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SUGGESTIONS FOR CARE DURING PREGNANCY

THERE are certain general principles to be observed during pregnancy which will contribute to the comfort and safety of the patient. The following suggestions are intended as a guide for prenatal care which your doctor may add to or alter as conditions may suggest.

Office Visits: You should consult your physician early in pregnancy, preferably not later than the third month, and regularly every three or four weeks during the first six months. Thereafter the visits should be more frequent as your doctor directs. Take with you, at each visit, a specimen of urine (2 or 3 ounces) collected at the first urination on the day of your visit.

The Clothing should be designed for comfort and suitability rather than to disguise the condition. The weight of the underclothing should be determined by the season and weather and should be of knitted rather than woven material. After the sixth month all clothing should be suspended by shoulder straps or from a maternity or elastic girdle which may be worn during the latter months of pregnancy.

Do not wear circular garters.

Wear shoes with laces and low heels.

Diet: All foods should be simply and thoroughly cooked.

Eat the heartiest meal in the middle of the day.

The amount and kinds of fluids, including alcoholic drinks, should be prescribed by your physician.

Throughout pregnancy one should eat foods that afford calcium and phosphorus. Some excellent sources of these are: asparagus, beans, cabbage, carrots, celery, chard, cheese, dates, eggs, figs, lentils, liver, milk, oatmeal,

oranges, peas, pineapple, prunes, raisins, spinach, whole wheat bread.

During the first three months, starchy foods are best. This is especially true if there is much nausea or vomiting, in which case it is advisable, also, to eat small amounts frequently—every two hours—rather than three meals a day.

Meat, eggs and fruits should be taken in moderation.

In the next three months a general diet is allowed; care being taken not to overeat. Candy and sweets should be omitted and starches reduced.

During the last three months, eat mostly green vegetables, cooked and raw, fruits, fruit juices, moderate amounts of lamb, beef, fish with white meat, or white meat of fowl. Your physician will advise you of any special diet.

Avoid at all times fried, highly seasoned or improperly cooked dishes and the foods to which one may have an idiosyncracy, such as strawberries, crabs, lobsters, etc.

Watch weight: Unless otherwise advised, do not gain more than three to three and one-half pounds a month. Sudden, rapid gain in weight may be disastrous. Twenty to twenty-five pounds is the gain in weight allowed during the average pregnancy.

Exercise: Walking is the best form.

For the first three months very little is required. If there is much nausea or vomiting, it is better to remain quiet.

After the first three months, exercise more and more, walking from one to two miles a day, but avoid fatigue. During the latter part of pregnancy, walking may produce discomfort because of the weight and pressure of the pregnant uterus. In this event, any exercise at this time should be slow and deliberate and never carried to the point of undue discomfort or fatigue.

Other mild forms of exercise are allowed some patients early in pregnancy. Ordinary housework is rarely harmful and is an excellent form of exercise if you do not do too much of it. If outdoor exercise is impossible, you should keep the windows open while working or exercising indoors.

Avoid rapid and excessive climbing of stairs, jumping from elevations, lifting heavy weights, standing for prolonged periods, horseback riding, tennis, badminton and long automobile rides.

Rest: Each month at the regular menstrual time.

Each day for an hour or two after the noon meal.

Fresh Air: Be out of doors as much as possible. At least two hours every pleasant day.

If unable to exercise in the open, spend a definite period each day in a room with the windows wide open.

Sleep in a well-ventilated room, or outdoors if possible.

Avoid theatres and crowded places where there is improper ventilation.

Bowels: Have at least one good movement a day.

Attempt to regulate diet with this in mind. Much can be accomplished by the use of coarse cereals, bran, whole-wheat bread, fruits and green vegetables.

If a laxative is needed, use cascara sagrada tablets, 5 or 10 grains as required, or a tablespoonful or two each night of a preparation of mineral oil and agar-agar.

Plain water or soap suds enemas may be used.

Avoid castor oil and saline laxatives unless prescribed by your doctor.

Breasts and Nipples: Do not wear corsets or binders that compress the breasts. Pendulous breasts should be supported with a proper "supporting" brassiere.

From the seventh month on, wash the nipples with warm water and soap each night; dry and anoint with Mennen Antiseptic Oil.

If flat or inverted, the nipples should be massaged. This is done by grasping the nipple between the thumb and first and second fingers and drawing it out. Repeat the maneuver for five minutes at a time.

Teeth: Have your teeth examined early in pregnancy and see your dentist frequently. Simple extractions and fillings may be done but extensive oral surgery is not advisable.

Clean your teeth morning and night with an alkaline paste or solution. Milk of Magnesia or bicarbonate of soda may be used for this purpose.

Bathing: Take a warm bath or shower every day, preferably before retiring. Avoid the shock of cold or hot water.

Shower baths are preferable to tub baths, and the latter should not be taken during the late months of pregnancy.

Marital Relations: Intercourse, during the early months in pregnancy, is a frequent cause of abortions. For this reason it should occur infrequently during the first three months and, in some cases, should be absolutely discontinued during this period. It must be discontinued during the time which would normally be the menstrual periods and after the eighth month.

Vaginal Douches should not be taken unless advised by physician.

Mental Attitude: The surroundings of the expectant mother should be conducive to cheerfulness. Everything

should be done to provide her with entertainment or amusement at home in the form of reading matter, light, agreeable occupation, and pleasing company.

Your pregnancy should not deter you from going out among friends and attending informal social functions, providing these occasions do not deprive you of rest or entail fatigue.

Smoking: Smoking during your pregnancy and the nursing period should be decided by your physician. Consult him.

Complications of Pregnancy: Conditions that need your doctor's attention and should be reported to him immediately are: Continued and prolonged vomiting, dizziness, spots before the eyes, swelling of the face, hands, legs or feet, bleeding from any part of the body, fainting spells, severe headaches, rupture of the membrances (bag of waters) indicated by an uncontrollable flow of fluid from the vagina.

You should also notify your doctor of swollen veins in the legs, hemorrhoids (piles) or severe pains in any part of the body. Watch carefully for any lessening of the usual quantity of urine passed. The normal amount is from three to four pints in twenty-four hours.

Advice: Do not seek advice from friends or relatives. Many fallacies exist regarding the care of expectant mothers. Learn the facts by consulting your physician and be guided only by him.

Examinations after delivery: You should be examined two weeks after your baby is born and again at six weeks. These are important. Do not fail to report to the office for your final, sixth week, examination.

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The following are suggestions for your care, when you are able to be out of bed or home from the hospital, and for your baby:

MOTHER

Do not go up or down stairs or do any housework until three weeks after labor.

Rest two hours every day after the noon meal and retire early.

Eat a general diet of three regular meals a day, including plenty of cooked cereals, starches, green vegetables and meats in moderation. Drink coffee, cocoa and milk in moderation. Tea is often constipating and should be omitted. Water should be taken freely between meals. Forcing one's self to eat or take nutritious drinks between meals with the idea of increasing the breast milk is not advised.

Take scrupulous care of the nipples. Wash them with boracic acid (1 level tablespoonful dissolved in 1 pint of boiling water) solution before nursing. Then apply Mennen Antiseptic Oil and cover with sterile gauze afterward.

As long as there is a bloody, vaginal discharge do not take a tub bath. Warm showers are permitted.

Do not take a douche unless advised to do so.

For constipation use mineral oil or one of the agar-agar preparations and enemas if needed.

Short auto rides are allowed after the fourth week, but do not drive a car until six weeks after labor.

BABY

Anoint the baby daily with Mennen Antiseptic Oil. If preferred, a warm water bath followed by the oil is allowed.

Feed at regular intervals. Start at 6:00 A.M. and continue at three- and four-hour intervals until 9:00 or 10:00 P.M., then at four-hour intervals if the baby awakens.

Place the crib in a corner where the baby will not be exposed to drafts.

Keep the nursery at an even temperature of 68° to 70°.

If the baby is born in the winter, it is advisable to have the under-garments of silk and wool. In warm weather cotton may be worn.

In warm weather the baby may be taken out doors when three weeks old. In cold or inclement weather, postpone the outing and give a daily airing in a room with the windows open.

If constipated, give the baby a warm water enema with an infant's syringe or use a glycerine suppository. See that the bowels move at least once a day. One to three movements are considered normal and nursing infants may have even more.

If not satisfied after nursing 20 minutes from one breast, try nursing for 10 minutes from both breasts. If this does not suffice, consult your physician.

Keep baby quiet. Do not handle except at times for feeding, bathing or changing diapers.

REGARDING VISITORS

In order to protect both baby and you against contracting infectious and contagious diseases, the number of visitors should be limited to a minimum during the first few weeks following birth. Friends and relatives should cooperate in observing hospital visitor regulations.

MEMORANDA

DR.

ADDRESS

TELEPHONE

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Reprinted for the Children's Bureau, U. S. Department of Labor, from the AMERICAN JOURNAL OF PUBLIC HEALTH.

Nutrition in Relation to Pregnancy and Lactation*

J. ERNESTINE BECKER, HUGH J. BICKERSTAFF, M.D., M.P.H., F.A.P.H.A., AND NICHOLSON J. EASTMAN, M.D.

Associate in Biochemistry; and Associate in Public Health Administration, School of Hygiene and Public Health; and Professor of Obstetrics, Medical School, Johns Hopkins University, Baltimore, Md.

THERE is no longer any doubt that fertility and nutritive efficiency are intimately related. One of the criteria of dietary adequacy employed generally by students of nutrition is the ability of animals to reproduce and rear young successfully throughout succeeding generations. Stock raisers and animal husbandrymen have long appreciated the value of providing their breeding animals with a food allowance of superior quality. The practice in the highlands of Scotland of supplementing the food of the sheep just before the period of the annual estrus is said to increase materially the fertility of the flocks.

Though it has been recognized for many years that extreme poverty of diet or the extreme deprivations of war or famine affects both fertility and birth weight in humans, the effects of specific dietary deficiencies and of suboptimal nutrition on pregnancy and lactation in women have only recently received intensive study. The abundance of evidence obtained from animal experimentation, the marked improvements in experimental and clinical technics, and the ever widening interest in nutrition have stimulated a keen desire for exact information on the rôle of diet in human reproduction and lactation. For the worker in the field of public health such information is of paramount importance.

A comprehensive review of the dietary requirements in pregnancy and lactation was prepared by Garry and Stiven [1] in 1936. More recently, after a critical study of the literature, the

TABLE 1

Recommended Daily Allowances for Specific Nutrients
Committee on Food and Nutrition, National Research Council

	Calories	*Protein* gm.	*Calcium* gm.	*Iron* mg.	*Vitamin A* I.U.	*Thiamin (B_1)* mg.	*Ribo-flavin* mg.	*Nicotinic Acid* mg.	*Ascorbic Acid* mg.	*Vitamin D* I.U.
Pregnancy latter half	2,500	85	1.5	15	6,000	1.8	2.5	18.0	100	400–800
Lactation	3,000	100	2.0	15	8,000	2.3	3.0	23.0	150	400–800

* Read before the Food and Nutrition and Maternal and Child Health Sections and the Oral Health Group of the American Public Health Association at the Seventieth Annual Meeting in Atlantic City, N. J., October 17, 1941.

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Committee on Food and Nutrition of the National Research Council has set up dietary allowances for people of different ages.[2] Since the purpose of this paper is to set forth in review the present-day knowledge of nutrition in relation to pregnancy and lactation, it seems profitable to consider in some detail the allowances set up by this committee, which are presented in Table 1.

ENERGY NEEDS OF THE PREGNANT WOMAN

Let us first consider the energy needs of the pregnant woman. The consensus among investigators is that there is a decrease in heat production in early pregnancy. After the third or fourth month there is a steady rise. Shortly before delivery the basal metabolic rate may be increased by as much as 25 per cent, but curtailment of activity at this period offsets this increased basal.

Obstetricians generally agree that pregnancy should involve a gain of no more than 20 to 25 pounds. Studies of Stander and Pastore,[3] however, indicate that normal pregnant women experience gains proportionate to their original size. A daily intake of about 2,500 to 2,800 calories readily meets the total energy needs of the average pregnant woman. Under continuing observation, bearing in mind relative as well as absolute increase, and rapidity as well as amount of gain, adjustments to meet individual needs may be made without detailed calculations.

The rapid weight gains associated with toxemias of pregnancy cannot be attributed to overeating. Such weight increase is of sudden and rapid onset and is pathological in contrast to the more gradual weight gains that characterize uncomplicated pregnancy.

Rarely, for the very obese pregnant woman, a low calorie diet may be necessary. In such cases *calories only* should be limited and the same amounts of protein, minerals, and vitamins must be provided as are recommended for the woman of normal weight. This involves special dietary calculations. Effort to limit the size of the fetus by restricting the food intake is rarely effective. Furthermore, it carries the serious risk of inducing nutritional deficiencies in both mother and child.

The recommendations of the Committee on Food and Nutrition do not indicate what proportion of the total calories should be derived from carbohydrate and fat. It is probable that the levels of these foodstuffs that have long been considered as desirable in the diet for the non-pregnant adults are likewise to be employed in pregnancy, *i.e.*, 50–70 per cent of the total calories from carbohydrate and 20–35 per cent from fat. References in the literature allude to a tendency toward lowered glucose tolerance and glycosuria and increased accumulation of acetone bodies and tendency toward ketone acidosis as concomitants of pregnancy.[4] However, such tendencies are not pronounced enough to justify any radical change in the carbohydrate and fat content of diets for normal pregnant women.

PROTEIN INTAKE DURING PREGNANCY

The idea prevails quite generally that excess of protein exerts a harmful effect in human pregnancy. Not infrequently the toxemias of pregnancy are attributed to the too liberal consumption of meat. In consequence, many practising obstetricians advocate some restriction of meat ingestion. On the other hand, Strauss[5] asserts that a diet low in protein may be a cause of pregnancy toxemias, and reports clinical cases successfully treated by a high protein diet supplemented by thiamin and liver.

It has been reliably reported that total net nitrogen requirement, over maintenance requirement, during pregnancy is about 135–145 gm. In addition, the maternal organism tends to store nitrogen far in excess of this

theoretical requirement. Macy and her coworkers [6] have called attention to the fact that in women the greater the retention of nitrogen in the latter part of pregnancy, the greater the likelihood of a sufficient milk supply. Thus, in the light of present-day knowledge and experience a generous rather than a restricted protein intake is to be recommended.

MINERAL REQUIREMENTS

Experimental evidence indicates that thirteen or more mineral elements are essential for human nutrition. Calcium, phosphorus, iron, and iodine have been studied the most extensively, and it is believed now that if these are provided in sufficient amounts in the daily diet the other nine or so will be present in satisfactory amounts. Actually, since phosphorus is an almost invariable constituent of protein, a sufficiency of the latter is a guarantee of an adequacy of the former. Except in regions of endemic goiter, iodine need receive no special consideration. In such areas the use of iodized salt is usually advocated.

That pregnancy exerts a drain on the calcium and phosphorus supplies of the mother is a demonstrated fact. Experiments on farm animals indicate that both of these elements are necessary for normal fertility and the birth of normal young. According to evidence cited by Maxwell and Miles [7] infants born of mothers with osteomalacia usually are osteoporotic and later develop rickets. True fetal rickets may also occur, accompanied by gross hypoplasia of the enamel of the teeth and defective dentine formation. Evidence of a similar nature has been obtained by a number of other investigators. In a recent study, Burke [8] has noted that 11 children with perfect teeth at 6½ years of age were the offspring of mothers whose daily diets during pregnancy included at least one quart of milk, in contrast to a group of 12 children with the largest number of defective deciduous teeth at 3 years of age whose mothers' diets included 1 pint of milk or less per day.

Studies have shown that the calcium content of the fetus at term is about 25 gm. Authorities generally agree that 0.68 gm. of calcium a day meets the needs of the normal adult. To avoid robbing the tissues of the mother and to assure storage, an ample excess over these combined requirements should be provided. In view of these facts and in consideration of evidence afforded by balance studies during pregnancy, it is safe to assume that the suggested allowance of 1.5 gm. of calcium per day suffices.

Attention should also be directed to the fact that there is some evidence that the calcium and phosphorus from milk is better than from other foods and that it is difficult, if not practically impossible, to supply in other foods amounts equivalent to what can readily be supplied in milk. Calcium in the form of its salts is not as effectively utilized as the calcium of milk, and at usual retail drugstore prices costs more than the same amount acquired from milk. Furthermore, when given in this form none of the additional nutritional value of milk is obtained.

It has long been recognized that the human infant and the young of other mammals at birth are supplied with a store of iron sufficient to carry them through the early months of life. Since the maternal organism supplies this iron, as well as that needed for the growth of the fetus, it is only logical that iron requirements are increased in pregnancy.

The drain upon the mother to supply the needs of the fetus, together with the rather frequent occurrence of pregnancy of gastric hypo-acidity, and the use of diets often inadequate in iron, may account for much of the anemia

so common in pregnancy. In substantiation of this is the observation of Wills [9] that there is a greater incidence of low hemoglobin values in pregnant women on low incomes, and that the blood hemoglobin level can be maintained at satisfactory levels from the fifth month to the end of pregnancy by the administration of iron. Similar evidence is offered by Corrigan and Strauss [10] who showed that the blood of apparently normal pregnant women can be considerably improved by supplementation with iron. Burke [11] cites the case of a woman whose diet was carefully followed through three pregnancies. She states:

> When first seen she consumed a diet rated "fair" in iron. This was toward the end of the second trimester of the first pregnancy. She had improved her iron intake to "good" during the latter part of the first pregnancy. In the second pregnancy she took a diet rated "good to excellent" in iron and had iron medication from the 6th month to the end of that period. In her third pregnancy she received no iron medication but had taken a diet "excellent" in food iron throughout this third pregnancy, using such foods as liver, apricots, molasses, lean meat, leafy greens, whole grain bread and cereal, etc., liberally. In each pregnancy she showed a higher hemoglobin level than at the previous pregnancy.

Improvement of the hemoglobin levels of the three children in the first 6 months of infancy paralleled that of the mother during her successive pregnancies.

In arriving at an adequate iron intake for the pregnant woman as in the consideration of all other dietary essentials, the factors of availability, absorbability, and interrelationships must be recognized. There is general agreement that iron to be absorbable must be soluble, ionizable, and ultrafilterable. Such forms are reduced iron, salts soluble in acid solution, and the hydroxides of iron, which are readily changed to salts by acids. Also ferric iron becomes available only when hydrochloric acid is present in the stomach, since in achlorhydria anemia occurs. Thus, as cited by McCollum, Orent-Keiles, and Day,[12] of the estimated iron in dry pork liver, 67 per cent is available; of that in dry oysters, 22 per cent is available; while of that in egg, molasses, raw carrots, apples, peaches, pears, 100 per cent is available.

A nutritional anemia can be produced by a diet inadequate in the quality or quantity of its protein. Anemia also develops on a diet deficient in vitamin A or ascorbic acid or one where the calcium:phosphorus ratio is unfavorable. It has been estimated that the iron contribution of the mother during pregnancy is 400 to 600 mg. and that the diet of the pregnant woman should provide for the absorption and utilization of 500 mg. of additional iron. A daily intake of 15 mg. of iron is thought to meet these demands. Practically speaking, a diet selected to meet the needs for protein and the various vitamins usually provides more than 15 mg. of iron. If, in spite of the above precautions, anemia exists, an iron supplement may be imperative.

Metabolism studies indicate that in pregnant women the sodium balance is usually positive and more than adequate for fetal needs. Because there is a definite relationship between the amount of salt eaten and the water retained by the body and because in pregnancy the tissues show a marked avidity for water, many obstetricians advocate the curtailment of salt intake. It is a judicious practice to restrict the use of salt to that amount used in cooking and to prohibit the use of additional salt at the table, with more stringent restriction in the event that rapid weight gain or other evidence of water retention appears.

FLUID INTAKE

Obstetricians generally indorse an ample fluid intake during pregnancy.

If for no other reason than overcoming urinary stasis incident to the loss of tone of bladder and ureters during pregnancy, fluids are important. The dictum of a liberal fluid intake often loses emphasis by its very generality. About two quarts of liquids daily are recommended. The daily use of one quart of milk, already alluded to, will furnish half of the fluid and the other half can be most acceptably provided by water, soup, fruit juices, and beverages.

VITAMIN REQUIREMENTS

In the recommended daily allowances, estimates are given only for vitamins A and D and thiamin, riboflavin, nicotinic and ascorbic acids. The committee [2] states:

> In addition to the three factors of the B complex included, other members of the group, such as vitamin B_6 and pantothenic acid should be given consideration. But at the present time no specific values can be given for the amount required in the human dietary. It should be added, however, that foods supplying an adequate amount of thiamin, riboflavin and nicotinic acid will tend to supply an adequate amount of the remaining B vitamins.

It is safe to assume that a diet deriving the aforementioned essentials from *natural food sources* will provide adequate amounts of the less well known factors.

The suggested allowance for vitamin A represents an increase of 20 per cent above that for the average adult. This estimate is based chiefly upon clinical tests on non-pregnant adults. Experimental investigations and observations on humans have demonstrated that the chief function of vitamin A is the preservation of the integrity of epithelial membranes. Probably as a result of the protection of these membranes, vitamin A serves indirectly to lessen susceptibility to infection, especially of the respiratory and genitourinary tracts. Garry and Stiven [1] cite several references to the beneficial effects of concentrates of vitamins A and D in reducing the tendency to puerperal sepsis. Vitamin A deficiency in animals results in disturbance in the estrus cycle in females, prolonged gestation, and fetal death. In males, testicular degeneration occurs which can be alleviated by the subsequent administration of vitamin A. Inclusion in the daily diet of whole milk, butter or fortified margarine, eggs, green, leafy, and yellow vegetables insures a vitamin A intake considerably in excess of that advocated by the Committee on Foods and Nutrition of the National Research Council.

There is an extensive literature on the rôle of thiamin in pregnancy. Some of the abnormalities described in experimental animals are undoubtedly due to multiple deficiencies, but it is an established fact that animals, and probably humans, on thiamin-deficient diets give birth to young which shortly after birth exhibit symptoms characteristic of polyneuritis. The increased demands of pregnancy, too, are frequently sufficient to produce symptoms of thiamin deficiency in pregnant animals on diets on which non-pregnant animals show no visible signs of polyneuritis.

In recent years there has been a growing belief that some of the pathologic conditions developing during pregnancy are manifestations of deficiency of one or more of the constituents of the B complex. Polyneuritis of pregnancy is undoubtedly a dietary deficiency similar to beriberi, and therapy should aim at provision of the deficient nutrients, especially the vitamin B complex. Marked improvement or disappearance of the polyneuritic manifestations occurs in many cases following thiamin treatment.

As stated by McCollum, Orent-Keiles and Day [12]:

The polyneuritis of pregnancy would seem to have its origin in several causes or associated factors, among which are anorexia and vomiting of pregnancy. Plass and Mengert have pointed out that in the forcing of high carbohydrate diets on patients with vomiting or pregnancy there would seem to be increased risk of producing vitamin deficiencies. Depletion of thiamin, of course, might be expected, since carbohydrate foods tend to increase the requirements for this nutrient.

Because of the increased need for thiamin, and especially because of its rather limited distribution in common foods, it is of paramount importance that whole grain breads, whole grain cereals, lean meat, eggs, peas, beans, lentils and other vegetables and fruits are accorded a conspicuous place in the diet of the pregnant woman.

Recently both riboflavin and nicotinic acid have been shown to have specific rôles in human nutrition. It is known that the former is effective in the prevention and cure of a specific keratitis and lesions at the angles of the mouth and nose. Nicotinic acid is frequently called the antipellagra factor because its absence or inadequacy is the chief, but probably not the only, factor involved in the causation of human pellagra. Reliable data for the absolute amounts of riboflavin and nicotinic acid required for normal nutrition are lacking at this time. However, the provision of protein and thiamin in sufficient amounts and from natural sources give assurance of adequate quantities of riboflavin, nicotinic acid, and the other constituents of the B-complex.

Increase in metabolic rate is invariably accompanied by a need for increased amounts of ascorbic acid. There is an increased metabolic rate after the first trimester of pregnancy and it has been established beyond a doubt that pregnant and lactating women need considerably more ascorbic acid than do non-pregnant adults. Neuweiler[13] has described ascorbic acid excretion studies on non-pregnant, pregnant, and lactating women which he conducted in order to estimate the requirements during pregnancy and lactation. He found it was necessary for the pregnant and lactating women to ingest considerably larger amounts of the vitamin in order to maintain an excretion level regarded as indicative of adequate vitamin intake. The studies of Teel and coworkers[14, 15] corroborate the findings of Neuweiler. The daily consumption of citrus fruits, tomatoes, and other raw fruits and vegetables will provide in palatable form the necessary ascorbic acid.

It is generally agreed that vitamin D is needed throughout life, the requirement being greatest during infancy and during pregnancy and lactation. The main function of this vitamin is its rather spectacular regulation of calcium and phosphorus metabolism. When it is present in optimum amount it brings about the maximal utilization of these two minerals. It is a vital factor in the prevention and cure of rickets and in the maintenance of a sound skelital structure throughout life. It undoubtedly plays an important rôle in the building of sound, caries-resistant teeth. If it performed no other functions than those enumerated its inclusion in the diets of pregnant and lactating women is essential.

Unlike the other dietary essentials, vitamin D is not widely distributed in natural foods. Indeed, it is the one factor that one must obtain from sources other than the food supply. Fish liver oils are commonly employed to supply this vitamin. In the Temperate Zone it is customary to prescribe a vitamin D supplement from October through April.

The rôle of vitamin E in the prevention of sterility in rats, cows, sows, and other animals, and as a factor of importance to the hatchability of hen's

eggs has been demonstrated. Some clinical reports have appeared which suggest that wheat germ oil, a rich source of vitamin E, is of value in preventing spontaneous abortions in women. Satisfactory controls are lacking as is so often the case in human nutrition studies. The distribution of vitamin E is such that a diet containing insufficient amounts would no doubt also lack other factors essential for a successful pregnancy. Where its administration in large amounts has proved effective in combating spontaneous abortion one wonders whether some metabolic perversion exists necessitating an intake so much greater than that which is considered normal.

There is as yet no generally accepted unit of vitamin E. The Committee on Food and Nutrition of the National Research Council have set up no allowances probably because of insufficient evidence of its rôle in human nutrition and the lack of a satisfactory unit of measurement and methods of assay.

No allowances have been set up for vitamin K as yet. However, its place in human nutrition has been definitely established. It is essential for the maintenance of a normal plasma prothrombin level and is an important factor in regulating the clotting time of the blood. Although a diet of natural foods seems to provide sufficient vitamin K for the normal person, circumstances may arise in pregnancy when this is insufficient. It has been shown that the administration of this vitamin, in pure form antenatally to the mother, effects a marked reduction in the hemorrhagic diathesis and cerebral hemorrhage in the new-born. Hence the routine use of vitamin K may well become a valuable addition to obstetric practice.

LACTATION

Throughout pregnancy the maternal organism is called upon to provide nourishment for the fetus. Lactation is but a continuation of this function through the medium of the milk supply rather than the placenta. As the child grows the need for nourishment is increased many times over that of fetal life. Consequently, larger amounts of all those nutrients that have been stressed as being essential for successful pregnancy are needed for the establishment of a milk supply of high quality. Abundant evidence exists demonstrating that the milk supply of any lactating animal is markedly affected by diet. Insufficient calories and inadequate protein reduce the quantity of milk produced; inadequate amounts of minerals serve chiefly to rob the tissues of the lactating animal; and inadequate amounts of any of the vitamins reduce the quality of the milk in so far as that specific vitamin is concerned.

SUMMARY

Enough evidence, both clinical and experimental, has been cited to call attention to the importance and need for sound dietary advice and practices throughout pregnancy and lactation. Almost every pregnant woman is sufficiently interested in her own health and that of her child to be willing to follow any practice that will lessen the hazards of pregnancy and aid in the building of a fine baby. She needs advice of a definite, positive kind, advice that she is capable of understanding and that she has the financial means of following.

It is not enough to state "no special diet is required during pregnancy. If you are accustomed to eat nutritious and easily digestible food in properly balanced proportions, no change in your dietary routine is necessary." How does a mother know whether her food is nutritious and in properly balanced proportions. The taking of a detailed dietary history several times during

pregnancy, followed by suggestions and help in the making of necessary changes, would seem as important a procedure in the management of pregnancy as the physical examination and medical history.

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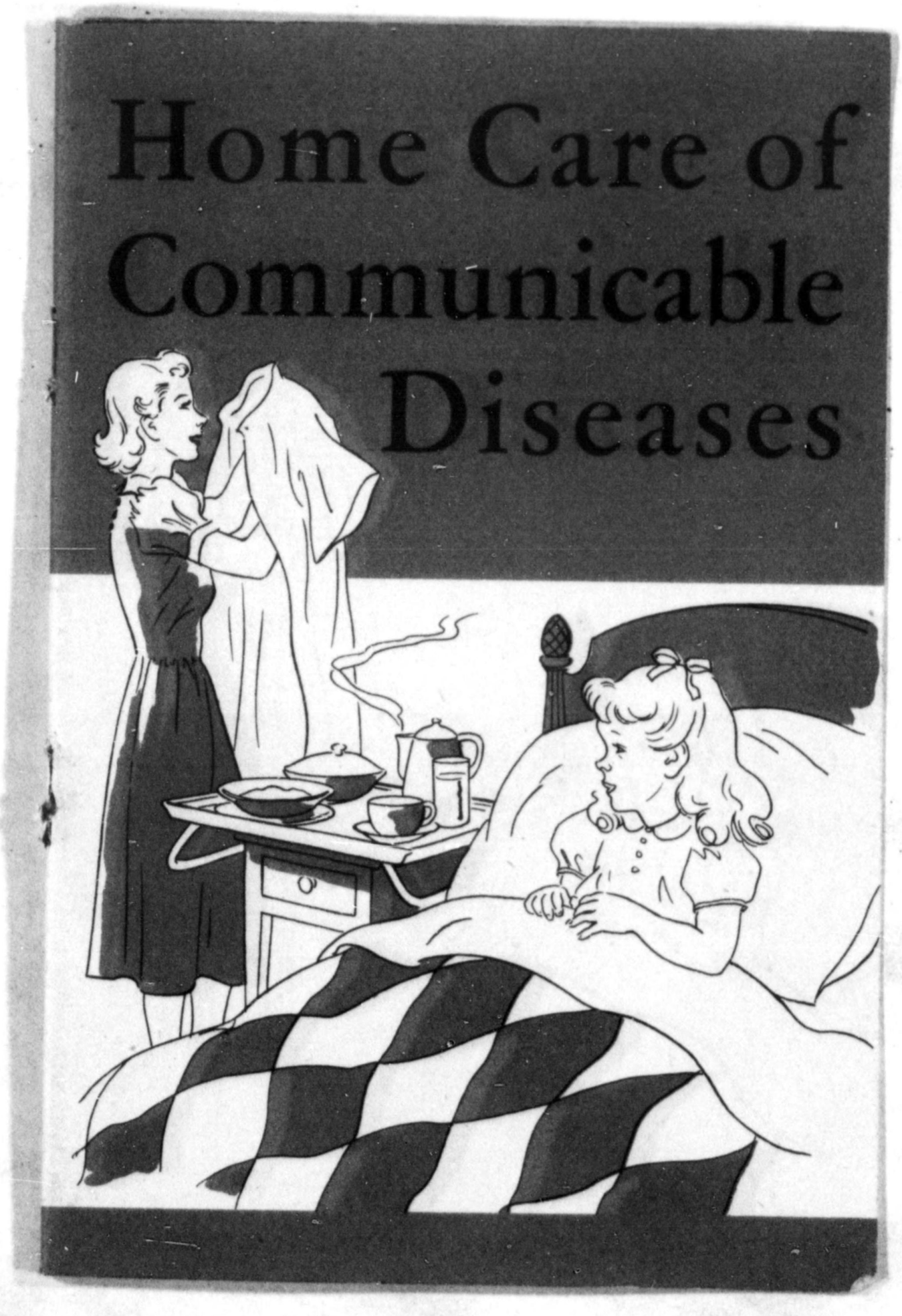

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HOME CARE OF COMMUNICABLE DISEASES

IF her child wakes in the morning or comes home from school with the "snuffles" and his eyes watering, if he feels feverish, and generally miserable, the wise mother puts him straight to bed in a room by himself and calls the doctor promptly. It may be only a cold. Even so, bed is the place for him. But it may be a condition much more serious. If it is one of the contagious diseases of childhood, bed is certainly the place for him.* The table in the middle of this booklet shows that most children's diseases begin with symptoms much like the first signs of a cold.

Although communicable diseases are most frequently spread during the early stages, often before a diagnosis can be made, it is still important to keep the patient in bed and away from his brothers and sisters and playmates because he can still pass on the

* The words "contagious", "communicable", and "infectious" are customarily applied to any disease that is spread from one person to another. In this booklet the words all have the same meaning as "catching".

infection to them. Isolation is of all the more value if there are smaller children in the household, for communicable diseases go especially hard for youngsters between the ages of six months and three or four years. Most deaths from these diseases occur among babies and toddlers.

There are three good reasons why the family physician should be called promptly when sickness threatens. It is important to know the nature of the illness, early medical treatment is always the most effective, and advice is needed about protecting others.

Often the skill and judgment of the most experienced physician are put to the test in deciding into what disease of childhood a condition may be developing. Certainly making a diagnosis is not something for parents to attempt, no matter how many such illnesses they may have been through. The family doctor should be called early because rashes sometimes appear and fade before they are noticed by a non-medical person. Aches and pains may be so vaguely described by the little patient that only a physician will recognize their significance.

Prompt medical care may influence the severity of the attack. In diphtheria the early administration of antitoxin may mean the difference between

prompt recovery and long illness. The outcome of other diseases, too, often depends upon early treatment. Giving household remedies while waiting to see if the disease will become serious may result in a really serious outcome.

All the members of the household are protected when the physician is called early. He will decide what precautions must be taken to protect others in the family and will give advice about watching for the appearance of symptoms in those who have been exposed.

Ways By Which Catching Diseases Are Spread

PEOPLE, not things, usually spread communicable diseases. Saliva is the chief agent which carries the infection. Until recent times there were differences of opinion about the transmission of disease. Our forefathers thought the infectious agent was the night air itself. Sewer gases were wrongly accused of spreading diseases. Peeling skin from recovered cases was mistakenly thought to be dangerous. Elaborate methods of fumigation based upon these misconceptions were used to ward off epidemics.

Catching diseases are spread by the transfer of saliva.

It is clear now that many of these old ideas were wrong. Medical science has shown that it is not infectious articles but infectious people who are the chief spreaders of communicable disease. There are a few well-known exceptions to this rule, such as malaria which is spread by mosquitoes.

Discharges from the nose, throat, or ears of a sick child, if such discharges occur, are dangerous but saliva is the most common spreader of the childhood infections. Saliva may be transferred directly from sick to well children through close contact. Kissing is the most direct method of transfer but the saliva may be passed from one to another by coughing, sneezing and perhaps even talking. Indirectly the infectious saliva may be spread on playthings or any article used by more than one child. Children habitually put fingers and toys into their mouths. The child coming down with a catching disease passes the infection in these ways to his playmates.

Not all children who can spread disease give evi-

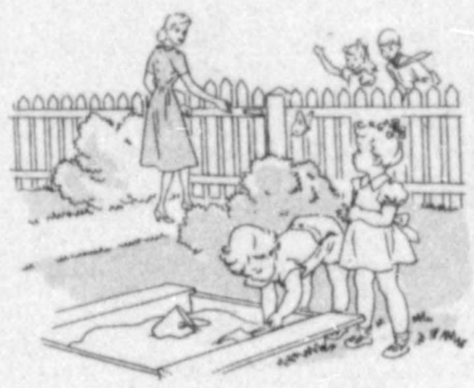
dence that they are ill. In some instances the infection is so mild that the child does not complain and hence is not put to bed, yet his saliva may be as infectious as that of a child who is frankly sick. Occasionally the saliva remains infectious after the child has recovered from the disease. Children who are not sick but may be infectious are called carriers.

Immunity to Disease

ONE attack of chickenpox, measles, German measles, mumps, scarlet fever, smallpox, whooping cough, or infantile paralysis usually protects the patient against a second attack of the same disease. Instances of a child coming down a second time with any of these infections are rare. One attack of influenza, pneumonia, or the common cold seems to confer no lasting protection. Natural attacks of diphtheria are not necessarily followed by immunity, especially if antitoxin is administered, yet treatment with toxoid renders the child immune in nearly every instance.

Preventing Infection

FOR those diseases against which we have no protective treatments, parents may help their children to avoid catching them even though all contact



During epidemics keep babies and toddlers from unnecessary contact with school-age children.

with infection cannot be prevented. Without making their youngsters morbidly afraid of illness, parents can do these things:

During epidemics babies and toddlers should be kept away from older school children, especially those who are coughing or sneezing.

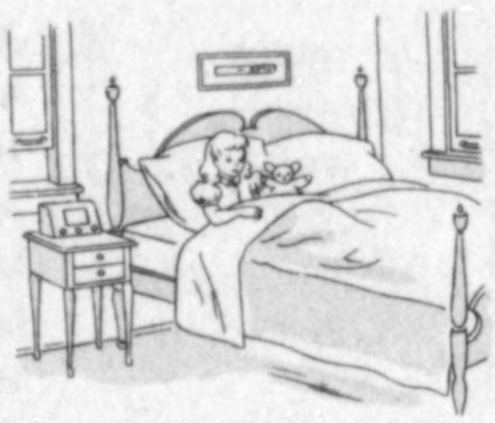
Teach children to keep out of their mouths articles that may have touched the lips of others.

Require children to wash their hands with soap and water before meals.

The Question of Hospital or Home Care

SOME diseases, such as diphtheria, poliomyelitis (infantile paralysis), and pneumonia which need special treatments, can be cared for most successfully in the hospital. Where such hospital facilities are available, foresighted parents will see to it that the child receives the benefits which these institutions have to offer. In communities without hospitals, or during epidemics when the institutions

can take no more patients, parents have no choice but to care for the child in the home. Other diseases, which require no special treatments, may be cared for as satisfactorily in the ordinary home as in a hospital.



The patient should have a bright sunny room, free from hangings and unnecessary furniture.

When a child, sick with a communicable disease, is cared for at home, the member of the family who attends to the patient has a great responsibility. In this booklet she is called the attendant. In giving care to the patient the attendant will be instructed by the family physician and she may be aided and guided by the public health nurse.

If the patient is to remain at home, he should have the sunniest, most easily ventilated room — completely screened and free from unnecessary furniture, rugs, and draperies — where he can be isolated from every one else in the household. All other members of the family should be excluded from the sick room, otherwise there is little point in having the attendant carry out all of the suggestions which follow.

The room should be equipped with two tables — one with pitcher, basin, soap and towel for the attendant's use. A second table is provided for the patient and equipped with wash basin, jar of cotton, tissue paper or soft cloths, tooth brush, comb, soap, mouth wash, and a thermometer.

Procedures for Communicable Diseases

HEALTH board regulations for the isolation of communicable disease cases vary somewhat in different parts of the country. When a case is reported, a doctor or nurse from the health department usually calls promptly to discuss with the attendant the rules which must be complied with. Subject to local variations, the following general procedures should be observed by the attendant in giving care to a patient sick with any of the communicable diseases.

1. Assemble all necessary articles before entering the sick room to avoid the necessity of leaving the room before care is completed.
2. Wear a large apron while caring for the patient and leave the apron always in the sick room.
3. Wash hands thoroughly after caring for the patient.

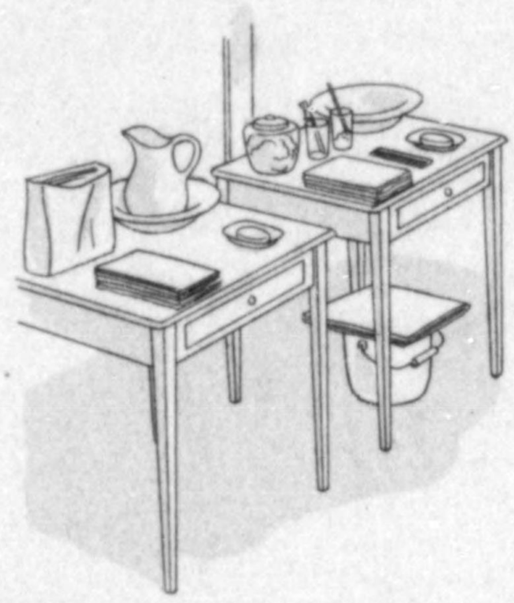
4. Turn away from the patient when he coughs or sneezes and keep own hands away from mouth.

When giving care to diseases such as influenza, pneumonia, whooping cough, German measles, measles, or mumps, the attendant should observe the following precautions:

5. Discharges from the mouth and nose should be destroyed. Clean cloths or paper handkerchiefs should be used and collected in a paper bag by the bed and later burned if possible.
6. Eating utensils may be washed with the household dishes provided plenty of soap and hot water are used. Bed linen may go in with the family wash.

In addition to the above, special precautions are to be taken with diphtheria, infantile paralysis, scarlet fever, and smallpox.

7. All articles used by the patient must be kept in the sick room or until they can be burned, boiled, soaked in disinfectant solution, or aired. Soiled linen should be washed in soap and hot water apart from the family wash and unnecessary handling avoided.
8. Dishes should be boiled for fifteen minutes before being washed with the household dishes.



FOR THE SICK ROOM: *Washboiler for soiled linen; bedpan; two hand basins and pitchers; nail brush and soap; tissue paper, soft cloths, and newspapers; thermometer in glass (with cotton in bottom); and toilet articles for patient.*

Partly eaten scraps of food should be burned (with the paper soiled by discharges).

Additional special precautions are also required in diseases that are spread by bowel or urine discharges, such as typhoid fever, dysentery, and infantile paralysis.

9. Before bowel discharges and urine are emptied into the toilet they should be mixed with disinfectant and allowed to stand an hour.*

Terminal disinfection of all cases.

10. When the patient has recovered, the room should be thoroughly cleaned with soap and hot water and aired.

11. All articles such as mattress, blankets, or books should be put in the sun for at least six hours.

* A solution of 2 percent tricresol, or 1/10 percent bichloride of mercury, or 5 percent chloride of lime is usually ordered.

Articles badly soiled, of course, should be cleaned or destroyed if they cannot be cleaned.

Practical Suggestions About Caring for the Patient

THE attending physician will outline the specific treatment and any special routines that the attendant is to follow, and the public health nurse will demonstrate to her the way the care is to be given to the patient.* Following are some general suggestions, which the attendant must be sure that she understands:

As soon as the attendant enters the sick room she puts on the cover-all apron which is kept hanging on a hook inside the door, and which should be worn whenever any care is given.

As she cares for the patient, the attendant should be on the alert for new symptoms which should be reported to the doctor as soon as they occur.

When the care is completed, the attendant straightens the room, collects waste material in paper bags, and gathers up soiled linen and dishes,

* Some of the common nursing procedures are described in "Caring for the Sick in the Home", a booklet which will be sent free upon request.

placing all this material outside the door, on newspapers spread there for that purpose.

The last thing before leaving the room the attendant washes her hands and then removes her apron. She leaves the apron hung right side out, so that it can be put on again without touching the outside which may be contaminated.

She leaves a supply of newspaper to be folded into bags for waste material or cut into squares to protect the hands when touching soiled articles.

Protecting her hands with squares of newspaper she empties waste water into the toilet, takes paper bags to be burned, puts linen to soak, and boils the dishes.

Finally, when all is done, the attendant scrubs her hands thoroughly in the bathroom or kitchen.

When "It's Only Measles"

"IT'S only measles" is a dangerous phrase. Parents assume a grave responsibility when they hold measles to be nothing serious, when they allow children only mildly sick to play with others, or when they say that "it's better to get measles early and get it over with".

Measles is a widespread, highly contagious disease causing many deaths each year among young chil-

dren. Health officers tell us that it is *not* better to get measles at an early age "to get it over with", and this is the reason. If a child reaches school age before he contracts measles, he is much more likely to have a light attack. Nine-tenths of the measles deaths occur in children under five years of age.

Measles usually appears in epidemic waves at intervals of two or three years and the epidemics usually start in early spring. When the disease spreads in the neighborhood or the town, parents of small children should keep them from playing with those who show symptoms of any illness and from all children who go to school.

If a tiny child has been exposed, the family physician should be called so that he can decide if it is advisable to give the protective serum treatment. Among children over five years of age measles usually is not serious if the patient is properly cared for in the beginning. It may become so, however, hence a physician should be called if the disease is suspected, regardless of the child's age.

When it's measles, prevent glare but do not keep child in the dark.

DISEASE	TIME TO OBSERVE EXPOSED CHILDREN (INCUBATION PERIOD)	EARLY SIGNS
CHICKEN-POX	From 14 to 21 days; commonly 17.	Usually mild fever at time of eruption, which resembles small water blisters, occurring on both covered and exposed parts of body; appearing in crops.
DIPHTHERIA	From 1 to 7 days; usually 2 to 5 days.	Mild pain in throat, moderate fever, rapid pulse, swollen neck glands, frequently with grayish-white membrane visible on back or sides of throat.
GERMAN MEASLES	From 14 to 21 days; usually about 16th day.	Mild symptoms of head cold for 1 or 2 days, followed by eruption, first on face, then on body. (May be confused with measles or scarlet fever.)
MEASLES	10 days to onset of fever. 13-15 days to appearance of rash.	Moderate fever, puffy, watering eyes, catarrh. Lining of cheeks and lips studded with small bluish white spots. 1 to 2 days later, rash appears first on head, then on body.
MUMPS	From 12 to 26 days; usually 18 to 21 days.	Swelling of glands in neck, in front of and below ears. One side usually affected first, other side in 1 or 2 days.
INFANTILE PARALYSIS	Variable; commonly from 7 to 14 days.	Symptoms of digestive upset, headache, fever, vomiting, followed by stiffness in neck, drowsy or irritable for about 3 days, then paralysis or muscle weakness.
SCARLET FEVER	From 2 to 7 days; usually 3 to 4 days.	Sudden onset, nausea, vomiting, headache, sore throat, "fur" covered tongue. Followed by bright red rash which fades when pressed.
SMALL-POX	From 8 to 16 days; commonly 12 days.	Sudden fever and symptoms of "grippe", 1 to 4 days later eruption appears, first on exposed parts, then on trunk.
WHOOPING COUGH	From 5 to 16 days; usually within 10 days.	Begins as ordinary cough, becoming more persistent and tending to occur in spells. Worse at night. Vomiting frequent. "Whoop" occurs in 1-2 weeks.
COMMON COLD	Brief, from 12 to 48 hours.	Running nose, eyes watery, slight fever, "feels bad".
INFLUENZA	From 1 to 3 days.	Fever, distress, aching in back and limbs, prostration, sore throat.
PNEUMONIA	Believed to be short; 1-3 days.	Sudden onset, fever, pain in chest, cough (vomiting and convulsions in children), sputum tinged or streaked with blood.
RHEUMATIC FEVER	Variable: from several days to about four weeks.	If family history is suggestive—poor appetite, loss of weight, low fever, fatigue, pain in muscles or joints, "growing pains", "St. Vitus' dance".

LENGTH OF ACUTE STAGE	COMMON COMPLICATIONS	PERIOD DISEASE REMAINS COMMUNICABLE	PREVENTIVE MEASURES
Usually brief, 3-4 days. Child commonly does not feel sick.	Skin lesions may become infected.	From day preceding eruption to probably not more than 6 days after appearance.	Disease so highly communicable that 9 out of 10 children catch it; usually early in life.
Usually brief if antitoxin given early. Convalescence is protracted.	Paralysis of heart and throat muscles, bronchopneumonia.	At least 16 days after onset, (usually 2 negative specimens taken 24 hours apart required).	All children should be protected with toxoid, before first birthday, another single dose is recommended on entering school.
Usually only few days. Child does not feel sick.	None.	From 4 to 7 days after onset of catarrhal symptoms.	Disease so highly communicable that most children catch it during epidemics.
Uncomplicated cases usually brief, rash lasting only about 5 days.	Chronic inflammation of ears, eyes, air passages; pneumonia.	Until the 5th day after the appearance of rash.	Avoid contact during infancy. (Babies and children below par may be protected by serum.)
Swelling usually subsides in week or 10 days.	Inflammation of other glands in older children and adults.	Not definitely known, assumed to be until swelling has disappeared.	Avoid contact (not a highly infectious disease) — most common in 5 to 15 year ages.
Usually long if paralysis occurs; convalescence slow.	Paralysis of affected parts of body.	Not known, probably most infectious during the early stages and usually until after first 2 weeks of illness.	Avoid contact with children with any illness especially during summer and early fall, if disease is epidemic.
Temperature usually returns to normal in week. Peeling occurs after 1 to 3 weeks.	Inflammation of middle ear. Damage to heart or kidneys.	Three weeks from beginning, and until all discharges have ceased.	Avoid contact. Children may be immunized with toxin, (usually not given as a routine).
Varies with severity of infection. Lesions last 14-48 days.	Infection of skin lesions.	From earliest signs to disappearance of all scabs and crusts.	If not vaccinated within 5 years immediate vaccination after exposure, (protects if given within a day).
Variable; usually 4 to 8 weeks of "whooping" stage.	Bronchitis and broncho-pneumonia.	Most catching in catarrhal stage and for at least 3 weeks of whooping period.	Children should be immunized against disease with vaccine.
Usually 3-4 days with proper care; rarely more than 7.	Sinus infections, Bronchitis, Grippe.	Believed to be limited to early stages, probably not more than week.	Avoid contact with persons sick with cold. Practice of good health habits is assumed to be helpful.
Usually 1-7 days.	Pneumonia.	Undetermined, probably throughout febrile stage.	Avoid exposure to crowds during epidemics, and contact with all sick persons.
Variable. "Sulfa" drugs frequently shorten acute stage.		Presumably until recovery is complete.	Avoid contact. Avoid chilling and exposure after colds and influenza.
Variable	Rheumatic Heart Disease.	Condition not communicable.	Keep susceptible children from contact with respiratory infections.

Measles is so highly contagious that nearly every child who has not had the disease comes down with it if he is exposed. When the day of the exposure is known, the child should be watched for beginning symptoms from the seventh to the sixteenth day following.

A child coming down with measles should be kept warm but the room should be ventilated without creating a draft. If his eyes become troublesome, glaring light should be screened out and a green visor provided if needed, but the child should not be left in semi-darkness. Only a bland diet such as crackers and milk, cereal or soup should be given until the doctor leaves instructions about his food.

Keep the little measles patient in bed until the doctor finds he can get up. This precaution is an important safeguard for the child's health, rather than that of the family, for children recovering from measles are less able to withstand other diseases, and pneumonia often follows if the convalescing child is allowed to catch cold.

Once or twice during the year after the child has recovered he should be taken to the doctor for observation.

If It's Scarlet Fever

MOST parents have a wholesome respect for scarlet fever. Not only is the little patient likely to feel quite sick, but frequently infection in the ears or a sore throat, which may follow the original disease, will hang on for weeks and may require continued isolation after the fever has passed.

Often the child feels so miserable that the parents make haste to call the doctor. It is well for the patient's sake that this is so because, for this disease, new methods of medical care can add greatly to the comfort and the safety of the patient as well as to shorten the attack.

As with the other communicable diseases, the family physician (or the head of the household if no doctor is called) is required by law to report the case of scarlet fever to the local health department. The health board doctor or nurse who calls will explain the regulations for the isolation of the patient, which do as much to protect the household as they do the community.

The child with scarlet fever must be kept away from others until all discharges have ceased.

Although the rules of isolation may vary in minor respects, most communities require the isolation of the patient for at least two weeks and until all discharges have ceased. Adults not in contact with the patient usually are allowed to continue at their business unless they are employed in handling food, but exposed children, while they live at home, commonly are not allowed to attend school. If a child who is susceptible to the disease is known to have been exposed, he should be watched carefully for at least a week.

Scarlet fever is caused by a germ called the streptococcus. Sometimes this germ produces the fever but there is no rash. Or there may be only a "septic" sore throat. There may be different strains, or varieties, of the streptococcus involved, but science has not cleared up this question. The point to be remembered however is that both scarlet fever and septic sore throat are likely to have serious aftereffects—ear infections, swollen glands, kidney complications. Prompt medical

The cover-all apron is left always in the sick room at the door, hanging right-side out.

treatment with new-day drugs and the best of nursing care are called for.

It May Become Rheumatic Fever

WE have placed rheumatic fever among the infectious diseases of childhood even though the condition as such is only in part communicable. The most widely held, present-day view is that certain children, because of their heredity, or because they live in unhealthy surroundings, or both, become abnormally susceptible to the streptococcus germs which in other children may cause scarlet fever or septic sore throat.

Rheumatic fever "runs in families." Rheumatic fever is more common among children who live in crowded homes and who get less than enough of the "must" foods.* Usually rheumatic fever follows a sore throat or a related condition in which the streptococcus is the invader. Children who have had one attack of rheumatic fever are likely to have repeated attacks. Most cases begin in childhood between the fifth and fifteenth years. These facts are the basis for the preventive measures that health authorities are undertaking.

Rheumatic fever often begins with misleading

* Ask for WHAT TO EAT AND WHY. It tells about the foods children and grown-ups need to maintain good health.

mildness. There may be only vague signs which are dismissed as "growing pains". Or, the child, who has had a sore throat or tonsillitis (a week to a month previously) complains of pain in a joint. He appears flushed and has some fever. A little later, other joints may be involved. Then for a while he seems to be well. The family decides that the worst is over. But if tests are made, it will be clear that the child is still sick with rheumatic fever.

Inflammation of the joints may cause discomfort but this is not the most serious effect: it is to the heart that lasting damage may be done. "Rheumatic fever licks the joints, but it bites the heart."

Our greatest hope in lessening the end-effects of rheumatic fever lies in early recognition of the disease and provision for prolonged rest. Where hospital care is available, children with rheumatic fever should have the benefit of the most modern methods of treatment. But as there are too few institutions devoted to the care of children with rheumatic fever, most children will have to be cared for in the home.

Rheumatic children should have the sunniest and driest room in the household. Once they are allowed to go out they should be protected against cold and wet, particularly in the fall and winter,

and should be taught to keep away from other children who have sore throats. They should get plenty of rest, while the condition is acute, and should be guarded against excessive physical activity when they have recovered. But they should be encouraged to resume wholesome activities when the doctor gives the word.*

Whooping Cough

OF the many diseases which health officials have to combat, whooping cough is one of the hardest to control. It begins as an ordinary cough and is highly contagious during the week or ten days of coughing before the disease is recognized by the "whoop". All too frequently playmates have caught the infection before the sick child is separated from them.

If the doctor is called early he can do much to relieve the patient's distress and make the siege less of a drain upon the child's constitution. His advice about diet and feeding schedules, and his suggestions about nursing care must be followed to the letter. During the year after the child has recovered, the doctor should have a chance to give him

* Suggestions about needed care of the sick child's body and mind will be found in the booklets: CARING FOR THE SICK IN THE HOME and DIVERSIONS FOR THE SICK.

one or two examinations until it is known that there are no lasting disabilities from the disease.

As most of the deaths from whooping cough occur among babies (and all but ten percent in children under three years of age), it is quite evident that small children should be protected from the disease. A vaccine is now available which, if given some months before the child is exposed, will almost surely protect him throughout childhood.

When a child is exposed to the disease, the first signs usually make their appearance within ten days, so parents of exposed children should be on guard during that time.

Infantile Paralysis

INFANTILE paralysis is a widespread disease but only a small proportion (possibly a tenth) of the children who are infected develop recognizable paralysis. By far the great majority are sick only a short time and parents think it only a feverish cold. Severe cases begin abruptly with fever, sore throat, and vomiting. For several days before the paralysis appears there may be headache, stiffness of neck, drowsiness or general irritability. Parents

Keep away from the patient's face when giving care.

are so apprehensive about this disease that a physician usually is called whenever it is suspected, especially during epidemics.

Although the physician will give explicit instructions about the entire care of the case when he makes his diagnosis, it is well for the family to be warned that during the feverish stage the patient must be kept quiet in bed. The treatment consists of rest, the relief of pain, measures taken to prevent deformity, and graduated exercises. The care should be given by a nurse with special training or by an experienced physiotherapist. Attendants without special instruction may do harm in attempting well-intentioned care.

A nation-wide agency has been formed to aid general hospitals and special institutions for the care of infantile paralysis cases. Where such hospitals are available, parents of a child with this disease should see that he gets this care. The family physician or the public health nurse will know the location of the nearest institution.

It Should Not Be Diphtheria

EVERY child should be protected with toxoid against diphtheria sometime during the second six months of his life. The treatment is simple, harmless, almost painless, and renders the child immune to the disease. All physicians urge the immunization of all children in the families of their practice. Most health departments offer the treatment at health centers.

Although there is no need for a child ever to be endangered by diphtheria, several thousand young lives are needlessly sacrificed to this disease each year. Diphtheria, smallpox, and whooping cough are the diseases against which we have proved preventive measures. Parents who deprive their children of these safeguards assume a great responsibility.

Like the other communicable diseases of childhood, diphtheria begins with a cough and sore throat and the child seems very ill. If the doctor is called immediately and can make an early diagnosis, antitoxin given in large amounts may save the child's life. It is those children who do not receive antitoxin early who succumb to the disease.

Colds, Influenza, and Pneumonia

COMMON colds and the other respiratory diseases are communicable infections and should be treated as such. As soon as the child develops the symptoms of a cold he should be put to bed and given a light diet until the doctor can call. And until the doctor can make a diagnosis, the patient should receive the same care as for any other communicable disease.

Properly cared for, the cold is not a serious matter and should last only three or four days. Uncared for, the cold is apt to lead to other and more serious conditions.

Influenza and grippe are terms used loosely to include any respiratory infection which is more severe than a common cold and which is accompanied by fever, distress, and marked prostration. The condition may be due to any one of several different germs. The important consideration is that all these conditions are communicable and the patient should be kept in bed and isolated from others in the household as long as fever and prostration continue.

Keeping the patient in bed is done as much for his sake as for the household, because the patient sick with grippe or influenza is often so weakened that

he has insufficient resistance against pneumonia germs which may be harbored in the mouths of well people. Though they may cause no harm to them, these germs are a serious menace to the patient.

Pneumonia is an inflammation of the lungs. The inflammation may be caused by one of a number of different bacteria, or it may be the result of a virus invasion. (A virus is a disease-producing organism too small to be seen through a microscope. Influenza and measles are other examples of virus-caused disease.) If a microbe is causing the disease, it is usually the *pneumococcus* against which the new drugs are so effective, or it may prove to be another, such as the *streptococcus*, which also responds to treatment with them. There are, however, some germ invaders which these new treatments cannot stop. So, it is clear that an early diagnosis must be made before treatment is begun, and that is one reason a physician should be called immediately if the signs of pneumonia are suspected.

The inflammation of the lungs may not be due to bacteria at all; instead it may be caused by a virus. If it is a virus-caused pneumonia, the modern drugs so effective against pneumococcus infections are of no help — though they may be used to ward off complications — but prompt medical and nursing

care can ease the patient's discomfort and support the body in its fight against the virus invader. So whatever the cause, immediate medical attention is essential.*

Some Milder Conditions

GERMAN measles, chickenpox, and mumps are considered less serious than the diseases already discussed. Although they seldom if ever cause death, a physician should be called when the symptoms of any of these mild infections occur, in order that he may rule out the chance of a more serious condition, and give advice about possible complications.

Chickenpox especially should be seen by the family physician at the first sign of illness so that it may not be mistaken for smallpox. In older children, especially those who have not been vaccinated since infancy, the possibility of mild smallpox must be considered. Chickenpox is highly contagious and usually is contracted early in childhood.

Mumps is regarded lightly by most parents. This is not strange for the poor victim looks so ludicrous with his swollen neck and usually he does not feel

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* From: NEWER KNOWLEDGE OF PNEUMONIA. This John Hancock booklet will be sent free on request.

very sick. The disease is not highly contagious and does not last long.

Mumps is a disease of the glands and may have serious consequences in older boys and girls. When it is confined to the salivary glands in the neck it causes only discomfort, but if it attacks glands in other parts of the body — especially the matured sex glands — the condition may be more serious, so the child with mumps should be put to bed and the doctor should be called as in any other communicable condition.

To sum up the whole matter: the communicable diseases of childhood are spread usually by the direct or indirect transfer of infectious saliva. The child showing the early signs of any of the diseases discussed here (and the first signs are much alike) should be put to bed in a room by himself, the rest of the family should be excluded from the room and the doctor should be called. As the diseases go hardest with tiny children they should be kept away from older children during epidemics and from any child who appears to be ill.

Life Conservation Service of the

John Hancock

MUTUAL

LIFE INSURANCE COMPANY

OF BOSTON, MASSACHUSETTS

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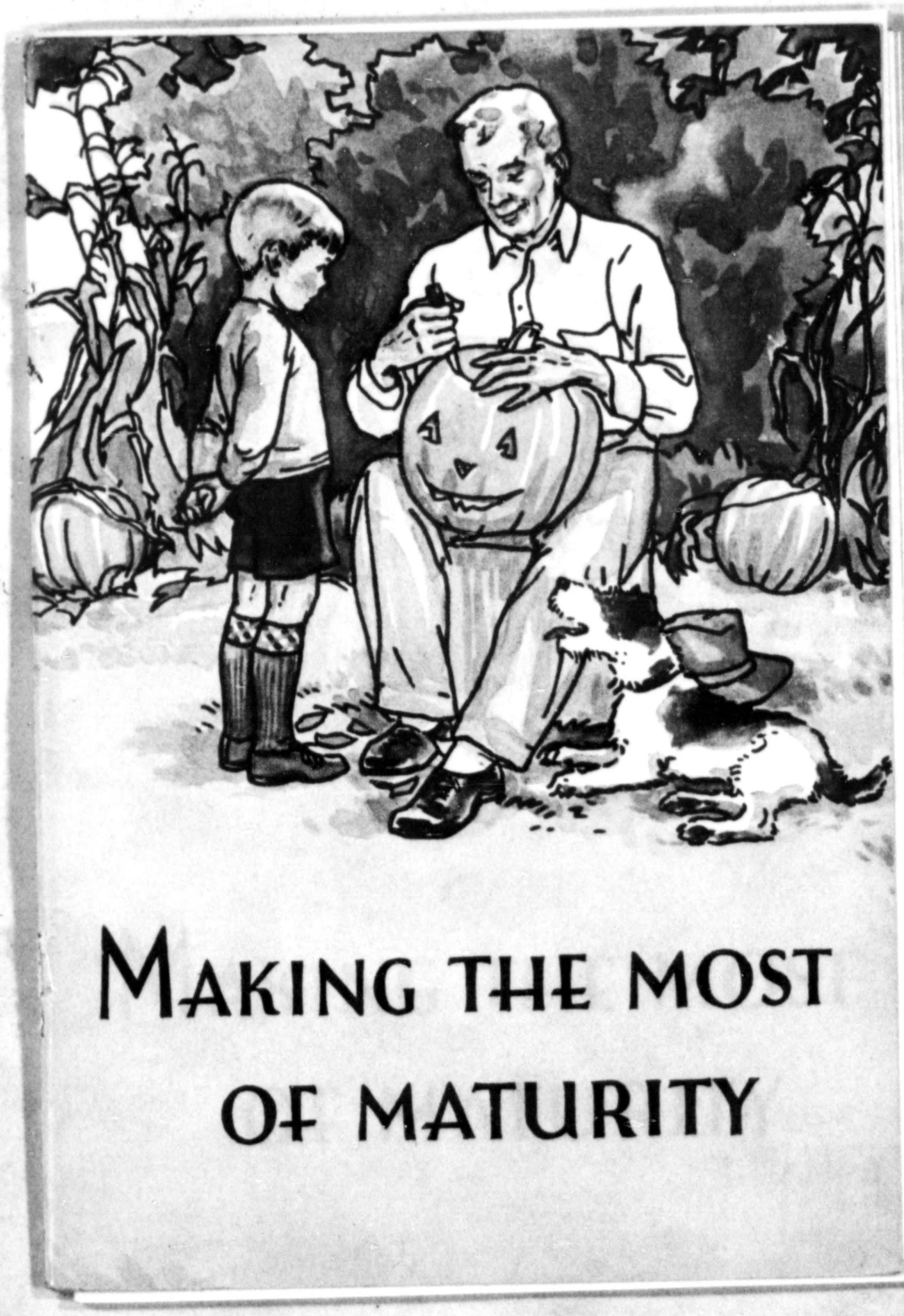


MAKING THE MOST OF MATURITY

MAKING THE MOST OF MATURITY

LIFE CONSERVATION SERVICE
OF THE
JOHN HANCOCK
MUTUAL LIFE INSURANCE COMPANY
OF BOSTON, MASSACHUSETTS

By way of introduction:

This little book is about interests and activities suitable for the time of retirement. It is addressed primarily to the middle-aged person who faces the restraints upon life that come with advancing years. But limitations in physical capacity may come about from injuries or disease as well as age.

So, it may be that this discussion of ways to make the most of our talents will have something to offer to the partially disabled veteran and the "veteran" of bouts with chronic illness—the patient cured of tuberculosis, the recovered "heart" case, or the man or woman handicapped by arthritis. To all it says, if limitations are faced courageously, contentment may be yours despite them.

Life Conservation Service

John Hancock
MUTUAL
LIFE INSURANCE COMPANY
OF BOSTON, MASSACHUSETTS

MAKING THE MOST OF

MATURITY

"WHEN I grow up!" Can you remember back to the day when these wishful words were often on your tongue? Even your play was influenced by this dream. Was your "make-believe" concerned with keeping house or tending store? Or were you of a scientific turn, a builder of castles, a nurse for sick dolls, or a frowning doctor? This play in imitation of grown-up life was, in a small way, preparation for it. It is clear that the serious side of your youthful activities was directed toward the future. Your schooling helped to fit you to make a living. You sought a mate—or were sought after—to make a home. Yes, you looked forward with keen anticipation to the glorious years when you'd be free to live your own life, as you sighed, "When I grow up!"

"When I grow old!" How often do these words pass your lips, now that you have reached the fullness of your maturity? Perhaps your hours are packed too full now to give thought to your future.

Or it may be that you deliberately close your mind to the contemplation of what life may be like in old age. You lull a troubled spirit by promising, "I'll cross that bridge when I come to it." But is it safe to wait? It's later than you think.

A short-sighted view of life can lead to tragedy. Though each of your days, while you are in the forties and fifties, may seem full to overflowing, the years have a way of turning quite empty later on in the sixties, if you have not by then found something new and suitable to do. Yes, the autumn of life may prove to be a time of idleness, loneliness, and boredom unless you make intelligent plans for it. On the other hand if you have prepared yourself for the new and different life you will lead then, your time of leisure may prove as rewarding and satisfying as any part of your existence. Truly old age is what we make it.

But why need life be different in the years to come? you challenge. It will be different: rest assured of that! For one thing your family obligations will be less demanding, for your children will have gone to homes and jobs of their own, and your work too will have to be lightened, if you have not been retired. And you will be glad that these burdens have been lifted. But—and this is a big "but"—you'll want something new, and dif-

ferent, to do, something within your capabilities to take the place of the business or family cares you drop. And it is not safe to wait until the day of retirement comes to cross that bridge of leisure-time activities, for by then you may have neither the time nor the energy left to prepare for that new and different life.

The nub of the matter is this: these new and different ways of living, suited to the changed person

From early spring until late fall the gardner finds many absorbing things to do: then he gardens indoors in the winter.

you will become, call for preparation well in advance. For this apprenticeship to the new must be served while you still retain the energy to break into new ground, to master new skills or gain new knowledge. So we repeat: you may be courting trouble if you wait to begin your apprenticeship, for when old age comes, that all-important store of energy may have seeped away. At forty many men and women have begun piano lessons to taste for themselves the joy of creating music. At sixty? Well, for all but the one in a million, it's too late.

But, you may be arguing, I have no intention of changing. I like my life as it is: I've a good job and I propose to hang on to it. A generation or two ago most Americans made their living on farms or small businesses or neighborhood industries. In those bygone days, men could, and usually did, continue on into old age, living and working in much the same way, their long years of experience compensating in some part for waning physical powers. For most of us, times have changed. Today the great majority of us are employed in commercial enterprises, in which the work of many is dependent upon the production of each in his group. We are, in effect, cogs in a vast machine and a cog cannot slow down; it must keep going at the set speed, or the progress of all is slowed.

Even though some of us may not be tightly meshed cogs in the world of business, if we see life whole, we do not want selfishly to "hang on" to a job after our productiveness begins to wane. We will want to step aside in order to let younger men and women behind us have their day while they are still in the fullness of their prime. But we will not want to quit altogether. Rust sets in when movement stops. That is why we must have some new objective for the later part of life.

There is more to successful retirement than just not rusting. When we've given half a life-time in the service of one cause, we begin to feel some loss in imagination and zest for the day's work. But when we've contributed our full share to the world's work and we turn to something new, something challenging, something suitable, we may find to our surprise that we enjoy a sort of "second wind." However, we will uncover this unsuspected store of vigor only if we still retain that essential vitality of body. So the fellow who clings too long to his job may find that he pays a heavy penalty for shortsightedness.

Very well, you agree, perhaps it may be wise not to wait. What can I, in these busy days, do about preparing for the leisure years to come? There are four ways in which you can prepare yourself.

Satisfaction in making things grow is greater, for some people, when the things are "alive."

You can provide, as well as circumstances permit, for those special comforts that older people need and enjoy. You can do your best to keep your body in health. You can take pains to keep your mind young and pliable. Finally, you can embark upon a hobby to add interest and meaning to your leisure years. As the selection of hobbies appropriate for elderly people is the principal concern of this booklet, let's skim quickly over the other considerations.

The first, that of providing material comforts for

old age, could not be dealt with adequately in this little book, for financial independence, the lifetime goal of provident people, is much too big a subject. It is enough to point out here that in recent years we have seen the general adoption of means of ensuring this goal. The subsistence needs of old age for the majority of employed men and women will be provided by the benefits of the Social Security program. Of more importance to the thrifty is the interest in supplementing the Social Security benefits through adequate personal or business retirement plans on an individual or on a group basis. But financial security is not the sole preparation we need to make for our retirement. We must have something to live for as well as to live on.

Conserving Your Health

Nearly everyone gives lip-service to health, but precious few do much else about it. On all sides we see intelligent men and women going at too hard a pace, overdoing in work and play, neglecting the commonly accepted rules of healthful living, and ignoring symptoms of physical disabilities that they must know can only grow worse with neglect. What can the prudent man or woman do?

First, he must accept the fact that, through the years, the body slows down in all its functions. He will suit his way of living accordingly. Man is at his physical best at about twenty-five, and by forty there are more evidences than an occasional gray hair to remind him that a change is underway. It should be clear that when middle age is passed, it is necessary for one to gear all his activities to his slowly ebbing endurance. Fortunately, there are many quiet sports and absorbing hobbies that may properly be carried over into later years. In the matter of strenuous activities, common sense should tell the observant person what and how much is suitable to his condition, but the prudent man will have his judgment bolstered by medical examinations and advice from time to time.* As common sense is needed in the matter of exercise, so it is with rest. Although older people seem to require fewer hours of sleep at night, they do need more frequent rest periods during the day.

You Can Cultivate Good Habits of Mind

When all is said, the satisfactions of the "philo-

* The reader will find help in his effort to conserve his health in "Foes After Forty," "Waistlines," "What to Eat and Why," and "Sleep, the Restorer." Copies of these John Hancock booklets will be sent upon request.

Raising pets seems easy, but it is a job that requires experience, judgment, and perseverance.

sophical years" come more largely from within, than from without. Even wealth and a robust body can contribute little to happiness if unfortunate habits of mind have warped character. Sound mental health, like physical health, is helped or marred by life-long habits. So whether that older, but new person, you are to become will prove to be an aimless and unhappy man or one who knows great contentment, depends in part upon the interests and habits you have developed all along the

way to this period of life's fulfillment.

One habit of mind much to be desired is the willingness to accept life gracefully and without petty complaint. As our children lose their dependence upon us, they tend to cut the family ties which have meant so much to us, their parents. Again, younger and more vigorous business associates may be given preference, or take the leadership we once enjoyed. When such situations arise, the chance to develop mastery of our emotions presents itself. If we rebel fruitlessly against such circumstances now, we are on the high road to an unhappy, petulant old age.

One can be alert to steer himself out of mental ruts by being willing to try new things or new ways of doing the old ones. Mental health depends, too, upon keeping in direct touch with human affairs. The older person, freed in part from demands of business or family, often has an opportunity to add his mite to the welfare of others through his church, fraternal group, or his neighborhood associations, for he has both time and judgment to offer. If he gives them generously, he may find that he will be richly repaid.

Hobbies to Suit Each Taste

What does it profit a man to gain renown or riches if he ends his days idle, lonely, and discon-

tented? Fame and a fat purse cannot assure continued happiness. Contentment is not so cheaply bought. Instead, contentment must be earned, and oddly enough, we earn it by losing ourselves in work. Everyone, old or young, wants to be busy at something worth doing. If it is to be satisfying, this activity must do more than just keep the hands in motion, it must call for the continued improvement in the use of some special skill, or the application of some ever-widening knowledge. It should be in a

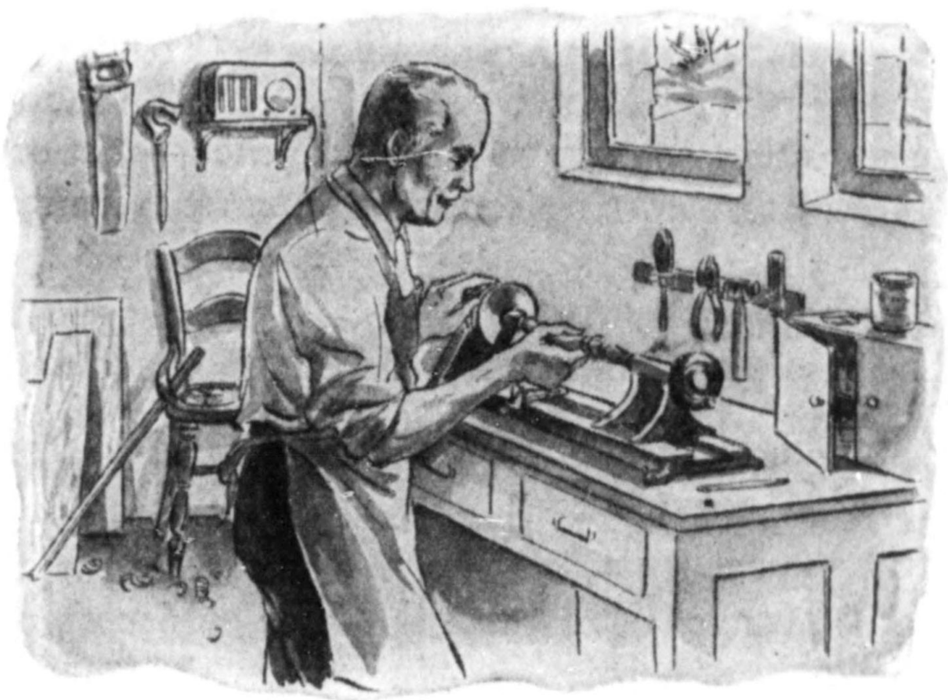
When you know how, camping can be great fun; but successful camping calls for knowledge, experience, equipment, and planning.

field in which the skill or knowledge acquired through the years makes up for the limitations that age imposes on physical endurance.

Many of us, as youngsters, developed an aptitude for some form of art or craft or sport, only to have our interest wane because of the pressure of day-to-day living during the middle years. But as life advances, more hours of leisure may permit the enthusiasms of our earlier years to return. Now we have more time to improve skills, more opportunity to read and plan, and more patience for reflection, and more ability for self-criticism of our handiwork.

It is doubtful if a lasting interest in a hobby can be forced, but this does not mean that expertness and understanding need never be cultivated. Indeed, most hobbies that give enduring satisfaction are reached through a period of apprenticeship which often requires a certain amount of grit and endurance to get to the point where the enjoyment begins and the hobby is ridden in real earnest. If we wait until old age is upon us before we begin to interest ourselves in a hobby, we may find that the apprentice period requires more energy than we have retained. So let it be repeated; start early, for it is later than you think.

No attempt will be made here to list all the



Whatever the handcraft you like best, give it the benefit of a real work place, where family or friends will not interfere.

hobbies that have brought contentment to venturesome souls. Instead we will make a brief survey together of a few typical activities and then look into the matter of choosing a hobby. But, first, it should be made clear that a hobby is not necessarily a means of livelihood. This booklet does not propose to teach elderly people ways to earn a good living. A hobby should earn for the follower some very substantial rewards in lasting satisfaction. It should prove to be a profitable venture in content-

ment, and if it also produces some monetary return, as often it does, that is certainly not to be set down against the hobby. However, financial gain must always be secondary to the main benefit—that of earning an absorbing, continuing interest in living.

Tastes Are Not Alike

Some people like best to do things. Others are happiest when creating things. Still others seem to have a natural bent for collecting. Some find contentment just in knowing.

Things to Do—For the man or the woman who finds satisfaction in growing things, gardening is the hobby of hobbies. Raising vegetables or flowers is a joy that will remain forever unknown to the person who thinks of gardening only as a back-breaking job of putting seeds in the ground, hoeing out weeds, and harvesting the crop. All the reading, all the thought, and all the planning that go into the garden give as much pleasure to the true gardener as the work upon the ground. Even in back-yard gardens it is possible to improve the strains of vegetables or flowers by selection and cross-breeding, and this can become one of the most absorbing of all hobbies. Many valuable new varieties of plants have been developed and patented by amateur "Burbanks."

Some folks get more fun from work with animals than plants. Either you like to raise chickens, or pets or you don't, and there is little to be done about influencing you either way. If you do, there is no need here to set forth all that can be said about the pleasures in store for the bird-or-pet-fancier. If you don't, nothing could be written here to alter your dislike. A word of caution: just because you once raised a puppy to doghood, don't for a moment assume that you know all about rearing pets. No animal-raising hobby is as simple as they all may seem. Wide experience is needed and woe betide the beginner who rushes into this field "in a big way."

Hobbyists who take to the water will find an ever-widening scope for their skill in raising tropical fish, ornamental cold-water fish, and aquatic plants. There are more exquisite varieties of water lilies than you have ever dreamed of, if you haven't looked into this specialty. Here again, knowledge, experience, and judgment are indispensable, but the fun to be had is worth the effort—and all the early failures.

Before leaving the discussion of things to do, we must pay our respects to the things that one may do solely for entertainment. In making life seem worthwhile, sports and games have much to offer

to the man and woman past the prime, but still blessed with sound hands and heart (and feet). Only three can be mentioned here.

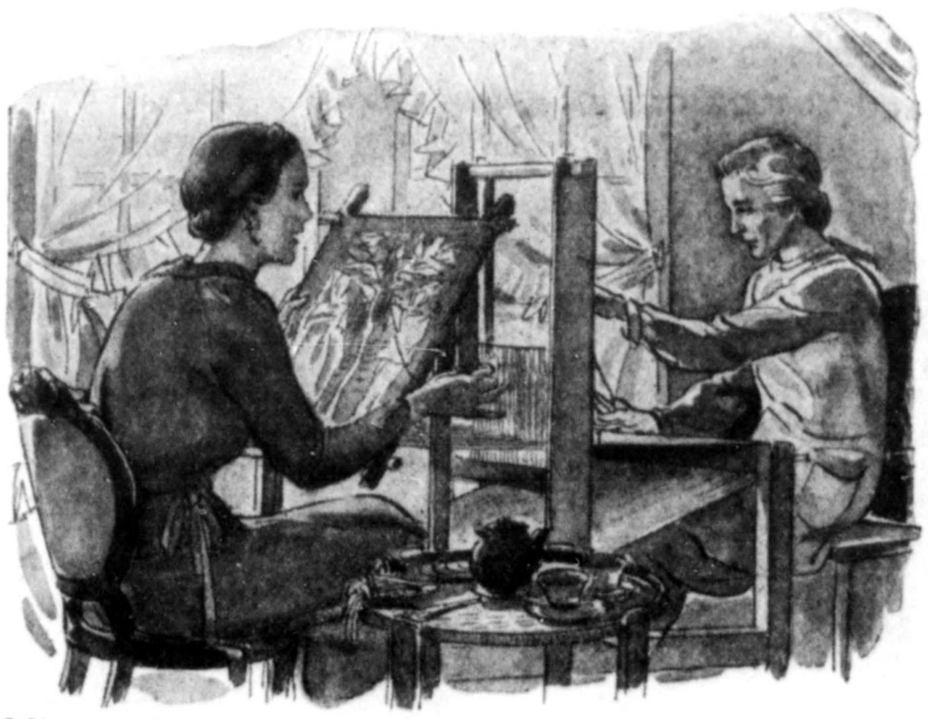
First and foremost, is the sport of your true philosopher—fishing. A born fisherman is happy not only when wading the chilly stream or bobbing about on a restless sea in a tiny boat, but equally so when making his own rods, braiding lines, and tying flies. Planning each new spring campaign or searching out new haunts are out-of-season joys known only to the confirmed angler.

For the man who must ever be on the go, hunting may seem superior to the quieter ways of the fisherman. Here, too, the fun is not limited to days with a gun. Your dyed-in-the-wool hunter tramps the fields at all times of the year "armed" with a camera or just field glasses, prospecting with an eye to the coming open season. No one but the true nimrod can know the joys of the chase, with or without shot and shell.

Take away his gun and your hunter becomes the "hiker." Hiking, aside from the Sunday afternoon variety, requires experience, practice, equipment, and planning. Again, give him a battered but still dependable car, perhaps with a trailer attached, or a tent and equipment stowed away in the luggage compartment, and your hiker becomes the

demon motor-camper. By one or the other of these means, the retired man—or woman—goes out into the world to see the places he or she had long hoped to visit. Now, at long last, comes the blessed leisure to make dreams come true.

Although a master craftsman must have good equipment to turn a chair leg, build a cabinet, forge ornamental iron, mould pottery, or bake a cake, the indispensable tools are a dextrous hand, a knowing eye and an understanding brain. All the handcrafts depend upon skills that improve with long



Many craft projects take time: be sure yours are well protected when they have to be set aside.

experience, critical observation, and searching study, but the craft well mastered, whether it is in wood or metal or fabric or dough, is a never-ending source of satisfaction, sometimes with incidental rewards in pocket money.

As varied as the heavier handcrafts are the many kinds of needlework, ranging from the finest needlepoint to coarsest hooked rugs. The skillful wielding of the needle, whether small or large, gives that scope for artistic design and originality in stitching which brings abiding satisfaction to the adept woman. It must be clear that the many hobbies in these creative fields open to both men and women cannot even be named here.

Things to Collect—It may be that there is some deep-down, age-old instinct responsible for the pleasure some people get from hunting out and arranging collections of all sorts of curious objects. Naturalists tell us that certain birds and some animals are tireless collectors.

Among the most completely absorbing of the collecting hobbies is album-keeping. It may be the assembling of humorous or historical items such as old advertisements, hand bills, or letters. As every one knows, autographs and postage stamps are among the most popular subjects, but there is an endless number of different kinds of things that

Real satisfactions come, not from snapping pictures, but in seeing them come to life in the dark room: this can be both a hobby and a source of "pocket money."

give delight to the true collector when classified and preserved.

Collecting curios and antiques is the happy-hunting-ground of the well-to-do. But the determined hobbyist can sometimes have a lot of fun by making his brains, perseverance, and canny bargaining powers work wonders in spite of limited funds. He may earn greater pleasure from the modest product of his clever bargaining than the well-to-do man gets from "first editions" of

great masterpieces he merely paid someone else to buy.

You may not succeed in assembling complete sets of authentic "Currier and Ives" prints, for instance, but there are other collections of historical pictures that you can hope to gather together when you have the time to hunt them out. You may not aspire to Chippendale furniture, but you may pick up interesting early American glass or china—if you will learn, as you can, to know your way about in the maze of antiques and "near" antiques. Clocks, guns, toys, pottery, ship models—who can even name the items which bring joy to the understanding collector, even one of limited means? Among the many natural objects for collection are rare minerals, shells, fossils, sea animals, and unusual plants. These, and many more, have given amateur naturalists an opportunity to contribute to the store of scientific knowledge and to add immeasurably to their own joy in living in the bargain.

The collector often sells in order that he may buy. Hence, exact knowledge, wide understanding, and sound judgment are all valuable tools. In the ability to make a good bargain, time and a mature mind may prove more productive than youthful enthusiasm. It is in the matter of judging

values then, that the hobbyist of mature years competes most successfully, for his critical faculties will be sharpened rather than dulled by time.

Things Just to Know About—In all that has gone before, "learning how" plays an important part. To make things always the same way becomes tedious, but a new way of doing things requires study, research, learning. There are, however, certain fields in which the knowing plays the principal part—the doing being largely incidental.

In the fine arts, like painting and music, simply to be able to appreciate the best in the old—and the new—gives untold pleasure to many men and women who never had time to dabble in such impractical matters when business had to come first. When leisure provides the time to open the doors to a whole new world of painting, sculpture, writing, or music, the man approaching retirement begins for the first time to understand how much he has missed all his years. Elementary practice in the fine arts often leads to a keener appreciation. So we find, among true students of the arts, many hobbyists quietly entertaining themselves with pencil and paper, with paint or clay, or a camera, or perhaps painfully (for the household and neighbors) mastering a musical instrument.

Science is another world largely unexplored by

most men and women of business but one in which the exploration may bring keen delights to the amateur with leisure. In astronomy, for instance, many important observations are being recorded by patient watchers of the heavens from the ranks of the hobbyists. Practical telescopes can be made at home at surprisingly small cost. In some cities there are active associations of amateur astronomers who have been brought together from all walks of

Pottery, ancient among the arts, is but one of several in which many people have proved that one's skill grows, rather than wanes, with the years.

life because leisure has given them time to scan the sky by night and the books by day. In meteorology too, amateurs are providing important supporting services to official weather forecasting.

About Choosing a Hobby

It must be evident that this is but a beginning of a review of all the fields in which men and women have found contentment through participation. Indeed, any list would necessarily be incomplete, for hardly a month passes but we hear or read of some novel venture with which someone has succeeded in building a place for himself in our hobbyist's hall of fame. It seems more to the point to discuss ways by which you may seek to discover in what type of activity you are likely to find the greatest pleasure.

Unless you are perfectly sure from long experience and solid conviction that your hobby has already chosen you, it may be well to put some questions like the following to yourself before embarking on an avocation. And don't accept a glib answer without some cross-questioning.

How much can you do? It scarcely needs to be said that you should know the limitations of your strength before choosing any activity, whether hobby or sport. Those of us past middle age ought

to have the expert advice of the family physician to confirm our beliefs. Are your hands strong enough for craft work? Can you get about without too much effort to attend lectures, meetings, or to make necessary observations? Yes, the hobby or sport must be within the physical capacity of your body.

What can you afford? Some hobbies and sports obviously require greater initial outlays than others for equipment, supplies, books, or training. The foresighted hobbyist makes a careful inquiry into these matters before—not after—he embarks upon his chosen venture in contentment.

What were your principal interests as a youngster? As was suggested earlier, what you liked to do most in your youth often is suggestive of the type of activity that may give lasting pleasure in maturity.

What part of your present life work gives the most satisfaction? Although your hobby should be a change from your regular means of livelihood, it may be that the one most satisfying part of your bread-and-butter work will find a corresponding activity among the avocations suitable for older people.

What are you good at? Are you handy with tools or "all thumbs"? Can you draw a recognizable

Restoring old things to usefulness can become one of the most absorbing hobbies—and a worthwhile service as well.

picture? Can you whistle a tune and keep on the key? (Your family will help you answer this question.) Have you forgotten how to read a book? Honest answers to these and related questions will guide you in choosing new interests.

Do you like to live with growing things? Whether or not you experience real pleasure from growing plants or animals is the product of life-long attitudes, perhaps, and something not readily

to be changed in later years. Either you do or don't, and it is unlikely that you can be influenced one way or the other.

Have you an "arranging" sort of mind? Do you like to set things in orderly array? Your natural-born collector takes pleasure in classifying, arranging, completing collections, not just gathering things hit-or-miss. If you possess that orderly instinct, then it is likely that your collections will become important to you and in the end may prove of value to some museum.

Beyond the application of these questions, the choice of a hobby is pretty much a matter of trial and elimination. That is but another reason why one should plan for the future before the future arrives! If in middle life a fair trial at gardening, for instance, produces nothing much but weeds and blisters, there is still time to experiment with woodworking before you discover at last that reconditioning old clocks, perhaps, was destined all along to furnish an abiding interest.

Where to Get Help

Earlier it was suggested that satisfying hobbies involve unusual skills or special knowledge. Where to get the necessary help in these matters is not always clear to the expectant hobbyist, although

there is usually a world of help if he but knows where to seek it.

Likely sources of informative pamphlets on all sorts of hobbies, ranging from apiculture to zoology are the various Federal Departments such as Agriculture, or the Office of Education. The corresponding departments at your State Capitol may prove another means for the help you will need.

Your local public library should be explored. Librarians are surprisingly helpful and understanding people as a rule. Give yours a chance to be.

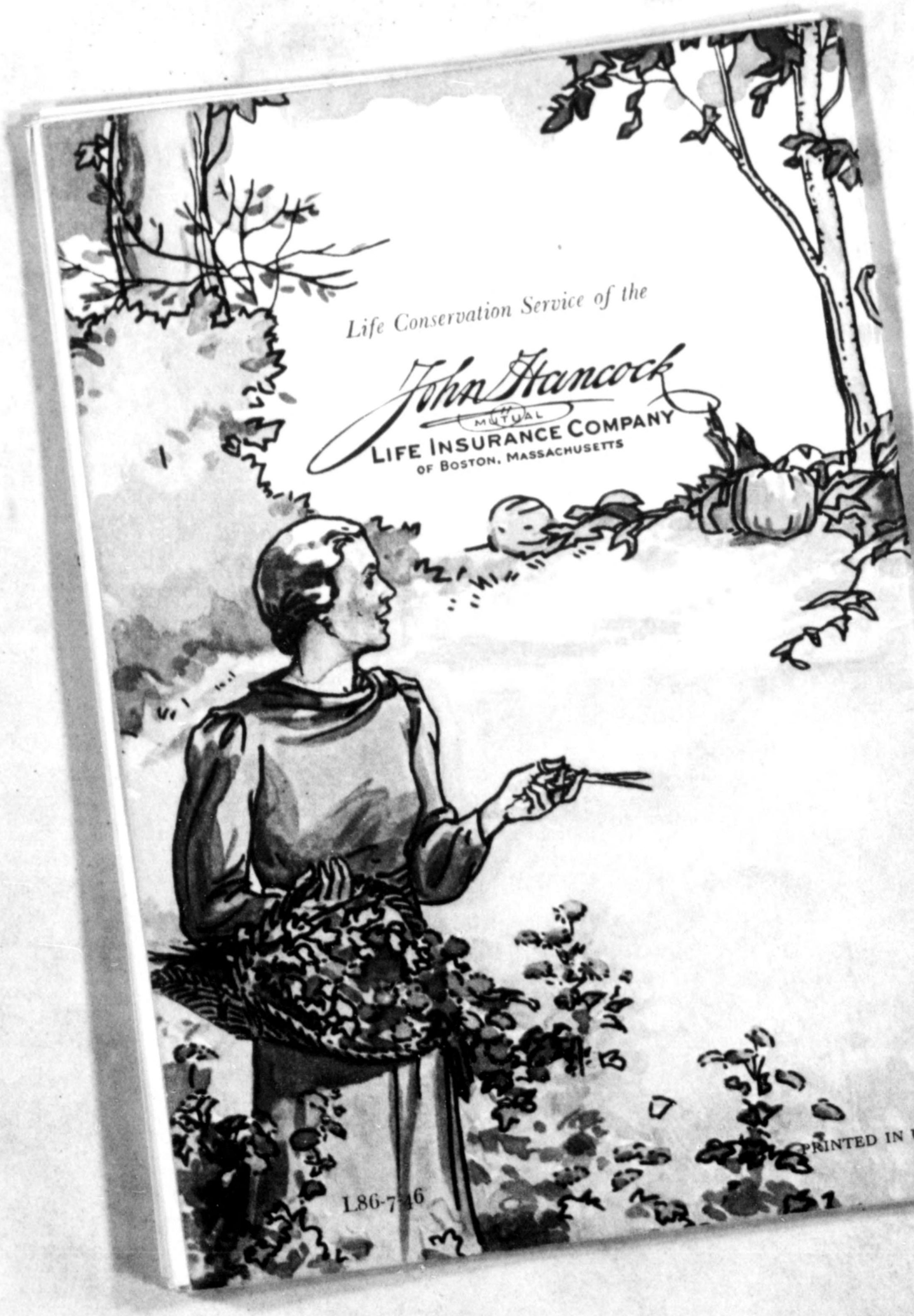
The best feature of many hobbies is that they form a bond of interest with others who "speak the same language" and enjoy the same things.

MAKING THE MOST OF MATURITY

There is an ever-lengthening bookshelf of manuals covering all sorts of handcrafts, occupations, and sports, and some of these you will want to own. Your local bookstore will hunt them up for you if there is not a craft shop in your community in which they are all displayed. There are general hobby magazines, as well as specialty journals. The wise hobbyist will not neglect these prolific sources of help for ideas and inspiration.

Best of all, many of the hobbies have the benefit of amateur associations, by joining which you may meet and mingle with others having the same interests and hopes as yours. Too often, as we grow older, we get out of touch with those with whom we should have much in common. This tends to make us draw unwholesomely each into his own shell. Perhaps the greatest benefit a hobby can offer to a person past middle age, is that it takes him out of himself and into contact with other men and women of similar interests who talk his language, and it offers that wholesome competition which adds to the zest of living. We need the companionship and the challenge of our equals.

Economic security, a healthy body, a serene mind, and something worthwhile to do, these are signposts that mark the road to contentment.



FEBRUARY • 1948

the CHILD

YOUTH AND THE EMPLOYMENT SERVICE

ROBERT C. GOODWIN,
Director, U. S. Employment Service

EACH YEAR more than a half million boys and girls join the labor force.

These youths include our future artisans, merchants, and professional groups. They are the leaders of tomorrow. The future of our economy and political existence rests in their hands. Let no one tell you that because they constitute such a small fraction of our labor forces they are unimportant. They and other youths who will join their ranks will constitute almost a third of our labor force 10 years hence.

What in general are the characteristics of these entrants? During the past year new entrants in the labor market have included a high proportion of veterans, youths who have had their civilian careers interrupted by military necessity. Some of these, because of aptitude, interest, or other abilities, have received training that will be vocationally useful in their civilian work. Others have been trained primarily in the art of war and find that they have to start anew upon returning to civilian life. Some of the veterans have not immediately entered the labor market, but have taken advantage of the benefits of the Servicemen's Readjustment Act. One million, one hundred thousand are enrolled in our schools to complete their interrupted training. These will be entering the labor market during the next several years. That 11,310,000 World War II veterans have found gainful employment speaks well of the resourcefulness of our country.

overcome the slack which is beginning to appear in other segments of our economy.

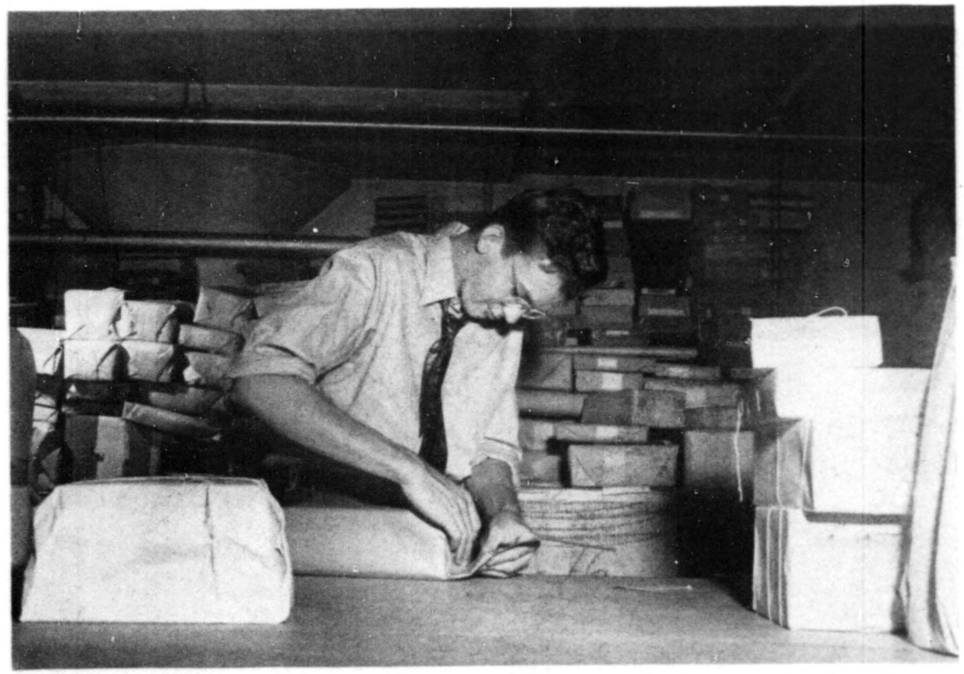
The maintenance of high national employment is essential, not only for high production and prosperity, but for the proper placement of veterans, youth, and other entrants into the labor market. If employment slacks off as a result of soft spots in our economy, veterans and young people will be the hardest hit. They are the workers of least experience and the least seniority, and in general will be the first to lose their jobs.

The youth entering the labor force in the next few months will come primarily from the schools. Some will be gradu-

requiring little skill, many of these new workers will find employment that will not lead progressively to better paying jobs.

It is this group that offers a special challenge to the public employment service. It is of the greatest importance that these new entrants into the labor force be directed to employment that will consistently and constructively use their potential capacities. In cases where they fail to get off to a good start, the Employment Service must assist them to shift out of blind-alley jobs into occupations with a future.

In approaching the employment of nonveteran youth, we must clearly recognize that school graduates and drop-outs will force increasing competition



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Will newcomers keep jobs?

During recent months we have been in a period of high national employment. Close to 57 million people are now working. Seasonal employment in agriculture is on the upswing. But the demand for workers in nonagricultural employment has slowed down. The big question now is whether employment expansion in such lines as construction, agriculture, and food processing will

ket. If employment slacks off as a result of soft spots in our economy, veterans and young people will be the hardest hit. They are the workers of least experience and the least seniority, and in general will be the first to lose their jobs.

The youth entering the labor force in the next few months will come primarily from the schools. Some will be graduates and some drop-outs. Many will be untrained and undisciplined in the world of work. Some will have learned (or will quickly learn) simple skills that fit them for immediate employment. Because of the temporary economic advantages of employment in occupations

Like many others, Bill left school for a good job. But times change, and now his job isn't much.

Excerpted from speech made at the thirty-fourth annual convention of the International Association of Public Employment Services, held May 26–29, 1947, at New York City.

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In approaching the employment of nonveteran youth, we must clearly recognize that school graduates and drop-outs will force increasing competition for future jobs. The backlog of youth who left school during the war and accepted the best-paying jobs (the ones in which they were most needed in the war effort) will face special problems in making a permanent readjustment. The veteran youth, still to be demobilized, will also have special problems in that they are older than the usual new entrants into the labor market. Some of them have married, or will marry

in the near future, and they carry additional responsibility not usually attached to the entry worker. The plan for serving youth must be based upon accurate knowledge concerning the needs of the entire group and in addition be geared to the varying needs of the individual.

If a youth program is to succeed, local employment offices, in addition to providing placement and employment counseling services, must assume leadership in organizing community facilities to advance the employment interests of young people. Specifically, local employment offices must provide information to training agencies on employment trends and the requirements of occupations to assure the development of training programs geared to the needs of the labor market; they must supply tools and information to the schools and other agencies useful in providing realistic vocational guid-

they must assist employers in identifying entry occupations and promoting their acceptance of beginning workers.

To assure that each local office program is realistically geared to the needs of the community it serves, periodic analyses of the number and characteristics of young applicants seeking work through the employment office should be supplemented by a similar study of those leaving school. On the other side, the employment office will need to know how the job openings available in the community compare with the qualifications and requirements of young jobseekers.

Important among our resources for assisting youth is our vast supply of sound occupational and economic information. We have made vast strides in these fields during the war years. We have established a body of materials and experience which will stand us in good stead in assisting youth in resolv-

Ida is fortunate to have found steady employment soon after she graduated from high school.

ment which will take full advantage of their interests and aptitudes is the general-aptitude test battery, currently being introduced into the 1,800 local offices. With this new aptitude test battery it is possible to analyze aptitudes in relation to 2,000 different occupations. Scores made on these tests by young people seeking guidance can be compared with the scores made by successful workers in 20 different fields of work. The probability of the youth's succeeding in each field may be accurately evaluated.

Students discuss employment

There is one other phase of community counseling activities which, though still in an experimental stage, I should like to mention briefly. Its objective is to effect the fullest possible gearing together of school guidance activities and the employment counseling function of the public employment service. Many communities are experimenting with programs which hold considerable promise. Briefly stated, these programs provide that, during the junior and senior years of high school, the school holds group discussions which explore in rather general categories the so-called "world of work." These divisions separate into the white-collar occupations, including clerical and sales activities, the trade and service fields, and the industrial field subdivided into skilled, semiskilled, and unskilled categories. During the study of each of these divisions, the local employment office, represented by a labor market analyst, an employment counselor, or a placement interviewer, is requested to provide information covering the kinds of jobs found in each of these groups, the basic requirements of these groups in terms of physical capacities or academic background, the general nature of the work and current information concerning

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supply tools and information to the schools and other agencies useful in providing realistic vocational guidance; they must provide information on occupational requirements and opportunities to student and teacher groups prior to graduation; they must develop an understanding by the students, teachers, and other community groups of service available to youth in the local office; they must secure from the schools and other agencies information needed for counseling and placement to supplement that provided by the applicant; and have established a body of materials and experience which will stand us in good stead in assisting youth in resolving their employment problems in the years to come. On the basis of current labor market information we are able to assist young people in relating their interests and aptitudes to current and potential job opportunities, in order that they may avoid the pitfalls which are inevitable if sound information is lacking.

One of our newest tools for assisting youth in selecting and finding employ-

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In successive sessions the students are "polled" to see which of the fields represent the greatest interests of the group. These are in turn subjected to more detailed analysis. Again, employment-office personnel are requested to participate, and full use is made of available literature, motion pictures, and other educational aids.

The advantages of such cooperative

(Continued on page 126)

How Can Your Community Plan For the Care of Children in Hospitals?

MARTHA M. ELIOT, M. D.,
Associate Chief, U. S. Children's Bureau

HOSPITALS have had over the years a deep sense of their obligation to render to the community the kind of service it needs. This concern with what the community needs and wants for its children is also close to the heart of the Children's Bureau.

We have about 42 million children under 18 in the United States—one-third of our population. These children, who hold in their hands the future of this Nation, are the most vulnerable group in their health and welfare needs. The incidence of sickness among those under 18 is higher than for any other age group except people over 64.

But if we are to have healthy children, we must begin with the care that the mother gets during pregnancy. Babies should be born in hospitals where all the facilities for providing the needed care is at hand. We know, for instance, from records of hospitals that have developed services providing medical and nursing care for premature infants, that many infant deaths due to prematurity are preventable.

In 1946 almost 80 percent of the births in the United States were in hospitals, as compared with 37 percent in 1935. States vary a great deal, however, in the percentage of births in hospitals. In 1944, the range was from 98 percent in Connecticut to 31 percent in Mississippi. It is now an established fact that when funds become available to pay for care, and the State and local health departments register the cases and plan with

children who now receive hospital care.

National medical and health organizations, however, are aware of the lack of information. In order to obtain more specific data, the American Academy of Pediatrics decided in November 1944 to make a Nation-wide study of the health and medical services being given to children. The Academy requested the cooperation of the U. S. Children's Bureau and the U. S. Public Health Service in making this study, which covers four major fields: (1) Pediatric education; (2) distribution and activities of professional personnel; (3) hospital and clinic facilities; and (4) community health services for children. From this study we shall get information on the number of children admitted to hospitals of various sizes in different areas, as well as the number of days of care given to children; and information on the number and qualifications and training of physicians and nurses and others on the hospital staff who care for children. This will provide us with knowledge that we have not had before and that is essential to our planning for the medical and hospital care of children.

Furthermore, data from State surveys of present hospital facilities that will be completed to meet the requirements of the Hospital Construction Act will soon be available. Every effort is being made to combine and correlate this material with the findings of the American Academy of Pediatrics.

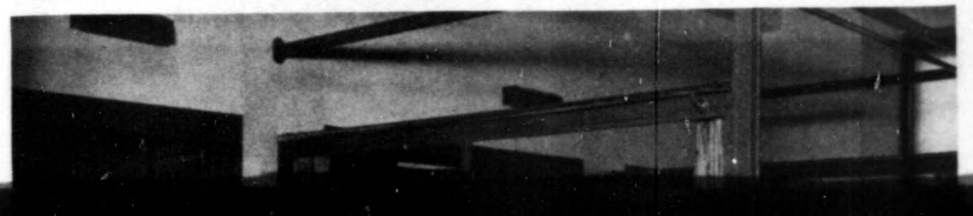
We are thus seeing at this time a convergence of effort to get the information that is essential for sound community planning—whether National, State, or local.

I should like to call your attention to another source of help in community planning. Since 1936 State health departments and State crippled children's agencies, in an effort to improve the health of children, have been drawing up annual plans of operation to qualify for Federal funds under the maternal and child-health and crippled children's programs provided for under title V of the Social Security Act. In all these, planning for hospital or convalescent home care figures largely.

The purpose of these programs is to improve, develop, and extend health and medical services to children. The State agencies determine the need for funds and submit plans to the Children's Bureau for furnishing services to children.

Next let us name certain underlying principles or conditions which should govern community planning for the hospital care of children, principles that have impressed themselves on us as these Federal-State cooperative services for children have developed. First, the most obvious: Health and medical services, to be of the greatest use to the individual child, must be accessible to him and they must be complete. Surely there should be a doctor within reason-

David is being cared for in the pediatric unit of a hospital. In this unit each bed is in a cubicle with windows, through which the nurse can see the children and they can see one another.



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It is difficult, if not impossible, to obtain information on the number of sick

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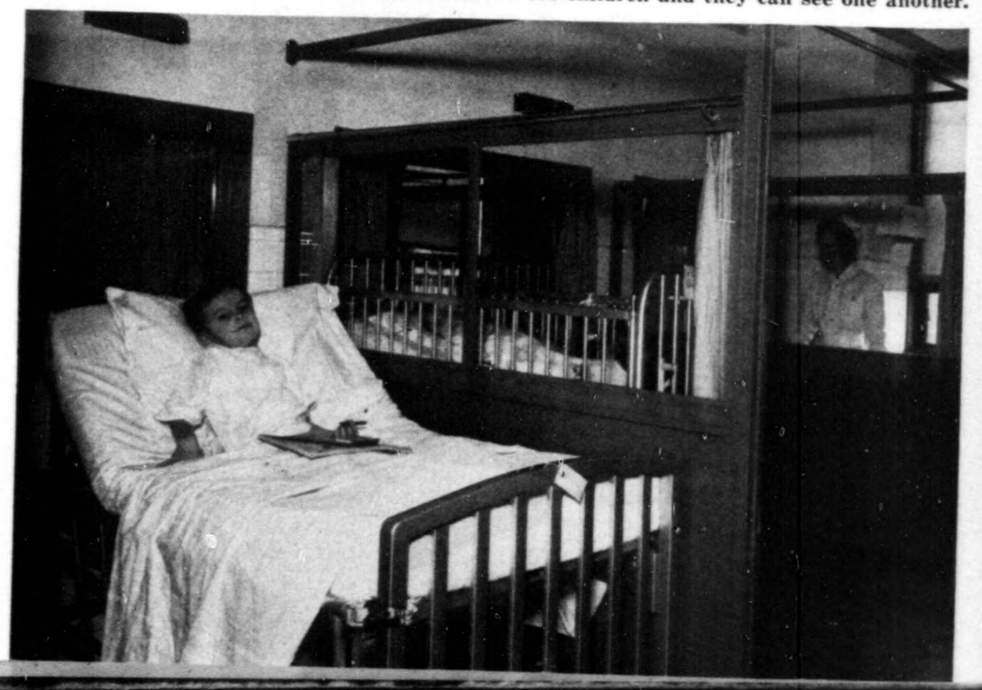
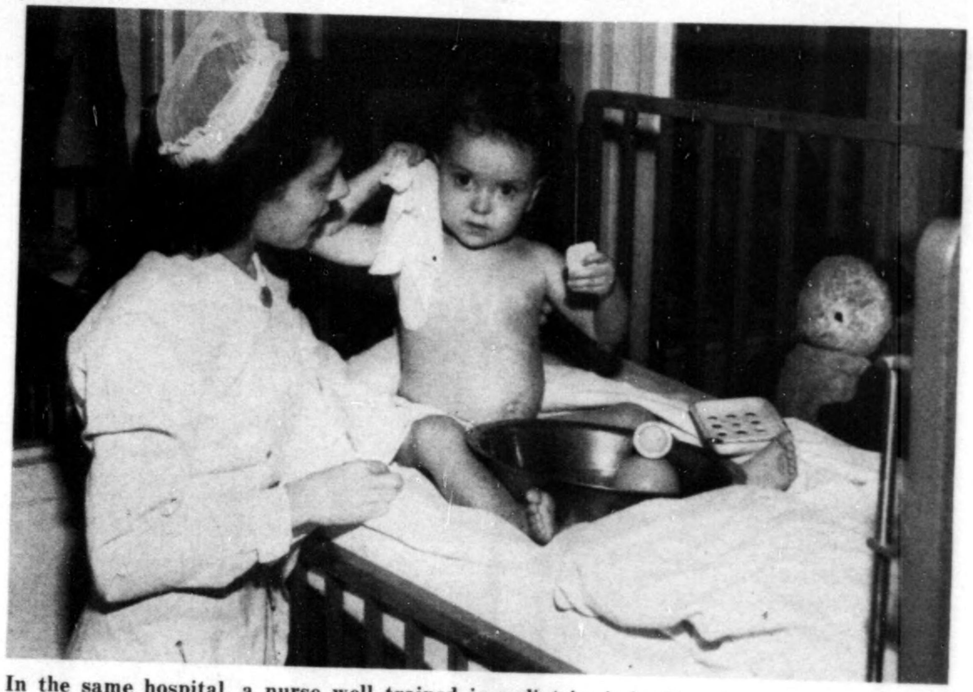


able reach of every child, and a hospital for the child's care as necessary—one that his parents can reach readily by the usual method of transportation. Where specialized pediatric and other medical service cannot be provided in his local community, there should be a plan for taking him to the place where it is available, or perhaps bringing it to him in special clinics or by a special consultant service.

Preventive, diagnostic, treatment, and after-care services should be integrated into a unified plan to meet the needs of the individual child. The chain of medical and hospital care provided in both smaller and larger communities should make available all the services essential for the adequate treatment of each condition, no matter how difficult of diagnosis or treatment. This requires the services of general physicians and specialists, nurses, nutritionists, medical-social workers, and workers in allied professions. In addition, recreational and educational services, child-welfare services, and any other services necessary to restore a child to full health must be available. The hospital will, of course, work with many other agencies, public and voluntary, in trying to reach this objective.

Secondly, experience has shown that in general the most economical method of providing hospital care for children is in special pediatric units within general hospitals of 50 or more beds. In small general hospitals with fewer than 50 beds, special arrangements for separate care of children should be made possible on a flexible basis.

Special children's hospitals as a rule are virtually general hospitals, self-sufficient in staff and equipment. They have played and still play an important role in establishing standards of care and integrating a diversity of services that are necessary for a well-rounded service to children. It is likely, however, that fewer such hospitals will be



In the same hospital, a nurse well trained in pediatrics is bathing Jeanne. Such a nurse plans her care of children in a way that will encourage each child's individual development.

other persons involved in giving services can be integrated with the staff and the teaching program of a medical-school center.

Next I should like to point out that extension of hospital facilities for children in urban areas where already several hospitals exist will require careful planning in relation to the needs of each community and the special conditions that must be provided for. Providing hospital care for children is not just a matter of beds. Any extension of facilities needs to be planned where the services of physicians and others qualified to treat children are, or can be made, available. Early attention should be given to strengthening pediatric units now existing in communities where there are physicians with special training for the care of children. Other units, however, should be developed as need for them is shown, taking into consideration the population to be served, the accessibility of the proposed unit to

community as is the care of children requiring bed care in a hospital for acutely sick children. Communities and hospitals must concern themselves with providing facilities for ambulatory care in clinics and the services of skilled physicians and specialists to furnish the care and to offer consultation services to physicians in general practice.

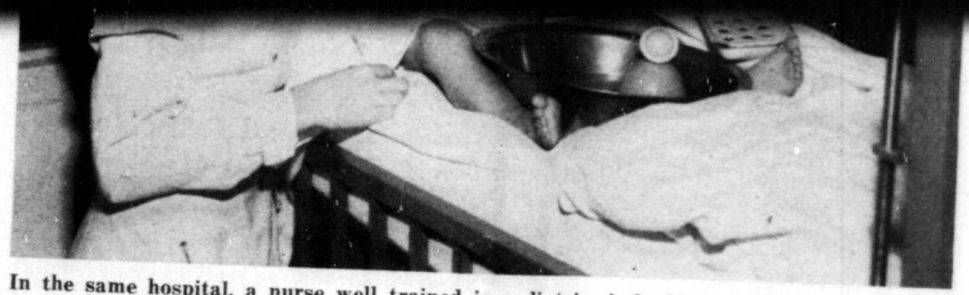
For long-time care

More adequate provision for convalescent facilities for children who do not require the many services of a general hospital is another aspect to which more thought and planning must be given. We now know something of the numbers of children with chronic conditions who need care and we know that many are not receiving the care they need. But if we had data on the number of children now in hospitals whose condition would permit being

needs of the individual child. The chain of medical and hospital care provided in both smaller and larger communities should make available all the services essential for the adequate treatment of each condition, no matter how difficult of diagnosis or treatment. This requires the services of general physicians and specialists, nurses, nutritionists, medical-social workers, and workers in allied professions. In addition, recreational and educational services, child-welfare services, and any other services necessary to restore a child to full health must be available. The hospital will, of course, work with many other agencies, public and voluntary, in trying to reach this objective.

Secondly, experience has shown that in general the most economical method of providing hospital care for children is in special pediatric units within general hospitals of 50 or more beds. In small general hospitals with fewer than 50 beds, special arrangements for separate care of children should be made possible on a flexible basis.

Special children's hospitals as a rule are virtually general hospitals, self-sufficient in staff and equipment. They have played and still play an important role in establishing standards of care and integrating a diversity of services that are necessary for a well-rounded service to children. It is likely, however, that fewer such hospitals will be built in the future, as most communities find it too expensive to provide, in a special hospital of this type, the whole gamut of services necessary to treat the many conditions that affect children. When large communities can afford to build and maintain general hospitals for children only, there would seem no reason why this should not be done, particularly where the medical staff and all other persons involved in giving services can be integrated with the staff and the teaching program of a medical-school center.



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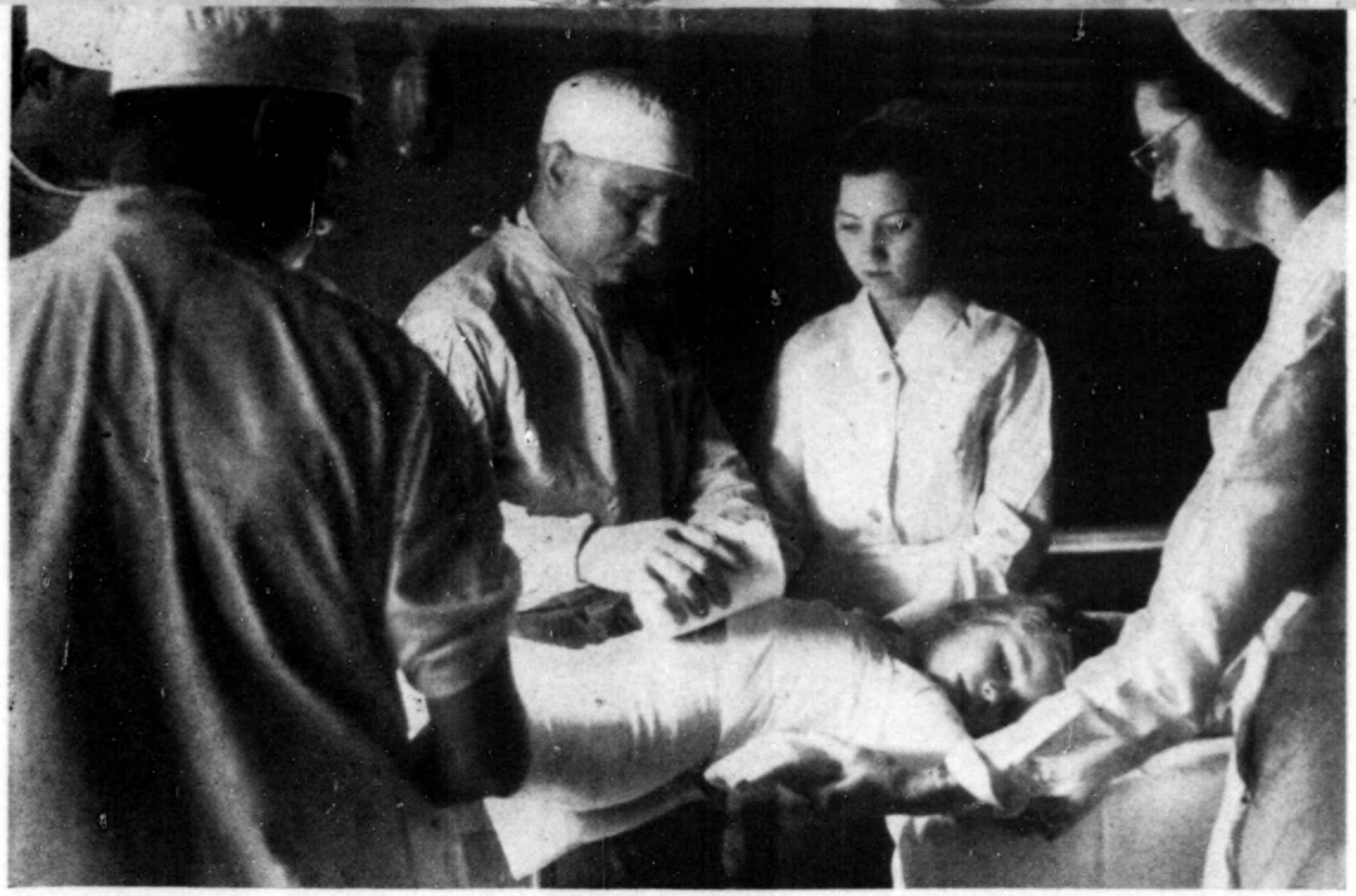
My fourth point also is obvious. Care for the ambulatory child patient and the convalescent child should be of as much concern to hospitals and the community as is the care of children requiring bed care in a hospital for acutely sick children. Communities and hospitals must concern themselves with providing facilities for ambulatory care in clinics and the services of skilled physicians and specialists to furnish the care and to offer consultation services to physicians in general practice.

Given at the annual meeting of the American Hospital Association, St. Louis, September 23, 1947.

For long-time care

More adequate provision for convalescent facilities for children who do not require the many services of a general hospital is another aspect to which more thought and planning must be given. We now know something of the numbers of children with chronic conditions who need care and we know that many are not receiving the care they need. But if we had data on the number of children now in hospitals whose condition would permit being cared for in convalescent facilities, better use of the beds now available in general hospitals could be made. Many of these children would be benefited physically or from a psychological viewpoint by being moved from the hospital to a good convalescent facility that is well-equipped and well-staffed to meet the requirements of children under long-time care. Such care in a convalescent home would have the



An orthopedic surgeon, internes and nurses join their efforts to give this child the best of care. And they are backed by other workers, such as medical social workers and nutritionists.

added advantage of being more economical to furnish.

These facts are well known to State health agencies and other agencies that administer services to crippled children. Any planning for the care of this group of children should be undertaken in cooperation with these agencies. Furthermore, guides in convalescent care have been worked out by a committee of the National Society for Crippled Children and Adults, in which the Children's Bureau has participated. Architectural plans for children's convalescent homes developed by this committee in cooperation with the architectural services of the U. S. Public Health Service are now available.

A convalescent home should preferably be developed in connection with a general hospital, both functionally and under its administration, to assure adequate direction of medical, nursing, and other professional services of high quality. It is desirable to have the con- has brought together available information and has set forth in its publications standards for various types of care in hospitals, including maternity care, care for the newborn infant, and also for the premature infant. The Bureau is interested in methods of maintaining pediatric-nursing standards. A study of pediatric nursing is now under way to develop a basis for determining these standards.

With respect to standards for medical care of children in hospitals or convalescent facilities, we believe that every child, whether a medical or a surgical patient, should come under the care or supervision of a physician who has had special training and experience in the medical care of children. When this is impossible, pediatric consultation service should be a part of the child's medical care by the hospital. This presupposes that a qualified pediatrician would be on the hospital visiting or consulting staff and always accessible for

munity and rural hospitals and to itinerant or rural health clinics.

We know how to give good care to children, but we have not devised the ways and means to make it accessible and available to all families. Hospitals and health centers have been lacking. Economic and geographic barriers stand in the way. Tradition, too, has established barriers that figure largely in discussions among the professions and among the people. On both sides some traditional practices, though certainly not all, must be replaced with new ones. For instance, if care of high quality is to be made available there will have to be great extension and improvement of practice in groups whether in a hospital and clinic setting comparable to that in many hospitals today or in the setting of a privately organized group of physicians who are banded together to improve the care of their patients. Both these methods of group practice are well known today, but do not exist everywhere. Any group practice should include not only general family doctors, but also the specialists needed by the average family at frequent intervals, such as the pediatrician, and they should have access to complete clinical facilities, including hospitals.

The family doctor in our smallest towns and villages should also belong to such a group, even though the specialists of the group and the hospital and the diagnostic clinics are located in a centrally situated town and the general practitioners are located on the periphery. Under such arrangement the group practice must exist in fact and not in name only if the children in rural areas are to be served adequately. There must be a two-way exchange of consultation and service be-

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A convalescent home should preferably be developed in connection with a general hospital, both functionally and under its administration, to assure adequate direction of medical, nursing, and other professional services of high quality. It is desirable to have the convalescent home removed from the environment of the general hospital but not so far away as to be inaccessible to the general hospital. It is thought that a convalescent facility should not be smaller than 50 beds or larger than 100 beds—large enough to be economically operated, and so operated that the atmosphere of a home will be retained.

Community planning for any kind of hospital or convalescent care for children should obviously take into account standards that have been established for their care. The Children's Bureau has brought together available information and has set forth in its publications standards for various types of care in hospitals, including maternity care, care for the newborn infant, and also for the premature infant. The Bureau is interested in methods of maintaining pediatric-nursing standards. A study of pediatric nursing is now under way to develop a basis for determining these standards.

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For rural children

It is evident that to attain this standard it will be necessary to have pediatric services available to small communities and rural areas. This will mean developing an interrelationship between hospitals in the large centers and those in outlying communities. Such a relationship will make practicable a flow of professional consultation from the larger medical centers to the small communities. For instance, if care of high quality is to be made available there will have to be great extension and improvement of practice in groups whether in a hospital and clinic setting comparable to that in many hospitals today or in the setting of a privately organized group of physicians who are banded together to improve the care of their patients. Both these methods of group practice are well known today, but do not exist everywhere. Any group practice should include not only general family doctors, but also the specialists needed by the average family at frequent intervals, such as the pediatrician, and they should have access to complete clinical facilities, including hospitals.

The family doctor in our smallest towns and villages should also belong to such a group, even though the specialists of the group and the hospital and the diagnostic clinics are located in a centrally situated town and the general practitioners are located on the periphery. Under such arrangement the group practice must exist in fact and not in name only if the children in rural areas are to be served adequately. There must be a two-way exchange of consultation and service between a rural or small-town family physician and the central headquarters staff of the hospital and clinic. The community child-health service and the local health centers should be connecting links in the chain that binds rural physicians to the central group.

To make such a plan of small city and rural group practice work, hospitals and clinics, health centers, and child-health clinics must be constructed and equipped in many areas. The Hospital Construction Act now provides the means for making such a plan possible.

To bring services of high quality to

the small communities and rural areas, it is easy to visualize a chain of hospitals and clinics and health centers in every State, developed in accordance with its own particular circumstances. The chain of hospitals would reach from the large medical center to the large-community hospital, and on to the rural hospital and health center. Diagnostic and consultation services, and treatment that could not be provided in the rural or small-community hospital, would be obtained at the larger medical center. There could be itinerant diagnostic and health services to reach out into communities too sparsely populated to warrant permanently established clinics. These could also be connected with the chain of health centers, hospitals, and clinics, reaching back to medical centers. In my opinion the links in this chain will have to be forged together by the State and local health agencies who carry the public responsibility for seeing that the health interests of all the people of the State are served.

It is clear that in any planning for care of children in hospitals, the medical-school hospital is an important center to which outside communities must be able to turn. The teaching medical center must collaborate with State health agencies in taking responsibilities for promoting, developing, and improving health and medical services as far out as there is need for its services. The medical-school center is facing the day when it must join in taking such leadership by extending its knowledge, its skills, and its opportunity to stimulate higher standards in the fields of public health, medical care, nursing, and all the allied professional services involved in safeguarding and restoring the health of children and adults.

Comprehensive project reported

The program that has been developed the medical services of a pediatrician of faculty rank from the medical school to the children in the Upper Peninsula, and makes diagnostic and treatment services available.

This Child Health Project at Rochester, Minn., demonstrates how services to the children of a community were assumed as part of the responsibility of a large teaching clinic. This is an integration of the efforts of local health and school officials, with the financial support in this case of the Mayo Foundation, the cooperation of the University of Minnesota's Medical School, the School of Public Health, and the Child Welfare Institute. This project is set up as a unit of the section on pediatrics at the Mayo Clinic. Here is a community health program that takes into account not only a child's physical health and welfare but his basic emotional needs as well.

At the heart of the planning for any program of care for children is the training of physicians and other workers in pediatric care, including training in the mental-hygiene aspects essential to good pediatric practice.

Adequate training in pediatrics for all nurses includes consideration of growth and development as well as the study of clinical conditions in children. Nurses preparing for positions in public work should be given additional opportunity to practice, under qualified supervision, the application of the principles of child care in a variety of situations, including those usually met in a broad program of community service. Consultants, instructors, and supervisors responsible for development of educational or service programs should have demonstrated professional competence in the care of children as well as having completed an advanced program of study in pediatric nursing.

In planning community health services for children, it has already been pointed out that the consulting services of pediatricians should be available for areas where there are no physicians especially trained in child care. Consultation services to hospitals by other types of consultants, nurses especially trained in pediatrics, nutritionists, and medical-social workers with basic knowledge of the health and social needs of children, are being developed by an increasing number of health departments.

Already, in 26 States, health departments have created positions for hospital consulting nurses on their staffs to improve maternity care and care of newborn infants. This pattern could be extended into the field of pediatrics with far-reaching benefits to children.

At present only a small proportion of hospitals have trained medical-social workers on their staffs. As with other professional personnel, there are not now enough of these trained workers to provide the services needed. Careful planning is required for the most effective utilization of those we now have and at the same time for the training of

(*Continued on page 126*)

These children are having fun while receiving long-time care in a convalescent facility. If such facilities are well equipped and well staffed to meet children's needs, better use may be made of the beds in general hospitals and—more important—many children will benefit.

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Comprehensive project reported

The program that has been developed for the care of children in the Upper Peninsula of Michigan is an example of the coordination of services that other communities could well study. A report of this was given by Dr. Moses Cooperstock in *The Modern Hospital* for May 1946. The report brings out how the department of postgraduate medicine stimulated a cooperative endeavor that promotes educational aims and opportunities for training, offers School of Public Health, and the Child Welfare Institute. This project is set up as a unit of the section on pediatrics at the Mayo Clinic. Here is a community health program that takes into account not only a child's physical health and welfare but his basic emotional needs as well.

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PSYCHIATRIC TEAM HELPS DISTURBED CHILD

HENRY H. WORK, M. D. *Director of Mental Health Unit, U. S. Children's Bureau*

THOSE who work in fields that serve mothers and children, whether concerned with medical or social problems, are constantly aware that many things interfere with the smooth functioning of what should be a normal relationship. As a result problems arise which may alter the child's entire life and certainly affect seriously his personality development.

The past 40 years have seen a marked increase here in the United States, both in recognition of the child's difficulties and in means of coping with them. The growth of services to diagnose and treat personality disorders has taken many different routes; they include psychological services, habit clinics, child-guidance clinics, formal psychiatric services for children, and, finally a spread of psychiatric knowledge to the field of pediatrics, with extension to services concerned with prevention.

Began with backward children

The child-guidance clinic, regardless of nomenclature, has its roots in the many attempts to classify the functioning ability of feeble-minded children, largely on the basis of the possibilities of educating them.

A more recognizable origin for the present-day clinics is Dr. William Healy's work in Chicago in 1909. At that time, when Healy began to work with boys referred to him by the juvenile court, he introduced more dynamic concepts of the problems presented by the behavior of the children. His work set an example for the thorough study of the total make-up of these boys and gave a new conception of the workings of the individual. Healy was far in advance of his time, and there was little community that the clinics serve. These changes have been evolutionary, but at present the clinics are mostly centered around the pattern of what is known as the mental-hygiene clinic team, consisting of the psychiatrist, the psychologist, and the psychiatric social worker.

Psychiatrist directs clinic

The basic member of this team is the psychiatrist himself. Although there have been many clinics where members of other disciplines have played the greater part in organization or function, it is now well-accepted that the psychiatrist holds the responsibility for the plan of treatment of the children and for the diagnosis, based on his fully adequate knowledge of disease and disease processes. He alone has the medical background to see the complete individual and to evaluate the complex interaction of related disease conditions.

In most present-day clinics the psychiatrist acts as the medical or clinic director and supervises other members of the staff in their therapeutic procedures. On him also falls the job of teaching, especially the teaching of other physicians, a service that has always been an essential part of the clinic program.

Complementing his activities are those of the two other branches of the field which make up the team, the psychologists and the psychiatric social workers. Although child guidance began in the psychological study of the feeble-minded, later the practices of the psychologists proved to be of utmost importance in understanding the problems of the child in relation to his abilities. Introduction of the Binet-Simon test in 1908 spurred the activities of this

edge of personality types, they are able to contribute enormously to the study of the disturbed child.

The third member of the team represents the newest of the disciplines, but the group of psychiatric social workers has grown to be both numerically important and of real worth in rounding out the combined functions of the clinic team.

Very early in the history of medical social work a few of these workers began to concentrate their efforts upon mental patients cared for in hospitals and clinics. As mental hospitals progressed, changing from custodial institutions to hospitals for the study, treatment and prevention of mental disease, the demand for social work for the patients expanded. However, the main development of psychiatric social services has been in the various psychiatric, mental-hygiene, and child-guidance clinics established to study and treat emotional problems.

Today psychiatric social workers represent an important element in every clinic, being responsible for most of the intake work, frequently handling therapy under the supervision of the clinic director, and maintaining an effective liaison between the clinic and the various independent organizations which the clinic serves. In terms of numbers they usually comprise the largest group of workers in the clinic, and their functions are adaptable to the variety of problems presented for care.

Teamwork pays dividends

The services which this clinic team has been called upon to perform have been as diverse as the capacities of the personnel and have reflected the variety of origins of its growth. Many of the clinics have not only been set up to meet

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Ten years later there were only 7 clinics in the country for psychiatric work with children, but so great was the impetus of these that by 1939 there were 776 such clinics.

Along with this numerical growth there have been changes in the organization of clinics and a shaping of the personnel groups to fit the needs of the

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At the present time, with a battery of testing material at their service and with a more thorough clinical knowl-

Written for presentation at the Ninth Pan-American Child Congress, Caracas, Venezuela, January 5–10, 1948.

social work a few of these workers began to concentrate their efforts upon mental patients cared for in hospitals and clinics. As mental hospitals progressed, changing from custodial institutions to hospitals for the study, treatment and prevention of mental disease, the demand for social work for the patients expanded. However, the main development of psychiatric social services has been in the various psychiatric, mental-hygiene, and child-guidance clinics established to study and treat emotional problems.

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Teamwork pays dividends

The services which this clinic team has been called upon to perform have been as diverse as the capacities of the personnel and have reflected the variety of origins of its growth. Many of the clinics have not only been set up to meet the needs of a particular demand but have devoted much of their time to the solution of a special mental problem presented to them by a health or welfare agency. In the main, referrals have come from three sources: Health services, social services, and educational facilities, and while some clinics have devoted themselves to working for one of these sources, many of the clinics have served all three.

In discussing the referrals that come primarily from the field of medicine itself it is curious to observe that guidance facilities often have had more difficulty in obtaining this type of referral than many others. In the present organization of clinics it is felt that the proper referral is from another physician, but often it was necessary for the clinic to prove its abilities before it could receive such referrals.

However, many physicians, especially pediatricians, now make wise use of the clinic's services. In many privately organized clinics the bulk of cases come from private physicians who recognize that the nervousness of a child is a symtom of a deep personality disorder and that the child needs the diagnosis and treatment which the clinic can provide. In public-health organizations both doctors and nurses were quick to see the advantage of these clinics for children whose symptoms were often those of organic disease but who presented no specific disease process and who later showed emotional difficulties. In this connection it should be mentioned that the clinics early demonstrated the marked correlation of emotional difficulties in the child with those in the parents and shaped their organizations so that they did not deal with the child alone but included the mother either in actual treatment or in a supporting role.

Organized health services gradually became aware of the possibility of using various members of the clinic team as consultants on their less serious problems; and in many areas where there was a dearth of personnel the clinic team functioned almost wholly in a consultative capacity, advising the medical and nursing personnel on specific cases. The psychiatric team has also been of great service in educating the members

eager to use them. It has been noted that throughout its history the National Conference of Social Work has presented on its programs psychiatric and mental-hygiene material, and throughout the social-work field there has been active use of clinics and their personnel.

In this field the use of the consultant has been carried to the point of perfection, and in some of our States the only psychiatric service provided for children has been in the form of traveling clinics advising child-welfare workers in the handling of their cases.

In the larger cities many agencies have retained individual psychiatrists as consultants and have used the clinics for their more seriously disturbed cases. In this general area one must consider work with the juvenile delinquent. In many cities there has been an intimate tie with the probation officers and court social workers so that the management of these children has been placed on a clinical basis, and a considered and intelligent approach to the problems of the delinquent child has been obtained. As was mentioned earlier, Healy's first work was with delinquents, and there has been a continual use and sharpening of the psychiatric resources bearing on this problem. At present the trend in this field lies in preventive work, and here again the clinic has been able to give wise counsel.

For disturbed school children

The abilities of the clinic were early and consistently tested by children whose difficulties first manifested themselves in the school situation. The schools have always remained a steady source of referrals, and much specialized work has been done with children whose problems were directly related to scholastic hazards as well as those whose difficulties antedated their school careers

tion overlap. Again in the educational field there have been problems in educating the members of the teaching profession itself to make them aware of their responsibilities toward children and of the actual psychological components of the teaching process. This area still requires much study and work and is another strain on the all too meager resources of the clinics.

The most hopeful aspect of the field of psychiatry for children lies in the expansion possible under the National Mental Health Act, passed to stimulate research, training, and services in the field of mental hygiene. When the full purposes of this act have been realized the adequate fulfillment of the mental-hygiene program can be anticipated. At present two important aspects of this program, that of research and that of training new personnel, are operating.

Professional standards set

Training for the separate disciplines follows definite outlines. The National Advisory Mental Health Council has set minimum qualifications for these positions, as follows:

The physician must first be a graduate of an approved medical school and have completed a year of general internship. This is followed by 3 years of further hospital work in the field of psychiatry, with some training in child psychiatry and then 2 years of practical experience, preferably in a guidance clinic.

The psychologist's training includes both undergraduate and postgraduate work in the specialty leading to a master's degree, plus 2 years of experience in an actual clinic, 1 of these years being supervised study.

The requirements for a psychiatric social worker include approved postgraduate work in this specialty, plus 1 year of full-time experience in social

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At all times in the history of development of social services for children there has been a keen understanding of the benefits of the psychiatric approach in case work and in the ordinary dealing with clients. No group has been so aware as the social workers of the possibilities of the guidance clinics and so as consultants and have used the clinics for their more seriously disturbed cases. In this general area one must consider work with the juvenile delinquent. In many cities there has been an intimate tie with the probation officers and court social workers so that the management of these children has been placed on a clinical basis, and a considered and intelligent approach to the problems of the delinquent child has been obtained. As was mentioned earlier, Healy's first work was with delinquents, and there has been a continual use and sharpening of the psychiatric resources bearing on this problem. At present the trend in this field lies in preventive work, and here again the clinic has been able to give wise counsel.

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The abilities of the clinic were early and consistently tested by children whose difficulties first manifested themselves in the school situation. The schools have always remained a steady source of referrals, and much specialized work has been done with children whose problems were directly related to scholastic hazards as well as those whose difficulties antedated their school careers but whose symptoms were overlooked by parents and brought to light by a more observant teacher. In many cities the school departments have brought the clinic team into the school system and have rendered extensive diagnostic and therapeutic service to emotionally disturbed children. The psychologist has been prominent in this role, and both the psychologist and the psychiatrist have been successful in handling children with special educational problems where the fields of medicine and education

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The requirements for a psychiatric social worker include approved postgraduate work in this specialty, plus 1 year of full-time experience in social case work in a health or welfare agency with acceptable standards. An alternate requirement is completion of a 2-year course in social case work plus 1 year of experience of the type just described, under the supervision of a qualified psychiatric social worker.

All this training heeds the important factor of working as a group to mold the three professions into a well-functioning and effective clinical team.

Reprints available in about 5 weeks.

TO SAFEGUARD CHILDREN PLACED OUTSIDE THEIR OWN STATE

I. EVELYN SMITH,

Consultant on Foster Care, Social Service Division, U. S. Children's Bureau

WHEN A CHILD is taken from one State to another to be placed in foster care, he faces greater hazards to his welfare than if he were placed in his own State. And the social agency in either State that is responsible for his welfare finds all the usual difficulties caused by taking a child out of his accustomed way of life, plus some additional complicated ones.

Sometimes the child's new home is a long way from the former one; and distance itself may add to the child's emotional disturbance. Distance may also make it more difficult for the welfare authorities in the child's home State to protect him.

Arrangements have to be made for supervision of the child in the new home, and matters often become complicated when several agencies—State and local—have to take part in the placement.

One of the most important difficulties is caused by a requirement in some States that a child cannot be supported at public expense unless he is a legal resident of the State. As a rule, a child has his legal residence in the State where his father lives, and a child born out of wedlock has legal residence in his mother's State.

Sometimes a child is deprived of proper care by requirements concerning residence. For example, Jimmy, aged 4½, is mentally defective and needs institutional care. But he cannot be placed in a public institution in his

Jimmy showed signs of mental defect and the couple decided not to go through with the adoption. The maternity home then placed him in a boarding home, where he still is, in a very unsatisfactory situation. The boarding mother is old, is unable to give the child satisfactory care, and does not wish to keep him. His mother pays his board with great difficulty.

When the public-welfare department learned of this situation, it tried to get court action to place Jimmy in a public institution, but could not, as the court considered him not a legal resident of the State, but of the State where his mother lives. His mother's State will not accept responsibility for Jimmy, as he has never been in that State, and the State of his birth also disclaims responsibility.

Besides the difficulties caused by restrictions concerning the child's legal residence, there are problems due to differences in the States with regard to material matters. Resources, financial or other, that were available in the child's home State may be very different in the new State. One State may have, for example, better opportunities for children to live in family homes.

An example of a child's life being changed for the worse by a necessary removal to a State of poorer child-welfare resources is the story of Mary.

Mary was born after her father and mother had separated. Her mother kept her for a year and then paid her

that Mary's father was living in another State, which was therefore the child's legal residence. Although Mary's father was unable to support her, she had to be removed to his State, and the only provision that the State could make for her was in a public institution.

With the idea of exchanging experiences on problems like these, and the even more complicated problems of international placement of children, child-welfare workers in a number of States have for some time been expressing a desire for a conference on placement across State lines. Accordingly, members of the child-welfare staffs of the Illinois and Missouri State welfare departments sponsored a Midwest Conference on Interstate and International Placement of Children, which met at Pere Marquette Park, Grafton, Ill., October 6–7, 1947. Child-welfare workers from 13 States attended—Arkansas, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio, Oklahoma, and Wisconsin. Representatives of the U. S. Children's Bureau also participated.

Recent laws stress child's welfare

As a background for the discussion a staff member of the U. S. Children's Bureau presented a summary of State laws relating to interstate placement of children. This showed that most of these laws were passed in the latter part of the nineteenth century and the early part of the twentieth, before adequate State welfare laws provided for the licensing and supervision of agencies placing children. The earlier laws did not take into consideration the idea of cooperation between State authorities, but stressed protection of the State from casual and undesirable placement of children by persons or agencies from another State. These laws were passed to keep the State from having to assume responsibility for support of children

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Sometimes a child is deprived of proper care by requirements concerning residence. For example, Jimmy, aged 4½, is mentally defective and needs institutional care. But he cannot be placed in a public institution in his State because of a technicality concerning his legal residence.

Jimmy's mother was unmarried, and during her pregnancy she left her own State and stayed at a maternity home in a neighboring State. After Jimmy was born she requested the maternity home to place him for adoption, and returned to her home State.

The maternity home placed Jimmy with a couple in a third State. But soon where he still is, in a very unsatisfactory situation. The boarding mother is old, is unable to give the child satisfactory care, and does not wish to keep him. His mother pays his board with great difficulty.

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An example of a child's life being changed for the worse by a necessary removal to a State of poorer child-welfare resources is the story of Mary.

Mary was born after her father and mother had separated. Her mother kept her for a year and then paid her board in a family who loved the child and where she was very well adjusted. She went to school with the other children in the family and the neighborhood and was happy.

Then, when she was 8 years old, her mother disappeared. The foster family could not afford to support Mary, and the welfare authorities took steps to provide for payment of her board from public funds. But they soon learned

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The conference agreed that in order to safeguard the child, as well as the family in which he is to be placed, and the State, the agency that plans to refer a child to authorities in another State for placement should provide a state-

Every child needs to be with his parents, as these twins are. Many are not; and State departments of welfare are much concerned about these children's welfare and happiness.

ment of all the essential facts about the case. Such a statement would include the reasons for considering placement of the child in the State, and also information on the child's personality and his most urgent physical and emotional needs. Such information was felt to be essential to enable the responsible agency in the receiving State to study the proposed plans for his care.

When it comes to the actual placement, all possible safeguards should be set up by the two responsible agencies—one in the child's home State and one in the new State—before the child goes to the new home. There should be a clear understanding with respect to the legal guardianship of the child. The family in which he is placed should be told why continued supervision of the child is necessary, and what to expect in the way of visits from representatives of the supervising agency. The division of responsibility between the two agencies should be made clear. The is the ultimate plan there should be an understanding as to which State the court petition is to be filed in, and after how long a trial period.

While it was recognized that the laws of both States must be conformed with, some workers felt that many State laws lag behind present-day philosophy and accepted social practices. This sometimes makes good planning in specific cases difficult. Since existing laws may not be changed soon, liberalizing of existing practices through administrative procedures where possible was recommended.

Children brought from other countries

The conference reviewed international problems relating to the placement of children in the United States from other countries. Some of the points discussed were admission of European refugee children, adoption of foreign-born children, placement of Canadian children for adoption in this

and that the welfare of the child should be the paramount consideration.

There was agreement that social services should be given to children on the basis of their own particular needs rather than on the basis of residence, unless the law specifically limits eligibility for services to persons who are legal residents of the State. The conference emphasized that the aim of meeting the individual needs of children could be realized more fully if Federal legislation would provide for financial participation by the National Government through grants in aid to States for foster-family care.

The findings committee was asked by the conference to prepare a draft for an agreement between the State from which a child is removed and the State in which he is to be placed. This agreement should include a statement of basic principles and procedures for interstate placement. It should also include an outline of information concerning the child, to be sent by the referring agency, and of information concerning the family under consideration for receiving the child into their care.

Such an agreement might serve as a tentative draft for consideration by the individual States with respect to the desirability of such agreements on interstate placement and the authority of the State to enter into them.

The findings committee was also requested to explore the question of Federal legislation regulating interstate placement or the possible passage of a Federal law authorizing the individual States to enter into interstate compacts or agreements on a voluntary basis.

The Children's Bureau was requested to (1) summarize in written form information relating to international problems concerning the placement of children, and (2) assist in developing a plan for a statistical study of the scope of interstate placements.

Every child needs to be with his parents, as these twins are. Many are not; and State departments of welfare are much concerned about these children's welfare and happiness.

ment of all the essential facts about the case. Such a statement would include the reasons for considering placement of the child in the State, and also information on the child's personality and his most urgent physical and emotional needs. Such information was felt to be essential to enable the responsible agency in the receiving State to study the proposed plans for his care.

When it comes to the actual placement, all possible safeguards should be set up by the two responsible agencies—one in the child's home State and one in the new State—before the child goes to the new home. There should be a clear understanding with respect to the legal guardianship of the child. The family in which he is placed should be told why continued supervision of the child is necessary, and what to expect in the way of visits from representatives of the supervising agency. The division of responsibility between the two agencies should be made clear. The agencies should come to an agreement upon reports to be made on the child's progress and adjustment. Also there should be determination of who will be responsible for the child's support in case he becomes dependent. The two agencies should be clear as to who shall decide when supervision is no longer needed and the procedure to be followed if it becomes necessary to return the child to his former State. If adoption is the ultimate plan there should be an understanding as to which State the court petition is to be filed in, and after how long a trial period.

While it was recognized that the laws of both States must be conformed with, some workers felt that many State laws lag behind present-day philosophy and accepted social practices. This sometimes makes good planning in specific cases difficult. Since existing laws may not be changed soon, liberalizing of existing practices through administrative procedures where possible was recommended.

Children brought from other countries

The conference reviewed international problems relating to the placement of children in the United States from other countries. Some of the points discussed were admission of European refugee children, adoption of foreign-born children, placement of Canadian children for adoption in this country, bringing to this country children born overseas whose fathers were American servicemen, and caring for repatriated children returned to the United States by the State Department, unaccompanied by parents or other guardians.

Throughout all the discussions at the conference it was emphasized that good standards of work for children should be upheld in all interstate placement financial participation by the National Government through grants in aid to States for foster-family care.

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The Children's Bureau was requested to (1) summarize in written form information relating to international problems concerning the placement of children, and (2) assist in developing a plan for a statistical study of the scope of interstate placements.

A follow-up conference was recommended for the spring of 1948.

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"The diversity of social-welfare practices is as great as is the diversity of climatic and soil conditions in the fifty-odd States, Territories, and possessions which comprise the United States. This could not be otherwise because of the different periods of settlement and the variety of backgrounds and economic conditions in the different States."—Emma O. Lundberg: Unto the Least of These, p. 10. D. Appleton-Century Co., New York, 1947. By permission of the publisher.

IN THE NEWS

United States Committee for ICEF Formed

The United States Committee for the International Children's Emergency Fund held its first meeting at the White House, January 19, 1948. This committee is a voluntary association of citizens, formed to advise the United States representative to the Executive Board of the International Children's Emergency Fund with regard to information and suggestions from United States sources regarding the work of the Fund. The membership is broadly representative of a wide range of citizens' groups throughout the country and of geographic areas. The chairman is Mrs. Oswald Lord.

The committee will cooperate with the American Overseas Aid-United Nations Appeal for Children.

Twenty-six nations are represented on the Executive Board of the ICEF. The United States representative is Katharine F. Lenroot, Chief of the U. S. Children's Bureau.

For Relief of Overseas Children

Individual contributions amounting to at least 60 million dollars are asked from the people of the United States to help meet the most urgent 1948 needs of distressed children and adults overseas.

Similar drives are being carried out in a number of other countries by the United Nations Appeal for Children. In each of these countries a national organization will collect the funds. In the United States this is being done by a campaign organization representing 21 voluntary organizations that are already furnishing relief in war-torn countries, and the United Nations Appeal for Children, whose proceeds in the United States will go to the International Children's Emergency Fund.

persons, and related services, many of which affect children as well as adults. Seventy percent will go toward special children's activities—21 million for the ICEF and 17 million for the children's programs of the voluntary agencies.

The national drive has already begun; local drives will begin at various times, according to the situation in the various parts of the country. Many will begin in April. Local committees are being formed to participate in the appeal, along lines compatible with local practice.

Contributions to AOA-UNAC are deductible for income-tax purposes by specific Treasury Department ruling dated October 14, 1947.

The headquarters of American Overseas Aid and United Nations Appeal for Children is 39 Broadway, New York 6, N. Y.

The agencies participating in American Overseas Aid-United Nations Appeal for Children are: International Children's Emergency Fund (United Nations), American Friends Service Committee, Church World Service—Special Projects Division, Unitarian Service Committee, War Relief Services—National Catholic Welfare Conference, YWCA World Emergency Fund, American Aid to France, American Hungarian Relief, American Relief to Austria, American Relief for Czechoslovakia, American Relief for Italy, American Relief for Poland, Greek War Relief Association, Philippine War Relief (of the U. S.) Inc., United Lithuanian Relief Fund, United Service to China, AFL Labor League for Human Rights—Foreign Relief Program, CIO Community Services Committee—Overseas Relief and Rehabilitation Fund, Freedom Fund—Cooperative League of the USA, International Rescue and Relief Committee, International Social Service, Tolstoy Foundation for Stateless Russians.

Canadians Redraft Model Vital-Statistics Act

certificates involving adoption and legitimation be filed at the Provincial rather than the local level. Exchange of adoption data was advocated, not only between Provinces, but between countries, also confidential handling and other procedure intended to safeguard data concerning births, adoptions, and so forth. As for the controversial questions concerning birth registration of allegedly illegitimate children born to married women, there was strong feeling in the group that common-law principles should be upheld.

The model act will be redrafted in the light of the conference discussion and will be submitted to the Vital Statistics Council and the Commissioners on Uniformity of Legislation before transmission to the Provinces. Each Province will, of course, be free to change the model act to suit its own views.

(For discussion of the social aspects of birth registration in the United States see *The Child*, August 1946 and June 1947.)

SOURCE: Concerning Children. Child Welfare Division, Canadian Welfare Council, Ottawa. December 1947.

Nebraska Expands Health Education

Health education in Nebraska is starting on a 3-year expanded program. Sponsors are the State departments of public instruction, of assistance, and of child welfare, in cooperation with the universities and teachers colleges. At each of these centers will be a health educator and a nutrition specialist who will teach and supervise in the area adjacent to the centers. State consultant services will be available as these are needed in the development of the program.

Films Show State Rheumatic-Fever and Premature-Baby Programs

A motion picture on rheumatic fever and one on premature infants—both for the public—have recently been produced by Virginia's State Health Department [illegible] with the U. S. Children's