

PARENT PARTICIPATION AND PLAY PROGRAMS
IN HOSPITAL PEDIATRICS IN ENGLAND, SWEDEN AND DENMARK

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To The World Health Organization who granted me the honor and made possible my travel study; to the program arrangers who understood my mission and arranged introductions to people and programs who helped me learn about parent and play activities, and to the nurses, psychologists, play leaders, physicians, parents and patients who shared so generously their experience, enthusiasm, wisdom, time and energy, I wish to express my deep appreciation. I truly learned the meaning of "hands across the sea," and hope that, together, we may continue to work to improve the situation for young hospitalized children and their families.

TABLE OF CONTENTS

Foreword.....	v
Introduction.....	vi
Certificate of Award.....	vii
Objectives.....	viii
Itinerary.....	ix - xiv
England.....	1
Government Policy	
Governmental Guidelines	
Health Services for Children	
Study Day Conference: Role of the Hospital Play Leader	
Volunteers and Consumer Groups	
National Association for the Welfare of Children in Hospital	
Save the Children Fund	
Noah's Ark Toy Library	
Role of Volunteers	
Interviews with James and Joyce Robertson	
Hospital Visits	
Great Ormond Street	
Amersham General Hospital	
Stoke Mandeville	
St. Mary's Praed Street: Mobile Unit	
Fulham Hospital (Charing Cross)	
The Nursery Nurse	
Denmark.....	23
Preventive Health Policy	
Parent Policy	
BRIS...Children's Rights Organization	
Hospital Visits	
Glostrup Community Hospital	
Hillerod	
Rigshospitalet	
Vangede	

Sweden	34
National Welfare System	
Parent Accommodations	
St. Goran's	
Karolinska Institute	
Umea	
Samariten	
Hospital Play	
History and Philosophy	
Staff Education and Roles	
Child Nurse Training	
Hospital Visits	
Samariten	
Karolinska	
St. Goran's	
Umea	
Holland.....	49
Queen Wilhelmina, Utrecht	
Amsterdam	
University of Leiden: Observatrice Program	
Hospital Based Day Care for Staff Children	51
Fulham	
Amersham	
Sweden	
Denmark	
Glostrup	
Hillerod	
Conclusion,.....	54
References and Bibliography.....	55

FOREWORD

My long standing concern with the need to involve parents and to incorporate play into the world of the pediatric hospital arises from a background on the faculty in Maternal Child Nursing at the University of California, San Francisco, after many years working with parents and children in nursery school settings. Work with students and staff nurses at UCSF to bring parents and play into our hospital uncovered difficulties that can block these two important activities.

Our work and study of the research showed clearly that many people share these concerns and are working to humanize the hospital environment by making it more family and child-centered. In particular, programs in England, Sweden, and Denmark suggested that innovations were available for importation to the United States. I therefore applied to WHO for a travel-study fellowship and happily was granted the opportunity to visit.

This report presents findings from that trip.

The itinerary covered three countries: England, Denmark and Sweden, with a brief excursion added on my own to Holland. As the three countries have similar social philosophies, I hoped to see the result of national priorities on hospital pediatrics. England was selected because so much of the impetus for family inclusion has come from the work of James and Joyce Robertson, John Bowlby, and Anna Freud.

In addition, I anticipated collecting ideas for new designs for playthings and furniture to accommodate parents. This very practical aspect has lots to do with parent invitation and acceptance in the hospital. A space-saving bed for parents can open the ward to parents where a hundred impassioned arguments fail.

After WHO funding was approved and before the visits, correspondence and counsel came from representatives of the Ministries of Health in the several countries as well as from James Robertson, Margaret Belson (then president of NAWCH) and others interested in helping to make the study fruitful. To them I express my sincere gratitude.

On the trip, representatives of Ministries explained the organizational structure of government agencies and their relationship to hospitals and to preventive health programs. Such interviews helped me understand the governmental philosophy relative to the hospitals. Additional time went to attending conferences and interviewing representatives of private groups active in advocacy for young children in the hospital. Hospital visits took up the remainder of the time. All the hospitals visited in England and Scandanavia had philosophies based on concern for the child's psychological well-being. No visits were made to institutions with weekly or twice weekly rigid visiting hours, although such programs still exist.

INTRODUCTION

I believe that hospitalization can be a positive experience for the pediatric patient and his family. The child can learn how precious he is to his own family and to caring people in the hospital and community. He and his family discover strengths they may never have known they had. The crisis opens them to learning as at no other time. If the child's supports are adequate, the hospitalization can become an adventure with the patient emerging a triumphant hero.

On the other hand, deprived of emotional support, the child and his family may have an additional psychological burden placed on the already stressful physical problem, thus lowering their ability to cope. The child and the family may become overwhelmed and not only fail to improve despite the hospital's efforts to help, but may actually be damaged by the experience.

It is the responsibility of the professionals who are aware of the research around the subject of attachment and separation to inform parents of their importance to the child and to help them in their plans to stay. Otherwise, parents, especially those with low self-esteem, may feel intimidated and uncomfortable and take flight under the pretext that they are only in the way.



PAN AMERICAN HEALTH ORGANIZATION
Pan American Sanitary Bureau, Regional Office of the
WORLD HEALTH ORGANIZATION

CERTIFICATE OF AWARD

This is to certify that

Carol Hardgrove

has been awarded a fellowship by the Pan American Health Organization to study

Family Centered Pediatric
Care Programs

in

United Kingdom, Denmark and
Sweden

for a period of

four weeks

Any courtesies and facilities granted during the period of this fellowship will be appreciated.


for ABRAHAM HORVITZ
DIRECTOR

Washington, D.C.

18 May 1972

OBJECTIVES

1. To see how hospitals in some advanced countries facilitate children's healthy development during the stress of hospitalization by:

Initiating or reinforcing family involvement.

Meeting their need for play.

Adapting space, furnishings and designs for parent and play programs.

Financing and publicizing programs.

2. To study the activities and functioning of government agencies, volunteer, and consumer advocate groups.
3. To bring back ideas for use in the United States.

ITINERARY

England

September 18 - 29, 1972

Monday, 18 September

Mrs. C.M.R. Mitchell, Hospital Nursing Officer
Miss M. Simpson, Nursing Officer - Research
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London SE 1

Tuesday, 19 September

All day conference on "Role of Hospital Play Leaders"
Sponsored by the Hospital Liaison Committee
Hospital Centre
King Edward Hospital Fund for London
24 Nutford Place
London W1Y2AA

Wednesday, 20 September

Interview with Mr. James Robertson, Tavistock Clinic
Tavistock Centre
Belsize Lane
London NW3

Visit to Great Ormond Street
London WCI

Interviews with Miss Jill Green, Play Coordinator and
Miss Virginia Newman, Wards A and B

Thursday, 21 September

Mrs. Susan Harvey, Save the Children Fund
29 Queen Anne's Gate
London SW

Representatives of National Association for Welfare of Children
in Hospital: Mrs. Margaret Belson, Chairman; Mrs. V. Southerland,
Secretary
7 Exton Street
London SE1, 8VE

Itinerary Continued
England

Thursday, 21 September
(continued)

James and Joyce Robertson at home.

Friday, 22 September

Miss M. Fraser, Nursing Officer, Planning
Euston Towers, Room 629
Euston NW1

Fulham Hospital
St. Dunston's Road
London

Monday, 25 September

Amersham General Hospital
Aylesbury, Bucks
Interviews with Matron Sister Daniel and Dr. Donald Garrow.
Observations and interviews with parents and children on the ward.

Tuesday, 26 September

Stoke Mandeville Hospital
Aylesbury, Bucks
Interview with Matron Sister Gilbert
Interviews with parents on the ward
Observations on the ward
Dr. Jane Grubbs, Pediatrician
Observation of nursery school program for children with
developmental deviations and handicapping conditions.

Wednesday, 27 September

St. Mary's Hospital
Praed Street
London W2
Tour of rounds made through Paddington Area with mobile
unit team.

Interview with Thomas Oppé, M.D., Medical Director
St. Mary's Hospital

Thursday, 28 September

Miss S. Earl, Public Health Nursing Officer
Miss R. Maguire, Public Health Nursing Officer
Discussion of Nursery Nurses and Nursery School Education, U.K.
Alexander Fleming House
Elephant and Castle
London SE

Denmark

October 2 - 6, 1972

Monday, 2 October

Briefing, The National Health Service, Nursing Division
Miss Maja Foget, Chief of Nursing Division
Miss Else Bagger, Public Health Nursing Division
Miss Elisabeth Rubner, Home Nursing Consultant
Dr. Harold Kreutzfeldt, Chief of the Division
1 St. Kongensgade
DK - 1264 Copenhagen K

W.H.O. Regional Office for Europe
Interview with Miss Dorothy Hall, Regional Officer for
Nursing and Vera Fry Maillart, Ed.D.
Scherfigsvej 8
2100 Copenhagen Ø

Tuesday, 3 October

Copenhagen County Hospital, Glostrup
Ndr. Ringvej
2600 Glostrup
Interviews with Miss D. Clode Henningsen, Director of
Nursing Service; Miss Westergaard, Head Nurse, Pediatric
Department; Mrs. Else Rafn, Psychologist

Day long visits to children's units, hobby rooms, demonstrations
of devices and areas used to teach children about management of
diabetes; observations and visits to hobby room, school room and
hospital sponsored day care center for staff members' children.
Visit to drop in day care center for siblings or children of
patients.

Wednesday, 4 October

University Hospital (Rigshospitalet)
Blegdamsvej 3
2100 Copenhagen Ø

Interview with Miss Elisabeth Pederson, Departmental Sister,
Pediatrics.
Meeting with psychologists assigned to pediatric departments
under leadership of Mrs. Kirsten Skinhoj, Psychologist.
Visits to wards and observations of play.

Visit to Day Care Center on hospital grounds for staff children.

Itinerary Continued
Denmark

Wednesday, 4 October
(continued)

Visit to BRIS headquarters and interviews with volunteers.
Borns rettigheder i samfundet
Fredericiagade 15
1310 Copenhagen

Visit with Dr. Torben Bille and his wife at their home regarding
programs in Denmark to encourage early family bonding, and the
aims and objectives and accomplishments of BRIS.

Thursday, 5 October

Interview with Bitten Poelsen, Principal Nursing Officer,
Frederiksborg County
Frederiksborg Amtsgaard
Kongens Vange
3400 Hillerod

Lunch, interviews and observations at Frederiksborg County
Central Hospital

Mrs. Hanne Vesterdal Jorgensen, Head Nurse Pediatric department.
Tour of patient areas, playrooms, hospital day care center.
Visit with Mrs. Vesterdal and her husband, a physician at the
hospital, in their apartment on the hospital grounds.

Dinner at Miss Poelsen's with a group of nurses from Africa,
Turkey, Greece, U.S.A., and Malaya.

Friday, 6 October

Hospital for Mentally Retarded Children
Bornehospitalet, Vangede
Sognevej 40,
2820 Gentofte

Tour of facilities and grounds, including exposure to exciting
adventure playground.

Visit to Bispebjerg Hospital, Miss Ellen Christensen,
Director of Nursing Service
Interview with Child Psychiatrist attached to the hospital's
psychiatric clinic.

Sweden

October 9 - 13, 1972

Monday, 9 October

The National Board of Health and Welfare, Division of
Information and International Cooperation.

Interview with Mrs. Birgitta Bjork, Secretary, Swedish
Committee on Foreign Health Workers; Nursing Section.
Drottningatan 71 D
Second Floor
Stockholm

Visit to Samariten Hospital.
Interviews with Miss Ulrica Spens, Play Therapist.
Observations and interviews.
Barnsjukhuset Samariten
Ringvagen 21
Stockholm

Tuesday, 10 October

Karolinska Hospital, Child Clinic
Interviews with Prof. John Lind, Chairman of Pediatrics;
interview with Dr. Karin Stensland Junker, Department of
Pediatrics.
Tour of Karolinska facilities for parents and for play.
Tour of Day Care Center for Karolinska employees' children.

Evening: Dr. and Mrs. Bjork entertained me in their home
for dinner where I met Qui Nystrom of the Swedish Radio
and her husband. I learned a great deal about recent
research in Sweden on the subject of parents and hospitalized
children.

Wednesday, 11 October

Stadshagsskolan (Nursing School)
St. Goran Hospital Child Clinic
St. Goransgatan 145
Stockholm

Mrs. Ulla Termmeden, Director of Studies...description of
Swedish system of nursing education.

Lunch with nurse-nursery school teacher team for undergraduate
preparation of Child Nursing program.

Wednesday, 11 October
(Continued)

Tour of St. Goran's Hospital with emphasis on parent
quarters and play program.
Interview with Dr. Marcel d'Avignon, St. Goran's Hospital
Child Clinic.

Tour of Rehabilitation facilities.

Thursday, 12 October

Day in Umea visiting Region's Hospital of Umea and interview
with Mrs. Ivonny Lindquist and her staff.

Friday, 13 October

Return to Karolinska.
Visit to Lekoteket with Karin Stensland Junker.

Dinner with Dr. Junker at her home.

Trips to shops for special play equipment.

Holland

October 15 - 16, 1972

Sunday, 15 October

Brief visit and interview with pediatric resident,
University Hospital, Amsterdam.

Monday, 16 October

Interviews and Observations.
Queen Wilhelmina Hospital, Utrecht
Anthony P. Messer, Psychologist

Interviews and Observations.
Children's Hospital
University of Leiden
Discussion of program to prepare Observatrices.
Discussion of their activities.
Observations of wards and playrooms.

ENGLAND

GOVERNMENT POLICY

The official policy of the Ministry of Health in United Kingdom regarding children in the hospital is outlined in a document known as the Platt Report issued in 1959. The Platt Report followed the work of James and Joyce Robertson and Dr. John Bowlby at the Tavistock Clinic regarding the potential damage that could come about to children and their families due to the separation that hospitalization entails. The Ministry did not issue directives, but assumed a consultant role to the health care delivery system. However, hospitals that do follow Platt Report guidelines may be in a more advantageous position when new programs are assigned priorities.

The Platt Report advises hospitals to encourage parents to visit children at any reasonable hour, and to arrange accommodations for mothers (or fathers) whenever possible. It further recommends that children not be nursed in adult wards, or scattered throughout the hospital, but gathered into a children's unit. It specifically suggests that "all children's departments provide accommodation for mothers and possibly on occasion for fathers so that they may stay with their children during assessment, during acute illness and from time to time during long stay care. For every twenty children's hospital beds, there be at least four beds for parents, free of charge, and that there be additional parent lounge, bathing and kitchenette facilities."

Not all hospitals adhere to the Platt Report's suggestions, but it does serve as a guide. The hospitals I visited do conform.

GOVERNMENTAL GUIDELINES

In England, as in other countries, programs and attitudes toward play vary from hospital to hospital. In some institutions, play leaders fill children's days with play schemes. In others, play is neglected or is relegated to parents or to busy nurses. Standards are high; but salaries are low, so there are fewer play leaders than are needed or desired.

The National Health Service encourages play programs in hospitals. In memoranda to regional hospital boards, boards of governors, and hospital management committees NHS stresses that play is important and recommends the employment of nursery nurses to "organize and encourage play for children individually and in small groups." Ministry guidelines in the form of hospital building notes recommend design and equipment to adapt children's wards for play, with dayroom space adjacent to multi-bed children's wards on the ground floor whenever possible, to allow access to outdoor play yards equipped with sand boxes, swings, and climbing frames (when ground floor wards are not possible, the Ministry advises that roofs and balconies be used for play yards in addition to play space on the grounds).

At least thirty square feet of floor area per patient bed is suggested to be

used for play, television, exercise, dining, school work, and parent-child play. Recommendations are specific as to kinds of toys, storage, and the decor for the children's day rooms.

HEALTH SERVICES FOR CHILDREN IN GREAT BRITAIN

In 1948, local authorities (government) were given responsibility for health visiting. Today, the health aspect of the child's care is under Health Services while the supervision of day care, nursery schools, home help services (homemakers or daily "mindes" for hire) are under social services.

Home health services provide booklets on child rearing for easy, inexpensive purchase or for free distribution as well as the services of a health visitor who teaches face to face as well as in more formal settings.

The home (or district) nurse is an RN with hospital training plus additional training in the social and emotional aspects of care. She has had a four-month in-service training in home care to adapt her hospital experience to the home. The health visitor is an RN with obstetrical or midwifery training plus an additional year of public health nursing. Her job is purely preventive medicine.

"Our main aim is to keep children out of hospital because of the potential emotional disturbance to them there. We feel that the child should not be admitted unless it is for skilled nursing and skilled medical care that he cannot get in the community," according to Miss Earl, the Public Health Nursing advisor for the Health Services, Children's Division.

STUDY DAYS

Staff members are granted several regular "study days" with pay each year to attend conferences and sessions dealing with subjects related to the well-being of children and their families. A number of volunteer agencies participate with representatives of the Ministry in presenting such conferences.

These study days are planned to offer common experiences to all participants and to provide opportunities for representatives of different disciplines to come together around topics that concern the well-being of the child patient. Course content includes items such as the emotional and developmental needs of children; organization to meet these needs; problems of special groups of children; the role of the parent in the ward, whether visiting or living-in; the relationships between staff members and family members and relationships among the ward team of doctors, nurses, play leader, volunteers, etc.

I attended one such study day sponsored by the Play In Hospital Liaison Committee at the King's Fund Hospital Centre* on the subject of "The Role of the Hospital Play Leader." Fifty-eight participants included nursery nurses,

* The Centre, an independent charitable organization founded in 1897 as a

occupational therapists, play staff members, both paid and volunteer, research assistants, representatives from Save the Children, NAWCH, nursery school teachers, psychiatrists, pediatricians and nurses.

Attitudes Toward PARENTS and Play

In the course of the conference there was a discussion of the spotty implementation of play programs and of living-in programs for parents. Some nurses expressed annoyance at being pushed into a villain role as other groups move into the hospital and take over pleasanter aspects of care. Some nurses resent having parents and play leaders step in to offer consolation and pleasure to the child after the nurse has given an injection. Play leaders and parents were urged to share the "good guy" role by slipping a sweet for the nurse to give or coaching her to pick the child up to offer comfort following an unpleasant procedure rather than pushing the nurse aside and administering the sweet and comfort themselves.

In hospitals where nursing staff, play staff, volunteers, and parents all participate in care, competition for the child's time can be a problem. All see themselves as important to the child's well-being. Sometimes nursery nurses and play staff members disagree about who has responsibility for the child's recreation. Consequently, especially where play space is located some distance from the ward, the play program is less well-used than it might be.

Participants at the conference agreed that for play programs to be effective, support from the top is needed. The more authoritative (authoritative here correlated with frequency and familiarity on the unit) the person who touts play, the more play programs are integrated and supported. The fact that not all hospitals yet accept play as an important activity in pediatrics was evidenced by one nurse who rose to say, "We don't need a play program in our hospital because our children are too sick. When they are well enough to play, they are well enough to go home."

Another concern arose: the time structure and identity of the play leader, how she might elicit maximum cooperation and harmony with representatives of other disciplines within the hospital. For example, should she help by doing nursing tasks? By changing diapers? Should she go on rounds? Was she responsible for the operation of out-patient department playrooms? Was

* cont.

memorial to Queen Victoria's Diamond Jubilee, possesses substantial capital resources, the income from which is used solely for the benefit of hospital and health services. The Centre's chief aims are to provide a forum for the discussion of current problems and to help accelerate the introduction of good ideas and practices in the planning and management of health services. The Centre has four main functions: conferences and meetings; exhibitions; library and information services, and research and development. Its facilities are available to anybody concerned with health services at home or abroad.

the play leader the logical person to accompany children to the operating room? How much time should the play staff spend with children in isolation? What, in other words, was the best use of her or his time? A Major concern was that the play leader not assume the whole burden of preparing children for major surgery. The group agreed that such preparations should be by teams.

Mothers made their plea, too. "Please tell us what to do. Free play is fine for children, but we mothers need more structure." Another recurrent theme of the conference was the importance of communication. One volunteer play leader wanted more information on the significance of the child's diagnosis. "I always feel uncertain about how to handle the children because I know so little about their medical problems or how to care for them. I'm constantly uneasy about whether or not to carry them or whether they should be allowed to engage in certain activities."

Representatives of several hospitals described their preparation programs. At Charing Cross, preparation for surgery is done by play leaders in the presence of the parent with the cooperation of the operating room team and the ward staff. The play leaders use books such as *Paul Goes to the Hospital*, developed at Charing Cross for older children. For younger children they use *Zozo goes to Hospital*, by H. L. Rey, and the child plays out the story with a Zozo monkey puppet. They also offer children a "hospital box" of props for playing out experiences.

At Brook Hospital, a tonsillectomy play preparation program takes place each Monday. At this time, one nurse is assigned to follow the group throughout their hospital stay. She brings a hospital box with props, dresses up in the garb of the operating room, offers the children rides on the gurney, and handles all the nursing care. She accompanies her patients to the operating room and is with them when they wake in the recovery room. Her voice, having become familiar in the course of previous play and caretaking, reassures the children when they hear it again in the recovery room.

VOLUNTEER AND CONSUMER GROUPS

In addition to Ministry of Health, several volunteer organizations work to help hospitals and families recognize the needs of children in hospitals. One such organization is the National Association for the Welfare of Children in the Hospital (NAWCH), with four thousand volunteer members who operate out of an office in London with a paid staff of one person full-time and one half-time. There are sixty-five constituent groups throughout the United Kingdom and a few members in Denmark, Holland, and South Africa. Two chapters have been organized in the United States. NAWCH was organized following the release of the first films by James Robertson describing the plight of children without parents or play in hospitals. The group's goal has been to encourage and assist hospitals in adopting the recommendations of the Platt Report and to educate families and communities to seek out those programs that offer appropriate, child-centered care. NAWCH keeps information about children and hospitals in the public eye by placing posters in public places, by distributing to hospitals and families literature about good ways of supporting young children during hospitalization and has developed slide and taped scripts about children's trips to the hospital to be used by nursery schools.

As not all hospitals conform to the recommendations of the Platt report, NAWCH helps parents find out which hospitals offer parent beds by keeping a record of the policy of each hospital and the number of parent accommodations. NAWCH conducts play programs for hospitals with volunteers who have taken special courses to prepare them as play leaders. The goal of the volunteer work is to demonstrate to hospital administrators and staff members the value of play so that the NAWCH-led program can be replaced with a professional staff supported by the administration. In England, salaries are low and standards are high, resulting in fewer play leaders and play programs than are desired.

NAWCH groups also provide transport services to enable mothers to visit sick children; organize child-minder and play-group services for other children; raise funds for mother and baby units, and provide material and equipment for the under-fives in hospitals while maintaining friendly contacts with local hospitals.

Save the Children Fund

Another organization contributing to the welfare of the hospitalized child is the Save the Children Fund (S.C.F.). Save the Children is an independent voluntary organization, professionally staffed and now more than fifty years old. Its purpose is "the rescue in disaster and the longer term welfare of needy children, irrespective of nationality, race or religion." SCF helps children in nearly fifty countries with teams of over 1,000 field workers including doctors, nurses, welfare workers, and administrators. Its goals are to create conditions in which children can grow to a healthy maturity and, overseas, to train local workers, where necessary, in the professional and technical skills required for child welfare. Over the years, SCF has raised and spent nearly thirty million pounds.

Save the Children Fund prepares play leaders and will, for a brief period, pay salaries for them in a hospital while programs are beginning. This Save the Children subsidy is supposed to be replaced by the hospital's administration once the program has proven its worth.

Save the Children also finances exchanges of play leaders between different countries. They will help with placement in a play program and with housing for two months and offer consultation to the exchange person. Play leaders must pay their own fare, but housing and placement assistance is provided for the two month visit. *

Funding

Save the Children Fund's contribution, as of 1972, has been approximately ten thousand pounds per year for the sixteen hospital playgroups it established. A Christmas appeal netted funds for the establishment of play schemes in two hospitals. Students of Aston University in Birmingham raised money to finance a hospital playgroup in their locality for at least two years.

NAWCH, too, raises funds and finances hospital playgroups. Indirectly, their educational efforts for the community attract financial help from other individuals and agencies.

Toy Library

Toy library materials for mentally retarded children were displayed at the study day conference along with descriptions of the Noah's Ark Toy Library program, a service organized and operated entirely by volunteers throughout the United Kingdom to raise funds and buy sturdy toys suitable for children with handicaps. Local organizations tour the countryside placing the toys with families and offering consultation on their use.

This helps families avoid the possibility of an expensive mistake in toy purchase. Toys can keep up with the child's development. The representative of the Toy Library can do tactful guidance to parents in choosing and presenting toys. The toy librarians also make a variety of toys to meet special needs. A texture lotto game is an example.

* Interested persons may contact Susan Harvey, Save the Children Fund, 29 Queen Anne's Gate, London S.W., England

Role of Volunteers

Volunteers play an important role in England in helping to humanize hospital care in pediatrics, especially where play is concerned. As money is scarce, their services are needed and encouragement and assistance comes from the Hospital Play Liaison Committee, the Friends of Hospital and, of course, NAWCH and Save the Children. Every local authority runs courses for adults on how to run play groups. The above organizations supplement this knowledge with additional information about hospitalized children.

The following suggestions came from the conference sponsored by the Hospital Liaison Committee for volunteers and play leaders:

Play leaders need to know how to deal with children's emotions intelligently, and how to deal with deprived children and how to cope with deprivation.

They must understand the meanings of tests and have enough knowledge about medical procedures that they can supervise children safely and adapt activities to the children's particular disability.

Good communication among play staff, medical staff, and parents is essential.

Play leaders must be professional in maintaining confidentiality, sharing relevant material with the health care team, yet never gossiping.

They must help staff understand play functions.

Play leader's time should not go for rounds; instead they should build enough rapport and trust to enable them to exchange necessary information about their children in a more condensed form.

Adequate training for volunteers adds to their status and to the entire play program. Their training should include, 1) Knowledge of normal growth and development; 2) Experience with well, normal children; 3) training and experience with hospitalized children.

INTERVIEWS WITH JAMES AND JOYCE ROBERTSON

The Robertsons have been working on behalf of young children for many, many years. In the early 1950's Mr. Robertson made his first filmed account to show first medical professionals and then the general public what hospitals were doing to their very young patients. When no results were forthcoming insofar as modifying hospital practice, he took the film to television and asked for viewer response. The results of this response led to the publication of a number of case studies as well as to the formation of NAWCH. Eventually, the Ministry of Health took heed and their concern led to the adoption of the Platt report.

The Robertson's work is truly inspiring. Not only has it changed the hospital climate to a large degree in England, but that influence is spreading world-wide.

I counted myself fortunate indeed to have Mr. Robertson's guidance prior to my visit in pointing out programs to visit, and the privilege of chatting with the Robertsons at home was a high point of my trip.

The Robertsons are concerned about too early separation for the child, whether in hospital or in too early day care. Their films on Brief Separation point out the damage incurred by a young child when no single caretaker occupies a central place (or the child occupies no central place in the caretaker's scheme). It is their belief that a series of kindly but changing strangers, no matter how well-trained or well-meaning do not substitute for a central, stable parent or parent equivalent. Mr. Robertson points out that historically mothers bring their children to the centers at first quite nervous about leaving them and call frequently to check on their well-being. After several weeks, they drop this behavior and soon begin to complain that the center doesn't offer more services ... such as providing the child's main meal. Often the staff at the centers construe this behavior to mean that the parent is trusting them now, but the Robertsons view it as gradual erosion of natural parenting behavior so essential to the child's healthy development.

In one of my own later observations at a day care center I was told by the director that although each four children have a special grown-up to relate to, they soon outgrow this dependence and after a few weeks only seek her out when they need special comforting. As the center was on the same premises as the parents' job, I asked if parents ever dropped in to visit. "No. The parents' lunch and the children's naptime coincide."

The damage is silent; the bond is never missed because it never develops, but what is not developed through that missing bond is the child's desire to please and to mind; to mark individual styles; to focus and concentrate...essential to learning; to feel intensely; to love. The lack of early bonding results in later indifference to learning; inability to concentrate; shallow relationships; divorce; disinterest in parenting one's own children, and irresponsibility.

Nursery schools are prevalent and important in England, and the Robertsons are much in favor of them when they do not usurp the parents' role for long periods of time during the first three years.

What is the parent to do who must work to survive financially or to keep self-esteem and intellectual life alive? Perhaps a society might find ways of meeting these natural needs with something other than full-time separations between mothers and their babies.

He suggests that perhaps sick leave might be paid to parents of ill children, either in or out of hospital, in recognition of their interdependence during those early years. So far, quite the opposite is true: nurses report that increasingly they have to admit children formerly cared for at home with childhood infectious diseases requiring isolation because parents cannot take time off without penalty.

Mr. Robertson hopes that the efforts of NAWCH as well as education through parent centers, nursery schools and the formal educational system will eventually make parent living-in common practice when children must go to the hospital. Word of mouth is the most effective way of educating the country about children's needs.

His further concern is that too often people are not allowed to do what they are educated and trained to do ... nursery nurses, parents, and all have so many divergent tasks piled on top of their primary roles.

"We need somebody with major responsibility to manage the wards. This person should have preparation in child development. We must change the conception from a hospital model to a home model, spare the child constant change of staff." Mr. Robertson would put the child under the wing of a principal or caretaker, bringing in medical or nursing staff as consultants. Children could use the time between treatments to continue their lives normally. As hospitals gain a reputation for truly wanting parents around, word spreads, but "when the physician feels omniscient enough to choose which parent can stay and which cannot, parents are less inclined to ask to stay."

HOSPITAL VISITS

The hospitals visited in England included Great Ormond Street Hospital for Sick Children, Fulham (Charing Cross), Amersham, Stokes Mandeville, St. Mary's Praed Street Mobile Unit.

Great Ormond Street

Great Ormond is a group of large old and newer buildings surrounding a courtyard. On the building that houses pediatrics, some of the balconies overhanging the courtyard have been enclosed to form parent alcoves in children's rooms.

Here I first observed that nurses in England dress to suit their rank. Clothing varies from the high-necked grey uniform of the Matron Sister with a small filmy cap perched on her head down through several gradations, quite distinguishable to the British professional. Colored uniforms -- still an issue in this country, have always been worn in England, but there each color denotes status. There are Super Sisters, Matron Sisters, Sisters, Nursery Nurses and students, each in her own specific costume. Although professional postures are erect and formal, and the buildings themselves austere, there is something cozy in the air. Beatrix Potter characters, and Pooh, Piglet, Kanga, and Christopher Robin adorn halls and walls. Children not in isolation are grouped together; inside the rooms babies are held by mothers (always referred to as "Mums") nurses, or nursery nurses.

Great Ormond Street first opened its doors in 1862 with 10 beds for children. Today it is a teaching hospital with 340 beds admitting 9,000 children each year. There are 6 medical units of 20 beds each, 4 parent beds plus an additional 2 parent spaces in isolation rooms for each unit. The father of one patient recently contributed funds to provide additional parent rooms and services as well as for the decoration of the nurses' sitting room-office.

There are several pediatric floors with children grouped according to age. The mothers' sitting room and kitchen for the hospital adjoin the infants' nursery, because the majority of mothers who stay are breast feeding. One play suite on a lower floor of the hospital serves all the wards and is presided over by a play leader and her assistant. The wards themselves are also equipped with playthings for mothers and nursery nurses to use on the wards. Children's wards have beds surrounding a center clearing where round tables and chairs are grouped for eating and play.

Great Ormond Street's brochure states: "There is a special residential accommodation at the hospital for mothers who are breast feeding their babies. Accommodation for other parents who need to stay with their child is very limited, but the medical social worker can give information on hotel accommodations nearby." However, at least one floor at Great Ormond Street conforms to the Platt Report's suggestion of four parent beds to every twenty patient beds. Parents who ask to stay are given free room and board as long as space is available, but these facilities are not

advertised. Parents who stay eat at no cost in the nurses' dining room. Nurses must pay for their meals, so this is a sore point with some.

Amersham General Hospital

James Robertson suggested the visit to Amersham General Hospital in Bucks County as one with a parent program in full swing. This program was inaugurated by Dr. Dermot MacCarthy and the then Matron Sister twenty years ago. Dr. MacCarthy was one of the first physicians who, though at first doubtful of Robertson's message, came to subscribe to it wholeheartedly. Amersham welcomes "mums," and has open visiting for siblings, grandparents, dads, and all significant others.

Amersham is a small country hospital located in gentle rolling green countryside opposite an ancient stone church. The town of Amersham dates back to William the Conqueror. The hospital is a series of old flintstone buildings with two modern concrete and glass structures and a few modules more recently added to house the rehabilitation unit, the nurses' residence apartments, and the creche (day care center) for staff. The pediatric unit is a long, low ground-floor wing on one side of a quadrangle. Outside the ward itself is a small square office used as a nursing station, for staff meetings, for record keeping, and for reports. Off the corridor connecting this office to the ward are the parent kitchen and sitting room. The ward itself is a large, windowed area with beds on three sides with parent chairs, toys, and chests for children's personal possessions prominently displayed. Adjoining the ward is a play porch with a T.V., some comfortable upholstered rocking chairs, and a welter of toys and furniture very homey in character. Children and parents wander freely. Meals are served family style and eaten where the diners prefer -- in bed, at the center tables or, in the case of parents, in the parents' lounge.

Matron Sister Daniel, nursing supervisor for pediatrics, scoffs at the idea of disallowing parent visiting before surgery. Mothers stay with children and hold their hands as they go under the anaesthetic in the operating room. "Of course they sometimes hate the blood and the smell, but they're mums that's their responsibility," Miss Daniel says. How word of parent accommodations gets out? "After twenty years, it's just general knowledge." Parent education? "Only surreptitiously."

"We are a dying breed -- the spinsters married to our work. I don't know who will replace us," said Matron Sister Daniel, who practised nursing as a missionary in Africa until illness forced her to return to England. Having seen how well African children managed medical treatments including hospitalization when parents stayed with them, she vowed on her return to hospital nursing in England that never again if she could help it would she hear that heartbroken crying of the lonely abandoned child. She felt at home at Amersham with its mothering-in policies. She trusts parents.

At Amersham, one consultant pediatrician and various subordinates are committed to policies of unrestricted visiting and to the accommodation of

mothers with infants from birth to five years (and older if necessary). Parent-child cubicles line the outer wall of the large wards. Each has one door to the ward and one to the outside to provide exposure to circulating air and reduce the danger of cross-infection. Many children whose parents live in are in isolation. Glass walls to the cubicles allow two-way observation. Mothers may draw shades for privacy. Each unit contains a parent bed, a crib for the child, a rocker, and a wash basin. As at Great Ormond, an additional parent living room and kitchen are provided. Parents serve themselves from food carts on which meals are brought in for family style serving.* They eat with their children or, if they prefer, retire to the parents' unit. If there are not enough beds for parents in or near the children's ward, parents are housed in the nearby nurses' residence hall, a modern, well-appointed high rise on the hospital grounds. No request for over-night accommodations by a family member has been turned down. Parents, eating and chatting together, usually form a strong social group, listening sympathetically to each other, minding each other's children when one must return home to check on the family there, and encouraging each other in their day-to-day encounters with staff members and patients.

When there are few physicians and many parents, the doctors sometimes feel the need to duck the questions so many parents have at the ready. Dr. Garrow admitted to a tendency to come through the bushes around the outside of the building, timing his rounds for just after dusk in order to conserve time and elude some of the more persistent questioners.

One mother, interviewed in her cubicle at Amersham, said she had received no advance information either from the hospital or from the health visitor about living in. "I heard somewhere ... maybe from the nursery school ... that it's good to stay when they are little like this." She had been delighted to learn that she could stay at no cost for bed or meals, but she had not been prepared. Fortunately, after the Sister informed her and her husband that a bed was available, her husband had found last minute help to care for their child at home, rushed home and brought back a suitcase for the mother.

* Supper the night I stayed was spaghetti with poached egg, mashed potatoes, white bread and cobbler.

Stoke Mandeville

Twenty miles from Amersham in Aylesbury, Bucks, is Stoke Mandeville Hospital. The pediatric unit, much larger than its counterpart at Amersham, is one section of a very large hospital that specializes in the treatment of paraplegics. The buildings are arranged so that specialties are housed in long units resembling wartime barracks extending at regularly spaced right angles to the corridors linking them. Again, the pediatric unit is on a ground floor, and some of the children are able to play outside occasionally as evidenced by a play yard with climbers and slides.

Although the atmosphere is institutional with long, unlovely corridors, bewilderingly complex networks of doors and anterooms, children appear relaxed and comfortable as they wander around or sit with their families, including brothers and sisters, most of whom are present. Parent-child cubicles line the outer walls of the unit. A small cozy chintz-decorated parents' room was full of chatting mothers, sharing stories and listening attentively to each other. Even in their small quarters, an additional parent cot had been fastened to the wall to be pulled down for extra sleeping space.

The consultant pediatrician is Dr. Dermot MacCarthy, physician seen in *GOING TO THE HOSPITAL WITH MOTHER*. Stoke Mandeville and Amersham work in unison. Both consultants are, in Mr. Robertson's words, human and enthusiastic.

At Stoke Mandeville the matron-sister conducts daily parent rounds. She solicits questions; tells family members about treatments planned and about the doctors' comments on the child's care and treatment; and suggests how parents can help during the day.

Matron-Sister Gilbert described her conversion to parent-inclusion by saying: "Nobody could have convinced me that it was a good idea to have parents around; Dr. MacCarthy ordered me to bring parents in. I hated the idea. Only watching the parents and the children showed me that children do indeed do better with their parents here, and that parents are not as difficult as I had feared; they are, for the most part, a help. I am afraid that it is my sisters, the nurses, who object to having parents in the hospital and the only way to change their attitude is to bring them to visit wards that have parents and let them see for themselves that parents help."

Mimeographed guidelines are distributed to mothers living in the children's ward. The paper includes instructions about food and drink, crib safety, obtaining information, and going home. Some excerpts suggest the flavor of Stoke Mandeville's program:

Visiting: "Your cubicle is, in a sense, an outpost of your home in which medical or surgical things can be done. Your husband or a friend or one of your children (providing Sister is asked) can come and visit you at any time."

Behavior of Children in Hospital: "Some children cry noisily and make a great fuss when a doctor or nurse comes to examine them or do something. This is normal behavior, we are quite accustomed to it. It is probably better for a child to protest and cry for Mummy than to be examined by strange people or undergo injections etc. alone without anybody to cry to, so please don't think we shall think your child is behaving badly."

Playing with or doing things for other children: "We want you to do the simple nursing, washing, occupying etc. of your own child, but not undertake these things for any other child. However, we do like the mothers to come out and join in the life of the ward and there are certainly lots of ways of helping other children who have not got their mothers or visitors; especially the little ones. We welcome your help here."

Going out or going home: "Please don't think you must remain beside your child the whole time. You are free to go out or go home for a short time if you can, provided you tell the Sister or Staff Nurse. Your husband can sometimes relieve you."

During visits to Amersham and Stoke Mandeville, an impressive number of parent-to-parent encounters were observed in patient rooms and parent lounges. No signs admonished parents to housekeep and clean up the premises, but nevertheless, they seemed to pitch in and tidy up as the situation demanded it.

At Stoke Mandeville, Matron Sister Gilbert mentioned an occasional problem with mothers feeling obligated to come. One mother laughed when asked about this, saying: "Did you ever try to tell Dr. MacCarthy you didn't want to stay with your child?" Customarily, during the parent's interview with the physician, when hospitalization is discussed, the doctor says something to the effect of "You are staying, of course, aren't you?" and some families do feel obligated as a result. Social service can recommend home-care givers, but most families manage home care with the help of relatives, neighbors, or nursery school confreres. Often parents bring other children with them. A NAWCH volunteer who operated a daily play program for both patients and well siblings had recently moved, leaving the hospital with no program. "It is hard for them (the parents) to be solicitous of the patient whilst trying to keep an eye on several other active little ones, but they manage," Matron Sister said.

Parents who wish to may cook their children's favorite foods at home and bring them to the hospital to tempt appetites. A growing East Indian population makes this especially important for the many children to whom English food is foreign.

Play at Amersham and Stoke Mandeville takes place directly on the wards and in the cubicles, spilling over at Amersham onto a cozy play porch awash with toys, rocking chairs, and television. Children and parents appear comfortable and at ease. Children of mixed ages grouped together

help each other. One eleven year old girl, seen during the Amersham visit, spent a lot of time feeding, stroking, and crooning to a severely retarded deaf-blind baby on the unit. Parents, too, interacted with each other's children, giving the wards a village-like ambience.

Neither Amersham nor Stoke Mandeville had a play leader at the time of this tour, although both Nurse Matrons expressed a desire for more structured and supervised play programs. Both hospitals had previously had programs and missed them. Meanwhile, parents stay and are encouraged to bring toys. Because families, including well siblings, are around, the children appear occupied and involved.

St. Mary's, Praed Street

St. Mary's is in Paddington, a poor section of London. It is a giant red brick 19th century edifice directly across from a University medical school. The visit here centered on a mobile hospital unit manned by a pediatrician and a nurse. This unit, the only such in London, is designed to bring the hospital into the home. Recently improved housing conditions and improvements in the general health of the child population have reduced problems that call for hospital care.*

The mobile unit itself is a large van donated to St. Mary's by the Variety Club, but it usually remains parked outside the hospital because the team prefers to use the sister's car. The van is unnecessarily large and harder to maneuver, and some families object to having it parked outside their homes. "The best thing about the van is that it doesn't collect parking tickets," the nurse said.

Calls are made to families living in a wide variety of housing situations throughout the Paddington section of London. On the day of the visit the team's itinerary included calls on a frightened West Indian toddler with an infected ear, several young children in crowded flats who submitted to examination cooperatively on their respective mother's laps, a tiny little Vietnamese two-year old with tuberculosis whose family lived on the top floor of an elegant embassy building, and an asthmatic East Indian ten-year old whose mother spoke no English. The team came to see him because their help allowed him to attend school fairly regularly despite his frequent severe attacks of asthma. While the physician and nurse were at the boy's home ... a brand new housing unit where he lived with his mother ... they did postural drainage and showed his mother how she could help him in the same way. The boy translated their instructions to his mother.

It was impressive how rich the visits were in peripheral instruction to families and to neighbors, as well as the children themselves. At one stop, the doctor chatted and questioned the father while the nurse fetched

* An increase in working mothers, however, is causing a resurgence of hospitalizations for contagious diseases once managed by families at home.

the little girl home from recess at school. She was back in the play yard before the period ended. Her father and she proudly displayed the birthday card the nurse had sent her the previous week, and the mutual fondness existing between the nurse and the families was obvious.

The mobile unit has been in use for 18 years. The home nurse who serves as part of the mobile unit team is Sick-Nurse trained. Her training differs from the Health Visitor's in that the Home Nurse extends the hospital into the home, treating the ill child.

Dr. Thomas Oppé, Chief of Pediatrics at St. Mary's, described the Mobile Unit and its services:

The mobile unit dramatizes the idea of keeping the young child at home. It is not for emergency care, neither an ambulance nor a flying squad but more than a house call by the doctor. (Doctors in Great Britain still make home visits.) Great Britain still uses more general practitioners and fewer pediatricians. To some extent the mobile unit serves the general practitioner by sending Pediatricians into the field to give their input and consult to the General Practitioner. The Home Nurse reports to the Home Visitor regularly assigned to the family's case while the Pediatrician reports to the General Practitioner.

In addition to its service to the family and the regular health care team that follows that family, the mobile unit is useful for the education of medical students and physicians.

The unit keeps children out of the hospital offering both economic and emotional advantages.

Although not all patients on home care would necessarily be hospitalized, not all children in hospital really need to be there. Caring for the child at home is better for parents in many cases because parents in hospital are fish out of water. When they are not instructed as to how to help, they tend to just sit. This is less helpful to the child than some people believe, Dr. Oppé thinks.

Home care, on the other hand, builds up the confidence of the mother so that she does not always rush her child to the hospital. Home care is often indicated for children who have seizures, asthma, or for dying children. The home care doctors and nurse need to be very sensitive, skilled and confident. They face hard, fast decisions and these must be made in close contact with parents. Not just any nurse or doctor can manage the task. They cannot have too restricted a view of nursing or medical functioning. They must be friends of the family.

A mother cannot initiate her home care. Referrals must go out from the General Practitioner. After the home care unit has the case, then the mother may alert the team if she feels there is need.

The home care team has no executive function. They do not make referrals to social workers, for instance, but report directly to the Family Practitioner and the regular health crew takes over from there.

Fulham Hospital (Charing Cross)

At Fulham the pediatric in-patient unit is on the ground floor, a happy arrangement allowing children access to outdoor play yards and offering views of greenery and activity. The wards house about thirty children, twenty for middle-aged children and smaller rooms for infants and toddlers occupying the same suite. Adjoining the bed units several play porches offer sand, water, carpentry and clay projects. Many children were up, sitting at the center tables or playing in the anterooms. Parents sat on straight chairs by their children. Parent quarters or accommodations were not in evidence. Children's art decorated the walls. Many windows gave the rooms a bright, cheerful, lively aspect.

Fulham's well-staffed, active play program is financed by Save the Children Fund. The three play leaders move among the children, parents, and staff ready to help with crafts, to interact with toddlers, or to prepare children for treatments using the battered box of doctor play equipment. The ward is colorful with children's paintings and buzzing with activity.

My visit found a boisterous group of boys playing in the sand pit while another group built airplanes at the carpentry bench under the watchful eye of two young men trained and placed by Save the Children Fund. In shed-like structures adjoining the large ward, a group worked with clay in an art room equipped with materials for all kinds of creative projects.

The ward itself had beds arranged so as to leave the center free for small round tables and chairs, wheel toys, and various play projects for younger children.

At one end, an Indian boy, about 12, was coming to following surgery. His family and the father of the child in the next bed, restrained him while the nurse administered a shot.

Two beds down, a couple of five-year olds played house on their beds surrounded by a portable Wendy House made of covered folding screen. They served each other pretend tea in doll cups, resting after hanging out their doll laundry on clothesline strung between their beds.

Across from them, an Indian boy in traction watched shyly, taking an occasional swing at a punching ball suspended within his range from the bar over his bed.

In the center, at a table, an eight-year old missing his left arm played a board game with two student nurses. They interrupted the play to take vital signs, then calmly resumed the game.

The leaders strolled from bed to bed, offering and joining play. A two-year old hustled along behind, bearing the suitcase with the doctor play materials -- a teddy bear, some bandaids, a stethoscope, some syringes, and a mask or two. These are some of the materials the play leaders use to prepare children for procedures they may soon encounter.

THE NURSERY NURSE

In England, girls just beyond high school age may take a two year course that prepares them for positions as nursery nurses. Their training parallels that once offered to prepare "Nannies" who cared for the children of wealthy English families. Today, while part of their training may include placement with an individual family, they are offered a program that allows them to choose positions in hospital pediatric units or in nursery schools. The preparation includes child development and health care. Both of these serve also as pre-parenthood education and it is the expressed hope of program advisors in the Ministry of Health and among the leaders in the volunteer agencies such as NAWCH and SCF that young women so educated will be more aware of their own babies' needs for support and attachment when they, too, are mothers.

Part of the training includes recognition of the young child's play needs and education on the delivery of age-appropriate play to the children.

The profession of Nursery Nursing has its counterpart in Denmark (care-taker nurse) and Sweden where the position is called Child Nurse. The Nursery Nurse or Child Nurse is different from the Play Nurse who is responsible solely for play. The Nursery Nurse delivers mothering care that includes diaper changing, temperature taking, feeding, and bathing along with play.

Both the Child Nurse and the Nursery Nurse positions are first steps on a career ladder. Certified at the end of their two year course, the graduates of these programs can stay in that position or can later decide to take course work preparing for more advanced degrees and status in either nursery school education or in nursing.

Nursery Nurse preparation involves three different sets of in-hospital behaviors: one-third are prepared to serve on maternity units in the care of the new-born. In-service courses teach them cross-infection prevention techniques, tube feeding etc. They work as aides to mid-wives. "Pediatricians are greedy to get hold of them because they do better with failure-to-thrives than do nurses or mid-wives," according to the Nursery Nurse government advisor.

A second third have preparation in sick children's units in the hospital.*

* At the time of the visits, a work party was studying hospital units to determine the play and companionship needs of the children on the unit in the light of proliferating services to meet mothering and play needs of hospitalized children. Sometimes competition over the child arises when several groups of interested caretakers, including parents and volunteers, all wish to meet the same needs. Sometimes the child is missed by all, falling through the cracks.

One-third get training for work in day care and nursery schools. Nursery Nurses also staff hospital day care nurseries.*

Candidates for training as Nursery Nurses must be at least sixteen. Students over the age of eighteen may have their course of study shortened from two years to eighteen months. Their training takes place in the particular establishment where they are placed with children younger than seven years. The training period is planned to ensure continuity both in the training of the student and in the care of the children.

Every candidate must submit to her training authority a factual and spontaneous record of observations of children made throughout her course. The significance of the observations is discussed by the student with members of staff both in the nursery where she is placed and at the training center. Students live and help with the children. They have opportunities, for a substantial period of time, to see how children behave and how they change. This understanding of growth and development is the basis of the training. Students are expected to supplement their observation of young children through informal contacts with those they know in their own homes.

Each training establishment has devised its own curriculum and keeps records of each student's practical experience. The government offers a framework to guide those responsible for the course. This includes the following suggestions:

- A. Students are expected to learn what young children are like at different stages in their growth and how they should be cared for. Students gain their knowledge through practical and theoretical training and through suggested reading.
- B. Some children with whom the students work will have a family background, others will be cared for away from their families. The importance of various aspects of the children's circumstances should be considered.
- C. Those responsible for the children must consider the means whereby the children's physical, intellectual, emotional and spiritual needs are met. In addition, students must know about such everyday matters as food, shelter, clothing, and other physical provisions. Children need opportunities for play and language development, for companionship and the sharing of interests and activities.

* The ministry has not encouraged day care for nurses because, they say, "If you are a good caring person, as you should be if you are a nurse, you should care for your own before you care for others." A brochure has been prepared for distribution to hospitals asking them to look at the need and the cost in relation to the long term reward and danger.

- D. Students should also realize the importance of continuity of individual care for the child, the need for responsible, confident relationships among adults and with children, and they should have an awareness of spiritual values. A detailed study of the means by which these basic needs of children are met, from babyhood onwards, is therefore necessary.
- E. Throughout training, as students observe growth and development, they need particular help to understand the interdependence between the physical, intellectual, and social-emotional progress of babies and young children. Most of their experience will be with normal healthy children, but variations in development will be discussed.
- F. Knowledge of health matters such as good nutrition; prevention and control of infection, both day to day and during outbreaks of infection; the prevention of accidents; elementary first aid; and simple steps to be taken when children are ill or convalescent, are taught. Experiences with care of children individually and in groups are taught and compared.
- G. Students are expected to assume increased responsibility throughout their two-year training, although still working under the guidance of experienced staff members. Students are advised to remember that they should see themselves as one of a group caring for children and follow the pattern of life in whatever establishment they are placed. Advanced students are expected to contribute to the training of other students and young assistants.
- H. Students take other course work and are expected to maintain a lively interest in life, taking every opportunity to enrich their own interests. Students younger than eighteen are required to take additional course work arranged under the general topics of:
 - I. English and the Creative Arts
 - II. Man and His Environment
 - III. Home and Society
- I. Every candidate must produce evidence that she will complete a course of study designed to increase her knowledge in vocational subjects and to her own personal knowledge. In addition to study of the care and development of children, her studies should also cover household arts and management and the study of certain aspects of social conditions.
- J. The Department of Education and Science is responsible for approving all establishments seeking to serve as centers for practical training of nursery students.

- K. Some students spend the entire two-year training period in an establishment catering to a wide age range of children; others divide the training between two establishments with not less than a year in each. It is expected that the choice of two complementary establishments gives the student experience with children in either day or residential nurseries or nursery schools and either nursery classes or infant schools.
- L. It is expected that each training establishment devise its own curriculum and that records of a student's practical experience be kept.

"Children need the companionship of lively minds and it is hoped that the student will take every opportunity to enrich her own interests. She should be encouraged to expand her own understanding through reading and through the development of her own creative abilities. A course of general studies enabling her to do this could be devised in such a way that consideration of the nature of man, the value of life, the wonders of nature, and the place of the arts and sciences in human life and progress could all be presented to help towards both a personal enjoyment of living and a philosophy of life."

The three headings as listed for additional course work are expanded to include the following:

I. English and Creative Arts:

Aimed at extending the students' powers to use their own language and enjoy its literature, and to find ways of self expression through music, art and drama. To achieve this it is necessary to create an environment in which the student is stimulated to use her natural abilities rather than to impose a discipline of work.

II. Man and His Environment:

The nature of the physical world and the use and misuse of man's mastery over his environment is constantly before us. To understand this it is necessary to have some knowledge of the laws of nature and man's place in the cosmos, together with an appreciation of living things and their interdependence.

III. Home and Society:

The aim is to obtain factual knowledge of how society has developed, is organized and sustained: to find how to enjoy its benefits and serve its needs; to examine the rights and responsibilities of the individual in relation to the home as the basic unit of society.

Schemes of work are not provided, so that teachers are free to develop the subjects under the three headings in a way most appropriate to their students.

In the changing pattern of adolescent development, in the need for relevance to their situation, the teaching should break away from traditional divisions of the timetable and the conventional treatment of subjects.

The paper goes on to suggest that modern techniques of visual aids be employed and that "people of lively minds and varied experience be invited to visit and contribute to the course" outside excursions are also suggested.

In light of the above, Mr. Robertson's comment was: "Our task now is to see that Nursery Nurses have the opportunity to practice what they are taught in the institutions where they later pursue their careers."

DENMARK

PREVENTIVE HEALTH POLICY

In the 1950's, 56% of all deliveries were at home. Mid-wives visited prior to the birth of a baby and then notified the health visitor for follow-up care. At that time every birth was followed by a health visitor. Today, most babies are born in the hospital and home visiting is selective and limited to homes where there is a problem. The first home visiting included every home and was for one year, later expanded to three years. Today's emphasis is a compromise between the original blanket visiting and the policies of selective visiting following early assessment that are planned for the future.

One reason that selectivity is important is that only 700 health visitors, 500 of whom are full time, are available. Denmark needs 800 to meet all the health needs including school health at a ratio of 6,000 population to one health visitor. At present the government has neither the funds nor the qualified applicants to fill all the slots. The birthrate is rising at a rate of 17 per 1,000, and is currently at 80-90 births to each 6,000 population.

A move to form teams to help with preventive health is growing and local authorities encourage this by providing space to such groups. Teams would be composed of a public health nurse, a physician and a health visitor. Some resistance to the inclusion of the health visitor comes from the physicians for fear that sharing practice with them may be a step toward socialized medicine.

Public health nurses work out of their homes on a basis of three days of home visits and two days of school nursing. The district nurse visits in the community selectively as requested by the private practitioner or the hospital. The chief of the hospital department of pediatrics serves as consultant.

There are 2200 home nurses, all RNs without the post-basic preparation that the health visitors have. Demand for them is declining either because health is improving, mothers are becoming more competent or because children are increasingly being hospitalized as more mothers work outside the home.

According to Miss Maja Foget, Chief of the Nursing Division for the National Health Service, the Danes are comfortable about modifying policy according to their experience. They continually seek improvement and are flexible about adopting new programs and ideas.

"The Danes characteristically can improvise. Our way of cooperation makes life go smoothly because we can combine. We aren't dependent on rigid structure. We never go to the ceiling about something. We find a compromise. We are careful in our use of language to avoid the suggestion of pressure or force."

The trend in Denmark is toward decentralization and more local responsibility. Increasingly, tax funds are directed to local authorities rather than the state. The 22 counties of Denmark are being diminished to 14 which are responsible to the local authorities and thus to the individual citizen to a larger degree than before.

Hospitals are under the Bureau of Inner Affairs. Child care institutions such as kindergartens, nursery schools and mother care are under the Bureau of Social Affairs.

Staff

Children's activities in play and in learning within the hospital are supervised by nurses, physicians, play leaders, care-giver nurses and by psychologists. Each psychologist sees up to 150 patients referred by the physician for screening and continues to work with a small percentage of those seen originally. She refers and consults with other staff members about the remainder. Hospital psychologists may, when appropriate, continue seeing patients after discharge. Glostrup is a community with many young families; many children come in with psychogenic problems. The psychologist conducts interdisciplinary meetings to share information gained during her interviews with parents and children. She also works with the nurses who teach children about diabetes to remind them of the psychosocial aspects of treatment and modify the strictly medical management of disease necessary if the patient is to cooperate in his self-care.

The psychologist sees all diabetic children to assess their ability to comprehend and profit by instruction and may also help the child maintain his friendships while managing his disease by showing him how to juggle his diet to allow an occasional pizza with friends without jeopardizing his well-being.

Each ward has a Play Nurse assisted by Care-giver Nurses and students in Care-giving Nursing. These young women are the Danish counterparts of the British Nursery Nurses and the Swedish Child Nurses. They are trained to manage the common developmental needs of young children in nursery school or hospital.

Half Time Shifts in Denmark

In Denmark, half time shifts for nurses mean one week on duty followed by one week off duty. This has advantages in that a family can vacation together or catch up on household and family tasks, but for the family with young babies, the longer hours of separation may be difficult to tolerate, and the longer stay in the day care center operated on the grounds for staff children may be less desirable for that age group than a system such as Amersham's.

THE HOSPITAL AND PARENTS

Parents do not live in as a practice in Danish hospitals. There is little demand for such services. Sixty percent of Danish mothers work outside their homes. Day care has a 100 year old tradition. Parents share household and income-producing tasks. Family time together is usually spent doing things together. Parents, unaccustomed to "just sitting around" at home, are not likely to do so in the hospital.

Opinions within the health care professions vary as to the importance of parental presence. At one hospital where self-care teaching was emphasized, a head nurse said: "Parents interfere with the teaching. We are very good at explaining just what is involved in a procedure to the child. Often, just as he understands and accepts, along comes the parent bringing her own fears. She makes a fuss and then all our work is undermined. That's why we don't allow parents to see patients on the morning of surgery."

Danish national concern for children's well-being in the hospital takes the form of heavy self-imposed taxation to provide quality care in quality facilities. Living-in is viewed by many professionals and parents as not necessary nor worth the attendant disruption of home or hospital routine.

The attitude toward parenting-in in Denmark is illustrated in the following statements:

A Pediatrician: "It is not good to keep parents at the hospital unless you give time to preparing them. Otherwise there is continual irritation between mother and nurse. It takes time ... it is more time-consuming to discuss leukemia with parents than it is to treat leukemia in the child. No one is better than the mother for children with chronic diseases, but conflicts arise when orientation is neglected. If you bring in parents you must allow time to talk with them, and they are demanding. Alternate solutions are day treatment, nearby hotels for parents so that they can be called as needed. In Denmark the trend is not toward parent accommodation."

A Danish nurse: "Some parents just won't leave until they have made their child cry; they seem to think that until he cries he doesn't understand that they are going. They keep saying good-bye and coming back until they have him upset."

"The surgeon plays operating room with the child before surgery to help the child understand what will occur and to develop trust and familiarity between himself and the child. A parent staying would interfere with this relationship."

A hospital psychologist: "If you use the parent to support the child you create a new problem ... you must prepare the parent to prepare the child, but then you have a scared parent performing the task instead of a confident, assured experienced staff member. Which helps the child most?"

Parent Encouragement

When Danish children are hospitalized, their parents are reminded to visit regularly and often. Brochures state that frequent daily visits help the child more than do long week-end visits. At Hillerod the head nurse arranges her schedule so that several evenings a week she can be available to families and fill them in on bits of information about their children that delight them. She offers counseling to families and children for whom the separation is especially painful. Parents there, as at Glostrup, are encouraged to stay through the supper hour to feed toddlers their evening meal, tuck them in and stay until the children go to sleep before leaving for the night. Living-in was neither requested nor encouraged at any of the Danish hospitals surveyed. A few beds available for the use of nursing mothers are reported to be seldom used. The Danes provide the best in buildings, equipment and staff; like to leave care to the professionals, who by and large agree with the parents.

While a public health nurse complained that it is difficult to do preventive mental health with young families who "do not like to look at unpleasant things, nor to talk about them until it is too late to take care of the situation easily," a child psychiatrist said one of the reasons so many children are seen in pediatric units of the hospital with symptoms of a psychogenic nature is that parents have no place else to turn: "Danish parents don't beat their children; they hospitalize them when they misbehave." Many children are admitted with such psychogenic disorders as enuresis, colitis, asthma, and aphasia.

To summarize, encouragement for parent involvement with hospitalized children in Denmark is mixed. On the one hand, parents are advised and encouraged to come visit often, but come as visitors. Their children are dealt with by professionals. Children's needs are the concern of the experts at the hospital while they are patients and, in some cases, after they leave. This idea is acceptable to young families who see disruptive behavior as unnatural and are accustomed to sharing the care of their children with others almost from the beginning of life.

BRIS: CHILDREN'S RIGHTS COMMITTEE

To educate the public about children's needs for early emotional support and bonding, an organization of predominantly professional people has been formed, THE COMMITTEE FOR CHILDREN'S RIGHTS. The name in Danish is Borns Rettigheder I Samfundet and goes by the acronym, BRIS. BRIS campaigns through the media as well as through study groups. Members serve as child advocates within the system to acquaint the government of violations of children's rights. The organization has shown the Robertson films on hospitalization and separation, and arranged television appearances by such crusaders from U.S./^{as} Uri Brofenbrunner, John Holt and Marshall Klaus.

I spent an evening with Dr. Torben Bille, a pediatrician and active member of BRIS, and his wife. Dr. Bille heads a BRIS work group on "the child in the hospital" who talk with administrators, local government officials, hospital staff members, and parents about the importance of early bonding. He is joined by a number of other professionals, physicians, nurses, social workers, and teachers who share his sentiments.

"We meet and advance one hospital ... then we point to them and say: 'Look what they are doing and see how well it is working.'" One goal of the group is to add clinical experience with hospitalized children to the curriculum for future nursery school and kindergarten staff members. By having them devote one year to this aspect of education, BRIS hopes to affect their future careers as parents and as teachers.

HOSPITAL VISITS

Four institutions were visited in Denmark: Copenhagen County Hospital in Glostrup; Frederiksborg County Hospital in Hillerod; Rigshospitalet (the University Hospital) in Copenhagen; and Vangede, an institution for the retarded, outside of Copenhagen.

Glostrup Community Hospital

Glostrup is situated in a new suburban community outside of Copenhagen. The building, of Finnish design, is shaped like a W. The beauty of its design, the space, and the decor are breathtaking. The lobby is hotel-like, with shops, banks, post offices, and other services in a giant, art-filled space. One wall is devoted to an outsized wood carving depicting little children coming to Jesus and the disciples, all nude.

A bornparking (child parking) for children of visiting parents occupies a large part of the lobby and is supervised by a cheerful young woman who manages to give tender affectionate care to her charges while simultaneously constructing a number of wall decorations. Children are at tables drawing, building with blocks, and playing games. A playhouse has been created in one corner of the space, complete with cardboard walls, curtained windows, and a fishnet roof to afford children a sense of privacy without blocking the playleader's view. Instead of child-sized furniture in the playhouse, brightly colored foam blocks and slabs in a variety of shapes allow children to build their own furniture. When they are finished, the area is quickly restored.

The patient areas are bright with color, and many windows bring in as much light as can be captured. Light is celebrated in Scandinavia; with so little sun much of the year, every possible device is used to bring light in when it is available.

Children are grouped in rooms with plenty of space. The furniture is modern and permits each child to have his own things nearby. Toddlers' play and eating space, adjoining their sleeping room, is lined with low toy shelves and furnished with small round tables and chairs, high chairs, and rocking chairs for adults. Appealing mobiles and works of art mitigate the sterility of the hospital. Small pieces of sculpture, plants, candles and bric a brac stand on low tables in the corridors and waiting areas; children's beds are hung about with their greeting cards from friends and family. Before 2:00 o'clock few mothers are visible, and the youngest children are silent and appear dazed, but in the afternoon as parents arrive to play and feed supper, the room begins to resound with the babblings and pounding one associates with children of this age.

Glostrup's pediatric service specializes in diabetes. A case load of approximately 80 families, receive in-hospital and out-patient services in connection with this disease. Children aged three to fourteen are in four-bed wards. Play takes place in the rooms, in adjoining day rooms, and in the large, well-equipped school, crafts, and hobby center.

Toddlers in Denmark are called "legeborn" which translates to "play age." Their toys are plentiful and available on low open shelves for them to help themselves. As children grow older, they are expected to use play for learning and constructive activity. Inventive devices have been developed by the professional staff to help teach the children to manage their own care. The philosophy in this hospital is that knowledge of the disease is essential. The Nurse-Matron (head nurse) who developed many of the teaching materials says: "We believe that once the child understands his disease fully and knows how to manage it, he can lead a normal life without feeling sorry for himself."

Parents and volunteers participate far less in the play program or the preparation aspect of pediatric care than in the United States or England. Play and preparation are the province of the physicians, nurses, or psychologists. Patients get a lot of emotional support. For example, no child goes alone from one area of the hospital to another; his own nurse accompanies him.

The school room is presided over by a male teacher supplied by the school district. He has one assistant. School age children from seven to fourteen must be in the classroom or in bed every school day between 9:00 and 2:00. In the several rooms are an impressive variety of learning games, audio visual aids, and teaching machines so that children can pursue learning with a maximum of independence. The teacher maintains good linkage with the public schools.

Adjoining the school room is a well-equipped crafts and hobby center. Children may not drop in but must arrange through their ward staff for craft times. Parents, except for those of long-stay patients well-known to the staff, are barred from the crafts suite. The equipment of the center includes sewing machines, a piano, a sand box, a work bench stocked with all kinds of carpentry tools, and a storage closet stocked with all kinds of games and crafts materials. The young man who supervises the area keeps a large notebook, each page illustrating a project that a child can choose. A patient can leaf through the book to decide what he wants to try each day. For new patients, the book allows a non-threatening introduction to the area. During the visit immigrants from non-Danish speaking countries were coming into the hospital. The project book was especially useful for communicating with them.

One of the nurse-matrons uses cooking projects to teach older children to manage their diabetes. They cook, using their own cook books, weighing and preparing their own meals in a kitchen adjoining their ward. She has developed age-appropriate booklets and video-tape cassettes. Similar devices used by the nursing staff teach children about injections. A loose-leaf notebook shows parents and older children what is going on in the body of a child with diabetes. For the younger children a colorful cartoon book "*Pers and Lisa Have Diabetes*" explains in simple language what the diabetic child can do and can eat. The plot includes an episode where Pers eats what he shouldn't one day and falls sick. He is confined to bed and Lisa finds someone else to play with. Pers recovers and having learned his lesson, watches his diet more carefully, avoids future illness,

and is able to resume normal play with his friend, Lisa. The chief physician did the illustrations and the nurse wrote the text. The nurse who developed this teaching program abandoned group teaching after observing that everyone learns at a different rate. Individual teaching took so much time that she found herself putting in fifteen-hour days before developing the books and audio-visuals that now allow parents and children to teach themselves and each other on their own.

Hillerød

The environment at Hillerød is quite similar to that of Glostrup. The buildings are older, but pleasant, colorful, and light. Wards and corridors are hung with interesting mobiles assembled by children or staff members. A central play area finds children in beds or sitting at long tables with the Play and Care-Giver Nurses busying them with paints and other crafts. Each patient bed is fitted with a white wire basket hooked over the end containing that child's personal possessions.

One of the nurses has devised a way of teaching her patients about disease and injections with a large wooden figure. A panel over the abdominal region when removed, reveals brightly painted insides. Accompanying this are wooden representations of medical instruments the child may use to give the wooden man injections.

I observed on a unit at Hillerød a ward of 18 patients, 3 - 10 years old. My guide was the head nurse, Hanne Vesterdal Jorgensen. She works to make the hospital a comfortable place for children and parents, staying for one night shift a week in order to speak to parents who work and don't come in until after 3:00. Children use the intimate form of address and call doctors and nurses by their first names. She asks parents to use first names, too.

Each nurse, student, and aide cares for three rooms to insure continuity of care, changing assignments monthly. Mrs. Jorgensen asks parents of children under six to come at bedtime, tuck their child in, and stay until he or she drops off to sleep. Because she, as a mother herself, enjoys hearing reports about her own children from their day care teacher, she collects anecdotes about their children to interest parents and keep up their interest and feelings of parenthood. She believes that as so many parents have worked most of their children's lives, such stories not only delight them but also increase their understanding and awareness about child development.

Like so many others interviewed in Denmark, Hanne Jorgensen was pessimistic about the prospect of parents living-in. She has succeeded in increasing the numbers of parent visits and their calls to children several times during the day. She is also an active member of BRIS, the Children's Rights Organization.

Rigshospitalet (University Hospital)

The pediatric unit of the University Hospital is housed in an old stone building to the side of the elegant new high-rise hospital that occupies the center of the grounds. Although the rooms and corridors were darker than those of the newer hospitals visited, the spirit was bright. Children were occupied with play or school accompanied by play leaders and Caretaker Nurses. They rove the halls freely and appear to be at home -- even the dark-eyed young Greenlanders who are carried by plane alone from their homes and families to Denmark with no language and little more to identify them than numbers on their backs. The Director of Nurses notes that their adjustment is amazing under the circumstances and attributes their acceptance and trust to their early mothering, where the practice is for mothers to carry children strapped on their backs during their first years.

Because of staffing problems, this hospital is experimenting with a five-day week treatment program. All children go home on Friday and all staff members take days off at the same time. The director of nurses complained that it is hard on the children in that tests must begin almost immediately upon admission without allowing a settling-in period.

Rigshospitalet has a patient population of 97 children from all over Denmark and Greenland housed in seven wards. Only the tiny babies are grouped together according to age. Children in the other six units are grouped family style. "Grouping all two year olds together leads to a factory feeling. Caretakers begin to change diapers or spoon in food according to a schedule that destroys the feeling that we want children to have here," the Director of Nurses explained.

Play takes place all over -- in the day rooms, the wards, and the corridors. Playthings are available, ample, and attractive. Children who can be up are dressed and out of their wards, involved in a variety of activities. Rooms and corridors are decorated with children's own creative efforts -- mobiles and three dimensional wall decorations.

A play leader is assigned to each of the wards except for the infants' ward. Two play people work in the isolation unit, and there is one kindergarten teacher.

As at other hospitals in Denmark, psychologists play a major role on the staff. They interview each child and pass on the results of their interviews to the play staff as well as to the nurses along with suggestions for individualized, helpful play. Doctor play is discouraged unless a knowledgeable adult is attending and interacting. The psychologists believe that such play without adult supervision is potentially dangerous to the children -- increasing rather than reducing fears.

SWEDEN

NATIONAL WELFARE SYSTEM

As early as 1774 the first pediatric textbook in the world was written by Nils Rosen von Rosenstein who recognized that the most important way to lower the infant mortality rate (only fifty per cent of Swedish children survived to the age of five at that time) was to educate mothers in childrearing. His pioneer work contributed to the establishment in 1845 of the world's first chair of pediatrics at the Karolinska Institute in Stockholm.

Although a first attempt to organize preventive child care was made in 1901 on private initiative, there was little further development until the creation of the national welfare system came about in the thirties. The special program for preventive child health began in 1938. The infant mortality rate drops steadily. Sweden has the lowest in the world.

In Sweden, benefits begin before birth. Prenatal care and all maternity care is free at nearly all maternity hospitals. Benefits from compulsory national insurance are additional to any contributions from employers or private insurance companies. All mothers receive a grant from the government of \$209 at the child's birth and \$232 a year until the child becomes sixteen years old, or eighteen if the child remains in school. If the mother is employed during her pregnancy, she receives a six-month leave of absence with a salary-based maternity allowance for six months. She may take another six months with her former job guaranteed but without salary if she is able to do so. Parents of handicapped children cared for at home receive State grants.

Hospital care is free of charge and consultations at out-patient departments and with practitioners are covered for the most part by compulsory insurance.

Sweden has a population of eight million and a nationwide network of about 1300 child welfare centers charged with carrying out the preventive child care program developed by the National Board of Health and Welfare in close cooperation with the medical community.

Welfare Centers are located at pediatric hospitals or in buildings of their own and serve about fifty per cent of the child population of Sweden. Registration is entirely voluntary, although all new births must be reported by the maternity hospitals.

The service is free to the family; the annual cost per child is about \$11.00, shared equally by the national and county authorities. 96% of all children are registered during the first year of life with a steady decline until the figures are 22% at five years.

All registered mothers get a home visit by a nurse within two weeks after delivery. They make their first visit to the center sometime between two to six weeks and thereon the visits average from four to seven for the first year and between one and two for the following years until school age. Service at the centers is purely preventive including medical examinations, vaccinations and advisory work. If the child is found to be sick or a problem comes to light, the family is referred either to a pediatrician in private practice or an out-patient department at a children's hospital for further examination and treatment.

The centers are staffed by a Pediatrician holding a part-time appointment and full-time nurses, specially trained, whose preparation and responsibilities are like that of the Pediatric Nurse Practitioner in U.S.A.

Advice about nutrition, health and everyday problems of childrearing are the realm of the nurse, available every day by phone. Additional advice is offered through pamphlets. In large cities child psychologists have been appointed to the welfare centers and attempts have been made to arrange group discussions with parents of children with simple behavioral problems such as eating, sleeping and toileting disturbances. The psychologists also assist personnel toward increased understanding of behavioral and psychomatic disorders.

Breast feeding is encouraged. About 90% of the newborn are breast fed in the hospital. There has been an increase in the tendency to seek advice on minor practical problems of child rearing as the living standard has become higher and nutritional problems have declined. The nursing staff provides the major part of these advisory services.

The hospitals visited in Sweden included the Karolinska Institute, Samariten Hospital, St. Goran's and Umea.

PARENT ACCOMMODATIONS

Sweden hospitals offer most complete physical accommodations for parents who choose to live-in. Three programs I visited set aside space that they called Parent Hotels ... in units containing four or five bedrooms with baths and amply furnished with bed, lamp, desk and chair adjoining a common living room and kitchen. Some have laundry and sewing facilities. Some hospitals make no charge for the rooms; some charge \$2.00 a night.

St. Goran's

St. Goran's has, in addition to the parent suite, several other arrangements whereby parents can room-in with children or sleep in a room adjoining their child's. Their booklet describing the planning of the hospital states:

".....In planning, we have taken into account parents' desire to stay at the hospital and every unit has one or more rooms for parents-with-patient accommodations."

The pre-admission booklet sent to parents to prepare them for their child's hospitalization makes no mention of the parent rooms. In fact, it reassures the parents that they should not be distressed if their child cries when they leave as the child usually stops before the parent is out the front door. The booklet urges parents to visit often.

Karolinska

At the Karolinska Institute parent apartments are located on the top floor of the building and consist of three four-bed rooms, a kitchen and a living room with television. Parent quarters adjoin the nurses' lounge. In the rehabilitation center 300 meters from the Children's Hospital are four more two-bed rooms for parents. A few chaise lounges can be procured to set up in patient rooms. No parents were in residence at the time of my visit.

"The hospital was built before the need was discovered for many parents to stay with the children. Most parents are told to visit their children every day. As our play therapy department has become more efficient, the need felt by the children to have mother or father around all the day and the night has greatly diminished and it is tremendously effective complement to the visits of the parents. The play therapy changes the whole atmosphere of the ward and much of the anxiety of the sick children

as well as of the parents has disappeared." *

Dr. Lind suggests that parents and nurses must be re-educated about the importance of parent stays with very young children. "We doctors taught nurses that parents were not important and the nurses went along with us. Now, we have changed our minds. The nurses are used to being without parents, so changing takes a little time." He, himself, believes in telling parents directly when their child needs their support and they should stay.

Umea

In Umea, in the northern part of Sweden, the hospital facilities are in a parent apartment similar to those at St. Goran's and the Karolinska, located on the ground floor and adjoining the play therapy unit. An intercom connects them with the children's units. Few parents take advantage of the rooms. One staff member predicted that when there is a new generation of parents and child nurses who are educated regarding the young child's need for attachment, hospitals will offer a welcome to parents so convincing that more will make use of the programs.

The major thrust in preparing such a new generation comes through the schools of nursing and through encounters between families and health visitors who follow mothers and children from pregnancy through the fifth year of life.

Samariten

Samariten Hospital in Stockholm allows parents, but overnight stays are de-emphasized. A room just outside the infant unit is provided at no cost and meals are free. Mothers may also share two-bed patient rooms with children. The hospital has no rules except that the space is for mothers only. The dormitory for nursing mothers has room for 2-4 mothers and this space is mentioned in the hospital's brochure. There is a parent kitchen on each floor also.

This is the only hospital visited with a routine system of pre-admission calls. The social worker and nurse make an in-take home visit to each family anticipating admission. They introduce themselves, pick up parent and child concerns and on their return to the hospital hold a planning conference with inter-disciplinary staff members to develop an individualized care plan based on findings from the home visit. At this visit, living-in is discussed, but parents are not urged to consider staying, especially if other children are in the home.

*Quoted from private correspondence from Prof. John Lind

that they are not overburdened with too many different encounters. Older children, who have different needs, are encouraged to leave the wards and participate in separate play areas on separate floors. These areas include gymnasiums, outdoor play parks, and rooms for a variety of exercise, therapy, and hobby activities.

In Sweden play is seen as more than diversionary activity sporadically offered to pass time. Play equipment is chosen and presented with as much care as is any other equipment used in the treatment and care of children. Play is directed by trained professionals who assume responsibility for play care plans as well-thought-out as are the other patient care plans.

"We cannot be everywhere to help the child handle the hospital experience, but we are there symbolically when we make the places pleasant and attractive. We make the institution softer and politer through the toys we have for children to use," says Ivonny Lindqvist, Play Leader at Umea. Her sentiments were echoed by play leaders at the other hospitals chosen for study.

While space and equipment are impressive, Mrs. Lindqvist warns, "It is dangerous to think you must have elegance to have a good program. Children can play under beds and tables when the spirit is present." She remembers fifteen previous, makeshift headquarters for play in the hospital, when all today's sturdy and beautifully crafted equipment was prefigured by things improvised out of cartons and crates but available for children's use.

Staff Education and Roles

Today's emphasis on purposeful play as part of hospital therapy calls for specialist training in addition to the pre-school teacher's education. Teachers' colleges in Stockholm and Malmo offer a one year course to qualify credentialed teachers as hospital play leaders. This training prepares a play director to bring along the rest of the staff, acquainting them with the value of play and of choosing appropriate playthings for patients.

The in-service educational aspect of the Play Sister's role is most important, because many children are tucked away in adult units and might be overlooked unless nurses make special efforts to meet their play needs.

Child Nurse Training

The Swedish equivalent of the United Kingdom's Nursery Nurse is the Child Nurse. Today in Sweden ninety per cent of all high school graduates choose to continue their education. Many young people elect to study Child Nursing. The group enrolled at University of Stockholm at the time of the visits included seventy-five young women and one young man all between the ages of sixteen and eighteen years. Child Nursing, a two-year

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Space is generously allotted to children's play. Outdoors, a woodsey plot just beyond the front entrance offers slides, climbers and natural terrain for play. Inside play space is integrated into the children's rooms. In addition, the entire top story of the hospital is given over to the play program. Here equipment fills two large rooms, an equally large hall, a kitchen and, a homey, wood-paneled conference room with eaves, window seats, and a fireplace for stories and quiet chats. Only twenty children at a time are allowed in the playroom. On the children's units, large storage cabinets are stocked with toys for nurses and parents to dispense for children who cannot leave the wards, and a large variety of well-used but well-cared-for play and school equipment stands ready and inviting. Mobiles and wall decorations fashioned of interesting and unusual materials catch the eye. Children's paintings of hospital themes adorn the walls.

Samariten operates its play program with only two full time play leaders for 120 child in-patients. Miss Ulrica Spens, a former nursery school teacher with a degree in Occupational Therapy, has directed the program for more than seventeen years. Her years of staff development have resulted in good collaboration with the nurses who use the well-stocked stores of toys on each unit to manage play for the younger children, and for health-care teaching.

The play staff selects and maintains equipment in the out-patient departments as well as on the play floor. They trundle their equipment around the hospital using infant bassinets and shopping carts as conveyers. After children are acquainted with play staff members, the older patients make their own appointment to choose activities which are selected with the careful consultation from the play staff to work out a suitable play prescription for each child.

Each head nurse decorates her own unit and corridors to make them appealing to children.

Two public school teachers, a part-time psychologist and one full-time social worker serve the in-patient departments as a team.

Pre-admission home visits are routine. The social worker and a nurse call on prospective patients during the week prior to admission to answer questions and ask some of their own, such as: "Why do you think you are coming to the hospital?" "What does your child think about the hospital?" "What do you want the hospital to do for you?" The team offers the family written guides on what to expect and what to bring. Information from the visit is shared with the rest of the staff at ward conferences and the group plans for the child's forthcoming admission.

Equipment in the top floor play department at Samariten includes twelve looms of assorted sizes, sewing machines, an adult kitchen, ping-pong tables, trays of sand, buckets of dirt and water, papier mâché, finger-paint, easels and water colors, clay, wheels and kilns, an extensive library, whole walls of shelves stacked with games of every description, hobby and crafts materials, tools and workbenches for carpentry, props for dramatic play, dolls and doll houses of all sizes, and a real broadcasting

program that is step one on a career ladder, helps educate young people for parenthood as well as for nursery school and hospital assistant positions. At University Hospital in Stockholm, a nursery school teacher and a nurse educator team teach a curriculum that includes family planning, beginning concepts in Child Development and Child Health. Students first participate in a pre-training assessment period to see how they like working with young children and to be assessed as to suitability for the job. If all goes well from both vantage points, the student moves into a two-year course and finishes as a certified Child Nurse. During training, students participate extensively on the wards, in the playrooms, and in the hospital operated play groups for siblings, clinic patients, and staff children. St. Goran's uses students from this program throughout the hospital and clinics.

Step two on the career ladder includes two and a half years of experience, followed by more education, leading to an R.N. After more field experience, the student may again return for graduate work in psychology and sociology and receive a graduate degree. Liberal arts education is built into the curriculum throughout in order to round out the student's personality.

The play therapy department of the hospitals visited offers observational and clinical experiences to students in other fields, such as Special Education and University level courses in Psychology, Medicine, and Nursing.

HOSPITAL VISITS

Samariten

Sykbradhusset Samariten is an old building on the grounds of a hospital complex. Samariten has beds for 120 children -- infants through adolescents, and is set amid gently sloping grounds studded with outcroppings of rock and trees which were, at the time of this visit, covering the ground with orange and yellow leaves. A play yard near the entrance gives the first glimpse of the hospital's attitude toward children. A slide set into a hillock, a small wading pool, some challenging rocks to climb, but no fence ... boundaries occur naturally because the yard is strategically arranged for easy supervision and containment.

Over the front door a frieze depicts a scene of children. The building was originally erected with funds raised by Jenny Lind during an American concern tour. The children, in mixed age groupings, family style, are up and around, dressed in their own clothes whenever possible.

The corridors and patient areas are light with lovely color, bright pictures -- many of them children's art work -- and cozy groupings of furniture. Small alcoves and corners are fitted with small round tables and bright chairs inviting a chat. Playthings within children's grasp are in use.

system to allow play leaders and children to transmit stories and dramas to the bedside of children on the floors below.

Large looms, sometimes reinforced to make the pull even stronger, are used for children with obesity problems who respond much more positively to weaving a rug or a bag than they would to callisthenics. For diabetic children who need to maintain a stable regime of exercise each day, ping-pong and other active games help not only for fun and release but also to regulate their energy expenditure.

The therapist at Samariten believes that children reveal their concerns, ask their questions, play out their own dramas, and work out their own therapy if the right materials are supplied and caring, observant, well-trained staff members are available for observation and consultation. For example, messy and organic supplies are displayed and readily available for children with problems such as encopresis which are helped by the constructive use of mud, sand, water, finger paint, and papier mache. Outdoors, children may climb hillocks and slide down, splashing into a wading pool in the summer or sliding on ice in the winter. Carpentry also allows release while life size or miniature dolls stand ready to help children play out concerns therapeutically.

Karolinska

This hospital, also set among leafy, sloping grounds, is part of a complex of hospitals. A warm, inviting atmosphere is enhanced by the use of color, sculpture, paintings, and plants that dispel the depersonalized institutional air. When a guest enters an office, the host lights a candle.

Karolinska Institute operates its play program from a central ground level room lined with equipment that the play staff transports to the children on the wards as appropriate to their needs. Larger equipment, like the looms, can be used in the play center or moved to the units as needed. The play center is used for crafts by patients, play staff, and students planning activities and creating decorations for the units.

Karolinska has developed booklets describing hospitalization through the eyes of small children. One version, mostly pictures, is for two-to-three-year olds; the second is for older pre-schoolers. These booklets deal not only with "what to expect" in terms of hospital routine and play activities, but also weave a story of the young patient's anger and shyness in the face of his mother's daily departures and his encounters with other children.

Karolinska has a play staff of professionals whose work includes the supervision of students.

The Lekotek

Another program, somewhat related to the Institute in that it shares the professional services of a psychologist and a pediatrician from Karolinska

is the Lekotek or Toy Library.

The Lekotek is housed in two buildings on the King's Grounds in a sylvan setting overlooking the water. This program, financed by the Boy Scouts of Sweden, is a library and school program where toys are used to diagnose and treat autism, aphasia, and other communication- and hearing-connected problems of young children.

Toys at the Lekotek are used to identify symptoms of autism, speech lags, or other deviations. Following the screening, parents and staff members confer and determine a program for use of the library's toys as additional stimulation for the child. This service is free and includes parent counseling. Some tests for determining residual hearing ability and communication disorders that might be present in an infant have been developed and are in use throughout Sweden and in a number of other countries. From research at the Lekotek involving parents and children some new programs for encouraging the development of mother-child communication immediately following birth have evolved. For example, at Karolinska, new mothers are provided with canvas slings to hold their babies so that speech and croonings go in a direct line to the baby, and the infant can also observe the mother's lips and eyes as verbal communication between the two begins.

St. Goran's

St. Goran's is a new building within a complex of medical buildings as beautifully designed as museum of modern art. The giant lobby is bordered by wide, low comfortable seats big enough for a parent and child to sit together. Wheeled vehicles for transporting patients are available, but stored behind an attractive lattice partition so that visitors are not immediately confronted with hospital equipment. The lobby houses bistros, banks, a post office, and a barnparking (play groups that care for well children while parents visit patients or attend medical appointments). Walls are decorated with hangings and woven murals, sculpted, and painted, depicting scenes about children. One handsome tapestry depicts children's experiences in hospital or clinic. A giant, brightly colored Rube Goldberg-like sculpture dominates the lobby, rising at least ten feet, the size of a small house. This mobile sculpture, set in a pool of water, has trigger controls a child can operate to turn on the water which activates paddle wheels, opens windows, causing funny faces to pop out, and setting in motion numerous other captivating gyrations.

One per cent of the cost of every public building in Sweden must go to its art and decor. St. Goran's was a very expensive building, and one per cent bought a lot of art.

St. Goran's is built around courts so as to allow direct sunlight into all patient areas. These courts are equipped for play. Each unit has direct access to the playroom of the lower buildings. Three-dimensional movable abstracts decorate walls on a children's unit at their level ready to be poked or rearranged, inviting exploration, and manipulation.

St. Goran's specializes in the treatment of handicapped children. The large swimming pool, gym, and occupational therapy rooms all have special adaptations to serve children with handicaps. However, all equipment is shared with other patients since exercise and emotional release take high priority at St. Goran's.

The pool features an adjustable floor, so that children of varying size and ability may use it. The occupational therapy unit has child-proportioned kitchens and housekeeping rooms with adaptive tools to allow handicapped as well as non-handicapped children to develop motor skills as they play out such normal household activities as cooking and washing up.

Additional rooms house looms for weaving, wheels and kilns for pottery work, carpentry, handicrafts, and even a small auditorium with a stage for impromptu dramatic productions.

St. Goran's with 229 patient beds, has space designed for play and storage for toys throughout the hospital. Play takes place outdoors on roofs and courtyards. Each specialty clinic, as well as the anterooms where children wait for x-ray, surgery, and other tests or procedures, are designed to offer play. One whole area at ground level is given over to playrooms and rehabilitation facilities complete with a pool with an adjustable bottom.

A playroom for visiting siblings permits parents to leave their well children while they visit hospitalized children. Space used by the psychiatric day treatment program doubles by night for in-patients who use the fireside room for songfests and jam sessions. One room with a stage where the day patients meet becomes available for young hospitalized children to use for impromptu dramatics in the evenings.

The occupational therapy unit adjoining the rehabilitation center includes a child-sized housekeeping center complete with a working kitchen.

Four classrooms house school activities with additional space provided on several of the wards.

Most children coming to the out-patient clinics play in a central waiting area but those with suspected infections wait in small isolation rooms. These curtained cubicles have beds so that sick children can rest comfortably while waiting to be seen.

The building is designed with varying levels and built around several courtyards. Some courtyards are used for play as is the roof level of the parking garage. The outdoor play areas are bordered with bushes, and offer ample space for wheel toys, for beds and buggies.

St. Goran's employs trained play leaders or nursery school teachers in every area of the hospital where children may be present, including x-ray and waiting stations. It is the job of these teachers to soothe and to prepare children for procedures. The booklet that St. Goran's distributes talks about Play Leaders as follows: "Play therapists on the staff of pediatric hospitals help decrease the stress of a hospital stay for the

child. They are of great help in relieving children's stress and anxiety before surgery and serve as part of the team as a child goes into the operating room. The play therapists were consulted about the design of the rooms."

Umea

Umea is a newer hospital with less greenery and more concrete than either Samariten or Karolinska. The ground floor play department opens to a courtyard equipped with climbing structures, slides, and sand pits. Bumps of plexi-glass skylights adorn the opposite side of the courtyard to satisfy the Swedish hunger for sunlight. The skylights serve the basement of the hospital.

The play floor and corridors were in full and boisterous use during this visit. Twosomes were engrossed in play in cozy corners. The play areas adjoin the parent apartments, so mothers are often around. Parents can invite their children into their quarters to visit. Accommodations are luxurious and well-appointed. Only one parent was in residence at the time of the observation and her reason for staying was that her home was too far away to allow regular visiting.

The attitude of welcome and understanding for children and their play permeates the institution. All the hospital waiting rooms are equipped with toys and decorated with art "so that even if we are not there, we are being kind through the materials," the Play Leader said.

Three teachers and a number of students involved in their four month pre-practice experience made up the play staff at Umea. Considering that the play program cares for more than 100 children each day directly and indirectly, the play staff is small. However, by giving careful attention to stocking all areas with playthings and by working with parents and staff members from other disciplines, the expertise of the small play staff is extended to reach many children.

When large groups of children come to the playroom, their nurse stays to help. Very young or disturbed children's nurses also stay in order to maintain familiar relationships. Play Leaders take playthings for very young children to the nurses so that the babies will not be unnecessarily burdened with new encounters. In return the Play Leaders help the nurses out on the wards, and also serve as their allies and advocates when the nursing staff is campaigning for something -- color uniforms, for example.

The play staff members work to maintain family ties by welcoming parents in the playroom. An apathetic mother is prompted tactfully by a Play Leader to appreciate her child's efforts. A mother watching her child at play can observe the Play Leader's techniques.

"It is easier to help if you are not so young," Mrs. Lindqvist says, "because you must talk to parents and staff with authority as well as kindness."

Color, light, tasteful and interesting decor are used extensively. Each waiting area and ward play space is unique but similar in its use of child-oriented art.

"We consider it very important that children are met by a friendly environment as soon as they come into the hospital door. What they see must invite activity. That's all we have here ... invitations," the Play Leader comments.

Materials from nature ... mosses, leaves, acorns and pine cone mobiles, reminders of the woods and the natural world outside ... are used extensively in the decor. Mobiles constructed from unlikely materials such as medicine cups, egg cartons, and styrofoam structures of all kinds, plus collages of lids glued in intricate patterns and swirls adorn the walls, tables, and ceilings. A clinic doorway sports a hanging of stuffed, multi-colored, multi-textured strands like fat bell pulls, each ending with a large bell.

Umea has seventy-five beds in the pediatric units plus an indeterminate number of children who are in adult wards. The play program serves approximately one hundred children daily, either directly or indirectly, by placing toys in areas supervised by mothers or nurses.

Brothers and sisters as well as parents can visit patients in the play area. The atmosphere is homey and comfortable. Children appear relaxed and absorbed in play while mothers quietly observe from the fringes as they do their own handwork.

Play equipment in patient areas throughout the hospital is chosen with the therapeutic use of the particular children served in mind. For example, in wards for children with eye problems, playthings feature interesting sounds and textures; children in orthopedic units have bed-height doll-height doll houses and similar equipment to allow both socialization and activity.

Each waiting area or day room on the hospital units that serves children has child sized furniture and storage for toys for the child patients in that area.

In the area reserved for play on the ground floor a large gymnasium opens to the right of a long, wide hall which can be divided into many smaller spaces. The adaptability of the space allows the play staff to arrange for the kinds of children they will see on any particular day. The gym and the corridor may be used for large muscle play, carpentry, block building and hobby pursuits. Space is so arranged that small areas can be screened off to make interesting alcoves and smaller nooks inviting small groups to form and encouraging the feeling of close companionship and privacy so important yet hard to find in a large institution. To the left of the corridor is a suite containing the director's office. A one-way vision mirror separates it from the playroom for younger children. The office doubles as hospitality center, conference-observation room and classroom for university students, community members, staff members and

parents who meet to learn about play and the hospitalized child. Observations of children at play trigger discussion. The play room is arranged in zones to invite children to group themselves according to their own interest. Two partitioned alcoves complete the suite. One contains a complete working kitchen, child-sized; the other a living room with low comfortable furniture. Throughout the play area, walls are honeycombed with storage shelves and cupboards, both open and closed.

A note on the Play Leader's bulletin board at Umea states: "The art of medicine consists of amusing the patient while nature cures the disease." Adherence to this principle is evident in the profusion and variety of play equipment throughout the hospital. Toys for children of all ages are placed in clinic waiting areas so that children are eager to return for check-ups, remembering, according to their parents' reports, the doll pram or the big truck rather than the finger pricks.

In addition to the standard play equipment one might hope to find in a hospital serving children, community organizations donate presents and surprises so that individual children may have their own toys whether or not parents bring them. Dolls, doll houses, and boxes of delicately handmade doll clothes afford children long hours of delight with materials more personal than even the best made commercial toys. Umea's program puts much emphasis on the personal, individualized approach to play, not as an alternative to group play, which is encouraged and amply provided for, but in addition to group play. Play staff members use shopping carts and baby bassinets on wheels to transport toys from the play department to the wards.

Another home-like touch is the collection of antique and miniature folk toys displayed on glass shelves in the playroom. Children are encouraged to look, to ask about and to handle the things, on the theory that these pretties will remind them of their life on the outside: "My grandmother has a doll like this" Children too weak or too lonely for active play gain a sense of involvement through these pleasant associations.

In the living room corner of the playroom, low polyurethane foam chairs, child-sized and brightly covered in orange-red allow children who might be unable to do anything else to join the group. Just sitting on such furniture feels more like play than watching from a gurney or a wheel chair. On the floor, a thick foam rug covered with a swirling patterned terry cloth lets children who cannot walk maneuver and change their perspective in a comfortable, stimulating atmosphere.

The play equipment includes sand and water tables, puzzles and paints, as well as blocks and construction materials. Children with disabilities can have fun with the materials because standing boards with cut-outs allow children unable to stand alone to work in groups at the water tables and socialize with other children as they play. Sturdy low wooden buggies with sand bags to keep them steady allow children, who cannot otherwise manage, to ambulate as they push them along.

Doll houses are very important in this hospital. They form room dividers,

are used as play hospitals, and allow bedridden patients to play together by using bed height doll houses which open on two sides. Much of the furniture is hand crafted.

A fibreglass climbing structure for the younger children is shaped like a mushroom with a removable domed top. The lower part serves as a hiding place with round port holes to peek out of; the top can be inverted for use as a water table. The whole structure is satisfyingly large but lightweight enough to be easily moved.

The reading room, with polyurethane foam furniture and rug, is especially hospitable to children with cerebral palsy. Because many such children are seen at Umea, the library has a picture story book of a child with Cerebral Palsy who comes to a special treatment school. It is entitled *PLATS FOR VANNA (Place for Vanna)*.

Toys for the expression of direct aggression are absent. Release comes about through the use of games such as "Mousetrap" (highly recommended) and through activities such as cooking, washing up, painting, carpentry, and waterplay.

The play leader speaks of the need for kindness in the environment. She explains that this means colorful, soft materials, comfortable, yielding furniture, and materials from nature.

She also stresses the importance of every patient's need to create something to give someone, especially if they are limited in what they are able to do. She teaches paraplegics step by step to use what little hand or foot control they have to make something. "What it means to someone who has had to lie in bed year after year saying 'thank you' to others to at last be able to make someone say 'thank you' to him for a present!"

The playroom has two child-sized kitchens ... one for pretend, one for real. In the real kitchen, children don chef's caps and aprons. Visitors are often greeted by a parade of these chefs, appropriately garbed, bearing a fancy bundt cake or a platter of cookies. When there is no company, they make parties for the porters and orderlies.

In the clinic waiting areas, where tension can build as anxious mothers wait with anxious children, toys permit both parent and child to relax. Children are encouraged to take a toy from the waiting area in with them while they see the doctor. This also helps medical staff members establish quick rapport by relating to the child through the toy.

HOLLAND

QUEEN WILHELMINA HOSPITAL, UTRECHT

Utrecht is a medieval city. The University was founded there in 1600. I visited the Queen Wilhelmina Children's Hospital there, escorted through the program by one of the large staff of social psychologists who assist with the play program. He informed me that the model for play in use there was eclectic, employing behavior modification and operating from an experimental psychology framework in contrast to the University of Leiden hospital's program which is based on the work of Bowlby, Robertson and Anna Freud.

Regarding parent involvement with pediatric patients, the psychologist remarked that as play and play therapy are considered the domain of the staff of play therapists and social psychologists, parents, who tend to focus on the child and prevent him from playing, are not encouraged to stay around.

AMSTERDAM

At one hospital pediatric department in Amsterdam where I made a very brief night visit, I was told that rooming-in was attempted in hospitals throughout Holland in 1958 and abandoned as unsuccessful because Dutch mothers are too home oriented to spend the night in the hospital. Most deliveries still take place at home. "Besides," my informant added, "If you fill up the beds with parents, where will you put the children?"

UNIVERSITY OF LEIDEN

At the University of Leiden attachment is the underlying concern. A corps of 20 observatrices (including students) serve a population of 40 hospitalized children. These are credentialed teachers, usually women over 22 years of age selected on personal qualities from subjective observations by the health care teams. A further special two year course prepares them to become observatrices. Salaries are equal to those of teachers.

It is their job to encourage attachment and reduce the number of encounters the young children must experience. They keep the mother-child relationship going or substitute for the mother. They provide appropriate person-social stimulation including limiting the infants' contacts to a few meaningful ones. Observatrices coach parents regarding appropriate techniques in play and other assistance of their children. For example: parents are instructed not to immobilize their children for procedures or participate in tests and treatments. They are advised to visit babies at least three times a day. It is the belief here that these frequent short visits compensate for the mothers' not living-in.

Mothers come after 10:00 A.M. They feed and play with their own child only and do not participate in bathing the child. If a mother needs help learning feeding techniques, she rooms-in a few days.

Observatrices look at the hospital situation through the child's eyes and intervene with their own specially skilled knowledge. "It is emotional suffering the child experiences in the hospital, and the role of the observatrice is to help prevent this," I was told.

The observatrice tries to get a total impression of the child. She (or he) keeps records on the child's reaction to treatments as she accompanies the child to each one. Potentially frightening experiences as well as other tests and treatments that the child is to face the next day are recorded and followed up with appropriate play preparation and support. Observations are relayed to the doctors. In preparing children for treatments, the observatrices use a doll, a bear, or the child himself to show what is going to happen. With older children, they elicit past experiences and then go over in detail the new experiences. A play hospital (a two room white box) with a ward and an operating room with dolls to scale representing parents, physicians, nurses, babies, is used along with masks, tubes, syringes and other paraphernalia. Children hold their own masks for anaesthesia as soon as they are old enough. "We prepare them to handle their feelings," was the observatrice's description of the procedure.

Each child spends one or two hours each day in the play room. There he has the opportunity to express anger and aggression with water and sand. Children may use messy play on the ward, but by and large, ward play is limited to the less boisterous activity. On the ten bed wards, most children are up and playing. Each child has a box of his own toys stored under his bed and a bed table to use for play. Tables and chairs are arranged in the center of the ward with games and an aquarium visible. Carts with special activities are wheeled daily onto the wards. An outside yard has packing boxes and climbing equipment.

Three workers are assigned to the ten bed isolation unit which has its own special play equipment.

The program was developed by Professor G.M.H. Veeneklaas in the early 1950's. Today, as nursing care becomes increasingly patient-centered and psychologically sophisticated there are some conflicts arising over the respective roles of the observatrice and the nursing staff. Because of the intensity of the involvement with the patients, there are occasional difficulties in keeping staff. Regular consultation with the psychologist plus regular group meetings are scheduled to deal with these problems. The Head Observatrice coordinates and teaches in the training program.

DAY CARE CENTERS

Although hospital connected day care centers were not the focus of this study, I could not help but be interested in such programs when I encountered them during my visits. Day care programs for staff children operate in England at Fulham and at Amersham. Stoke Mandeville had none. "Nurses are supposed to be nurturing people," the Matron Sister said. "What are we doing when we entice young mothers to leave their children to come care for someone else's?"

FULHAM (CHARING CROSS)

At Fulham Hospital in London, staff children share facilities and some parts of the daily program with children from the Child Development Day Care Center. When activities are suitable for the mixed group of handicapped and non-handicapped, the group gathers as a whole. Where the differences in abilities and interests make a total group experience inadvisable, they divide.

AMERSHAM

In place of the spinster married to her career is today's young nurse graduate, married and with a baby or two. At Amersham Matron Daniel has established a creche on the hospital grounds for the infants and children of these young women. She was forced by circumstances to provide child care because,

"..... one day the inevitable happened: I had no theatre sister. No one, and we had surgery scheduled. I called all the women who had been working here in the theatre (operating room) earlier and begged each in turn to come help me. The answer was always the same ... 'I'd love to help you out, but I have no one to leave the baby with.' So I said, bring the baby here to me and I'll care for him"

That was the beginning of the creche where children are cared for four or five hours while mother works. If mother works at night, she may bring the children to play while she catches up with her sleep. The children enjoy their stay and mothers have more time for play and for concentrating on their families because less of their home-time energy is spent in continuous cooking and child care. Matron Daniel arranges four hour shifts for all her staff who have young children so that they will not deprive their children of adequate mothering.

Since the adoption of this plan, Miss Daniel said she has had less difficulty keeping a full staff with more than twenty young mothers sharing

shifts. The plan allows the hospital to use the recently trained nurse without diminishing her effectiveness as either nurse or mother.

SWEDEN

In Sweden, each hospital I visited offered day care for children of staff, but discouraged infant care. A common family plan for child care, I was told, is for each parent to carry one half-time job, share household and child rearing and use day care centers to cover any remaining time needed. Day care centers are plentiful, well staffed and well equipped.

DENMARK

I visited three hospital based centers in Denmark: one at Glostrup, one at Hillerød and one at Rigshospitalet.

Glostrup

Glostrup Day Center is housed in two low attractive buildings reached by way of a wooded walk across the hospital grounds. Infants and pre-school age children are housed in one building; the school agers in the other. In the infant and pre-school center, each room has its own color scheme and all the belongings of that room are colorcoded for easy identification. In addition, each child has his or her own symbol which is carried out on all his possessions in each area ... for eating, bathroom and sleeping areas. Small, child height portholes offer children glimpses, their own size, of the world outside. Toys are plentiful and beautiful. Innovative structures have been designed by a Finnish designer, Utti Lutker. One such storage unit has steps to allow a child to climb and sit while his shoes are put on and includes a series of low cubbies for the older children and higher storage space for the youngest. The whole edifice makes an attractive and efficient multi-purpose island in one of the anterooms.

Babies sleep outside year round in a line-up of blue wooden buggies hooded to keep off the snow and covered with infant size eiderdowns. Their mattresses are stored in a warming closet when not in use, so that they will sleep warm during the winter, too.

Much thought is devoted to maintaining good parent-child and staff-child relations. Frequent get-togethers take place at the school. The occasions are social rather than educational. The director has plans for a bistro area so that parents will linger when arriving and leaving, making the link between home and school even more associated with the parents.

Children still on the bottle get all their food requirements including formula for the parent to take home from the nursery school. This is to allow continuity of quality and save parents time for more playtime with their children. The older children get only a snack of dark bread sandwiches at the end of the day in anticipation of their sharing dinner at

home with their family. Children breakfast at the Center at 8:30, have mid-morning salad, mid-afternoon juice and fruit. The older children have an exciting playground with many of the adventure "junk" materials so popular in Denmark. This includes a large row boat.

Hillerød

The day care center at Hillerød has, in addition to the many exciting and beautiful playthings for the infants and children, a special vehicle room for the use of parents in transporting their children to and from the center on their way to work. Many of the families who use the center live on the hospital grounds in apartments built for the use of staff members. The vehicle room features wooden wagons and buggies. A parent may leave his bicycle at the center at night, borrow a wagon and tuck his child or children in and trundle them home. Next day, children return in the wagon, Dad or Mother pick up their bikes and spin off to work.

The staff-child relationship is very good, and the atmosphere in the Centers is comfortable.

Pediatricians in Denmark stress the importance of keeping the mother-child couple together during the first years. Families get a child allowance every three months to support mothers and enable them to stay home. Mothers who work are more likely to bring someone into the home for the youngest babies during their first year, but infant care in the centers is booming, and I was told that the centers cannot keep up with the demand.

CONCLUSION

Intractable Problems Considered

There are countries where the entire family moves in and sets up housekeeping when a member is hospitalized. This is more prevalent in underdeveloped countries than those with advanced medical technology where, since the days of Florence Nightingale, hospitals maintain control over patients' visitors and consider parents as visitors.

Parental belief in yielding responsibility for their child's support to the expert professional has become part of many cultures even as many concerned health professionals now recognize the importance of the parent for the child during the crisis of hospitalization. Hard as it once was to push parents out, it would now take heroic efforts on the part of the institution to turn around the parental diffidence and/or indifference that now exists.

Unfortunately hospitals still rely on the parent to decide whether or not to stay. That this decision cannot be fairly placed on the parent was dramatized in a survey conducted by several Swedish hospitals with differing visiting hours. Each family was asked what hours seemed most appropriate for them and each answered that the best hours were those in practice at the hospital where they had their family member.

Today, hospitals and professionals are called upon to see what they can and are obliged to do in order to serve their communities as centers of psychological as well as physical healing. The child's need for care and attention remains the same no matter how valid are the parents' reasons for leaving him.

Unless our institutions can promote caring and intimacy, bring families in and help them see how important they are to their individual members, we are threatened with a society of indifferent, uncaring people a generation from now.

It would appear that organizations of consumers assisted by professionals are the most effective agents for public education with regard to the necessary services parents should request of their institutions and the effective ways in which pressure can be applied in order to bring about the necessary changes. NAWCH in England and ACCH in Canada and the U.S. are good examples of such agencies.

Happily, the trend is toward increased family involvement. The mechanics and the good-will exist. The largest block remaining is that of community education and communication.

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REDUCING THE PSYCHOLOGICAL TRAUMA OF HOSPITALIZATION:
HOW FAR HAVE WE SUCCEEDED?

By

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Twenty-five years ago, Dane Prugh reported to this organization that regardless of excellent medical and nursing care, children younger than four years remain disturbed in the hospital and have more behavior disorders after discharge than do older children, and that the practice of including the parent effectively reduces anxiety. In this paper I am focusing on only one aspect of reducing trauma: avoiding separation. I refer to children under four when I say child and to a familiar person who gives mothering care when I say mother.

The child needs the physical presence of the mother. She is his geography, his security, and his ego. This is obvious but has not been easy to get across.

Much of the push to implement the findings of Prugh and others has come about though the ^{combined} efforts of concerned professionals and crusading parents.

Today I shall talk about: 1) the growing network of parent groups throughout the country; 2) the Association for Child Care in Hospitals (ACCH), 3) parent-inclusive pediatric units, and 4) progress since 1953 with statistics drawn from a recent study I did regarding parent accommodations and staff attitudes toward living-in. First, the parent groups. There are more than twenty parent groups currently working toward some aspect of parent and child advocacy. Some of these organizations are specialized, such as Parents of children with heart disease, or the Candlelighters, (parents of children who have or had cancer). Hospitals do respond to the efforts of such groups. For example, seven hospitals in the Boston area changed from limited to open visiting and/or rooming-in even before the results of a survey of hospital policy being conducted by the parents' group were published. Just seeing that other hospitals were doing what they were should for one year before publication caused some administrators to rethink their own policies.

In addition to surveys and parent information services, groups offer telephone

consultation and hot lines for parents. One parents' group is currently exploring affirmative action to get a state regulation requiring hospitals to inform parents of their right to remain with their children; to explain why staying is important for the child's well-being;^{and} to tell how they would like the parents to participate. Other causes championed by parent groups include gaining for parents the right to stay with a child until sedation takes effect before operations, and the right to be with the child in the recovery room.¹ They make the point that parents who must give consent must have access to their child to judge conditions in order to make an intelligent decision.

Parent groups share information and experiences in their newsletters, develop pamphlets to alert parents that they are needed by their children in the hospital, and offer hints about how to insist on staying and how to behave to minimize embarrassment and resentment. Currently, all the materials are being translated into Spanish, reflecting cultural as well as language differences.

Association for the Care of Children in Hospitals

ACCH is an interdisciplinary group of professionals focusing on the psychological and social aspects of care of hospitalized children and their families. The organization grew out of a meeting of play leaders in hospitals (now called child life activities directors) 10 years ago, and now boasts a membership of several thousand. Child activities is still an important focus, but other professionals are now in a majority. The ACCH's newsletter has recently become a Journal. By sharing ideas through the Journal and through the annual meetings, ACCH has advanced knowledge and promoted program to humanize clinics, emergency rooms and adolescent units; suggested methods for preparation of volunteers and paraprofessionals; shared information about mother banks, and ward grannie schemes.

Statistic³ Then and Now

In 1963, 9.3% of hospitals with approved pediatric residencies reported having

¹ Annas, George The Rights of Patients, Bantram 1975

hospitals with approved facilities
parent facilities (14 out of 150). In 1974, 154¹ responded that:

76% had parent beds; (38% said they had enough,
62% said not).

51% said facilities were qualitatively adequate.

59% inform in advance.

57% encourage rooming in, 7% discourage, and 40% tolerate.

We have cause for jubilation. . . look how many hospitals are seeing the light. . .
but also reason to continue to press for change: look how many are not, and after
all these years.

To illustrate how vague the guidelines are that determine whether or not a parent
will be welcome at a given hospital, here are some sample comments from respondents
to the survey: Top runners, "If parents ask", "demand", or "request", then came a
long list of "depending on's": "Depending on child", "depending on illness" "dependi
on situation", "depending on parent attitude" "depending on need". . "census" and
so on. Other qualifiers were "If child is retarded", "~~If child is retarded~~", "If
it helps child" "On rare occasions only" and "only if doctor orders". Only one
hospital wrote "depending on child's age" which, if there isn't room for all parents,
should be the priority choice. One hospital wrote that they require a parent or
other responsible adult with each child. Several said that they have no space now
but plan some in future projects. And one wrote testily "Has NEVER been under
consideration".

James Robertson, a pioneer parent-child advocate in England points out that as long
as the physician and/or other ward personnel feel omniscient enough to choose which
parents can stay and which cannot, parents are less inclined to ask to stay. Even
parents who know how to work the system report that they prefer to be part of an
established program that includes family members. It hurts to know other children are
crying alone at night even though your own has your support. Fortunately, many
parents who have insisted on working the system and staying have advanced parent
programs by showing staff and other parents that children are helped and that par
involvement is worth the effort.

I think that the most effective way to change is to share experiences and transplant good ideas. A campaign aimed at parents to inform them that their children need them is essential, too. Theory alone is not enough to bring about change. If you say, "Children younger than four need parental support", the answer is often "Yes, I know, but we don't have the room". Saying "Here's how they handle that in Michigan or Johns Hopkins or D.C. Children's" is more likely to encourage hospitals to try another way.

Changes are occurring: In 1954, most New York hospitals had parent visiting hours 1 hour twice a week. This was typical of most hospitals at that time except for those in the South where parents have traditionally been expected and accepted.

In 1974, twenty years later, 1198 general and 53 children's hospitals responded to a questionnaire requesting information about their accommodations for parents of children between the ages of 6 months and 5 years. The questions were addressed to Directors of nursing and asked the following questions:

Do you have any beds for parents?

Are your facilities for parents adequate in quantity, in quality?

Do you systematically inform parents before admission about facilities?

What is the predominant staff attitude regarding parent-living-in?

Encourage
Discourage
Tolerate

The complete responses were as follows:

54% of general and 83% of children's hospitals have beds for parents.

47½% of general and 75½% of children's hospitals inform in advance.

41% of general and 59% of children's encourage rooming in.

23% of general and 16% of children's discourage rooming in.

38% of general and 33% of children's tolerate.

205 responded that they had all services but discourage or tolerate living-in.

57 responded that they have beds for parents, enough quantitatively and qualitatively; inform in advance and encourage parents to live-in.

published
in ACCH
Journal
1975
faculty
research
funds

Parent Living-in Plans

1. Care By Parent A survey done at Yale-New Haven showed that over a three month period, 30% of admissions might have been handled in Care-By-Parent Units, (recommended where acute nursing care is not essential). In the majority of these cases, parents said they would have been most willing to avail themselves of such a program.

The first Care by Parent unit, at University of Kentucky Medical Center, was designed to bring in families from remote rural areas who would not otherwise relinquish their children to the hospital or clinics.

The Kentucky unit boasts a kitchen, laundry, sewing machine, materials for, quilting and for whittling. The child care assistants work with parents in designing innovative teaching devices such as scrapbooks of permissible foods and recipes for diabetic children. The units at Kentucky and Vancouver Children's have combination living-room playrooms where the families congregate. James Whitcomb Riley in Indianapolis has a new unit with 12 well furnished double rooms for a child and one or two other family members.

Care by Parent units cost approximately 1/3 less than ward beds because of the reduction in nursing staff.

Both at Riley and at University of Kentucky, children who have been maternally deprived or who are failing to thrive are housed on the unit. The staff tries to help the parent see what is happening without overwhelming with guilt.

2. Family Participation Units: Some hospitals offer parents a choice of several plans. In the Family Participation Unit at Boston Floating Hospital, parents have assistance from nurses and a social worker by day and are on their own with their children by night. The unit is connected with the general pediatric service by a hotline. Nursing attention focuses on supervising the parents, who give much of the care during the day. The atmosphere is home-like. Parents baby-sit for each other, so one does not see a crowd of parents hovering over their children all day. The

neighborhood atmosphere permits a neighborly ebb and flow that prevents exhaustion and the subsequent irritability that many professionals fear.

3. Parent and nurse shared care: In this plan parents are welcome and helped to be available for their children, but nursing staff stays at the same ratio or is increased in order to make the experience positive for all concerned. When Mt. Zion in San Francisco remodelled their traditional unit to accommodate parents, they added and a full time nurse clinical specialist as living-in coordinator, a half-time social worker, ~~coordinator~~, ^{was created} they remodelled to create a parent lounge with a snack center, ^{and} a parent bath and shower, ^{room with 600 parents} and they furnished double ^P patient rooms ^{were remodelled} with a folddoor ^{include} and a chair bed to accompany each ^{of the 2} patient beds. ~~Their~~ census increased as word got to the community that parents are welcome.

University of Colorado

Signs around the hospital contribute heavily to the messages conveyed to parents. At the University of Colorado, wall beds have been installed in patient rooms, waiting areas, and offices with signs on them that say, "Parents, your doctors, nurses and hospital administrators have placed this bed here to be used by parents or close relatives of hospitalized children. There is no charge. You are encouraged to stay here at night. When you are ready to retire, the nurse will help you prepare this bed". A snack kitchen for parents displays a sign saying "Parents: this kitchen is for your use. Help yourself or your child". No prohibitions, no admonitions. Nurses deal directly with parents where special restrictions are concerned. The only complaint by nursing was that there weren't enough spicy foods for the Indian and Mexican families using the ward.

Parents are an accepted part of life on the unit at University of Colorado, but not every child has a parent there, so a foster grandparent is assigned to nurture any child who would otherwise be alone, and an active, well-staffed child life program functions daily.

Children's Hospital at Stanford

Children's Hospital at Stanford has a family-centered children's oncology unit

with a rollaway cot by each child's bed. Parents and children eat together family style in the day room. Because the philosophy of care is one of aggressively fighting the disease, and children feel and look sicker during treatment than they did on admission, the staff believes that parents and patients must understand and participate in every aspect of care and treatment. There are no secrets; parents and children read charts, are encouraged to question and speak up about anything and everything. One young boy suggested that the lab technician should take blood from a different vein than he had intended. "Are you telling me how to do my job?" the technician challenged. "Are you telling me how to use my vein?" the boy countered.

Care Through Parent

The ~~we call our plan~~ ^{is named} "Care Through Parent." With neither space nor funds to remodel, ~~we begged~~ ^{was procured and} a small storage closet, ~~the hospital auxiliary bought six~~ ^{beds,} rollaways, 2 mats, and ~~two~~ Japanese futons (foam mattresses). ~~They also purchased~~ ^{was donated} a chair bed for parent use in each isolation room.

Parents take responsibility for transporting their beds to the playroom a few yards down the corridor, and make them up both night and morning so the playroom can be used during the day. A daily meeting introduces parents to each other and gives the staff leader an additional chance to touch base with parents. Priority goes to parents (one per family) of children under 5, but usually, by improvising with couches, sleeping bags, pillows, etc., everyone who wants to can stay.

A series of cartoon drawings with text in Spanish and English is posted on a ward bulletin board to show how to use the services. The name, Care Through Parent, refers to the fact that nursing care goes from nurse to parent to child. The program is far from perfect, but we decided that children can't wait for parent support until the new hospital with parent-child rooms is built.

New Professions

Hiring advocates to facilitate the smooth assimilation of parents and promote

the child's welfare throughout the hospital system is frequently suggested, but programs to prepare such specialists are rare. Consequently, when institutions want to change, they are often at a loss to know whom to hire or what guidelines and job descriptions are needed. At UCSF School of Nursing, a new graduate program to prepare a clinical specialist called the Parent-Child nurse is now in its third year. This person is a skilled pediatric nurse who recognizes and promotes the parent-child relationship. These students choose a residency and because there still are so few family oriented units in the Bay Area some of the more mature students work with staffs of hospitals who want to change to living-in or open visiting.

Bringing Families In

Getting word to families in advance so that they can plan to stay is one of the greatest problems. For so many years, families have felt like intruders in the hospital setting that now, even where they are very much wanted, that reputation must be counteracted. Families need advance information to allow advance planning. However, it is not easy for hospitals to get the word to parents. Distribution of literature is difficult. (U.C.S.F.Moffitt Hospital, for instance, is used by more than 1000 referring doctors, and only a small percentage of admissions are scheduled in advance.) A sustained national campaign ^{is needed} to inform consumers and hospitals everywhere that hospitalization should be a family affair,

Parents, especially those not from the middle class, must be courted and supported as well as housed. Otherwise, the old mystique of the hospital as unfriendly creates a moat between the family and the health care system.

Even hospitals that welcome parents in urban areas report that they seldom have more than 40% staying. In the South where parents customarily stay the percentage is higher. Henrietta Eggleston in Atlanta reports that 90% of their parents stay.

Helping the Parents

Families also need orientation to the ward at the beginning of their stay. In

a study by Skipper and Leonard in 1968² an experimental group of parents was given a 5-minute orientation upon admission from a special admitting nurse that included the opportunity for them to ask questions. Their children had lower blood pressures throughout the hospital stay, lower pulse rates, lower temperature; fewer vomited after their operation than did the control group children. . . (5 compared to 14 out of a number of 80); could urinate sooner and drink more. During the convalescence at home, fewer mothers in the experimental group reported that the child had fever; fewer called the doctor (14% compared to 41% in control group) and all recovered at the end of one week at home. Only 50% of control group mothers said the same.

Conclusion

Hospitalization can be a positive experience for the pediatric patient and family. The child can learn how precious he or she is to everyone. Both the child and family often discover new strengths. If supports are adequate, hospitalization can become an adventure with patient emerging as triumphant hero.

Since 1963 we have advanced from 9.3% parent-inclusion in hospitals with approved pediatric residencies to 76% today, and happily, some of these hospitals no longer think in terms of allowing; they want parents--almost as much as the children do.

²Skipper, James et al. "Child Hospitalization and Social Interactions: An Experimental Study of Mother's Feeling of Stress, Adaptation and Satisfaction". Medical Care 6:496 Nov-Dec. 1968.

Outline

1. Ousting the family or Boosting

Family is born in delivery room.

Earlier than that

Perhaps never born at all

Principle: making it easy to care:

History -

England

~~other~~

U.S.

Parents in

Parents out - no one but nurses, skul -

"Ducking in" rounds. "Couldn't do that to the nurses"

Knowledge of parent need - 2-way -

Long term effects

Up the airy mountains - "thought that she was fast asleep but she was dead with sorrow"

Opening the hospital
gradual -

Hooking the parent / Bonding

Making it easier to
Vengade - slid

Profession arise to help -

Organize to sustain selves -

Fingers deflected from orig. task, or
distracted.

and society is left with the residue.

AGO

★ ★ ★
DEAR ABBY: Birth is a normal, natural human function that should be celebrated by the entire family. Siblings who are prepared for what is happening will be more understanding and loving to the new baby they "helped" to bring into the world. There is so much more unity in the family that has "birthed" together. When one considers its beginning, no wonder the American family is disintegrating. Mom is in the recovery room, Dad is pacing the corridor, the baby is in the nursery and the siblings are shuttled off to Grandma's. The family never had a chance; it wasn't even born together.

P. GEDDES, BAKERSFIELD

Mention in Text:

New trends

I C U + Recov. room
Parent groups
CTP, C B P, C W P -
Ronald's me Donald Houses
Home care - of anesthesia -
Induction ~~of~~ Sweden
Laws - ~~of~~

~~Still~~

A long way to go to make hospitals serve
~~the~~ we think they might -

And that a whole new system, the
hospice, must ~~grow~~ grow to fill the
vacuum ~~being~~ created by the hospital
which has become a caretaker
rather than a care giver -

PARENTS ON PEDIATRICS

by

Carol Hardgrove, M. A.

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by a research grant from United States
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Institute of Mental Health.
MH 17230-01.

Room 411
Clinics

15

but few if any of them have in the community and responded so totally, and few give such respect and equality to all professionals -- specialist, family doctor, nurses, and workers in the social services alike.

Physically Different in almost every way possible from Hunterdon Medical Center is Johns Hopkins Hospital in Baltimore. It is surrounded by deteriorated red-brick ghetto, housing a low-income, largely minority population, patients as well as from every state and many foreign countries. Since it opened in 1889, endowed by private funds, Hopkins has expanded its facilities until it now has more than one thousand beds, and its buildings are spread over fourteen urban acres. The long established position of the hospital as a separate island in the city blocks which stretch around it, and the very size of the staff several hundred doctors as well as nursing, social work, therapy, and other personnel would seem to preclude any personal and individualized commitment to the community outside its doors. However, the pediatric department here carries out policies of total concern with individual children and their families which are among the most forward-looking in the country. The implementation of these policies in the inpatient pediatric units has been discussed elsewhere.

There are many pediatric specialty clinics at Johns Hopkins, as well the general outpatient clinic. The Child Life Department staff, which will

serve all of pediatrics, has conducted activities programs in these clinics since 1961. Field Work Students from colleges and universities carry out the programs under the supervision of the department; this aspect of the Child Life Program and its involvement with parents is still being evaluated and implemented. But it is another activity of the Child Life Department, one which brings John's Hopkins directly into contact with the community, around it and which adds another dimension to the usual role of such an institution, that concerns us here. To clarify how this new link with the ghetto surrounding the hospital came about, and the work of the Family Life Coordinator who is responsible for carrying it out, one must first understand the hospital's Comprehensive Child Care Program and the part played by the Child Life Department.

Comprehensive Child Care is a program funded by a federal grant for the delivery of health care to the well child, and carried out by the hospital through the use of its own facilities and special services, and through cooperation with schools and outside agencies. The Comprehensive Child Care Clinic in the hospital under the direction of Dr Robert Cooke, became increasingly concerned several years ago about the background to which inpatient and clinic children returned after care in the hospital or after clinic visits; more than twenty-two thousand children in areas adjacent to the hospital are eligible for

Comprehensive Child Care and a large proportion of them are enrolled in the program. As part of their involvement with all aspects of pediatrics, and given impetus by the concern of Dr Cooke, the Child Life Department undertook a study of the play facilities, supervision and care at home in several adjacent small ghetto neighborhoods, followed the study by a demonstration of community needs, carried out by students in a summer program. The results of these investigations showed the community needs for facilities of all kinds to be very great; the area surrounding the hospital is a potentially explosive one in many ways, since it is not only a low-income minority area but is also badly overcrowded and inadequately housed.

The position of Family Life Coordinator was created to meet these needs; Mr Lou Gwynn, who had filled the position since its inception is also an Associate Director of the Child Life Department. The outlines of his job are broad in scope: His area of involvement is the community, although he works in and through the hospital. "We hope basically," he says, "to make ourselves available to children and parents in the community, to work with the child and with the world around him: local organizations, his family and friends, his play areas. Then we want to follow up when he's been in the hospital, to go back into his community and help with problems that can arise there. We have access to all kinds of research and technology that is furnished by the hospital -- the drug abuse program, psychological studies, and many

other resources -- that we can use to help families and neighborhoods."

One way to facilitate this relationship between the hospital and the surrounding area, is to use the existing organizations and concerned group in the census tracts adjacent to the hospital. Mr Gwynn started to make contact with these groups in the most direct and informal way by going into the neighborhood and talking to people in their own clubs, churches and organizations, in their homes and on the streets.

Even with the advantage of familiarity with the area and the people faced with distrust and lack of confidence. This was overcome "by showing them that I'm not an expert. Nobody's an expert -- we don't even know all the problems. But whatever information we had that might be helpful to them, I offered to them. "Mothers concerned with starting day-care groups, families who wanted play areas and after school programs for their childrens, found him willing and helpful in writing proposals; families concerned with the special needs of individual children learned that he had access to resources they could use. As the community gradually began to trust him, and as they learned that he was never aligned with any political faction, ("I wouldn't take a stand on either side, because I was just there for the children,") the people of the community began more and more to us him as a consultant and to come to him for help with problems.

In the less than two years that this position has existed, the results

are remarkable. Mr Gwynn has established a community center of communication within the hospital itself. People from the surrounding area come to his office to hold discussions, to consult individually, and to form groups concerned with a particular project. In the community, he has met with church boards to help them fund programs in their own churches, and he sits on the Citizens Council for Recreation for the City of Baltimore.

Currently the training is a group of local high school seniors as Family Life Assistants. Funded by the Office of Economic Opportunity, and with the help of a speech therapist and a graduate in home economics, he gives his students one hour a day of course work, meeting in the hospital, and additional paid job training either in ward playrooms or in the community. This program, which was initiated by Miss Barbara Haas, then Director of the Child Life Department, with Mr Gwynn, began with a group of seniors who were potential school drop-outs, and for the first few months showed minimal response. However, during following summer, when the program had been operation for about six months, the Family Life Assistants, under supervision, brought recreation and activities to more than 1500 children in the area who otherwise would have had no summer programs. Camps, recreation in local neighborhoods, and an effort which registered many children in the clinic for the first time, were part of a highly successful initiative for bringing better care directly to the neighborhoods,

and at the same time for training the Family Life Assistants to deal with community problems.

This direct involvement on a local level is the key to Mr Gwynn's policy: the use of resources near at hand, and the education of families to help solve the problems of their own neighborhoods. Outsiders, even skilled ones, can sometimes make social and psychological blunders which impede progress. simply because they may be unaware of indigenous culture or attitudes; Mr Gwynn also stresses the fact that often many resources already exist within a community which need only some professional help, or some access to information to make them effective. He has given impetus to two leisure-time programs in local churches which are carried out in the evenings, oriented to entire families, with recreation, remedial education and health services which can lead back to the services of the clinic. The churches also have day-care programs which, by involving parents and children together, can bring to light problems which might otherwise pass unnoticed.

"We have a Parents' Advisory Council now," says Mr Gwynn, "which meets on Saturdays. One of the members' new ideas is to volunteer in our clinic on one or two days a week. They could help with the child care program and be learning something about child development and good health care at the same time. I meet with the Council to help with a successful newsletter which goes out to the families of clinic patients. It reaches about nine

thousand families."

A typical example of the way in which a community potential can be developed was a nearby program which was already funded to include about seventy children from four to twelve years old. Although it could draw on donations of supplies and of milk and cookies from several sources, it was in danger of becoming ineffective through misunderstandings among staff members. By listening to the problems, and taking time to befriend the program, with new enthusiasm, involves both parents and children in educational and arts and crafts projects, with a health and medical service, and a library.

Mr Gwynn also acts as liason by participating in the work of Fellowship House, a multi-purpose interracial center which has been active since the 1940's and draws its membership from every part of Baltimore. Here he finds valuable contacts between groups and an opportunity to coordinate efforts which otherwise might be fragmented.

A very important part of the position of Family Life Coordinator, he is convinced is communication with staff and personnel within the hospital itself. Because the medical institution is large and complex, and because its personnel includes many people from various backgrounds, as well as students from abroad, he finds there are areas of unawareness about the lives of local patients, their home situations, and even the conditions of the streets, housing and sanitation to which they may be returned after dismissal from the wards.

"I'm constantly meeting with people, talking, discussing -- sometimes

with reports or proposals, sometimes with sometimes with some films we have made in the community, following the community children as they move around, showing what they do and the kind of environment they live in. This office is always open for use as a resource, and for information. I find the hospital staff tends to use it more and more. I'm trying to bridge a gap between people and between groups."

Mr Gwynn is now working with a Child Care Improvement Committee, in conjunction with the office of the Mayor, on a city-wide basis; he will soon be scheduled for speaking in other parts of the state.

In a ghetto area like the one which surrounds the magnificent new buildings of the hospital and the traditional red brick of the original building, visual contrasts are very noticeable; and the underlying lack of communication, the strong emotional reactions which lie close beneath the surface, are still in evidence. Many cannot be solved easily or in a short time. While they still wait for solution, the crowds continue to pour into Johns Hopkins from every state and country, filling the halls with the surf-sound of thousands of moving feet, waiting for elevators filled to capacity, directed by tireless hostesses at information desks; the medical staff, nurses, aides, therapists, students and Child Life workers continue to try to meet difficult schedules and heavy case loads. Almost everyone in a professional capacity in the hospital will speak the need for more space, more time, more profess-

ionals. Lou Gwynn, driving through the surrounding run-down streets will point at an empty building, "We could use that for a program if we could get the funding."

The remarkable and heartening fact is that despite all this, and without sacrificing its research and training programs or its standard of superior care, the pediatrics department has made a transition from the traditional concept of the hospital as dispenser-of-care and unassailable authority, to partner-in-care and participating member of its own community.

Other large hospitals in many cities are beginning to reorganize their outpatient clinics to meet community needs similar to those which surround Johns Hopkins. Indicative of the kind of new thinking emerging in urban areas is a federally funded program in Philadelphia, which involves five medical schools in a coordinated attempt to bring better health care to communities within the city. Under a coordinating executive board which includes public health and school representative medical schools, each with its own chairman of grant deed, have set up five clinics in Philadelphia to carry out community care in target areas, and to pool their research and evaluations. Basically a community service project, each also collects data on its own effectiveness and on community needs and on operational costs.

The clinic carrying out this program at the Children's Hospital of Phil-

Philadelphia, Operation Rebound, is typical of the way in which the service is structured to serve an individual area. Operation Rebound is centered on a single target area of about 530 families within walking distance of the hospital. It is housed in a small building adjacent to the hospital proper, but makes use of hospital services.

The criteria for eligibility for the clinic service are geographical location and patient age: all patients come from the target area and the age limitation is from one day old to fourteen years. Children's Hospital of Philadelphia provides staff for the clinic, and the Chief of Pediatrics of the hospital, also on the faculty of the University of Pennsylvania Medical School, provides leadership for the clinic as well as a close link with the hospital.

The structure of the clinic is like that of a private practice group. Teams which include the doctor, nurse, dentist and social worker have an ongoing continuous relationship with each family, which sees the same personnel at each visit, and thus is able to build familiarity and trust in the same way in which a family at a higher income level relates to a family doctor. After clinic hours, the hospital telephone operator will take clinic emergency calls and attempt to get in touch with the physician who has been especially assigned to the family.

Records of the families using the Operation Rebound facility indicate that eighty percent of the families very much prefer this system to the more usual clinic arrangement in which families see an available staff doctor--often a different one at each visit.

One effect of the team approach in the clinic has been the peer relationship which has developed within the professional staff. Team conferences have led to a more autonomous role for nurses, and more equality of status with the medical staff, since nursing evaluations and relationships with families can contribute importantly to team knowledge.

"We find that people often think in terms of stereotypes of doctor, dentist, and nurse," says Dr Wilson, director of the Clinic. In a group like this, where all contributions are of equal importance, and where good communication and teamwork are a necessity, we are getting rid of stereotypes. With the facilities of the hospital available, and staffed as we are, we can do anything that for a family a private practice group of doctors can do."

As an part of the community, Operation Rebound is working with the schools, in conjunction with school nurses, and it recruits some of its social workers directly from the target area, for a closer liason with the families of the neighborhood. The clinic has been operation for less than four years, and is

still in the process of evaluating its own services and collecting research data.

A similar clinic restructuring is under way in New York, where the New York Hospital-Cornell Medical Center is setting up four clinic teams to care for patients in the same way as Operation Rebound, with particular families seeing "their own" doctors on a continuing basis. The four team divisions have been given the names of flowers (Azalea, Begonia, Carnation, Daisy) in order to make them easier for families to remember and identify, particularly those families who speak imperfect English or are only partially literate. In the short time that the new team plan has been in operation, there has been evidence that, although the problem of broken appointments common to all clinics has not been appreciably bettered, there are more telephone calls to notify the clinic that a patient will not keep an appointment.

The staff is encouraged, by this indication of patient obligation to the clinic, to believe that the attitude of families toward a team with whom they can become familiar will encourage the keeping of appointments and better health care.

An interesting sidelight on this clinic is that the restructuring into teams was preceded by a series of meeting of the nursing staff, at which individuals were encouraged to discuss problems which they had experienced in dealing with

patients, and work situations which they considered unsatisfactory. From a discussion of problems and dissatisfactions, the dialogue moved to solutions and new approaches, encouraging participation and wide range of ideas, many of which were found to be workable and valuable. As a consequence, the staff was enthusiastic and cooperative about the changes, and the transition was made with a minimum of difficulty. Emphasis on the role of the clinic nurse as team member, and partner of the medical staff, as contrasted to a more conventional way of viewing the nurse as a mechanism for seeing that the doctor's orders are followed, appears to be a trend which accompanies the humanization of policies toward patients and families. In clinics, as well as with inpatients, concern with the child and his family as individuals leads to a view of nurses and other hospital personnel as individuals as well.

Operation Rebound and the clinic at New York-Cornell are indicative of a growing awareness that the patients's family and background are key factors in on-going health care. Satellite clinics in other cities are reorganizing staff into similar cooperative teams to give families a continuing relationship with a single group of medical workers whom they can communicate more readily.

At Cleveland Metropolitan General Hospital, the outpatient clinic playroom is used to generate this kind of trust and communication; it is worth attention because within the structure of a conventional clinic, has a multiple

function that reaches beyond the primary one of keeping children amused and occupied while waiting for appointments.

The pediatric outpatient clinic handles as many as 150 patients a day, and has eleven examining and treatment rooms. The playroom is supervised by Mrs Wilma Rice, under the direction of Mrs Emma Plank, the Director of the Child Life and Activities Department, and Mrs Rice is assisted during the mornings by two high school seniors on a work-study program, and by college students during some hours as well.

The playroom is a large open area, separated from the parents' waiting area only by a low wall of book and toy shelves. It is adjacent to some of the examining rooms, which are separated from it only by curtains, and brightened by mobiles in gay colors and wall decorations supplied by the playroom staff. Children frequently look at these rooms and play near them, familiarizing themselves in an informal way with the medical setting; even the occasional loud crying of a child behind drawn curtains does not seem to cause undue anxiety.

The parents' waiting area is supplied with pamphlets on child care and development, and there are nutrition charts on the wall. It is so close to the play area that the children come and go informally, sometimes bringing their mothers into the play area. Mrs. Rice sees the whole pediatrics clinic

as her area of concern; she uses the playroom to observe children's reactions, and may make entries in the charts or, on occasions consult with the pediatricians and nurses. She is sensitive to clues from the mothers as to the home situation, and can often reassure them and help them with understanding the day -to- day needs of children; she can consult social workers and make recommendations to them on the basis of her friendship with the family.

There are opportunities here for parents to see a child display skills and qualities of which they might not have been aware, and Mrs. Rice tries to assure an atmosphere of freedom of expression for the child, considering this a learning situation for the parent as well. She may call the attention of the parent to a skill or an independence on the part of a child which the parent will then begin to encourage at home. She also sometimes gives away age-appropriate materials for the parents to take home, to help the child develop and at the same time to help the parent become aware of some of the growth stages of young children.

She makes a particular effort to plan ahead for days when parents with neurological-defect children will be coming in, and tries to have appropriate materials ready for them. This is often quite an eye-opening situation for such parents, who may not have been aware of the ways in which they could help their children, or of the children's capabilities. The clinic playroom serves as a demonstration of some of the ways that therapeutic procedures can be brought into the home.

The Philosophy of the Child Life Department, and its concern for families is shared by Dr. Hansbarger, Chief of Outpatient Pediatrics, who is also a consultant in Maternal and Infant Care, and a staff member, of two of the city's satellite clinics. In his triple role inside and outside the hospital, he sees a greater need for relating hospital patients through their own communities.

"We have enough inpatient bed," Dr. Hansbarger says, "but our patients often live quite close to the hospital here on the west side, so they could be treated at home. I would like to see more short term care done in the home. It is unrealistic to think in terms of complete care-by parent in this hospital. The parents often have many problems at home: many of the mothers, for instance, are living apart from their husbands, or have never had a husband. If they have no one at home with whom they can share the responsibility, it is doubly hard for them to take on the extended job of supporting the child in the hospital, at the same time carrying out their role at home."

Like Mrs. Plank, Dr. Hansbarger thinks that the problem of total child and family care cannot be solved by adding volunteer services. Rather, he would like to see trained professional teams which can bring medical care to homes in the area where hardship would be involved in bringing the patient to the hospital, he himself now makes house calls at least once a week, sometimes tracing a non-English speaking family or one which has no telephone, sometimes visiting a newly-arrived migrant family, unused to city services. "If you deal with one family, at a time, you can learn from the one. Sometimes this is the key to a policy which will make things better for many."

There is not much distrust on the part of established families in the area,

since they were often patients here as children themselves. "They rely on us," he says, "which is not the same thing as liking us. Of course there are complaints--families had to wait too long, something wasn't right--but, over all, they tend to use us as the family doctor. We try to deal with any complaints on an individual basis. You see, they feel that we're doing our job, so they count on us, and they usually come back when anything goes wrong."

The head nurse in the Outpatient Clinic adds, We do get pregnant girls as young as fourteen. In that case, I try to get the mother--often it's the grandmother--and talk things over with her before we make any arrangements with OB. If the family will share this with the girl, and help her with it, and we can keep her in Pediatrics until we go with her to OB., it's much easier for her. Many of these girls are afraid to tell their families, so we try to help them with that."

The Hunterdon Medical Center, Johns Hopkins, Operation Rebound and its counterpart clinics in Philadelphia, and Cleveland Metropolitan General Hospital in different ways and under various pressures and limitations, are all attempting to find new and better solutions for some of the urgent problems posed by increasing case loads and the need for better preventive health care. These problems, although they can be most dramatically seen in the crowded ghettos of large cities, are no less present in rural districts. At the University of Kentucky Medical Center, for instance, a travelling clinic which makes use of a station wagon in lieu of an equipped unit, takes medical

care will be assembled at regular stops on the route, and to follow up the clinic visits with supervision in the homes.

Distrust of strangers and suspicion of what appears to be unwarranted interference, as well as fears of strange medical equipment and procedures, are found in these rural communities as well as in ghettos, and give way only gradually to mutual understanding and cooperation.

The tendency of private physicians to move away from crowded ghetto areas and into suburbs, and the growth of large medical centers in cities, have led to a situation in which low-income families use clinics and emergency rooms more and more as a substitute for the family physician. The resultant centralization and overcrowding of hospital facilities, and the gaps that exist in health care in ghettos phenomena; the present great need for more health professionals and for bringing preventive care to the community are topics under discussion in many circles.

Less obvious as a recognized problem, but an important factor in preventing recidivism, and in educating families, is the perception the community has of the experience of hospitalization. Some hospitals with a very high standard of medical care, and with increasingly attractive housing and services for patients, demonstrate an unspoken distrust for patients and their families which parallels the suspicion shown by indigent, illiterate or no-English-speaking patients for the hospital. The barriers to understanding are obvious when demonstrated by families broken clinic appointments; parents who disappear and

and are difficult to trace when a child has been hospitalized; children who make repeated return visits to the hospital because of improper follow-up care at home; active hostility to the staff or interference with the nursing procedures by parents on the wards, accusations, even outbursts of temper.

Distrust and lack of understanding are less obvious when demonstrated by the hospital: short visiting hours with restrictions; many prohibitive signs on the walls, warning of silence, no-entry areas, and curtailment of activities; purposeful avoidance of conversations with parents, avoiding greeting them, answering briefly and uninformatively if at all; most subtle of all, but with an unmistakable message for families, a policy of allowing parents to sit by their children only "if they insist", and to stay overnight "if they ask, if they get written instructions from the doctor, if they're determined to stay." The message conveyed by this last attitude is that a parent is a nuisance and a hindrance to good care, if not actually a hazard, but that the hospital, against the better judgment of the staff, will have to put up with it.

With such resistance fear, and confusion on the part of many patients and families, and with insistence on rules professionalism often overriding any sympathetic understanding of human feelings on the part of hospital staff, it is small wonder that changing social pressures and increased costs have exacerbated difficulties for hospitals and for the patients who use them.

The hospitals just discussed are unusual in their realistic appraisal of the needs of those they serve, and in their efforts to meet those needs by taking patients, their families and their neighbors into active partnership. In perceiving their patients as in need of their understanding as well as their technical skills, they are reaching out to discover who patients and their families are -- where they come from, what social and psychological problems contribute to their need for health care, and how the hospital can expand its role into that of good neighbor, and on from this first step into a realistic force for social change.

These developing trends toward the community outside are not always easy to carry out, and often seem unrewarding and slow to show positive results; in common with most social and cultural change, they depend on degree of readiness, education for change, and the tireless efforts of dedicated professionals.

These hospitals have made a beginning, using the facilities at hand. They are not the only institutions which are aware that social problems and medical problems are closely linked, and they are not alone in making new moves toward implementing this awareness. But they are innovators, and may well be valuable models.

appropriate volunteers perform valuable functions. For instance, at Children's Memorial in Chicago volunteers use puppet plays to prepare children for specific procedures, such as heart catheterization. Some suggested ways in which volunteers can serve without adding to the families confusion are: serving as hostess in the waiting room. While children are in surgery a cup of coffee and a sympathetic ear for relatives is a comfort for the family and saves staff from frequent interruptions to answer parents' questions; ~~In some hospitals volunteers~~ ^{ing} assist by caring for well brothers and sisters so parents may stay with the patient; ~~Volunteers serves live-~~ ~~in units by escorting pre-admission and orientation tours;~~ ~~In a Houston hospital, where parents are required to live-in with children under five, volunteers babysit~~ ^{ing} ^{living-in} so mothers can have a little time off. Some programs have mother banks, volunteers ready to spend long, continuous hours with children starved for mothering as a result of deprivation.¹⁶ ~~At Children's Medical Center in Houston, where mothers are required to stay with the young child throughout his hospital stay, volunteers baby-sit from time to time to give mothers a break.~~



Range of Fees for Parent Services

Johns Hopkins with its eighty available beds for parents, has a special living-in coordinator to facilitate policy. Parents who stay are provided room, bath, lounge privileges and meals. A charge of five dollars per day is made but is cancelled because a five

dollar fee reduction occurs because of the parent's presence.

Financing at Johns Hopkins for the parent program comes one quarter from the Women's Board, one quarter from hospital administration, one quarter from granting agencies, (Children's Bureau and N.I.H.) and one quarter is raised (as of 1968). The living-in coordinator is a psychiatric nurse.

Parents at Boston Floating's F.P.U. have their child's fee reduced by \$3.00 per day in return for their assistance. Staff is inter-disciplinary, but the social group worker on the unit serves as chief ombudsman.

While many agree that running a pediatric hospital along mental health lines is more expensive, Dr. Vernon James disagrees that this must always be the case. The Care-By-Parent unit under his direction at the University of Kentucky Medical Center was established to counteract both the emotional and economic disadvantages of admitting the child to the hospital.

More text

The unit is located on the pediatric floor, adjacent to the out-patient clinic. Clinic facilities such as the treatment room are available to the Care-By-Parent Unit. The clinic nurse has chart rounds with the Care-By-Parent staff each morning before clinic hours and she is on call during clinic hours if she is needed. She assists the physicians in procedures and plays a vital role in teaching parents. Although all are in-patients, the unit is administratively part of the outpatient clinic. In-patients are covered

by insurance or other payment plans.

Fewer hospital personnel staff the unit. No nurses are assigned; the parent provides complete care. A child care supervisor functions as unit manager and is responsible for administering the unit. She is the liaison person between the patient, the parent and the hospital. She trains the child care assistants and works closely with the medical director who is also director of the pediatric clinic and a member of the pediatric faculty.

Three Child Care Assistants (C.C.A.S.), former nursing aides with training and experience in many areas of the hospital such as premature nursery, the pediatric ward, the out-patient department and the physical therapy department, have been given additional on-the-job training by the child care supervisor and the clinic nurse. The assistants have the responsibility for instructing parents regarding the care of sick children and seeing that people get to appointments, are ready for doctors' visits, have what they need to make them comfortable and have what they need for learning.

Dr. James emphasizes that parents have complete responsibility for their children's care. He finds that parents can do such things as collect a 24 hour urine, not just as well, but frequently with adaptations that are an improvement on what can be managed by a series of nurses on three different shifts.

The cost of direct personnel services is significant when one observes that 60% of the hospital is reflected in personnel charges.

A comparison made by Dr. James during a typical 4 month period in

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1966 showed the personnel cost on the acute, general pediatric ward to be \$10.31 per patient per day while the cost in the Care-By-Patient Unit was \$3.81. The hospital administration is satisfied that the Care-By-Patient Unit costs 40% less than the acute general pediatric ward. Patient charges of \$17.50 (report, April 1969) include meals for the mother and child and the room fee, coming to \$10.00 less than charges in the acute general pediatric ward.

At Children's Hospital of Philadelphia there is no charge for cots, Barcaloungers, or bed chairs, but overnight stays are for short hospitalization such as tonsillectomies, except in special cases. The parent counselor is also a nurse but performs her parent child teaching role full time.

At the University of Colorado, supervision and staff services to parents come from all staff with no one especially assigned for this role exclusively. Wall beds are available at no charge. In addition, a comfortable parents' lounge with additional wall beds, telephone for parents and children and bath facilities are available. A small pantry with refrigerator and appliances for heating canned soups, chili and popping corn is right on the unit for parents to help themselves or fix snacks for their children, diets permitting. There is no charge for beds and food money is available for parents.

Yale New Haven has showers and dressing rooms for parents at no fee, but charges \$2.00 per night if a cot must be set up.

To summarize (See Table 7), in the programs welcoming and providing for parents, costs vary from those who see the parent as

an assistant so reduce the bill to those who see parent as patient and include parent accommodations as part of the service to the child or charge a little extra. The more comfortable the facilities, the less the cost.

A question worth exploring today might be: Does an atmosphere that invites and supports parents keep census up? Can week ends be better utilized through parent involvement units? Are families and pediatricians avoiding hospitalization because of the attendant psychological threat? If so, might a better service be performed and more stable census maintained by providing parent involvement in hospital care?

DESCRIPTIONS OF HOSPITALS

A history of family involvement; high public expectations.
--Hunterdon Medical Center.

Hunterdon Medical Center in New Jersey, with its sixteen year history of serving the entire family, is deeply rooted in the community. Family involvement permeates the entire hospital: Fathers go with mothers into the delivery room; (they are instructed in how to faint inobtrusively so as not to interrupt proceedings); rooming-in is policy for the maternity patient unless a mother specifically requests otherwise. Parents take their meals up to the playroom so that they can eat with their children.

The hospital is, as it were, an extension of the family and community. Families feel that they, as owners of the hospital are

TO: Carol & Evie

FROM: Stan

Attached is the rough draft of our article. Please accept my inept typing...since I had to do some editing while I typed, I thought it best to do myself (oy, my aching back!).

Where I especially see the need for your input, I refer, in parentheses to C&E, an acronym for the two of you. Where reference numbers will be placed in the future, I just set an empty pair of parens.

I see this as still fairly rough...but I need fresh eyes to work it out. Are there some people you'd like to run it by? after you've had a chance to work it over, let's brainstorm again and do a final polishing job.

Take care,

THE EMOTIONAL CARE OF HOSPITALIZED CHILDREN
A Review of Pertinent Literature
(Survey)

Stanley E. Fischman, M.D.
Carol Hardgrove, M.A.
Evelyn K. Oremland, M.S.W.

INTRODUCTION

The psychological care of children hospitalized with physical illness has improved significantly over the past twenty-five years. Gone are the days, for instance, when parents were excluded almost totally from the care and nurturance of their hospitalized child, and hospital environments are being designed and redesigned (Glazer and Minneapolis) to enhance the psychological well-being of children. In addition, so-called "Child-Life" programs have been developed in many hospitals to help children and their families to cope with the practical issues that confront ill children and the fantasies and distortions engendered by the complex interactions of the child's levels of development, the ~~xxxx~~ stresses involved and the youngster's idiosyncratic responses.

While structural, organizational and programmatic changes have occurred in many pediatric settings, research and observation indicate that much more needs to be accomplished in the psychological care of ill children to minimize inadvertent but deleterious effects on their development (Reference*?). For example, the work of Douglass has demonstrated significant pernicious behavioral outcomes to hospitalization. In more concrete areas there are many works demonstrating that cooperation with medical treatment regimens is related to the family's understanding of medical information and the comfort of their relationship with the care givers (Wolff & Visintainer, Korsch); clearly, then, active attention to the emotional needs of sick children and their families can reap essential physical benefits.

Increasing public and professional awareness of these needs as well as the economic pressures involved in medical care require balanced and research-based planning by the pediatric community if effective programs are to be employed and monitored by professionals sensitive to the mental health aspects of pediatric care. Unfortunately, much of the critical child development and behavioral research necessary for such planning is scattered throughout literature not widely accessible to members of the pediatric community.

This review will summarize the literature which we believe pertinent to the role and function of programs aimed at improving the psychological health of hospitalized children ^{thru} ~~while~~ minimizing the potential risk of physical and behavioral problems secondary to ~~xxxxxxxxxxxx~~ a hospital experience which may seriously threaten the emotional stability of the child.

THE DEVELOPMENTAL APPROACH

A potentially useful frame of reference for examining children's needs and problems through hospitalization and recovery involves concepts of child development that stress ~~and~~ orderly, progressive and task-oriented processes. Unfortunately, as stressed by Oremland (), "Much valuable knowledge is already available regarding the psychological aspects of children's illness...however, much of what is understood is not translated into treatment given."

Julius Richmand () points out that ~~xxx~~ important issues of child development are not sufficiently utilized in treatment, largely related to his observations that Child Development as a basic science is usually not included in the training of physicians and many mental health professionals. Richmond urges that ~~the~~ teaching of Child Development become ~~xxxx~~ broader in scope allowing

trainees to observe normal infants and children to learn perspectives on the critical periods of nervous system growth; periods during which the child may be exceptionally vulnerable to adverse physical or psychosocial circumstances. The resulting approach should then focus on preventive ~~xx~~ and therapeutic interventions for the child and family (Refer to Klaus, Kennel and Fraiberg**). Stocking () emphasizes the importance of such attention, having found that although as many as 70% of the children in his study of routine pediatric admissions were hospitalized for clear-cut medical reasons, the hospitalization was unnecessary and disadvantageous for the remaining 30%. Significantly, in the group for whom hospitalization was judged necessary, the incidence of emotional disturbance was surprisingly high. This study suggests ~~x~~ that ~~xx~~ pediatric units are serving as a mental health resource but performing well below ~~xx~~ their potential because ~~xx~~ they lack well-planned programs to meet patient needs.

As is customary in a developmental study, we will first direct our attention to pertinent areas of research dealing with infancy.

INFANCY

Edelston (Sula Wolff*) emphasizes the necessity of identifying vulnerable children very early. As did Douglass (op cit), she found that many disturbed children seen in ~~x~~ child guidance clinics had prior histories of prolonged hospital stays during their early developmental years.

The recognition of children's needs for parental support and for opportunities to express themselves actively in their realm of ~~w~~xperiences is based on well-known and exceedingly well-documented ~~xx~~ work by psychological researchers ~~xxxxxx~~ developed over the last thirty years. Renée Spitz defined

hospitalism when he enumerated the responses of infants to institutional care and emphasized the disintegrating effects of the babies who were institution-
alized. This work is highly pertinent in terms of what we now know about
the special needs of infants, especially since nearly 600,000 children
under the age of one year (C&E...does this include normal new borns?*)
experience hospitalization in this country annually (*Source).

Separation was studied and documented by Anna Freud and Dorothy Burlingham ()
and Christophe Heinicke and Ilse Westheimer (), each elucidating the regressive
aspect of children's development when they suffered parental separation at
early stages of development. Mary Ainsworth (), Kennel & Klaus(), and
Huntington () emphasized the significance of these early periods by
enhancing our understanding of attachment, separation, bonding and the complex
interactions of infancy. ~~XX~~
~~XXXXXXXXXXXX~~

Bowlby and Robertson enlarged and extrapolated from ~~XXXXXX~~ these findings
in terms of pediatric hospitalizations, culminating in Bowlby's Attachment
and Loss, Robertson's Young Children in Hospitals, and their joint work
represented by A two Year Old Goes to the Hospital.

"Absence of mothering means emotional starvation...leading to a progressive
deterioration engulfing the child's whole person...manifested first in the arrest
of the child's psychological development...paralleled by somatic changes." ().
Spitz' words, while accepted as a truism today, was considered revolutionary
but thirty years ago and are often not heeded in some of our most prestigious
hospitals and teaching centers even today.

Klaus and Kennel stress the importance of the parent's bonding to the child
with ~~XXXXXXXXXX~~ research suggesting that without adequate bonding the infant
is at risk for ~~XXXXXXXXXX~~ "failure to thrive" and/or child abuse.

DRAFT

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DRAFT

Eight separate studies () offer evidence of an early sensitive period for bonding with the human mother and father. For example, fathers who are given their new babies to play with soon after birth spend much more time with them during the first three months of the infant's life than if they do not have this opportunity (). ^{De Chateau} Mothers experiencing handling their newborns in this early period spend more time with their baby during the first month, soothing ~~the~~ the youngster (More effectively???) during stressful situations (). One study of premature infants () has shown a significant difference at four months of age between the developmental quotient of babies who were given to their mothers in the first day of life and those of babies who were given to their mothers on the twentieth day (C&E...for this ref you have written 14, Stolz & Lind).

XX

Barnett, et al, found similar results and also noted greater parental commitments to the infant, ~~more~~ more self-confidence in the ability of the mother to care for the infant, and generally more effective care-taking amongst mothers who had contact with their premature infants throughout the hospital stay. Risk of infection and disruption of the nursing care of the infant ~~were~~ were not increased, contrary to staff expectations prior to the study. Of importance in this regard is the interesting study by Brain () who reported ~~significantly~~ lower incidence of emotional problems and infections when a mother was admitted to the hospital with her infant.

De Chateau

EARLY CHILDHOOD

The presence of the parents and their involvement in the care of ~~the~~ children seems extremely important in mitigating the stresses of hospitalization on the very young as well as fastening normal developmental tasks that would take place outside the hospital. More and more hospitals are providing opportunities and encouragement for parents to stay either at the bedside or close to the hospitalized youngster whenever possible. ~~XXXXXXXXXXXX~~ Unfortunately, ~~these facilities~~ the facilities provided are often not planned for when a pediatric wing is designed and are makeshift and often uncomfortable. (~~XX~~ C&E...do we have a ref for this latter contention?).

One of the concerns frequently cited by nursing and medical staffs is that the parents' presence often makes management of the children more difficult and that there is an increase of negative ~~behaviors~~ behaviors such as crying. It is most important to understand the function of crying (and, perhaps, other annoying behaviors) in helping children cope with very strange and threatening surroundings. Robertson () states that crying does not necessarily decrease when the frequency of parental visits increase because such visits provide the child opportunities for release of feelings of grief and pent-up misery. The child may cry more loudly during treatments or procedures but ^erecovers faster. In addition, there is considerable clinical experience which suggests that the parental presence assists the child to see treatment as help rather than punishment or torture by strangers. In this regard, when parents are intimately involved in the care of their children, they should be helped to not adopt detached and clinical methods that they might learn from observing nursing care.

Angoff + Inge

Shaffer and Callender^() found significant regressive and dissociative behavior, in response to a brief hospitalization, in 67 out of 76 children under one year of age. Of the nine children who did not show these untoward responses, four were younger than two months and one was only four days old. It should be noted that little parental contact was allowed in the setting that this study was done. (C&E... Please check for accuracy of this statement...also, don't you think that a description of which signs of regression the authors found should be included here???...also, as I type this I wonder if it shouldn't have come earlier, say before the discussion on crying).

Prugh's classic study () showed that regardless of the excellence of ~~and~~ medical and nursing care and the sensitivity of the handling of the children, patients under four years of age remained manifestly disturbed while in the hospital and had more behavioral disorders after discharge than did older children. None of the changes in practice at the hospital designed to counteract anxiety in children ~~xxxx~~ were effective with the ~~xxxxx~~ youngster under four years of age admitted without a parent. Children who had~~ed~~ been exposed to traumatic experiences prior to hospitalization and children whose relationship with parents were poor are (were?) more vulnerable and are ~~xxxxxx~~ (were?) more likely to exhibit behavior disorders. (C&E...I'm somewhat confused here, especially in tenses...is this referring to Prugh's work or to other work?)

Parents and staff can be very helpful to the child who is under four or five since he is likely also to misunderstand and misinterpret ~~what~~ what is happening to him, viewing illness and treatment as attack or punishment for some wrongdoing, fearing the unknown, and regarding separation from the family as abandonment (). In this regard, preparation needs are essential for the

successful outcome of hospitalization. Vaughan() reported that although children prepared for ~~xxxx~~ their eye surgery were more anxious on the wards, six months later only 15% of these children had emotional sequelae compared to 55% of the control group (which was not prepared). (100%?) All of the children under four who were not prepared had emotional sequelae~~x~~! It is also significant that the prepared children generally recovered physically from their surgery even though their behavior on the ward "looked" more disturbed.

Preparation is often more easily said than done: Learner,~~(x)~~ et al, () demonstrated that parents frequently misunderstand medical directions even when the doctor believes that he has been understood. Another source (C&E... you have just the number 37 here) points out that the hospital may contribute to the impedance of important communication by not allowing for doctors to routinely be available at times when fathers can be present. This, of course, is a very complex ~~xxx~~ problem and has many societal implications.

Murphy's () studies of the coping process underline the value and ~~xxxxxxxxxx~~ necessity of including opportunities for play. Erikson () described the self-curative function of play, and others have described the repetitive play activities of children as mastery and ^{the} working through of psychological pain. In fact, there is an aspect of children's play, seldom recognized in pediatric settings but well documented by serious research to be selectively ~~highly~~ discussed below, that may enable children to express many deep and serious concerns, such as fear of loss of body parts. These deep fears may be present whether or not there is a ~~xxxxxxx~~ basis in reality, and may be easily ~~xx~~ overlooked by parents and staff.

Erickson noted that children with hospital experience play with medical equipment and medically -oriented toys in a manner different from the way children without such experience play with these same objects, indicating

()
 specific concerns of the hospitalized child. Recognizing the necessity for children's experience through play in the hospital, Emma Plank, the pioneer in this effort in the United States, devised ingenious methods and programs to enable children to best utilize their hospitalization and illness experiences (C&E... any refs.?). Escalona () elaborates that through play children turn the passive into the active in their efforts to master anxiety and fears.

Children of the nursery and kindergarten ages have grown aware and sensitive to body parts, often exploring through play the workings of their bodies. Characteristically rich in fantasy and limited in testing reality, ~~medical~~ relatively benign ~~medical~~ they can readily transform/medical events into excessive anxiety, especially when the medical events bear similarity to their fantasy and distortion (). (C&E...How about an example here?)

*Therese Bergman
 Petrillo; dip in your veins - Plank*

LATENCY

By the ages of seven or eight, phobic tendencies give way to more obsessional organization associated with the strengthening of the senses of guilt and responsibility. Children at this age may especially view illness as a consequence of wrongdoing, ~~imagined~~ real or imagined. This concern may be reinforced when adults view the child's anxious behavior as "weak" or ~~bad~~ "bad". ~~These~~ These concerns may also be compounded by the reality of the illness, e.g., burns and accidents.

Illness in latency age children affects ego functions, body image, and family relations. It produces heightened concerns about physiologic ~~functions~~ functions, thus forcing the child to cope prematurely with concepts of illness and death. The newly developed sense of mastery through physical activity is curtailed, and the youngster may fear falling behind his peers in various areas of competency. ~~Boys~~ Boys seem to be particularly concerned about

threats to body intactness (Reference?). In addition, the child's image of the parents as benevolent guardian is challenged by the reality of ~~xxxx~~ their helplessness (C&E... the #32) Regression often ~~occurs~~ as a response to these anxiety.

As mentioned earlier, the fear of falling behind one's peers in this age group is quite compelling and anxiety producing (Erikson ref). ~~I~~ Active attention to the youngster's school work, even during relatively short hospitalizations or during convalescence at home, can be of considerable reassurance. (C&E... do you have a reference to support this contention?)

ADOLESCENCE

Older children and adolescents require links to their peers and educational activities, for this sense of continuity adds to their ongoing growth and development ~~xxxx~~ ing competency, too. The stress of illness and regression heightens the anxieties over conflicts of dependence and independence, a central task for adolescents. Hospitalization is particularly difficult for teens who fear their illness will mar their appearance, compromise body functions, and threaten relations with the opposite sex. The hospital adolescent unit must offer measures to enable educational pursuits and provide space for privacy and sanctuary ~~x~~ removed from hospital authority (C&E... I think we may need more references or authority for this passage).

(kidney?)

Studies of transplant patients indicate that factors for success ~~xxx~~ of the transplant in this age group ~~xxx~~ involve the personality of the sick child, the stage in growth and development in which the illness is experienced (C&E...this last phrase could use clarification), and the family support systems. The significance of the stage of growth and development is demonstrated by the experience with adolescent girls undergoing renal ~~xxxxxx~~

transplantation, which has significant cosmetic, as well as life-threatening, implications. Korsch () found that of twenty-six adolescent girls who underwent transplantation, almost all of those with significantly impaired personalities (C&E...this needs to be spelled out) failed to take the prescribed immuno-suppressant medication necessary for transplant survival. She found that ~~there is good communication (or, good communication if patterns...) within the family, and~~ ~~is there is at least one strongly supportive adult or older sibling, there is excellent prediction for~~ (Carol...This next part is confusing...I'm not sure how it relates...I'll type it just as written):

Of 196 burn patients followed after discharge, 80% had emotional disturbances compared ~~with~~ to 7% of their unburned siblings. The symptoms included specific fears and anxieties, difficulties of behavior management, negativism, eating and sleeping disorders, and enuresis. Following the introduction of a daily therapy program with the mothers by a psychiatric social worker in the hospital, only 20% manifested emotional disturbances ~~at~~ one year after discharge. (12).

(C&E... I think we could use more info relating to the needs of adolescents)

CONCLUSION

THE NEEDS OF THE PROFESSIONALS

Few would argue ~~with~~ with the necessity of providing a psychologically ~~an~~ therapeutic hospital environment for the treatment of patients of any age. However, since efforts towards developing such environments are often insufficient and seldom supported beyond "lip service," it is necessary to emphasize that such efforts do make a difference in the developmental progressions of young children and have a major preventive impact on health, both of a physical and ~~and~~ psychological nature () (C&E this was the

quote from Kliman, :Psychological emergencies of childhood).

When considering why "lip service" is often the best that is offered with regard to the emotional aspects of the care of hospitalized children, it must be recognized that certain responses of children to illness and hospitalization, even though they are normal mental mechanisms ~~are~~ in ~~the~~ coping with crisis, create additional stresses in the working environments of pediatric staffs, atmospheres already fraught with tension. It is wearying and difficult to work amidst regression, irritability, crying and protesting. Understanding that children (and adults) may need to regress with the impact of a crisis helps in the acceptance of such behavior, although encouragement and support of progressions are important when the individual child is ready. It is prolonged regression, as well as a given child's stolid tenacity in resisting regression that may be pathological or potentially disabling (Ref. by A. Freud in Solnit and Provence).

~~xxxxxxx~~

Irritability may, in fact, be a sign of beginning recovery (Ref. by Solnit and Priel) and the protesting of children occurs most often when they have their familiar and beloved caretakers to whom they can appeal, and without whom psychologically serious signs might be evident. Opposite behaviors, such as docility and extreme compliance, could, in fact, indicate despair and denial, potentially pathological symptoms (Bowlby ref).

Professionals on pediatric units need to have the protection and support necessary for their ongoing work. Specific models for appropriate management, examples of which are referred to here, (C&E... need more specifics) may lend such help. Unfortunately, they are rarely developed and/or utilized in most pediatric settings.

Other difficulties stem from the lack of agreement or understanding regarding how (including economically), when, and which mental health ~~approach~~ approaches to integrate into the care of particular children. The developmental approach outlined above may provide the framework for understanding and meeting the needs of sick and recovering children; the professional judgements regarding appropriate interventions must then also take into account the individual children's responses and capacities (C&E...how about a brief example).

The full understanding of the particular needs and problems is necessary to enable decisions regarding parental inclusion or exclusion based on thoughtful knowledgeable professional judgement and justification which includes the consideration ^a fo the psychosocial realm. Certain instances require limiting the constant presence of the parent; for example with many adolescents or where the problems of the parent interfere actively with the medical care or constrict the child's coping efforts. In addition, sometimes the parent needs staff ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ protection ~~xxx~~ from exhaustion, frequently seen with the critically ill child. When parental presence must be limited, it is necessary to continue sensitive and skillful work with these parents to help them later resume their parental roles as fully as possible.

As with all other aspects of good medical care, consultation with trained workers in the field can yield directions and avenues for such determinations (ref to pediatric liaison work), as would continued research to emphasize the dynamic, longitudinal evidence of outcomes which hospital staffs seldom have the opportunity to ~~xxx~~ observe for themselves.

Since the pressures for physical care often seem more immediate and often distract from adequate attention to the psychological needs of the pediatric patient and his family, a number of hospitals have dealt successfully ~~xxx~~ with these complexities by developing positions and programs staffed by professionals in areas of Child Development. In addition, new academic programs developing specialists in the psychological aspects of pediatric care (Oremland) will hopefully provide ~~xxx~~ well-trained personnel to carry out similar programs in diverse pediatric settings.