and Measuring Room

It is convenient to have the weighing and measuring room between the waiting room and the physician's room. A space of about 8 feet by 10 feet is needed, *well lighted and ventilated, heated in cold weather, and free from drafts.*

Equipment (Essentials are in *italic*).

Closet or wall cabinet for supplies.

A *table* about 60 inches by 30 inches, or 2 smaller tables for scales and measuring board.

Two tables for the convenience of the mothers in undressing and dressing the babies, *or*

A shelf about 30 inches deep by 48 inches long, with ends about 12 inches high, and divided into two equal compartments by a partition of the same height. This makes a convenient arrangement for undressing and dressing the baby. Two such shelves would be adequate for both undressing and dressing. Similar cubicles with a back the height of the partition can be made by a carpenter to fit over the top of a kitchen table. These have the advantage of being portable.

Baby scales.—Balance platform type.

Measuring board or *stationary tape measure* on the table.

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Standard platform *scales* and *measuring rod* for older children. In case there is no measuring rod on the scales a metal tape line secured straight and flat against the wall will serve. It should be attached at a point where there is no molding at the contact angle of wall and floor.

A desk or small table for use in recording; pen, ink, pencils, and scratch pad.

Clinical thermometer.

Four chairs.

Wall thermometer.

Wastebasket or pillowcase on chair back or large paper bag for paper that has been used on the scales.

Supplies (Essentials are in *italic*).

Pads about 16 inches by 30 inches for measuring and dressing tables with rubber sheeting or oilcloth slip cover for each.[1]

Several baby blankets for mothers who may come unprepared.

Scale paper,[2] *soft paper towels, or sheets of tissue paper for baby scales, measuring board, and dressing and undressing tables.*

Safety pins.

Baskets, shopping bags, or large paper bags for carrying clothing while child is undressed. Mothers ordinarily should supply their own.

Physician's Consultation Room

Minimum size of room needed is about 6 feet by 8 feet. *Good light* (natural light if possible) and *heat* in winter are essential.

Equipment (Essentials are in *italic*).

Examining table. A shelf underneath is a convenience.

Steel *tape measure, otoscope, stethoscope, flashlight,* and percussion hammer if not provided by physician. An extra battery for the flashlight should be on hand.

Table for trays, and for pen, ink, *pencils,* laboratory blanks, scratch pad, *sample diet lists, leaflets, and literature,* and printed or typed instructions for mothers.

Posture charts.

Samples of proper shoes for infant and preschool child.

Chairs.

[1] Made like pillowcasing and left open at both ends. This has the advantage of completely covering the pad and it will not slip out of place on the table.

[2] Paper that has been sized so as to be semiresistant to moisture, such as the paper used by retail meat dealers.

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Blanks for report to family physician or specialist or to clinic if family has no regular physician, on abnormal conditions found on examination.

Bowl with hot and cold running *water*. If this is not available, *a basin and pitcher*, *hot plate* for heating water, and *pail* for waste water. *Soap*.

Closet or wall cabinet with lock for supplies.

Wall thermometer.

Wastebasket or large paper bag for waste.

Supplies (Essentials are in *italic*)

Pad, *or blanket*, about 16 inches by 30 inches, for examining table, with rubber sheeting or oilcloth slip cover.

Scale paper, *soft paper towels*, or *sheets of tissue paper* for examining table.

Specimen bottles.

Tray containing—

- Small-size *tongue depressors*.
- Throat swabs.
- Glass slides.
- Gauze sponges in jar.
- *Cotton sponges* in jar.
- Roll 3-inch *adhesive tape*.
- Roll sterile 2-inch *gauze bandage*.
- Blunt-pointed *scissors*.
- Alcohol.
- *Tube of petroleum jelly*.
- *Silver-nitrate pencil*.

Immunization and venapuncture equipment and supplies:

Sterilizer or *basin for boiling syringes and needles*.

Tray containing—

- *Tuberculin-test material*.[3]
- *Smallpox vaccine*.[3]
- *Diphtheria toxoid*.[3]
- Wassermann tubes.
- *Syringes*, two 2-cc., marked for ½-cc. doses.
- *Syringes*, two 2-cc., marked for 0.1-cc. doses, one of which is kept for tuberculin tests only.
- Syringe, 10-cc.
- *Needles*, 1 dozen ½-inch 26 or 27 gauge.
- Needles suitable for venapuncture.
- *Forceps*, straight, 8-inch, 2 pairs.
- Iodine, 3-percent solution.
- *Alcohol* or *acetone*.

[3] These must be kept in a refrigerator between conferences.

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Green soap.
Cotton.
Applicators.
Spirits of ammonia.
Sterile towels.
Tourniquet.

(The articles provided for the immunization tray need not be duplicated on the regular tray for the examining table.)

Equipment for urinalysis:

Test tubes.	10-percent acetic-acid solution.
Test-tube rack.	Blue litmus paper.
Test-tube holder.	Red litmus paper.
Test-tube cleaner.	Alcohol lamp.
Urinometer.	Benedict's solution, qualitative.

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REGULARITY AND FREQUENCY OF CONFERENCES

The primary aim of the conference is to *provide continuous health supervision for the child.* In order to do this it is considered that a regular schedule is essential—weekly, biweekly, or monthly, depending on the size of the community and the attendance at the conferences. It is important to set a definite day and hour for the conference—for example, the first and third Wednesdays of each month at 2 p. m.—and adhere to the schedule. When conferences cannot be arranged for throughout the year they are planned for as much of the year as is feasible.

In some areas annual itinerant conferences are held. Conferences held as infrequently as this, or even those held twice a year, do not meet the requirements of general health supervision. They do, however, serve to demonstrate the need for and value of such service, and to call the attention of parents to abnormal conditions and give them some information on child care in general. For these reasons they are considered worth while, even though far from adequate.

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APPOINTMENTS FOR EXAMINATION

The advantage of appointments for examination is unquestioned and in most places they have been found feasible even in rural areas.

When making appointments the hour as well as the day is specified. As a rule it has been found best to schedule new cases and the more urgent cases first. An appointment for a new patient is given for about an hour before the time when the child will be seen by the physician. For example, when the conference is scheduled to begin at 2 o'clock, the first appointment would be made for 1 o'clock. This allows time for the child's history to be recorded and the height, weight, and temperature to be taken, so that no time will be lost by the physician between his consultations with mothers. Since taking the history of a new patient, or of several children of one mother, requires considerable time, it is a good plan to schedule ahead of new patients, one or two children who are making revisits. Having all in readiness beforehand gives the public-health nurse more opportunity to be present at the physician's conference with the mother; her presence is desirable although not always possible.

There is a tendency in some communities to make the child-health conference a social occasion, the mothers congregating early and staying until the last examination has been finished. This custom provides good opportunities for group instruction. It has disadvantages, however, particularly in winter, when colds are prevalent and rooms may be poorly ventilated; but even this situation could be utilized for health education, such as teaching the mothers the needed precautions against transmission of colds.

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THE CONFERENCE STAFF

The minimum conference staff includes the physician, the public-health nurse, and from one to three volunteer helpers to work in the reception room, the weighing and measuring room, and, if desired, the physician's room.

When available and where facilities permit the services of a nutritionist, a dentist, and a social worker, especially in the capacity of advisers and consultants to the medical and nursing staff, add to the completeness of the conference service. These special consultants need not all be present at each conference. When any are present additional room is necessary so as to avoid confusion.

The conference staff should keep in mind always that the purpose of the conference is to serve the individual mother and child. To do this best, it must make all service as considerate and prompt as possible; each mother is made to feel that her individual problems are being given careful consideration and she is given such satisfactory service that she will wish to return and will influence other mothers to come for similar service.

Such things as a friendly reception, assistance in disposing of wraps and in finding a place to sit while waiting, a simple explanation by the nurse of conference procedure and especially of the need for the information asked in taking the history, aid greatly in the psychological preparation of the mothers. Likewise a quiet understanding manner on the part of all conference workers in handling the children not only will do much to help overcome apprehension on the part of the children but is an excellent demonstration for the mothers.

The Public-Health Nurse

The effectiveness of a child-health conference depends in large measure upon the services of the public-health nurse. The quality of her services, in turn, depends upon her qualifications for public-health nursing in the field of child health.

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In most communities the public-health nurse, because of her acquaintance with many families through her general health services, will know of the children in need of conference service and will refer the parents to the conference.

Because of her knowledge of the health, economic, and social conditions of the family, the public-health nurse can at the time of the conference supplement the information of the doctor. At the same time she can interpret to the parents, in terms of their particular home situation, the medical, dental, and nutritional advice given at the conference and will show them how they can put it into practice.

Although the efficient management and smooth operation of the conference are a responsibility of the public-health nurse, they are only a part of her larger responsibility of making sure that the educational potentialities of each conference are fully realized for each mother. Efficient management is important because it facilitates the creation and utilization of opportunities for teaching by public-health nurses, as well as by other members of the professional staff.

The number and types of services performed by the public-health nurse at the child-health conference are influenced by the physical arrangements of the conference, the number of public-health nurses present, and the number of other types of workers assisting. As the most important services for her to perform are those that contribute most to the educational value of the conference, the duties of the public-health nurse may be summarized as follows:

General management of the conference.

Taking part of the histories of newly admitted children. (This may be done in the home before the conference takes place.)

Conferring with the mother before she sees the physician.

Observing signs of illness of children as they come to the conference and isolating or excluding them as indicated.

Instructing and supervising volunteer aids in the performance of their nonprofessional duties.

Carrying on individual or group instruction or demonstrations of exhibit materials for waiting parents.

Introducing to the physician the mothers and children who come to the conference for the first time.

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Discussing with the physician any facts related to the progress being made or to home conditions.

Being present, whenever possible, during the physician's conference with the mother.

Conferring with the mother before she leaves the conference concerning the recommendations of the physician, to give her an appointment for her next visit to the conference, to determine whether or not her questions have been satisfactorily answered, and, if indicated, to make an appointment for a home visit.

If indicated, referring parents to other community agencies, such as hospital, clinic, welfare agency, school, or private physician.

Participating in joint conferences of professional staff following the conference to review recommendations and plan jointly for carrying them out.

Seeing that individual service records and activity reports for each conference are complete.

Probably the most important function of the public-health nurse is further to interpret medical advice and to give practical help to the parents in carrying it out by means of visits to the home. This type of individualized health service is a necessary supplement to the service of the child-health conference and an effective method of health teaching.

The number of the public-health nurse's visits to the home and the intervals between them are governed by circumstances such as the intelligence and cooperativeness of the parents, the condition of the child, the economic and social conditions in the home, regularity of attendance at the conference, and the progress being made in carrying out the medical recommendations.

The medical examination at the child-health conference can be regarded as the incentive for continuous health supervision of the child, to which the public-health nurse contributes in other environments and in other ways.

The Volunteer Helpers

Volunteer helpers not only give valuable service in the conference by releasing the nurse from the more routine work so that she may confer with individual mothers but widen the interest in and understanding of the work in the community.

These helpers are selected for their intelligence, dependability, and interest in child-health work. *They must be*

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impressed with the need for guarding honorably all information of a personal nature that is acquired in connection with the conference. It is important that they refrain from giving advice to mothers from their own experience. It would be helpful if volunteers could be found who had had some special training pertinent to the functions of the child-health conference, such as nurses, nutritionists, nursery-school workers, laboratory technicians, social workers, or teachers. It is important to have a substitute for each volunteer.

The volunteer staff is under the direction and supervision of the public-health nurse. Each helper must be individually instructed in the duties she is to perform. Group instruction also may be given and conferences held with the volunteer staff for the purpose of improving individual efficiency and developing teamwork.

When possible without hardship, volunteers might wear simple smocks to identify them as members of the conference staff. Superfluous jewelry should not be worn.

All volunteers will be at the center ready for duty at least half an hour before the conference is scheduled to start. *When one cannot be present she will arrange to have her substitute attend and will notify the nurse in charge.*

One volunteer may be made responsible for opening the center and seeing that it is properly heated and ventilated before the scheduled time for the conference to start. This duty might be rotated among the volunteers.

At the close of a conference each volunteer sees that the equipment in her department is properly cared for; that the paper towels and other waste are disposed of; and that everything is left in good order.

The Conference Physician

Choosing the physician is a matter of particular importance. The success of the conference will depend to a large extent upon the qualifications of the physician in charge. A pediatrician is chosen when at all possible. When a pediatrician is not available an endeavor is made to procure a physician having special training in child-health work. If no such physician is available in the community, the State health department

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may be requested to assist an interested local physician to acquire the necessary experience in conference work. It may be possible to enlist the aid of a pediatrician to act as consultant to the regular conference physician and to conduct demonstration conferences from time to time for local physicians to observe. It is advantageous to have a pediatrician or a physician who has shown an interest in the public-health phases of pediatrics or in general public health, and who has the confidence of the community. In some areas it will be necessary for the health officer to do the work. It is important to have the same physician serve regularly at the conference.

A substitute physician also is chosen having the same qualifications, if possible, as the regular conference physician. *An agreement is made with the regular physician that he will arrange for the substitute physician to attend the conference when he cannot be present and that he will notify the nurse whenever this is necessary.*

Rotation of conference physicians is not conducive to satisfactory service and is done only where there are several qualified physicians in the community who wish to serve. In this case arrangements are made for each physician to serve for at least 6 months and preferably longer. There should be continuity of service of the conference physician and *he should be paid a stipulated fee for his services.* The fee may be determined by the administrative agency and the local medical society.

The Duties of the Conference Physician.[4]

The physician is the medical director of the conference, and his attitude toward parents and children and the type of service he renders make for the success or failure of the conference. It is important that he be present at the hour appointed for the beginning of the conference; otherwise the consultations and examinations must be hurried and the entire plan of work disturbed.

He will wear a washable gown or coat while making examinations and *wash his hands before the examination of each child.*

The physician reads the child's record before the child is brought to the consultation room. When mother and child

[4] Objectives and Techniques for Conducting Child-Health Conferences, by Amos Christie, M. D., Department of Pediatrics, University of California, San Francisco. Reprints are available without charge from the Children's Bureau, U. S. Department of Labor, Washington, D. C.

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enter, a kindly greeting helps to put both at ease. It is important for the physician to make the mother feel that he is interested in assisting her with her child-care problems.

The Medical History.

A good medical history is essential, and the physician will need to obtain this, although he may assign to the nurse the responsibility of assisting. The value of the advice given by the physician to the mother at the child-health conference probably depends as much upon his obtaining a satisfactory medical history as upon his examination of the child. Aside from obtaining specific data regarding the child's background, which physician and nurse must know, *they will find out what the mother considers to be her problems regarding the child and the points on which she wants help.*

It frequently happens that the physician in charge of the conference is so occupied with the examination of the child and with entering notes on the record that he overlooks giving the mother an opportunity to talk. After the physician has obtained from the mother the desired information on the child's history, it may be a good plan for him to ask the mother: "Now what do you want to tell me?", giving her a chance to relieve her mind and at the same time furnish clues for further questions pertinent to the individual case. The physician will be careful in his questioning not to suggest the proper answers. The taking of the history offers an excellent opportunity for teaching by both physician and nurse.

Getting Acquainted With the Child.

With the little child who is attending the conference for the first time and to whom the procedure is new and strange, the physician needs to make friends. If the child is apprehensive, timid, or shy, it may be well not to pay too much attention to him at the start but to talk with the mother regarding the more general phases of the child's history, perhaps handing a toy to the child and giving him opportunity to orient himself and become more at ease. He should be approached quietly and gently. It strengthens the older child's confidence in the physician if the physician explains honestly to him any

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unfamiliar or disagreeable procedure that is necessary. Never tell a child a procedure will not hurt if it will.

The Physical Examination—Appraisal of the Child.[5] [6]

At least 15 minutes is required for a satisfactory examination of the child and conference with the mother. New cases, of course, will require longer.

In making the examination it is important to keep in mind the picture of a normal healthy child—not merely the "average" but the child who is in an optimal state of health. With a standard of excellence in mind and a knowledge of the fundamentals of nutrition and of mental hygiene, the physician is able to give advice to the parent that will help toward the attainment of optimal mental and physical health for each child.[7]

Both the infant and the older child are completely undressed for the examination and for subsequent inspections. There is probably nothing that will so impress the parent as to see the physician make a thorough examination. Time must be taken for details, and the physician should not be nor appear to be hurried. It is well to bear in mind the educational as well as the inherent value of strict adherence to cleanliness throughout the examination and of aseptic technique where this is indicated.

> The order of procedure in examining a child varies with the child's age and disposition. One cannot proceed in a stereotyped course, as is possible with the adult. One must pick and feel one's way, starting generally with the things that are not unpleasant and gradually, as the child's confidence is established, passing on to things that are more unpleasant or more dreaded. The throat is nearly always best left until the last unless there is something still more unpleasant, except in the case of the older child who knows that the ordeal is inevitable and wants it over with. (See footnote 6, below.)

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[5] The Appraisal of the Newborn Infant, by Ethel C. Dunham, M. D., Director, Division of Research in Child Development, Children's Bureau. Single copies available without charge from the Children's Bureau, Washington, D. C.

[6] Examination of the Child in the Practice of Pediatrics, by Joseph Brenneman, M. D., vol. 1, ch. 19.

[7] Signs of Health in Childhood. National Education Association, 1201 Sixteenth Street NW., Washington, D. C. 20 cents per copy.

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The *general appearance* should be noted, alertness, state of nutrition, color of mucous membranes and skin, posture, gait, responsiveness, and activity.

A child in good *mental health* is alert, with a happy expression, and is interested in his surroundings. There is a very close relationship between bodily and mental health which cannot be too strongly emphasized. In order to be able to appraise a child's mental status, the physician must be familiar with the psychological aspects of child development.[8]

Optimum nutrition is evidenced by smooth, clear, and elastic skin; good color of the mucous membranes; sound teeth; firm but not superfluous subcutaneous fat; muscles that are well developed and firm. To determine the amount and turgor of the fat and muscles the physician should feel the tissues of the upper arm, the abdomen, and the calves or thighs. The muscles should be felt relaxed as well as under tension.

Weight should be suitable to body build. A number of years ago there developed a practice of judging a child's state of nutrition by comparing his height and weight with tables giving average heights and weights of children of his age. It has been generally accepted that this is not a reliable method of judging nutrition because in the compilation of the height-weight-age tables, no consideration was given to the variations in type of body build. For example, a child having a large bony frame might compare favorably in height and weight with the average given in the tables for children of his age, but, having small amounts of muscle and subcutaneous fat, he might be much undernourished. Another child having a small bony frame might weigh considerably less than the average for children of his height and age and yet, having well-developed muscles and subcutaneous fat, he might be in an excellent state of nutrition. For these reasons the height-weight-age relationship should not be the basis of judgment of nutritional state. The picture of the whole child is taken

[8] Child Management, Are You Training Your Child To Be Happy?, Habit Clinics for Child Guidance, The Child From One to Six—His Care and Training, pp. 1–5 (Pubs. 143, 202, 135, and 30, Children's Bureau, U. S. Department of Labor, Washington, D. C.).

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into consideration. Satisfactory *gain in weight* is an important evidence of good nutrition.

Good Posture.—Signs of good posture are—

Level *shoulders*.

Flat *scapulae*.

Spine free from abnormal curves.

Head held erect with chin level.

Symmetrical *chest*, with equal expansion on both sides during respiration.

Abdomen, protruding slightly in children up to about 5 years of age but in line with the chest in older children.

Legs neither bowed outward nor with knees inclined inward.

Inner and outer sides of *ankles* equally prominent; the inner not projecting as when the arches of the feet are weak.

Feet strong and flexible; inner borders straight from heel to tip of great toe. The feet are normally flat in the infant and very young child, but the arches should develop after the child begins to walk. The arches of some children are normally higher than those of others.

Head.—Scalp clean and free from scaling or signs of irritation. The anterior fontanel is usually closed before the child is 15 months old.

Eyes are bright and clear, lid slits equal, movements coordinated, and pupils equal. Obvious defects in vision and muscle balance may be detected in the conference. Such cases and those in which any abnormalities are suspected should be referred to an ophthalmologist. (For a discussion of screening tests see p. 34.)

Mouth with smooth and pink *mucous membranes; teeth* that are well formed, well enameled, clean and even, free from cavities or with cavities properly filled, with good occlusion (the grinding surfaces of the bicuspids and molars meeting directly, the upper incisors and canines slightly overlapping the lower). This inspection will of course not take the place of an examination by a dentist.

Tonsils.—Large tonsils are not necessarily abnormal unless they cause obstruction to breathing and swallowing or give evidence of acute or chronic infection.

Ears.—Canals clear; drums showing well-defined light reflexes and other landmarks. Obvious hearing defects may be detected in the conference, and such cases and those in which any abnormalities are suspected should be referred to an otologist. (For a discussion of hearing testing see p. 34.)

Nose unobstructed, free from discharge, septum in the midline; mucous membrane pink and moist.

Thyroid gland.—Not enlarged.

Cervical lymph nodes.—Not enlarged or tender on palpation.

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Heart.—Satisfactory examination of the heart can be made only when the child is quiet. The heart rate is normally more rapid in a child than in the adult, and there is greater variability of rate with activity. A murmur is not necessarily evidence of a pathological condition, but it is an indication for careful examination and medical supervision.

Lungs resonant to percussion and clear to auscultation.

Abdomen flat and soft when the child is reclining, with no enlargement of the viscera. When the head is lifted the abdominal muscles normally become tense without midline separation or bulging. Likewise, there is normally no bulging in the inguinal region when the child stands or coughs.

Umbilicus should be healed and dry when the infant is 3 weeks of age. There is normally no herniation.

Genitals:

Female—clean and free from discharge and signs of irritation.

Male—clean, foreskin easily retractible, testicles descended.

In addition to the attributes of positive health outlined above, the physician obviously should search for the recognized evidences of physical abnormality. Many abnormal conditions such as glandular dyscrasias, nutritional disorders, allergic diseases, and mental retardation make their appearance during infancy and early childhood. Their early recognition and advice as to the steps necessary for early correction are important functions of health supervision.

See also Examinations, immunizations, and tests needed (p. 34).

The Conference With the Mother.

The physician's responsibility does not end with the making of the examination. While it is essential to have the best possible physical examination, this alone does the child no good. If it is to be of value, the mother must be informed of the findings and of better ways of caring for the child so as to *promote his optimal mental and physical health.*

Mothers of infants and young children need some general principles to guide them in everything they do with or for their children. These include not only matters pertaining to physical health but also principles of mental health. These

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principles need to become part and parcel of health-guidance work. It is not logical that parents receive only medical guidance from the physician, and receive their guidance in forming attitudes and habits of everyday living from a psychologist or, as is more usual, from grandmothers and the neighbors. Emotions and physiological functioning are too closely interrelated to permit this division of responsibility. An important causal factor in producing the "below-par" child is frequently found to be the parents' inability to cope with either their own emotional disturbances or those of their children. Under these circumstances good health habits cannot be developed.

For these reasons, in the best health supervision time and thought will be devoted to the psychological aspects of child development as well as to the physical aspects.

The physician in making recommendations, particularly with reference to diet, will keep in mind the economic status of the family and avoid recommendations which the family will be unable to follow. To make effective his advice, the physician needs to have the confidence of mother and child. A kindly attitude and genuine interest in their problems will rapidly build confidence. Care needs to be taken not to overburden a mother with too much advice at one time. It is often better to stress one thing at a time and to take up other matters at later visits. Most mothers who come to the child-health conference are eager to learn better ways of caring for their children and are perfectly capable of making good use of the advice given by the physician. The child may, if desired, be excused from the consultation room during this conference. Care should be taken not to discuss the child's behavior in his presence. When possible, it is very desirable that the public-health nurse who is responsible for the conference follow-up service be present, although when the physician and nurse have learned to work together the physician's notes on the child's record will usually give the nurse sufficient information for her conference with the mother.

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The physician's conference with the mother will include information on—

a. The child's general condition.

b. Any deviations from normal, with recommendations for correction and referral to a private physician, or to the proper public agency for the family in the low-income group. Every effort should be made to find means for correction.

c. The relationship of daily habits to the health of the child and the importance of establishing from the beginning proper habits of—

(1) Taking food.
(2) Sleep and rest.
(3) Elimination.
(4) Cleanliness.
(5) Exercise and play.
(6) Emotional control.
(7) Social habits.

d. The prevention or overcoming of undesirable habits—thumb sucking, bed wetting, and temper tantrums, masturbation, and so forth, as the need for such information occurs.[9] [10]

e. The management of breast feeding.

f. The need for proper preparation of food and the addition of certain foods to the diet at certain ages. It is important for the physician to keep in mind the economic status of the family and avoid making recommendations the family will be unable to follow.

g. The importance of *satisfactory gain in weight.*

h. The need for immunization against diphtheria and smallpox for all children and against other diseases in special cases.

The physician will indicate clearly when the child is to be brought again to the conference. The date will be entered on the appointment record and also on a slip which is given to the mother.

Printed Material as an Aid to the Physician's Conference With the Mother.

It is very helpful both to the conference staff and to the mothers attending to have approved information and directions on certain subjects in printed or mimeographed form. Paper of different colors may be used for different subjects if desired. The purpose of this is to supplement, *but not to take the place of*, the physician's or the nurse's explanation, and to give the mother the material to refer to when necessary.

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[9] See footnote 8, p. 23.

[10] The Psychological Aspects of Pediatric Practice, Benj. Spook, M. D., and Mabel Huschka, M. D. New York State Committee on Mental Hygiene of the State Charities Aid Association 105 East Twenty-second Street, New York, N. Y. 25 cents.

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Such instructions are written in very simple terms. Many subjects might be treated in this way, such as—

Breast feeding.
Food for the nursing mother.
Routines for the care of the child at various ages.
Preparation of the milk formula.
Bathing the baby.
Directions for laundering diapers.
Sleep, exercise, and play.
The need for cod-liver oil and directions for giving it.
The need for sunshine and directions for giving sun baths.
The care of the baby in summer.
Prevention of digestive disturbances.
Prevention of colds.
The baby's teeth.
Weaning the baby.
Bowel and bladder control.
The importance of immunization against smallpox and diphtheria.
Forming good eating habits.
Low-cost nourishing foods.
Playthings for the little child.
Common communicable diseases.
Enuresis.
Thumb sucking.

Source material on these and other subjects can be obtained from State departments of health, and from the United States Children's Bureau and the United States Department of Agriculture, Washington, D. C.

The Nutritionist

A nutritionist can add to the effectiveness of a conference in a number of ways. She may supply simple posters, food models, and other devices for teaching the waiting mothers. She may be able to furnish or to suggest sources of printed material on low-cost foods for families with young children. A nutrition consultant on the State health-department staff can often interest local nutrition workers (county home demonstration agents, home-economics teachers, and others) to give volunteer service at child-health conferences. She can also give them supplementary training for this new activity.

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If a nutrition worker in the community can attend conferences regularly, she can instruct both individuals and groups. If someone is present to entertain the children the mothers are free to listen to a short talk on low-cost foods, preferably accompanied by a demonstration of the preparation of some simple, nourishing dish. If there is no time that can be set aside for teaching the entire group, the nutritionist can carry on a continuous demonstration for small groups of mothers waiting for their turn with the physician.

The physician and the dentist will find that some mothers need detailed instruction in how to carry out the dietary recommendations noted on the record. Much of this instruction will be given by the nurse as she explains also other recommendations of the physician and the dentist. A nutritionist can observe the nurse's instruction of the mother, so that she may know the points that should be stressed in her staff-education work with nurses. She can also confer with mothers in the presence of the nurse as a demonstration of how to teach them to make the most of the money they have to spend for food. Following the conference, the nutritionist can go over with the nurse special food and budget problems that can be worked on during the nurse's visits to the homes of families represented at the conference.

The Dentist

A dentist who has had special training or experience in children's dentistry and is interested in teaching dental health would contribute to the value of the conference service. In some localities dental hygienists serve in conferences. Consultation between physician and dentist regarding dental conditions affecting the child's health is obviously desirable.

A separate room or partitioned space is needed for the dentist's work. As equipment he will need dental explorers and mirror, which he will usually supply, a small sterilizer, paper towels, a small table, and chairs.

Plenty of time should be allowed for the dentist to become acquainted with the child. He will explain to the mother the need for regular dental supervision, corrective procedures, and prophylactic measures.

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A summary of the dental findings and recommendations is entered on the child's conference record.

The Social Worker

The public-health nurse and the physician will often find social problems that make it difficult for a mother to care properly for her child. It is important that the services of the local social worker be utilized to the fullest extent in dealing with these problems. In some instances it would be helpful to ask the local social worker to come to the conference from time to time to receive and to give reports and discuss these problems with the physician and the nurse. In rural areas, particularly where the functions of the social worker are not fully understood, there would be advantages in introducing her at the conference to families needing help.

Plans for assisting the family will be made jointly by the public-health nurse and the social worker, and they will confer with each other as frequently as seems necessary between the conferences in regard to the families receiving social care. Significant social reports should be summarized on the child's chart.

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PROCEDURE FOR MOTHER AND CHILD VISITING THE CONFERENCE

When a mother attending the conference for the first time is not acquainted with the conference staff, the person in charge of each department will be careful to introduce to her the person in charge of the next department when she is received there.

In the Reception and Waiting Room

a. The hostess, usually a volunteer worker, who has been previously instructed, should be on the alert for signs of obvious illness in infants as they are received. As she greets a mother and perhaps assists her to remove her wraps, she has an opportunity to observe the child for possible signs of illness. If any are noticed, the mother is questioned regarding the child's condition and is requested to occupy a place apart from others who may be present. The doctor and nurse are notified, and the doctor will see the sick child immediately. If the case appears to be of an infectious nature, the child is usually dismissed immediately from the conference. But if conditions are such that the mother is unable to take the child away at the moment every effort is made to isolate the child as completely as possible while arrangements are made for suitable care. The method of providing for isolation will be determined by the physician and nurse, depending upon the facilities of the individual center.

When a child appears to the hostess to be well, the mother is taken to the admission desk.

b. Identification data such as date, names of child and parents, and address are obtained and identification numbers are assigned. In most conferences the person acting as hostess obtains this information. The mother is then referred to the nurse, who takes the part of the history delegated to her unless this has been done at a previous home or office visit.

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In the Weighing and Measuring Room

There may be a volunteer helper in this room to weigh and measure the children and to enter the weight and height on the record cards. When there is available a volunteer helper who has had nursing training, she might well be assigned to weigh and measure the children. It is a good plan to utilize this opportunity to teach the mother how to weigh and measure her child.

The weighing and measuring should be done promptly so that the physician does not have to lose time between examinations. However, after children are undressed, long waiting, which causes restlessness and apprehension, is to be avoided.

To be of value the weight and height must be *measured and recorded accurately*. Incorrect measurements may be harmful by causing anxiety on account of a supposed failure of the child to grow in height or gain in weight, or by creating a false sense of security in the belief that the child has grown or gained when he has not. Great care should be taken to see that each measurement is correctly taken and correctly recorded. To facilitate this the scales and measuring board should be placed where the light is good. The scales should be checked for balance between weighings.

A fresh sheet of scale paper or paper towel is used for each child on the scale pan, on the measuring board, on the platform scale, and on the undressing and dressing tables.

While the child is still on the measuring table it is a good plan to take his temperature. Although single isolated temperature recordings are of doubtful value in themselves, the taking of the temperature at the conference affords a valuable opportunity to teach the mother this procedure. It certainly should be done if the child appears ill.

After being weighed and measured the child is not dressed before the examination but should be adequately covered with the small blanket which the mother brings. The child who walks may put on his shoes after being weighed. The diaper should be replaced on the infant.

For children who object to complete undressing, lightweight underwear, shorts, bloomers, or sunsuits may be left

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on. Their weight is negligible. Infants, however, should be entirely undressed for weighing.

In the Consultation Room

Each child coming to the conference for the first time should be given a complete examination. In places where the appointment system is in use every effort will be made to keep to schedule. This will call for careful planning and for limiting the number of appointments. If a mother comes in without an appointment, an effort should be made to accommodate her. If she cannot wait, an appointment may be made for a later date and an opportunity given for an interview with the nurse, who will consider the advisability of a home visit and perhaps give the mother some appropriate literature.

A thorough physical examination of a child, allowing opportunity for the mother's questions and for discussion and instruction, requires time (15 to 20 minutes) to be effective and should not be hurried. Obviously less time is required for children coming to be weighed, measured, and inspected after having had a recent complete examination.

Immunizations or any other procedures which are particularly unpleasant or painful are best deferred until after the completion of the examination and the conference with the mother. There is real advantage in allowing a crying child time to recover before he is sent back to the weighing room or the reception room.

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EXAMINATIONS, IMMUNIZATIONS. AND TESTS NEEDED

Medical Examinations

Each child will be given a complete examination on his first visit to the conference. The frequency of subsequent examinations will depend largely on the needs of the individual child and will be determined by the physician.

The following schedule represents good practice for complete examinations: [11]

During the first year—examination at least once a month.

During the second year—examination at least every 3 months.

From the second to the sixth year—examination at least every 6 months.

Inspections with the child undressed and conferences with the mother will be scheduled between the examinations at intervals depending upon the needs in the individual case.

Parents should be informed that an examination is advisable after any illness.

The weight and height are taken and recorded at each visit to the conference.

Screening Tests for Vision and Hearing

Because they require a special room, special equipment, considerable time, and ordinarily two persons to give them, vision and hearing tests for preschool children at regular conference sessions are not usually considered advisable.

However, it is highly desirable that children's visual and auditory acuity be determined before they enter school; and if proper facilities can be arranged for at the conference center and the tests done by special appointment, they would add to the completeness of the health supervision.[12] [13]

[11] The Health Supervision Program Your Child Should Have. Leaflet prepared by the American Academy of Pediatrics, 636 Church Street, Evanston, Ill.

[12] Publications of the National Society for the Prevention of Blindness, 1790 Broadway, New York, N. Y. (these include directions for testing the vision of children of preschool age). Testing the Sight of the Young Child, by Parke Lewis, M. D. (American Medical Association, 535 West Dearborn Street, Chicago, Ill.; 10 cents.)

[13] Publications of the American Society for the Hard of Hearing, 1537 Thirty-fifth Street NW., Washington, D. C. (these include suggested hearing tests for children of preschool age). Testing Kindergarten Children With the 4-A Audiometer, by Warren H. Gardner, Ph. D. (Reprint No. 468 available from the Volta Bureau, 1537 Thirty-fifth Street NW., Washington, D. C.).

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In case the examining physician discovers at any time any evidence of impaired vision or hearing he will promptly refer the child to a specialist, if possible, for further examination and recommendation as to treatment.

Urinalysis

It is advisable to make routine examinations of the urine of children who can urinate into a receptacle, in order to detect the presence of albumin or sugar. Laboratory facilities are necessary in examinaing for urinary-tract infection.

Dental Examination

Dental examination and advice on the care of teeth by a dentist should be begun after the second year.

Immunization

Inasmuch as there is considerable difference of opinion as to the immunizing agents to be used, dosage, interval between administrations, and age when immunization should be started, it is suggested that the State department of health be consulted regarding its recommendations.

The committee on immunization and therapeutic procedures for acute infectious diseases of the American Academy of Pediatrics has issued a report [14] giving information on immunity including *technique of tests and dosage of immunizing agents*.

Vaccination against *smallpox* before the age of 12 months is generally accepted as the best practice.

It is recommended that the baby be immunized against *diphtheria* through the injection of three doses of toxoid at about the age of 9 months. A Schick test about 6 months after the last dose and another about a year after the last dose are advised in order to determine whether protection against the disease is complete or whether another injection is needed. The Schick test should be repeated when the child enters school and again when he enters high school, or at about the ages of 6 and 12.

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[14] Copies of the report are available at 10 cents each from C. G. Grulee, M. D., Secretary of the American Academy of Pediatrics, 636 Church Street, Evanston, Ill.

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Some physicians now immunize against diphtheria and tetanus in the same injection.

Typhoid immunization is seldom necessary in infancy because of the precautions taken in preparing infants' food and in sterilizing their drinking water. However, in later childhood, if children are at all likely to come in contact with contaminated water or milk supplies, typhoid vaccine may be indicated. The immunity produced is of limited duration.

While the effectiveness of vaccine for protection against *whooping cough* is not established, the protection that it may afford during early childhood, when the mortality from whooping cough is highest, would seem to justify consideration of its use.

It is advisable that each child be given a tuberculin test.[15] Children having positive tuberculin tests are referred to a physician for further examination and recommendation as to care. A positive test in a young child usually indicates contact with someone who has active *tuberculosis*. Every effort should be made to determine the source of infection, which, when discovered, should be reported immediately to the local health department.

Routine blood tests for *syphilis* are being advocated, particularly in areas where syphilis is prevalent. State departments of health make provision for the treatment of children whose parents cannot pay for this service.

[15] For technique of tuberculin test see report referred to in footnote 14 and Diagnostic Standards, issued by the National Tuberculosis Association, 1790 Broadway, New York, N. Y.

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RECORD FORMS AND RECORD KEEPING

Orderly recording of significant information regarding the child's health and development and services rendered at the conference is essential for insuring continuity in the child's care and for the evaluation of accomplishment in the conference program.

The record system should be flexible enough to permit adaptation to the needs of the area concerned, but as a basic principle the use of the same form is recommended for recording service at the conference and in the home. This procedure promotes the integration of services and lessens clerical work. It is advantageous also to have entered on a single record the findings and recommendations of all professional personnel serving the child in the conference.

To be of maximum value, a copy of the preschool health record should be furnished to the school health authorities upon the child's entrance to school.

In addition to the record form relating to the care of the individual child, certain records are essential in connection with administrative reports and arrangements for the conference, and in the preparation of summaries of conference attendance.

In order to have available at all times information on the children attending the clinic and the dates of their attendance, an attendance-record book is helpful. It can also be used for keeping a record of the appointment dates for visits to the conference.

Statistics for monthly or annual reports of conference attendance may be compiled from the information in the attendance-record book. Another plan for assembling this information is to count from the individual case records, at the end of each conference session, the number of infants and preschool children in attendance, the number of new admissions, and the number of readmissions. The count is entered on the daily report of the nurse or on a summary sheet relating to service in one or more conference centers. At the end of the month or year the counts relating to each conference session are added for the statistical report.

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Appendix A.—SUGGESTIONS FOR ORGANIZATION AND FUNCTIONS OF LOCAL CONFERENCE COMMITTEE

The local conference committee is an advisory committee serving the district, county, city, or town health department or the local sponsoring agency or agencies. This committee is selected with much care since it will be a permanent one. Members are appointed so that their terms of office will expire in different years. In appointing the members the health officer or appointing body should give careful consideration to the community needs and the background of community life, as well as to the qualifications and interests of the individuals selected. Members are chosen who can be expected to attend meetings with reasonable regularity. The size of the committee should be governed somewhat by the size of the community to be served, 10 to 12 members probably being adequate for most communities. The district, county, city, or town health officer and public-health nurse are members ex officio.

It is important to have on this committee, which is composed of both men and women, representatives of the local medical and dental professions, the public-health-nursing groups and other public-health and public-welfare organizations, the public schools, the local government, hospital administration, church organizations, organizations and clubs interested in community improvement or civic service, and parent-teacher associations. It is advantageous to include also a capable businessman on the committee.

The officers of the committee include chairman, vice-chairman, and secretary. These persons should be community leaders, preferably with some knowledge of and particular interest in public-health work.

Counties, districts, cities, or towns having full-time public-health departments may already have public-health committees or councils which have agreed upon policies and standards for child-health conferences applicable to the whole area. In such places the local conference committee may be a subcommittee of such a public-health committee or it may be an independent committee. It should be informed of the policies adopted by the public-health committee in order that such policies may be discussed and that the plans of the local conference committee may not conflict with those policies.

The local conference committee meets at regular intervals. It is helpful to the physicians and nurses directly responsible for conducting the conference to discuss with the committee the progress of the work and questions of policy, equipment, publicity, and so forth. The manner in which the work of the conference committee is conducted will have much to do with the success of the conference. Reports of subcommittees should contain material of interest in addition to the necessary statistical material, and

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there should be opportunity for free discussion by all members of the committee. Each local cooperating agency or group is kept informed by its representative regarding the work of the conference.

It is advisable for the committee to hold an annual meeting to which the public is invited. The purpose of this is to acquaint the public with the accomplishments of the child-health program during the year and the committee's plans for the future, and to stimulate further community interest in the service. Arrangements might be made for a special address on some phase of child health at such a meeting.

Appointment and Duties of Subcommittees

As need occurs subcommittees may be selected by the chairman of the conference committee in consultation with the health officer, or, if the local conference committee is under a voluntary agency, by the chairman of the local committee in consultation with the sponsoring agency. Only such subcommittees are appointed as are immediately necessary and will be active, and they may be dismissed on the completion of their specific tasks.

The subcommittees may include any or all of the following committees:

1. Medical advisory.
2. Finance.
3. Conference center.
4. Volunteer personnel.
5. Publicity.
6. Transportation.

The work of each of these subcommittees also is important and great care should be exercised in the selection of its members. Individuals should be appointed who may be expected to have a sustained interest in the service, who are capable of performing the necessary duties, and who have time to give to the work. It is considered advisable that the public-health nurse in charge of the nursing service of the conference be a member ex officio of each committee. The physician in charge of medical service at the conference will be a member of the medical advisory committee. The chairman of the local conference committee will be a member ex officio of the subcommittees.

Medical Advisory Committee.

The membership of the medical advisory committee includes the local health officer as an ex officio member and members of the local medical profession, particularly those physicians who are experienced or especially interested in child-health or general public-health work.

Where there is a full-time local health officer, he may appoint the medical advisory committee after consultation with the local medical profession. In rural areas where there are few physicians all of them may be members of the committee.

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The functions of this committee include advice on the plan and scope of the conference, the medical procedures to be followed, and selection of physicians to conduct the conferences; advice on medical problems; assistance in preparation of medical information to be included in publicity; assistance in preparation of subject matter relating to medical problems for all publications prepared locally; interpretation of the work of the conference to the medical profession and assistance in arranging for public speakers on subjects pertaining to child health.

Finance Committee.

In communities where the State or local health department does not assume the financial responsibility for the conference, this committee will be responsible for estimating the financial needs of the center (the preparation of the budget) for the year; for obtaining money to meet the budget requirements; for purchasing the equipment for the conference center; and for paying bills, including rent, incidental to the operation of the center.

It is probable that most of the equipment, supplies, and furnishings for the center can be obtained through interested groups and individuals so that little will have to be purchased.

The finance committee works closely with the conference-center committee, purchasing as promptly as possible any needed supplies or equipment that the latter committee is unable to provide.

Conference-Center Committee.

This committee will probably be required in the beginning to give a considerable amount of time to its duties. These will include cleaning and renovating the rooms in the beginning; considering facilities for heating and water supply; obtaining and installing the furnishings, making the center as attractive as possible but keeping the furnishings simple and of a type that can be cleaned or replaced easily; obtaining the necessary equipment and supplies and arranging them in their places.

This committee will be responsible for the general housekeeping of the conference center; it will keep informed on the condition of supplies and see that they are replenished as needed.

Committee on Volunteer Personnel.

The committee on volunteer personnel, together with the public-health nurse, will analyze the conference jobs, taking into consideration the number of public-health nurses available regularly for duty at the conference, and will determine which places are to be filled by volunteers. The requirements of each place should be carefully studied and a person should be selected for each place who is qualified to fill it. A substitute is chosen for each volunteer. It is important to select volunteers who can attend regularly.

Volunteers and their substitutes are instructed and trained for their work by the public-health nurse.

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Publicity Committee.

At least one member of this committee should be familiar with publicity technique. It would be well to have a member of the medical advisory committee also on this committee. The services of a representative of a newspaper, a broadcasting station, or an advertising agency would be helpful if available.

The functions of the publicity committee are to inform the general public of the service offered by the conference, its purposes, principles, and progress, and to stimulate public interest in the conference. This may be done through newspapers, radio, and public addresses. The publicity committee will make arrangements with the local *newspapers to carry ample notice of conferences*. Similar announcements might be made in schools or at local meetings.

It is desirable to plan a year-round publicity program, including newspaper articles, radio talks, and local addresses by qualified persons on subjects pertaining to child health and community responsibility for child health. Members of the local medical profession and organizations such as parent-teacher associations, service clubs, farm bureaus, and home-economics extension bureaus are often available for this purpose.

Transportation Committee.

The duty of the committee on transportation will be to endeavor to find transportation facilities for parents so situated that they cannot avail themselves of conference service unless some means of transportation is provided. It is well to determine as far as possible in advance of each conference who will need this assistance.

Volunteers performing this service carry their own automobile liability insurance and need to be fully informed on State laws regarding such liability.

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Appendix B.—SOURCES OF POSTERS

Children's Bureau, U. S. Department of Labor, Washington, D. C. Posters on diet for the expectant mother and on posture.

Bureau of Home Economics, U. S. Department of Agriculture, Washington, D. C. Charts on nutrition and child feeding.

Extension Service, U. S. Department of Agriculture, Washington, D. C. Charts on nutrition.

Maternity Center Association, 654 Madison Avenue, New York, N. Y. Posters on prenatal, postpartum, and infant care.

American Medical Association, Bureau of Health and Public Instruction, 535 North Dearborn Street, Chicago, Ill. Posters on infant and child care.

American Dental Association, Bureau of Public Relations, 212 East Superior Street, Chicago, Ill.

National Society for the Prevention of Blindness, 1790 Broadway, New York, N. Y.

National Child Welfare Federation, Educational Building, 70 Fifth Avenue, New York, N. Y. Posters on health and mental hygiene, and educational posters for children of preschool age.

National Safety Council, Educational Division, 1 Park Avenue, New York, N. Y.

National Dairy Council, 111 Canal Street, Chicago, Ill. Posters on the contribution of dairy products to good nutrition.

National Live Stock and Meat Board, 407 South Dearborn Street, Chicago, Ill. Posters and charts on nutrition.

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K

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Maternal, Infant, and Childhealth, Health Education K

"Teaching Aids" - by Maternity Center Assoc. .....1 - K

"The Child Health Conference U.S.Children's Burcau .....2 - K

"Bathing Time for the Baby" .....3 - K

"Bathing your Baby the Right Way" ..... 4 - K

"Care of the Newborn Baby" ..... 5 - K

"Appraisal of the Newborn Infant" ..... 6 - K

"Your Child from 1-6"- U.S.Children's Burcau ..... 7 - K

"Infant Care" - U.S.Children's Burcau ..... 8 - K

The Public Health Nurse and School Health ---------- 9 - K

Mental Hygine in the Class room ---------- 10 - K

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教育の手引

紐育市二一マディソン街六〇五
母性保護協會 編

産児小図類

一九四二年再版 價五弗

十六の實物大石膏彫塑一著名な「ゲッキンソン・ベルスキー」
写真機写

産児描写四ー六ー七週、二ヶ月半、三ヶ月半、四ヶ月半、七ヶ月
及臨月、胎児の継續状況を五盤にて示す。なお二ヶの
描写ハ子宮が平常の大きさと位置に於ける回復の
状態を示す、一ハ双生児一体と兄弟を示し、その
彫刻の細部に亘りて極めて正確にして教室用として
17×22インチの断面に禁もて連結するもの。

第二は二つの新盤にして一ハ四ヶ月半の胎児他ハ双生
児を示す、之等の新盤ハ各部位料金三五弗にて
別々に入手出来る。

解剖教課図

一組 二〇〇弗

一組は五枚の解剖教科図（実寸）にて子宮の地の器
官に成育の関係を示す。然を準図式にて画いてある
17×28インチ、各図に8インチ×11インチの説明書附。

貴女の産児ハ如何して成育するか 價七五仙

壁図28×44インチ彫刻による線画にして
子六週より子七ヶ月に至る産児の発達状況を示す。
各画に短文の説明を附す。

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産科に於ける保健婦の看護

看護婦用度用の手引の第一部は今日に於ける産婦看護の意味を理解し、そして地方部落に於ける母子の看護を適当に遂行する様に立案されて居る。数多く看護婦達に役立つ様に立案されて居る。

八七頁　一九四〇年度　五〇仙

第二及三部は（未出版）出産の成績と災害、妊娠中母体に於ける変化、普通母性周期中に於ける看護法

第四部は父母関係に対する指導、胎教を含む。母親達に対しては出産、育児、労力と出産、新母と子の心理、妊娠と子の心理、出生児と子の心理及解説と実行期等

父親達に対しては産児の第一年間の生活、家族生活に入り来る関係と解説及実行期等、数多の図解。

一九四五年改版　一二二頁　一〇〇弗

簡易版——一九三六年六月出版される

一九三七年購読料　一〇〇弗

妊産婦母性に関し医療面、看護婦及保健婦の立場より集められる資料を含む

あなたの産児は如何して成育するか

一部　一〇〇部　一〇〇弗

一〇〇部　五〇〇部　五〇〇弗

一部　五仙

産児に熱心な母親達の為に又は若い人々の為出版された一二頁にして月々に大きくなり行く産児の成育、出生の様を「ポケット」に彫刻の小写真、説明付に説明をそえる様に書かれてある。

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母親になる用意　　カロリン・コナント・ヴワン、ブラーコム著
（第12版 ハーセル・コービンによる改版）
マッグラニラン、コムパニー發行
一九12の年　一、五〇弗

概して妊娠の出来るか知らんと疑する母さん、教師、若い人達の女の多数にして最多なる年齢、元来は母さん達の組織に及ぶ四箇（が）出来るもの即ち義良なる世話の機関、出産の準備、出生児を保護に適する様、出生児の指導、等、九十の興味ある多数望まる図解。

父親になる用意　　ハザード・コービン、マッグラニラン
コムパニー發行
（父）男子の質問に答えて、一九三九年　一、二五弗
野球に信頼を置く親達の彼の妻に希望を有つ様になる、その所内に於ける多数の父！
明かなる家族体にて。

母性手引　　母性保護協會、
ケイ・ビー・ブトナムスソンス、
一九三二年　一、〇〇弗
母さん、父さん達の組織に於ける有用なる
本にて、母性に就ての豊富な資料にて充
満する。

母性保護協會
安兼なる母性のための二十の年月に亘る協會
の輝かい歴史、アメリカ全最国に於ける社科
研究に就き感謝する必要。一九12三年
八12月　五a仙

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ブルーリボン・ベビー（最高品質の赤ちゃん）

一組二付 一、〇〇弗

教育用の一新型

安全と満足まる世界が九年間の姫娘期間に於ける行届いた醫療と衛陽の手法によるのみならず往年母父親自身がまだ子供時代に於ける生活情況と健康及び能力等を考へある八枚の圖面を以て

七のポスター教學書と簡短な画により話して説明す。

見出しは平易な語を用ひ説明は簡潔にして色彩に飾り付けてあるから一目瞭然たる。學級編成、陳列及び家庭

完全学校なる表示に適する、四×二二インチ

弾性と富める宣傳ビラ

出産児が発育生活の路程に於ける一層詳細な記録、ポスター類の小さい積年版、表紙類各種に

就いて種々の記録一般産婦或は先生方と共に研究

八個人用に関する編纂を出す考を持ち立

つ様に。

一六頁 四×五インチ 一〇〇部

一〇〇〇部 三五弗

一部 五仙

一〇〇部 一、〇〇弗

希望を持つ母のために

母さんの教育に及ぼす影響ビラ 八頁

一〇〇部 一、〇〇弗

希望を持つ父のために

父の教育に関する実用小冊ビラ 12頁

一部 五仙

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6-K

THE APPRAISAL OF THE NEWBORN INFANT

BY
ETHEL C. DUNHAM, M. D.

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The Appraisal of the Newborn Infant

INTRODUCTION

The necessity for careful and adequate appraisal of the infant during the neonatal period has not been generally appreciated, nor have methods for making such an appraisal received sufficient attention. (The term "neonatal" is used to describe the period from birth through the first 30 days of life.) The neonatal period is one of great danger to the infant as well as one about which too little is known. That more attention should be given to the appraisal of the newborn infant and to his care is indicated by the high mortality rate among infants in the first month of life. It is well known that, although the mortality in the first year of life has been greatly reduced during the past 15 years, the mortality in the first month of life (neonatal mortality) has been reduced relatively little and the mortality on the first day of life has not been reduced at all. Contributions to knowledge of the problems concerning the neonatal period have been made through intensive study of individual infants as well as of groups of infants, but the information at hand with regard to these problems must be carefully evaluated and made readily available to all physicians. It is obvious, furthermore, that if appraisal is to be adequate new information must be collected, particularly in regard to well infants. The appraisal of the newborn infant will, of course, be made more exact by improvement in clinical methods of examination, by establishment of certain standards of growth and development, and by more intensive study of causes of neonatal deaths, supplemented by post-mortem and other laboratory examinations.

It is hoped that this bulletin will be useful to physicians in the examination of newborn infants and in the interpretation of the findings.

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BASIS OF APPRAISAL

An appraisal of the newborn infant, to be adequate, should not be based on physical examination alone. It should involve also consideration of the socioeconomic background of the family; constitutional factors in the medical history of the family, especially the history of hereditary or transmissible diseases or defects; the prenatal history (the mother's pregnancy); and the natal and immediate postnatal history. Knowledge of the influence of these factors may tend to modify an examiner's appraisal.

The physical examination should be complete and should be supplemented by physical measurements, and, when indicated, by laboratory and roentgen-ray examinations. It should be repeated at least once during the first month, and more often if indicated by the history or by the development of some abnormal symptom. At the end of the first month of life another complete examination should be made.

SOCIOECONOMIC FACTORS

In the appraisal of the newborn infant socioeconomic factors play an important role which has not been sufficiently studied. That infant mortality is higher under poor socioeconomic conditions, such as low income, employment of mother, and congested housing, has been clearly demonstrated.[1]

HISTORY

FAMILY HISTORY

It is of great importance to inquire into and record the family history of the newborn infant, because, as has been noted, the influence of inherited traits (constitutional factors) and of transmissible diseases or defects must be considered in the total appraisal of the infant. There are certain hereditary or familial defects and diseases which are obvious at birth, such as harelip and cleft palate, and others that are not apparent until the period of later infancy or childhood, such as Friedreich's ataxia, progressive pseudohypertrophic muscular dystrophy, and amaurotic idiocy. Developmental defects such as Mongolism may be obvious at birth; others, such as certain cerebral defects which result in convulsions and spastic palsies, may not become obvious until later. Certain sex-limited defects, such as color-blindness and hemophilia, are not apparent at birth, and therefore a knowledge of the family history should be taken into consideration in the appraisal of the infant.

[1] Causal Factors in Infant Mortality; a statistical study based on investigation in eight cities, by Robert Morse Woodbury. U. S. Children's Bureau Publication 142. Washington, 1925. 245 pp.

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INFANT'S HISTORY

The history of the newborn infant consists of the prenatal history (mother's pregnancy), the birth history, and finally the immediate postnatal history, especially in regard to the onset of respiration.

Prenatal history.

The mother's health during pregnancy must be considered in relation to the maturity and weight of the infant and his adequacy for extrauterine existence.

The mother may have suffered during pregnancy from some disease which interrupted the pregnancy at some time before term or which may be transmissible to the infant. The most striking example of this is syphilis. That an infant infected by syphilis may be born prematurely or at term and with or without evidences of the disease is well known. Intrauterine transmission of almost any of the common communicable or infectious diseases, such as smallpox, chickenpox, and erysipelas, is possible. In fact, cases have been reported of infants born with typical scars of smallpox, as well as cases in which the acute lesions of the disease were present at birth. Erysipelas lesions in the infant may make their appearance within a few hours after birth if the mother is suffering from the disease. Tuberculosis, typhoid fever, and malaria have also been reported as transmissible to the fetus. On the other hand, the mother may confer on the fetus immunity to certain diseases, such as scarlet fever and measles. There are certain acute conditions in the mother, such as the toxemias of pregnancy, the effects of which on the fetus are not entirely clear. The infant is likely to be born prematurely, but studies have shown that if the infant is born alive at or near term no specific deleterious effects of the toxemia can be determined.

If the mother suffers from a deficiency disease the health of the infant may be affected. The outstanding example is thyroid disease in the mother resulting in cretinism in the infant. Women suffering with diabetes are likely to give birth to abnormally large infants.

There is some evidence that roentgen-ray therapy of the mother during pregnancy may result in injury to the central nervous system of the fetus (microcephaly).

In many instances the physical condition of the mother does not affect the infant, since normal infants may be born of diseased mothers. The history of the mother's pregnancy should, nevertheless, be considered in making the appraisal of the newborn infant.

The subject of immunity to disease in the neonatal period is an important one. The transmission of immune bodies and allergy from the mother to the infant has been rather extensively studied in recent years. It is well known that the antibodies of syphilis and tuberculosis may pass the barrier of the placenta and may be demonstrable in the infant's blood for weeks or even months after birth although the infant may be entirely free from infection. Likewise, immunity to scarlet fever, measles, poliomyelitis, and diphtheria in this period has been established.

Certain hormones that affect growth are probably transmitted to the fetus in the latter part of pregnancy. The therapeutic effect of such

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hormones when given to prematurely born infants has been studied, but their value has not been accurately determined as yet.

Natal history.

When the course of the infant's birth is in any way abnormal, the effect on the infant may be apparent immediately or in the course of a few hours, or signs may appear at some period later in infancy and childhood which must be attributed to injury at birth. Of special significance are rapid or prolonged labor, dry labor, difficult delivery, instrumental delivery, and so forth.

Postnatal history.

The immediate postnatal history of the infant may be even more important than his natal history. Under ordinary conditions the respirations should start immediately and the infant's color should become good. If respirations are delayed artificial means to induce respiration must be used and the type and effectiveness of these methods must be considered in relation to immediate or remote effects on the organism. In this connection a history of any anesthetics and drugs given to the mother during labor must be known, particularly depressant drugs such as morphine and barbiturates. Appearance of cyanosis, pareses, paralyses, hemorrhages, twitchings, or convulsions in the immediate postnatal period, even if transitory, must be considered in making the appraisal of an infant that is apparently normal at the time of examination.

Fetal maturity.—After the birth of an infant the physician is at once confronted with the task of estimating its maturity. Since the exact date of conception is usually not known, calculations of the duration of pregnancy are ordinarily based on the date of the last menstrual period. The results of these calculations are often not accurate because menstruation may occur after conception takes place. It is usual to regard a fetus of less than 28 weeks' gestation as nonviable. When the time of gestation is estimated as between 28 and 38 weeks, the infant is called premature. When the time of gestation is estimated as between 38 and 40 weeks the infant is said to be mature. As a matter of fact it may be just as hard to draw a sharp line at the point where the "nonviable" fetus becomes a "viable" one as it is to set off sharply the "premature" from the "mature" infant.

A number of criteria are in use for the diagnosis of prematurity, none of which is entirely satisfactory from a scientific standpoint. Among them are (1) a birth weight of 2,500 grams (5 lb. 8 oz.) or less, (2) a crown-heel length of 47 centimeters (18.5 in.) or less, (3) relatively greater disproportion between head and chest circumference or head and shoulder girth than in the full-term infant, (4) an occipitofrontal diameter of the skull of less than 10 centimeters (3.9 in.), (5) a foot length of 7 centimeters (2.8 in.) or less, (6) roentgenographic evidence of absence of certain centers of ossification in the long bones.

Since two concepts are involved in any measurement of maturity—physical development and physiologic development—the exact period of gestation at which intrauterine life ends is a matter of legal or academic importance only. For clinical purposes, however, it is important that physicians recognize indications for special care and

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that they have some basis for making a prognosis. The birth weight of the infant seems to be the best criterion from these points of view. In the first place weight is a measurement which is easily made and widely in use. Secondly, a background of statistics is available as to results of care in relation to birth weight. From clinical experience and mortality statistics it is clear that when the infant at birth weighs 2,500 grams (5 lb. 8 oz.) or less or measures 47 centimeters (18.5 in.) or less special care is needed. Moreover, statistics show that for infants weighing at birth 1,000 grams (2 lb. 3 oz.) or less survival is comparatively rare and that for infants above this weight at birth the chances of survival vary according to the birth weight. If the infant at birth weighs more than 1,500 grams (3 lb. 5 oz.) its chances of survival are four times as great as if it weighs 1,500 grams or less at birth. There are, however, some infants who according to weight or height or some other criterion should be capable of extrauterine existence and yet physiologically are incapable of such existence.

No rule should be laid down at present for determination of fitness for extrauterine existence, since the factors affecting viability are variable and not very well understood. "Immature" is a better term than "premature" to apply to infants who are physically or functionally unprepared for extrauterine existence.

The initial respiration.—Independent extrauterine life is not established until the infant breathes. Although the beating of the heart in the absence of respiration is evidence of life, it is merely evidence of persistence of intrauterine life. There is, moreover, evidence that the respiratory mechanism may function in utero, but the significance of this phenomenon is not clearly understood. Respiratory movements may occur when the head has been delivered and the body is still in the birth canal or immediately after separation from the body of the mother, or they may be delayed for varying periods, sometimes as long as an hour or more. Injury to an infant's central nervous system during birth or narcosis from anesthetics or such analgesic drugs as scopolamine, barbiturates, or morphine, administered to the mother during labor, may be a factor in delay of the onset of respiration.

Usually the infant at birth respires spontaneously and cries vigorously. When these physiologic processes do not occur at once it is necessary to take steps to induce respiration before the infant's heart stops beating. What is the best method to use is a debatable question. There is, however, agreement that, whatever method is used, the approach should be gentle and great care should be taken to keep the infant warm. Before any mechanical method is used the upper air passages should be cleared of mucus and other fluid by aspiration, through the use of a soft-rubber catheter attached to a negative pressure bulb. Following this, gentle rhythmic compression of the chest can be used, care being exercised not to squeeze the upper abdomen. Too violent compression in this region might raise intracranial pressure or rupture the liver. At the time that artificial respiration is being carried on inhalations of oxygen or of a mixture of 5 percent carbon dioxide and 95 percent oxygen may be given by various means, such as a mask or a nasal catheter.

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The infant should under no circumstances be spanked, swung, or plunged into cold water; but, as has been mentioned, care should be taken to keep him warm throughout the time when attempts are being made to make him breathe.

Considerable variation in the rate and volume of respirations may occur in the newborn infant in the early days of life without pathologic significance, so far as is known. Even during sleep the respiratory rate may vary widely (16 to 93 per minute). The rate and volume are greater when the infant is awake than when he is asleep. There is a tendency, moreover, for the volume of inspired air to increase from day to day. On the other hand, marked change in the respiratory rate—slowing or accelerating—particularly if combined with increase or decrease in volume, should be regarded as evidence of some abnormal condition such as intracranial injury or acidosis.

A certain degree of atelectasis is physiologic after birth. It has been stated that this may be demonstrated by an actual measured daily increase in the circumference of the chest, as well as by roentgenograms made on successive days after birth, showing that complete expansion of the lungs is a gradual process taking place over a period of days or even 1 to 2 weeks. The physician's attention is drawn to atelectasis of an abnormal degree when the color becomes cyanotic or the breathing becomes abnormal or when physical signs are present in the chest, such as râles, impaired percussion note, or diminished or increased breath sounds. When atelectasis persists and seems of sufficient degree to cause symptoms it is usually secondary to some condition interfering with the normal functioning of the respiratory center or to some abnormal condition within the thorax such as a congenital defect in the circulatory system or persistence of undeveloped lung.

PHYSICAL EXAMINATION

A detailed and careful physical examination of the newborn infant can usually be made with safety shortly after birth. There is no contra-indication to making as complete an examination of a newborn infant as of an older infant if the conditions are satisfactory. Indeed, it is of the utmost importance that such an examination should be made of every newborn infant, since on the basis of the findings treatment may be instituted which, in many cases, may save the life of the infant. There is, moreover, a distinct advantage in making an examination of the infant as soon after birth as possible to be sure that the upper respiratory tract is clear, the color of the skin good, the cry vigorous, and respiration well established.

If the infant is immature and weak the immediate examination should be brief and made with as little exposure as possible. Further examination may be made after the infant's rectal temperature has become stable.

It is of particular importance that the examination of the infant should be made in a warm room, since the infant must be completely undressed. The room should be well lighted, as observation plays a very important role in the examination of any infant.

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All methods used in the examination of an older infant may be used in the examination of a newborn infant. The smaller the infant the more care should be taken to apply all methods known for a detailed and careful physical examination. Procedures cannot, however, always be carried out in the usual order. It may be best to use the stethoscope first, while the infant is sleeping, and to use palpation or percussion later. If information is to be gained by these methods the physician's hand as well as the bowl of the stethoscope should be warm, and percussion and palpation should be gentle.

MEASUREMENTS

Weight.

The infant is usually weighed immediately after birth. The average weight of the full-term infant at birth is stated to be about 3,175 grams (7 lb.).

An infant weighing 2,500 grams (5 lb. 8 oz.) or less should be regarded as needing the care given to a premature infant, regardless of the history of the duration of pregnancy. Some infants weighing more than 2,500 grams may also require such care.

In appraising the infant, comparison of his weight with the weight of the average infant is of little value, as weight is affected by a variety of factors, chief among which are sex and race. Male infants tend to weigh more than female, and white infants tend to weigh more than colored. The gain in weight is the important consideration. The weight of a newborn infant usually decreases in the first 3 to 4 days. This loss in a full-term infant is about 6 to 9 percent of the weight at birth. The birth weight is ordinarily regained between the tenth and fourteenth days. During the neonatal period after the first few days the average gain is at the rate of 30 grams (1 oz.) or more per day.

Skeletal growth.

Certain measurements of the infant should be made within 24 hours after birth because they are important from the point of view of determining maturity and also because they serve as a base line in respect to growth. These measurements should be accurately made and recorded. The important ones are as follows:

Crown-heel length.—The crown-heel measurement should be made with the infant flat on his back and extended. A measuring board or a metal anthropometer should be used. Measurements of the total length made by tape, with the infant hanging by the feet or even in a prone position, will obviously be inaccurate.

The average length of the full-term infant is usually stated to be 50.8 to 53.3 centimeters (20–21 in.). Length, like weight, is affected by various factors, such as race and sex. Growth in length during the neonatal period has not been satisfactorily studied.

Head circumference.—The occipitofrontal circumference of the head should be measured with a *steel* tape 24 to 48 hours after birth; this measurement should be made on the third or fourth day of life, since considerable edema of the scalp and molding of the skull are frequently present at birth. It is important to have this measurement recorded, as abnormal size of the head or abnormally rapid

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growth of the head or disproportion between the head and shoulders or the head and chest has important clinical significance. The average circumference of the full-term newborn infant's head is 34.8 centimeters (13.7 in.). The head circumference should be considered in relation to the length. The head grows relatively rapidly, and the circumference at each age period is equal to approximately one-half the body length plus 10 centimeters (3.9 in.).

The occipitofrontal diameter of the head is a measurement that has been found to be closely related to weight. It may be used as a measure of maturity; a diameter of 10.5 centimeters (4.1 in.) or less is said to indicate prematurity. Calipers are necessary to make this measurement.

Measurements of the circumference of the thorax, shoulders, and abdomen are not easy to obtain accurately and are therefore of relatively little value in determining the degree of prematurity.

It is probable that some measurement of width should be made (the bi-iliac or bitrochanteric diameter, for example) to use in relation to crown-heel length in estimating the nutritional status. No indices have been worked out, however, for infants in the neonatal period.

TEMPERATURE

Immediately after birth the temperature of the infant is said to be slightly higher than that of the mother. In the next few hours it drops 1½ to 2 degrees and it has a tendency to remain low during the first day. The body temperature of the newborn infant is easily altered by changes in the environment and therefore even the normal full-term infant should be spared exposure and variations in the temperature of the environment.

GENERAL OBSERVATIONS

It cannot be too much stressed that ample time should be given to careful observation of the infant. Special attention should be paid to his color, the movements of his arms and legs, the ease with which he can be awakened or made to cry, the type of the cry, and his ability to suck. Observations should be made when the infant is asleep, or at least quiet, and again when he is awake or crying. The order in which the rest of the examination is carried out depends upon the state of activity or inactivity of the infant. When the infant is asleep is an opportune time to listen to the heart and lungs and to test the reflexes, as resumption of activity or crying makes these examinations difficult. On the other hand, the deep respiration during crying is of inestimable value in auscultation for the detection of râles.

Activity.

Normally a newborn infant remains asleep throughout the greater part of the day, but it is with difficulty that any part of a procedure requiring actual handling can be carried out without waking him. An infant is normally more active when hungry than after a recent feeding. He resists any attempt to change his posture, as well as any restraint of free motion of the head or extremities. Crying

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is usually accompanied by vigorous movements of the arms and legs. Sudden noises or sudden change in body posture will often elicit in the normal infant a clonic flexion of the arms and legs (Moro reflex). A normal infant will remain awake throughout the examination while being handled, and if recently fed and comfortable will soon return to sleep when the examination is concluded.

The activity of the infant has great significance. The mature infant should cry when stimulated, maintain this cry for at least a few minutes, vigorously move the arms and legs, and then gradually settle back to sleep again. Difficulty in waking the infant and in making him cry and a feeble or poorly maintained cry are indications of the presence of some abnormality such as immaturity, atelectasis, narcosis, or intracranial lesions.

Posture.

The newborn infant lies with the head held to the right or the left and resists strongly any attempt to change this position of the head. (See Magnus reflex, p. 18). Usually, however, the head will be turned to one side when the infant is sleeping, and it will acquire a midline position when he is crying.

The newborn infant lies on the back with the arms and legs slightly flexed. There is normally slight outward rotation of the legs at the hips, and the legs tend to assume the same position both when the infant is awake and when he is asleep. The arms may assume varied positions when the infant is asleep. It is important to turn the infant over so that the back may be examined. The symmetry of bony points, such as scapulae, hips, and vertebrae should be noted. At birth two vertebral curves are present, a dorsal and a sacral, each convex posteriorly. The cervical and lumbar curves are not established until the infant is old enough to stand.

If the newborn infant is held upright and supported under the arms and the feet are brought in contact with a smooth, hard surface, he will tend to straighten the legs, flatten the feet, and bear a little weight on them; sometimes one leg and then the other will be raised and flexed as if making walking movements. When he is placed on his abdomen he usually makes an effort to raise his head. Frequently the newborn infant is able to raise his head well off the examining table and sometimes to maintain this posture for several minutes.

Special senses.

The special senses of the infant and the response to various stimuli have been studied to some extent. As is known, the infant can see light.

The sense of smell is probably present from birth. Observations of this sense in newborn infants are few and are not altogether conclusive.

The newborn infant is said to be deaf at birth and for several days thereafter. In the neonatal period infants vary greatly in their response to auditory stimuli, some starting at sudden or loud sounds, others not reacting to them. The testing of hearing is difficult in infancy.

Tactile and thermal sensibility and the sense of pain and of taste are all present at birth.

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Crying.

It is important to determine the tone and strength of the cry. Most normal newborn infants cry during part of the examination. If the infant is hungry there will be a tendency to crying throughout the greater part of the procedure. If he has just been fed and is well satisfied it may be necessary to stimulate crying by gently snapping the soles of the infant's feet. If during the examination the infant cannot be made to cry or if the cry is feeble, shrill, difficult to elicit, or not maintained, it should be considered abnormal. A crowing cry, not accompanied by any signs of laryngeal obstruction such as cyanosis or retraction of episternal or suprasternal notch, is probably evidence of so-called congenital laryngeal stridor. It is attributed to looseness or redundancy of the vocal cords and has no pathologic significance. It usually disappears in a few weeks but may persist for several months. Tetany, and possibly enlargement of the thymus gland (very rarely) as causes of the crow should, however, be considered.

Yawning and coughing.

It is seldom that the newborn infant yawns or coughs. If he is examined before respiration is well established there may be gagging and vomiting of mucus or gastric contents, accompanied by irregular and difficult breathing. Hiccoughing and sneezing occur rather frequently in the normal infant.

Sucking.

Sucking is a well-developed reflex present in the infant at birth. Even after a sufficient feeding, sucking movements are stimulated when the nipple is placed in the infant's mouth. Absence or poor development of the sucking reflex indicates immaturity or the presence of some other abnormal condition such as intracranial lesions or narcosis.

SKIN

The skin of the newborn infant at birth is covered with vernix caseosa; the amount varies considerably. After the initial cleaning with oil the skin is normally moist, soft, and elastic. Pigmentation varies with the race of the infant and in the darker-skinned races may be deeper on certain localized areas, especially over the genitals, at the base of the nails, and around the areola of the nipples. Bluish pigmented areas, the so-called Mongolian spots, are frequently found on the back, buttocks, or extremities of infants of certain races, notably Italian, Jewish, Negro, and Oriental. The newborn infant's subcutaneous fat is well distributed and gives to the skin of the normal infant a soft, elastic feeling. The general color is normally a bright pink and in the dark-skinned infant is best seen by observing the palms, soles, nails, and mucous membranes. Physiologic jaundice is seldom observed during the first 24 hours of life. Coarse desquamation is sometimes present during the first 2 to 3 days of life. The hair of the scalp is present and varies in amount and length. It is fine or moderately coarse and usually is straight. The eyebrows are present, but in infants with light hair they may be difficult to see. The fingernails are normally well formed and often extend to or beyond the fingertips. The toenails are subject to great variations in size and shape, are often small, and appear embedded at the distal end.

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LYMPH NODES

The various groups of lymph nodes are very frequently palpable in the newborn infant, especially if the subcutaneous fat is small in amount. Only when the nodes are definitely enlarged should they be considered abnormal. The groups of nodes most frequently palpable in normal newborn infants are as follows, in order: Inguinal, axillary, epitrochlear, posterior cervical. The anterior cervical, occipital, posterior auricular, and anterior auricular nodes are not palpable as a rule.

HEAD

The variation in the shape of the head due to molding may be very great in the first 24 hours. In some infants such changes are completely absent and in others they are very marked. The point of greatest molding may be asymmetrically located and may give the head a true asymmetry. Changes due to molding disappear rapidly and are usually gone in 24 to 48 hours, but may last much longer. The parietal bones normally are smoothly convex and slightly prominent. The forehead is usually on a horizontal line with the face but may be slightly prominent or slightly receding. The scalp should overlie the bones of the head closely and the bones should be firm. Careful palpation of the head is important, as edema, caput succedaneum, cephalhematoma, or defects in the skull bones, which are not obvious on inspection, may be present.

The principal sutures are: The sagittal or longitudinal; the coronals, which separate the frontal bone from the parietal bones; and the lambdoids, which separate the parietal bones from the occipital bone.

Great variation is found in the sutures in the newborn infant's skull; they may be overlapping, approximated, or gaping. Usually the bones at the edges of the sutures feel hard, but they may occasionally feel soft or thin or be movable. Within 24 hours after birth a suture that was overlapping at birth may became gaping. In hydrocephalus all the sutures are found to be gaping.

There are many fontanels, but the most important clinically are the anterior and posterior. The examination of the anterior fontanel is very important. There is a great variation in the size of this fontanel. It may be large enough to admit four or even five fingers in its anteroposterior and lateral diameters, or it may be so small that it is barely palpable, or even not palpable, on account of overlapping of the sutures. A wide-open fontanel may be impossible to measure because anteroposterior and lateral angles run into open sutures. The size of the anterior fontanel is usually of no significance if the tension of the fontanel is normal. A fontanel that is level with the surface of the skull or somewhat depressed is normal.

The posterior fontanel may be just palpable or may be widely open, but no clinical significance should be attached to the size of this fontanel when considered alone.

The parietal fontanel is a small fontanel situated about half way between the posterior angle of the anterior fontanel and the posterior fontanel. In many newborn infants it may be barely palpable or it may admit the fingertip. It has no clinical significance but is merely a developmental point in the growth of the skull.

There are a number of other fontanels which are not normally palpable, such as the mastoid and the sphenoidal.

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Eyes.

When the physician examines the newborn infant on the day of birth, a solution of some silver salt has usually been instilled into the eyes, making the examination of them difficult. There may be a mild conjunctivitis, or a severe one with edema of the upper and lower lids and photophobia or even some purulent discharge. The possibility of gonorrheal infection must be kept in mind. These very acute symptoms, which are nonspecific, should disappear within the first 24 hours, leaving merely an injection of the palpebral conjunctivae. A mild inflammatory condition may persist for several days in spite of treatment. The tear duct or ducts may not be patent at birth, but this condition is usually remedied spontaneously.

The infant may stare fixedly or turn the eyes suddenly from one side to the other. A transient strabismus of one or both eyes is frequently seen. A few coarse lateral jerkings suggesting nystagmus are occasionally seen in the normal infant.

The pupils vary considerably in size from time to time and react very readily to light. It is important to note the reaction of the pupils and whether they are equal in size. Observations should be made with the light thrown with equal intensity into both eyes. Inequality of pupils or differences between them in reaction to light have important significance in relation to the central nervous system. After the photophobia of the first day or two the eyes do not seem to be especially sensitive to light, but the normal infant will wink if the light is brought close to the eyes.

Sight is difficult to determine in the neonatal period but perception of light can be determined readily, as described above.

Jaundice of the sclerae is seen in the majority of infants between the second and tenth days of life, a manifestation of the physiologic jaundice characteristic of the newborn period.

Frame-like subconjunctival hemorrhages are seen in so many infants in the first 3 days of life that although not normal they are more or less physiologic and are probably not significant except as evidence of changes in vascular tension during the process of birth. They disappear rapidly and completely.

No great difficulty should be encountered in examining the eye grounds of a newborn infant with an ophthalmoscope. If the infant is wrapped tightly and given a bottle of water or milk he will often open his eyes and hold them quiet for a considerable time, even when a strong light is reflected into them. Sometimes, and too often, of course, only transient glimpses of the disk can be obtained. The normal disk of the newborn infant is pale and sharply outlined. Small hemorrhages are frequently seen, which are evidence of increased intracranial pressure during delivery and are apparently of no pathologic significance unless other symptoms pointing to birth injury are present. Failure of the pupils to react to light is probably an indication for an ophthalmoscopic examination, for blindness may be due to retinal defects that will entirely escape notice unless ophthalmoscopic examination is made.

Nose.

The nose of the newborn infant is relatively small and flat. At the time of the onset of respiration the nares should be cleared of any secretion. Small whitish-yellow spots are often seen in the skin over

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the tip of the nose. They are follicles of the skin filled with sebaceous material and they disappear spontaneously.

Ears.

The external and internal parts of the ear are well formed at birth. The drums may be retracted until the Eustachian tubes open. The surface of the drum forms an obtuse angle with the external auditory canal. If this angulation is appreciated and the otoscope tilted accordingly, examination is possible and the landmarks of the drums can be clearly made out. Otitis media is not unknown even in the first few days of life.

Mouth.

The lips should be red and smooth, but may show puckering and even desquamation of a coarse type apparently due to trauma from sucking.

The gums are smooth and pink and frequently show slight puckering or even grooving at the distal margins. Frequently small gray cystlike bodies are found, especially in the upper gums. When the infant cries the lips are drawn back symmetrically so that the nasolabial folds are equal. Rarely one or two teeth are present at birth.

The soft and hard palates and the uvula are well formed. There is often considerable variation in the width and in the height of the palate. In the midline of the hard palate whitish or yellow glistening raised spots may be seen, the so-called Bohn's nodules. They mark the fusion of the halves of the palate.

The tongue should be moist, smooth, and symmetrical. Fine fibrillary waves may be noted passing down over the sides of the tongue when it is extended during crying. The tongue should not normally be seen extending between the lips or protruding beyond them.

The buccal surfaces should be smooth and pink and usually the openings of Stensen's ducts are easily seen.

Throat.

Examination of the throat of the newborn infant is difficult because as soon as the tongue is touched with a tongue depressor the infant will make such strong sucking movements that the tongue cannot be depressed. In order that the examiner can see the throat satisfactorily the infant should be made to cry or should be gagged by the introduction of the tongue depressor. A good light should be thrown directly into the throat. The examination will be more satisfactory if an assistant holds the infant's head tipped back and straight in the midline. On the first day the throat will often appear red. This is due to trauma caused by the wiping out of mucus after delivery and perhaps to lack of fluids. The tonsils are not visible in the neonatal period, although occasionally there is a slight follicular appearance as if little bits of lymphoid tissue were present in the fossae. The voice should be clear and strong.

NECK

The newborn infant usually lies with the head turned on one side. The infant resents changes of this posture but there should be no actual stiffness of the neck when the head is turned from side to side or when the head is flexed on the chest.

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The sternomastoid muscles are well developed and should be smooth and equal, with the head in the midline. When the head is turned from one side to the other the muscle on the side opposite that to which the head is turned becomes more prominent. The muscles should be palpated, as hematomata in these muscles are common as the result of trauma at birth. They are frequently not diagnosed until calcification takes place. Their only significance is that in an occasional case permanent torticollis results. This can usually be prevented by postural treatment.

The thyroid gland is not normally visible or palpable.

CHEST

The chest is normally well rounded (barrel shaped), although the contour may vary considerably. The costal angle is usually 90° or more.

Mammary glands.

Enlargement of the mammary glands is not present normally during the first day of life but usually appears in the early neonatal period even in male infants. The enlargement may be unilateral or bilateral. The breasts may contain a milky fluid. Manipulation should be avoided because of danger of infection; no treatment is necessary for this type of enlargement of the breasts.

Thymus gland.

The relation of the thymus gland to the well-being of the newborn infant is a matter which has been the subject of a vast amount of speculation and investigation.

Pathologic studies have shown a close relationship between the weight of the infant and the size of the thymus gland. The well-nourished infant has a relatively large thymus gland while the poorly nourished infant has a relatively small one. Any symptoms or clinical findings pointing to an enlarged thymus should lead to roentgenographic examination (see p. 19); but in the light of our present knowledge, treatment of an "enlarged" thymus gland by roentgen ray is justified only if symptoms are present that are regarded as characteristic of an enlarged thymus gland and that cannot be otherwise explained.

Lungs.

Respirations are chiefly abdominal in type. The rate and depth of the respirations are extremely variable, even in sleep. Light percussion produces normal resonance over the entire lung areas. Auscultation reveals bronchovesicular breathing of equal intensity over the corresponding areas of each side, without râles. The expiratory phase is longer and louder in the newborn than in the older child or the adult.

Heart.

Three points should be borne in mind when examining the heart of a newborn infant: The variability in the heart rate, the difficulty in determining the size of the heart, and the frequency of murmurs.

The heart rate of the new born infant is rapid and varies greatly with the phases of respiration and with crying and also with sleeping and waking (80 to 160 per minute). At times a very marked