THE PARENT CARE PAVILION

by Morris Green and Janice G. Green

The current emphasis on parent participation is one that should have considerable influence on hospital facilities and arrangements for children in the next decade. Involvement of parents in educational programs and in the direct care of their child in the hospital will increase their comfort and competency as they gain a better understanding of their child's health needs. Through what might be termed the demystification of hospital and medical care, we can help parents become effective allies in service of their child's recovery.

Child health professionals are increasingly concerned with the strengths and resources that help parents and children cope, as well as with their vulnerabilities and weaknesses. More and more pediatrics is viewed as a parent-child specialty, one that seeks to strengthen, not weaken, families. During a family crisis, such as the birth of a handicapped baby or the diagnosis of a fatal or life-threatening illness, and during the period of a child's hospitalization, doctors, nurses and other health workers have a unique opportunity to promote growth and minimize maladaptation.

Other trends in addition to that of increased parent participation have also led to changes in hospital planning. One-half of the patient population of pediatric hospital services is now comprised of children younger than two years of age. Children in this age group should have their parents with them in the hospital.

The composition of the patient population of children's hospitals has also changed as more intensive care units have become available for both newborns and older children in difficulty and as the development of complex surgical procedures has enabled more children to be treated. There has also been a relative increase in the number of young patients hospitalized for cancer treatment. In addition, more hospital services have become regionalized and children are now referred to regional centers for a large variety of problems. Such children's hospitals or specialized pediatric services require a range of patient care arrangements that extend from ambulatory care and traditional nursing services to maximal intensive care. At the same time, the availability of sophisticated outpatient services means that many children need to be hospitalized only if they are seriously ill, require surgery or live a long distance from the hospital and have problems which cannot be managed in a day.

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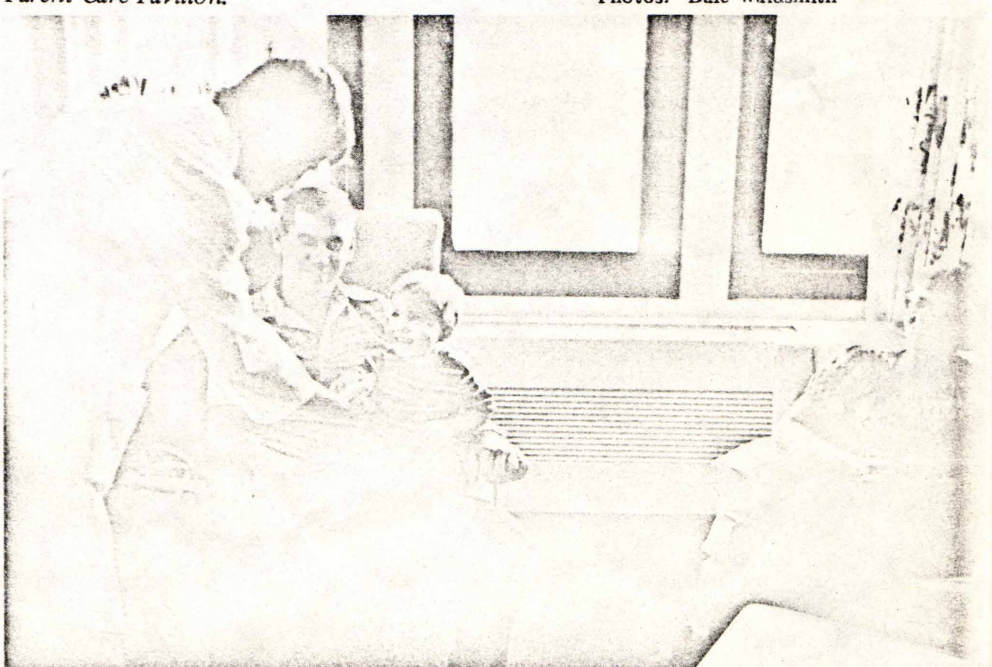
The Parent Care Concept

A number of years ago a study undertaken at the James Whitcomb Riley Hospital for Children in Indianapolis indicated that up to 35 percent of patient care days might be spent in parent care facilities, where parents would play a major role in the care and recovery of their child.[1] In response to the study findings, construction of such a facility, the Parent Care Pavilion, was begun with a grant from the Baxter Foundation.

The Pavilion, with 12 parent care rooms, opened at the hospital in 1971. Each room has a bed for the child, a single or twin beds for the parent or parents, and a bath and shower. A colorful curtain can be used to screen off the parent's sleeping area. The Pavilion also has a large play-dining area, a parents' lounge, a nursing station and a laundry room. Parents and children eat together in the play-dining room, where food is served cafeteria style.

The unit is staffed with a head nurse, two full-time registered nurses and a ward clerk. The nurses, all enthusiastic proponents of the concepts embodied in the parent care unit, have strong clinical backgrounds and are knowledgeable about child development and committed to parent

A young hematology/oncology patient greets a doctor upon his arrival at the Parent Care Pavilion. **Photos: Dale Waldsmith**



education and participation. Instead of uniforms, they wear ordinary street clothes. Other necessary services are provided by housekeeping and dietary staff.

The nursing staff is on duty weekdays from 8:00 a.m. to 6:30 p.m. On evenings and weekends the family may take their child to the emergency-admitting division of the hospital to be seen promptly by a nurse or physician, or they may call the emergency-admitting room.

House staff are assigned to this facility just as they are to other patient care units, with teaching rounds made on a regular basis. After the admitting appraisal, an appointment schedule is arranged and updated each day.

Although it is the mother who usually stays with the child, occasionally a father or brother or sister will also stay. Fathers and siblings, however, are not actively encouraged to stay because if several of them did, the unit would become crowded. Grandparents and close family friends are welcome to visit during the day. Some children and parents go home for weekends if the patient's admission is to be one of several weeks duration.

Only oral medications are given on the parent care unit. The nurses show mothers how to measure the medicine, which they keep in a locked cabinet, and how to follow a child's treatment schedule. To preserve the feeling of the Pavilion as a safe and home-like place, no painful procedures, even venipunctures, are done there. Rather, such procedures are performed and all intravenous medications given in the hospital's admitting-emergency division.

Mothers take their children to and from all scheduled appointments, such as X-ray and occupational and physical therapy. Children may attend grade school classes while in the hospital or be involved in a variety of other activities under the care of child life workers in various units of the hospital.

The mother's schedule allows time for relaxation, consultation with the social worker, attendance at parent education sessions and visits to the canteen or gift shop. Mothers or families can have privacy when they seem to need it, the companionship of other parents when they desire it, and the help of doctors and nurses when they have questions.

The average length of stay in the unit is five days. Children may be admitted to the Parent Care Pavilion for their entire hospital stay or as a phase of progressive patient care. In the latter case, the child may have diagnostic studies done while in the parent care unit, then have surgery followed by transfer to a traditional nursing unit. Or the child may pass through the parent care unit in transition from care by nurses in the hospital to care by the mother at home. For example, an infant who has been in the newborn special care unit may be admitted to the Pavilion before discharge so that the mother may assume responsibility for the child's care while she still has ready access to the hospital staff.

The kinds of problems for which children are admitted to the Parent Care Pavilion include the following:

- Birth defects, such as congenital heart disease and genetic disorders;
- Developmental problems, such as developmental delay, autistic behavior or feeding problems;
- Diagnostic problems, such as fever of undetermined origin or failure to thrive;
- Malignancies, such as Hodgkin's disease, Wilms' tumor or leukemia;
- Blood disorders, such as anemia or hemophilia;
- Gastroenterologic disorders, such as chronic diarrhea, chronic liver disease and recurrent vomiting;
- Sensory disorders, such as blindness, deafness or other communication problems;
- A variety of other disorders including diabetes, nephrosis, cerebral palsy, epilepsy, cystic fibrosis and chronic asthma.

Children are also admitted for postoperative care after cardiac or eye surgery, for example.

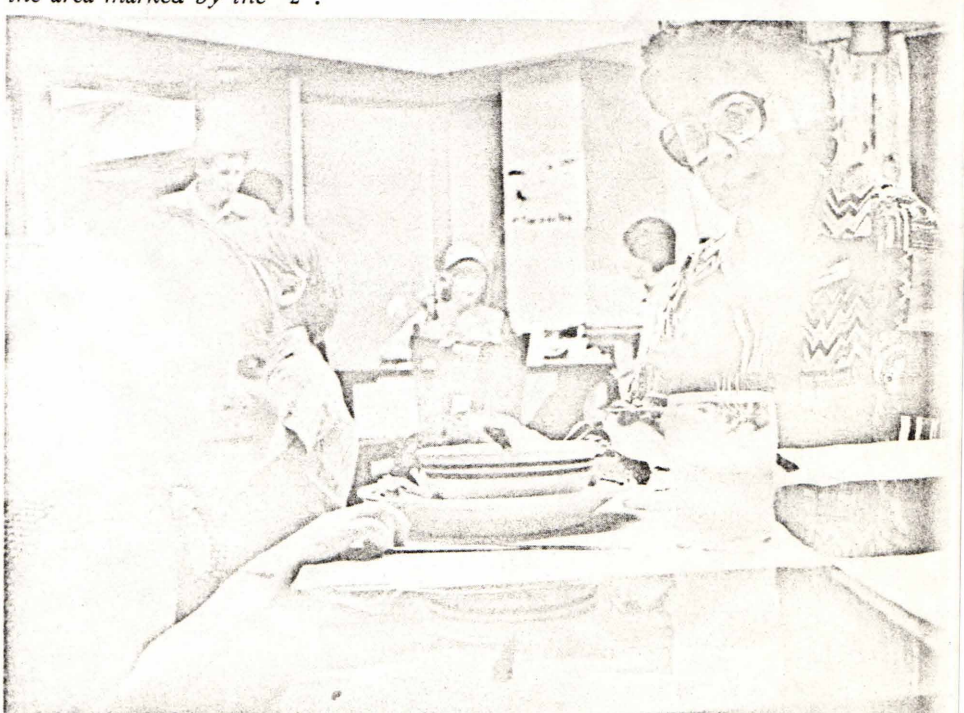
Patients who can be managed wholly on an ambulatory basis are not admitted to the Parent Care Pavilion.

Benefits of Parent Care

One of the most impressive benefits of the Pavilion has been total elimination of the psychological trauma of hospitalization. In large part, this is attributable to the mothers, who feel welcome and effective and who can participate actively in the preparation and care of their children, answering their questions and helping to personalize their care.

By placing children in the Parent Care Pavilion we are able to alternate their exposure to unavoidable painful or anxiety-provoking experiences with periods when a child can feel secure in a home-like sanctuary. As a result, children here sleep and eat better and behave more as they would at home

After lunch in the play-dining area, this mother will accompany her daughter to radiation therapy, where the little girl will receive treatment for a tumor in the area marked by the "z".



than they do on traditional patient care units. For example, the mother of a 2-year-old boy, who was transferred to the Pavilion following three days in the hospital's toddler unit, was surprised to see her son fall asleep as soon as she put him down for a nap after lunch. She said that it was the first time he had taken a nap since being hospitalized. That evening the child also ate well in the play-dining area. On the previous unit, his mother said, he was always upset and crying and had "barely touched" his food. She remarked that the traditional nursing care unit had always seemed so busy and confusing to her and her child.

Parent education has also been highly effective. We attribute this to:

- The competence of the staff and the ambience of a unit that makes parents feel important and validates their ability to manage.
- Parents' active participation based on their considerable understanding of the diagnosis and treatment of their child.
- The positive reinforcement and feedback parents receive from staff members as they learn to manage their child's daily needs, first by observing a demonstration of a procedure, then by performing it under direct supervision, and, finally, by doing the procedure independently—with nurses readily available.

In this manner, parents like Mrs. Smith gain confidence in their ability to care for their child.

Mrs. Smith's infant son had undergone surgical repair of a tracheoesophageal fistula and was admitted to the Pavilion from the infant intensive care unit so that his mother could learn gastrostomy feeding techniques and become acquainted with her new baby. At first Mrs. Smith was afraid of the feeding tube and did not feel that she could use it. Five days later, however, when the baby was discharged, she was all smiles and relaxed. "It really wasn't that difficult after all," she said.

In another case, a 16-year-old, unmarried mother was admitted to the Pavilion with her infant daughter, who had just been diagnosed as having phenylketonuria (PKU). Overwhelmed at first by the daily care and special nutritional requirements of her new baby, she responded promptly to instruction and mastered the details of both baby care and dietary management. When they were discharged from the parent care unit, the mother was coping well.

The parent care arrangement permits parents to gain understanding of a child's problem over time rather than in one final, often hurried conference at the time of discharge. Parents need such an opportunity to understand a problem and to begin to accept a diagnosis—to think, to reflect, to repeat questions, to do procedures by themselves and to see changes in a child's behavior that may occur in the supportive Pavilion setting.

At a time when many factors converge and tend to weaken families, the parent care unit serves to bring them together. Group processes which develop in this facility are not usually noted on traditional nursing care units. With the child and his or her mother and father spending a concentrated period of time together, communication among family members is enhanced. The father, especially, becomes more involved with his child and more supportive of his wife's role. He also learns what he can do to help both his child and his wife. And, as families share experiences as they visit in each other's rooms and eat and talk in the common dining room, they gain a great deal of mutual support.

In addition, a special spirit of interdisciplinary cooperation develops among the Pavilion nurses, doctors, occupational and physical therapists, social workers and other health professionals who see the children on the unit regularly. Everyone becomes more involved in enhancing the contribution of parents.

As families develop a strong therapeutic alliance with the staff, they also experience a sense of belonging—they feel they are part of the hospital "family." Many later send photographs of their children and visit the unit as old alumnae when they return to the hospital with their children for outpatient visits. In short, the Parent Care Pavilion tends to maximize satisfaction and minimize dissatisfaction with the hospital experience.

Children here do not feel abandoned by their parents, or puzzled, as they may have been while hospitalized in traditional units, about why their mothers play such a secondary, passive role in the hospital—or even why they seem to be almost as puzzled and uncertain as the child. The Pavilion setting also serves to foster healthy childrearing practices as staff members answer parents' questions, offer suggestions, arrange for them to observe their child in a nursery school group in the hospital and use, when appropriate, behavior modification techniques.

The Parent Care Pavilion has also had an appreciable impact on the educational experiences of medical students and pediatric residents because it provides the opportunity for—and, in fact, requires—a truly family-centered approach. In the home-like setting, the doctor finds himself almost automatically sitting down while talking to the child or parents rather than standing and edging toward the door. Students and residents find themselves more thoughtfully attending to the physician-patient relationship than might otherwise be the case, and doctors spend more time with the parents in the Parent Care Pavilion rooms than elsewhere in the hospital. While this may require more of the doctor's time, it contributes to making the hospitalization a more productive experience for the whole family.

Family diagnosis is also facilitated. With the aid of perceptive nurses, the physician may gain a helpful and detailed appraisal of the interaction between parent and child and mother and father.

For example, a 3-year-old was admitted to the Pavilion because his mother was certain that he was neurologically impaired. The child was delayed in his speech, and the mother thought he was extremely hyperactive. The admitting interview revealed that there was considerable marital discord in the home and that the mother had been depressed. After a short time in the parent care unit, both the mother and staff members noted that the child had begun to talk more than he had before and his behavior also

demonstrated a striking change—he no longer appeared to be "hyperactive." These obvious changes enabled the physician and social worker to discuss with the mother the real etiology behind the child's behavior and, later, to gain the cooperation of both parents in a program of marital counseling.

The Pavilion has also had a constructive influence in promoting a greater orientation to parent involvement throughout the hospital. As parents are seen in the hospital around the clock, accompanying their child to such hospital services as the clinical laboratory or radiation therapy, hospital policies that serve to ensure the prompt and compassionate care of children are reinforced.

Reduction of hospital costs has been another important benefit of the Pavilion. Because of the effectiveness and efficiency of care here, the average length of a child's hospital stay has been reduced by one day. The need for repeated hospitalization has also decreased as a result of the intensive parent education offered during the initial admission. Since nurses are not assigned to the Parent Care Pavilion at night or on weekends, the per diem cost for children and their parents admitted to the Pavilion is $30 less than admission to a semi-private room on a traditional nursing unit.

Suggestions for Other Hospitals

Based on our experiences during the past six years, we would suggest that the following be considered when planning and operating a unit of this kind. First, the unit must have the full support of the medical and surgical chiefs of service, and of the nursing service and hospital administrators. Because such a program may initially represent only a relatively small number of beds, and because it is unusual and everyone in the hospital may not understand its underlying philosophy, the unit will need firm support from hospital leadership in order to flourish.

Nurses for the Pavilion will have to be highly competent and carefully selected. They must enforce the requirements of the program aggressively, recognizing that there will be a general tendency in the hospital to refashion the Parent Care Pavilion into a traditional inpatient unit. The nurses should be personally warm, knowledgeable about illness in children and skilled in interviewing and teaching parents. In addition, they should enjoy working with parents and be non-competitive with and supportive of parents and accustomed to identifying and capitalizing on parents' strengths and resources. Since they will also be advocates for the parent and child they must be aggressive in the pursuit of excellence in patient care. Especially during the first few months, weekly meetings should be held between the head nurse, the directors of pediatrics and surgical services, the hospital administrator and representatives from such services as housekeeping, dietetics and laboratories.

The Parent Care Pavilion must be integrated into a comprehensive facility, including a highly developed ambulatory department, rather than segregated into a medical care cul-de-sac. It must also comprise an individual nursing unit. A unit that is partially traditional nursing care and partly an attempt at parent care will not work well. The kinds of conditions accepted as reason for admission must be continually monitored and the purpose of the unit periodically reinterpreted, not only because optimal patient care is a fragile creation which requires constant attention but also because of the rapid turnover among student nurses, medical students, residents and staff. At our hospital, the appropriateness of all admissions is reviewed by the head nurse. Also, on admission, each new family is carefully oriented to the philosophy and program of the unit.

The Parent Care Pavilion should not be considered as a minimal care unit, nor should it be used merely for convalescent patients. On the other hand, patients who require intravenous fluids or 24-hour monitoring are not candidates for admission to the Pavilion, nor are dying children. The severity of illness with which the parent care staff feels comfortable depends upon the competence of the child's mother. Children of parents who do not wish to or who cannot participate in their child's care round-the-clock in this manner are not admitted to the unit.

Children of mothers recognized as being seriously depressed or emotionally ill are also not considered appropriate candidates for the Pavilion. A mother who is depressed or otherwise disturbed, if not identified prior to admission, can usually be recognized very quickly by the nurses in their interview with her or by her behavior. An effort is then made to arrange appropriate psychiatric care for her.

Mothers who appear to have major interactional problems with their infants may not be admitted initially to the unit. However, as the baby improves while being cared for on a traditional unit, the baby and mother may be admitted to the Pavilion in preparation for discharge, as were Mrs. Jones and her 7-month-old baby.

Desperate, Mrs. Jones had brought her baby to the hospital because he was steadily losing weight and vomiting continuously. A diagnosis of rumination (almost constant spitting up due to a nervous habit) was established, and the baby was admitted to the hospital. His mother was urged to take a few days break and get some rest. As the baby improved in the hospital, Mrs. Jones spent increasing amounts of time with him on the traditional nursing care unit. When she had regained her confidence in caring for him and the baby had begun to thrive, both mother and child were admitted to the parent care unit for the remainder of the baby's hospitalization. Both did well.

More than 30 years ago, Sir James Spence was conducting a program, one similar in some respects to ours, at a children's hospital in Newcastle-on-Tyne. There, a row of old houses were arranged so that a mother could stay in a room with her child and provide all nursing services, except for certain technical treatments. Speaking of the advantages of this arrangement in a lecture at the Royal College of Physicians in 1947[2] Sir James pointed out many advantages of the program, advantages that are as significant today as they were then:

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Parent Care Pavilion *(Continued from page 8)*

"The advantages of the system are fourfold. It is an advantage to the child. It is an advantage to the mother, for to have undergone this experience and to have felt that she has been responsible for her own child's recovery establishes a relationship with her child and confidence in herself which bodes well for the future. It is an advantage to the nurses, who learn much by contact with the best of these women, not only about the handling of a child but about life itself. It is an advantage to the other children in the ward, for whose care more nursing time is liberated. In teaching hospitals it is of further advantage to the students, who gain a practical experience of the form of nursing they will depend on in their practice and learn to recognize the anxieties and courage which bind the mothers to their children during illness, a lesson which fosters the courtesy on which the practice of medicine depends. I advocate this method of nursing not on sentimental grounds but on the practical grounds of efficiency and necessity." ■

[1] See Green, M. and Segar, W. E., "A New Design for Patient Care and Pediatric Education in a Children's Hospital: An Interim Report," *Pediatrics*, November 1961, and Green, M., "Innovative Methods of Expanding Ambulatory Services," *Advances in Pediatrics*, 1973.

[2] Spence, J. C., "The Care of Children in Hospital," *British Medical Journal*, January 25, 1947.

Single Mothers *(Continued from page 4)*

and they may appear to be just sitting back and becoming observers of their own destiny. Depending upon the young woman's personality, she may seek out the social worker frequently to discuss problems in depth—or, if she is less likely to be open to the counseling process, we will hardly ever see her. Some of the rebelliousness against the program structure has been worked through and the mothers are now carefully evaluating what they are doing and wondering whether they are headed in the right direction.

We feel that this is a "therapeutic" phase, since it represents a fusing of learning and redefinition of goals. Staff members need to be readily available to offer support and encouragement during this phase, which must also be carefully monitored so that it is not so prolonged that immobilization sets in.

If appropriate support is provided and the women can be helped through this phase within a reasonable length of time—usually about three to six weeks—they are able to move on to the next stage, *productivity*. Here the mothers are actively involved in a job or training program and the long-range goal is near. They are talking about where they will want to live and they are interested in the subjects discussed at the "preparation for life" sessions.

The time spent in the productivity stage is also very significant and staff members must work very closely with the mothers in order to help them complete the steps toward termination in the program. If they stay too long in this stage, a peak is reached and enthusiasm then lessens and problems develop. Being able to move on at the peak of productivity enables them to successfully establish independence and self-reliance.

Follow-Up Services

We attempt to provide follow-up services, including regular contact, counseling and support regularly for about six months after the young women leave the program, and we encourage them to contact us after that time if the need arises. In addition, a newsletter is published every three months, giving information about agency programs and the current addresses, employment and family situations of former residents.

Since the program began in 1973, 69 young women (and 69 children) have been involved in the Single Parent Program, including 14 mothers and children currently in residence. Of the remaining 55, 37 gained a saleable skill and are now employed, and 18 left the program for such reasons as marriage, lack of readiness to pursue full-time employment, and inability or unwillingness to adjust to group living.

Based on the major goal of the program—to help the young women gain a saleable skill—we have had a success rate of about 67 percent. We have found that establishing such a concrete means of measuring success makes the program more readily acceptable and open to support by the public. It should be noted, however, that the great majority of the women —85 to 90 percent—made various strides in their personal growth and in developing the skills they will need for independent living.

The Single Parent Program is continually being evaluated as we learn from the young women and adapt the program to meet their needs. We have made errors, and undoubtedly we will continue to do so, but in view of the staff members' flexibility and willingness to evaluate both themselves and the total program, we are optimistic that it will continue to grow and provide even more effective supportive services for the single mother and her child. ■

* *The Single Parent Program, supervised by Diane Gilmore, is one of the services offered by Child Saving Institute. It receives approximately 34 percent of its funds from United Way; approximately 25 percent from the Christian Church; approximately 30 percent from rent and day care paid through the county; and the remaining 11 percent from contributions. The cost per mother is about $12.00 per day and, for a child, about $19.00 per day.*

HISTORICAL DATA BASE

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FAMILY-CENTERED CARE
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SHRINERS HOSPITAL FOR
CRIPPLED CHILDREN
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Sheila Kodadek, RN.

Family-centered care of the chronically ill child

The number of children with chronic illnesses and handicapping conditions is increasing. In fact, chronic disease is today one of the major health problems of children. Different demands the chronically ill and acutely ill child and the family make on nursing staff can cause misunderstandings on both sides. This results in failure of the staff's care goals and setbacks in the family's struggle to control effects of the disease or handicap.

In this discussion, chronic illness and handicapping conditions will be considered to have a similar impact on the family. The handicapped child often is not ill in the strict sense of the word. But long-term family stress, frequent contact with the health care system, and various limitations on child and family are similar to those of chronically ill children.

Families of all hospitalized children tend to look to nurses for expert knowledge and care directly associated with the reason for hospitalization, which could be a corrective surgical procedure or an acute episode of a disease. Families of chronically ill children often look for additional knowledge and help. They expect to share control and decision making, and they expect the staff to appreciate the impact of the chronic illness on the family.

Providing family-centered nursing for these families is complex. A pressing issue for nursing is to learn the needs of these families and effective interventions. Many types of problems arise in dealing with these families. Most health professionals are educated in acute care settings. It is probably safe to say that those who prefer continuing contact and supportive interventions with patients or clients tend to choose settings such as long-term care facilities, clinics specializing in chronic illness management, and hospices, whereas those who prefer episodic and more direct care can be found in intensive care units, emergency rooms, operating rooms, and similar settings.

Those traditional lines are blurring, however. For example, in one university hospital, a child remained in the pediatric intensive care unit for over six months, going from crisis to crisis. Handling the physiological crises was relatively easy for the staff, compared with the stress of dealing with the child's family daily over a long period. Continued contact can be disturbing to a health professional prepared to be an expert provider in acute situations,

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where expected results are usually quickly achieved. The family's increasing sophistication may also threaten and challenge the professional.

Adding to the problem is the fact that most acute care facilities are not designed for chronically ill and/or handicapped children. Assessment and admission forms stress acute episodes, with little emphasis on maintenance care. Parents who have been monitoring care at home often are not allowed to give medications, do physical therapy, or handle routine physical care. Control shifts from the family to the hospital staff. Children who have been participating in their own care may not be allowed to do so in the hospital. Long sought and hard won independence is diminished by professionals who wish to help in the ways to which they are accustomed.

Rooming-in, open visiting hours, and parent participation units are not enough. Although they are certainly better than the restricted atmosphere of traditional care settings, these innovations are not themselves sufficient. Staff's attitudes about family involvement in care and the role of the family in the child's life may remain traditional.

Nurses at Shriners Hospital for Crippled Children in Chicago are studying how families respond to the chronic illness or handicapping condition of a child. The Department of Nursing Research was established in January 1979 with funding from the Joint Boards of Shriners Hospitals. The ultimate goal of the research department is to develop a program of family-centered nursing care based on research.

A preliminary study of the minutes of two years of parent group meetings shows several areas that need investigation and provides some clues for possible interventions. Themes from the parents included recurring and sometimes continuous stress of the child's condition on the family, and the struggle of the family to contain the impact of the illness or handicap—to control it according to the family's needs.

For these families, a hospitalization had many different meanings. It could provide a much needed rest for the family. In a decision about elective surgery, it could revive stressful feelings of yet again leaving their child with an unknown hospital staff or of facing changes in care routines. Or it could be a maturing experience for the child and family.

What these families asked for from staff was the opportunity to choose their degree of involvement and to have control regarding their children's care. Their needs changed from hospitalization to hospitalization, and sometimes within a single hospital stay. How the nursing staff could be sensitive to their changing needs was not directly addressed, but it was clear that parents felt nurses should be aware of their needs.

Parents told many stories of hospitalizations where their knowledge of their child's unique responses to his disease and treatment were not appreciated. In particular, the mothers talked of being labeled "overprotective," "underprotective," "bossy," "neurotic," and "amateur physicians." If they were anxious about leaving their child in the hospital, they were made to feel they should be used to it by now. If they were relieved to have help, they were seen as "dumping" their child.

Parents mentioned that, with both chronic illness and handicapping conditions, family members often become the experts in the care of the child. This has significant impact for nursing. Not infrequently, parents and sometimes siblings are extremely knowledgeable about the disease or handicap, therapy alternatives, and prognosis. The family may have well-established therapeutic and maintenance routines that have

Families asked for the opportunity to choose the degree of involvement.

been worked out by trial and error. Diet, exercise, medication schedules, and the like—however casual they may appear to the professional—may be adapted to the unique needs of the child and family. In addition to being disruptive in ways that are common to all patients and their families, a hospitalization may also threaten the family's control of the effects of the child's chronic illness or handicap. The impact on the child and family may last far longer than the hospitalization itself. For example, a ten-year-old child with a myelomeningocele was hospitalized in a university hospital for a fractured leg. The family's hard-won victory over their child's bowel and bladder problems was negated by well-meaning staff. They tried to simplify the child's care without checking their goals with the family's goals and their general experience with the unique experiences of the family.

In another example, the parents of a two-year-old child with biliary atresia used one of their daughter's frequent hospitalizations as an opportunity to get away for a much-needed weekend vacation. A nurse not familiar with the family was openly critical of the parents' decision, basing her evaluation on her knowledge of the negative effects of hospitalization on the toddler. In both these cases, failure to discuss with the family what would fit their needs caused the families unnecessary distress.

Underlying all nursing interventions with chronically ill and handicapped children should be an appreciation of the family's impact on the child's emotional well-being and sometimes on physical well-being. Generally, the child is not cured by the health care system. The long-term care demands, frustrations, and worry can only be estimated by those not actually living with the situation. There is a direct role for the nurse in treating the child, but there is an equally important supportive role for the nurse with the family.

To provide assistance appropriately and effectively, nursing needs data about how the family defines the chronic illness, the acute episode, the hospitalization, and its role. Labeling and unchecked assumptions, as well as a lack of appreciation for the parents' knowledge of their child, have no place in family-centered care.

Many questions are left to be answered. There is evidence that chronically ill children and their families are more vulnerable to psychosocial problems than healthy children. Among chronically ill children, some are more susceptible than others. A major task for nursing is to define what factors are indicators of this vulnerability. With this knowledge, nursing interventions can be tried and evaluated for their effectiveness in relieving and/or preventing distress.

Other questions include, but are not limited, to the following: What is the impact of stressing normality instead of the illness or handicap from the time of diagnosis? Where does denial fit in? How can siblings be involved constructively? How can grandparents and other relatives affect the family's ability to cope? Can we expect different responses depending on diagnosis, age at onset, manner of onset, degree of physical involvement, prognosis, and other such variables? What happens when the family's needs conflict with the child's needs? Can coping be enhanced through nursing interventions? How can the level of family functioning be evaluated?

Nursing needs to find answers to these questions. In the meantime, nurses can learn from families what they need and how they define the hospitalization. They can also provide information so families can make informed choices when needed and then support and facilitate the choices the family makes. This subtle but significant acknowledgment of the family's responsibility and authority is family-centered nursing at its best, as we currently know it. □

Suggested reading

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Minority RN students proportional to population

The proportion of minority group members in registered nurse education programs is about the same as the general population. And it comes as no surprise that men have a long way to go before they are represented equally in nursing. As in other health fields, nursing has minority group members underrepresented in professional employment and overrepresented in nonprofessional jobs. These are general findings from a government report, *Minorities and Women in the Health Field* (US Department of Health, Education, and Welfare, Bureau of Health Manpower, October 1978).

In 1974-1975, 13.6% of students enrolled in all three types of professional nursing education programs were from minority groups. Minority representation in the US population is about 13.2%. Male students made up 6% of school enrollment.

In the nursing work force, 9.6% of registered nurses are from minority groups. For practical nurses, the proportion is 22.9%; and for aides, orderlies, and attendants, it is 26.6%. For all health fields, 7% of professionals are members of minority groups, whereas 22% of nonprofessionals are. (The report uses 1970 employment figures since that is when the last US census was taken.)

The report does not break down data for RN specialties such as operating room nursing, but there are figures for operating room technicians. In 1975-1976, 17.5% of those enrolled in OR technician training programs in junior colleges were from minority groups. The proportion in hospital-based training programs for 1973-74 was 13.4%. There are more men enrolled in technician training programs than in RN programs. In 1975-1976, 13.6% of OR technician students in colleges were men.

FAMILY-CENTERED NURSING CONCEPTS IN PEDIATRIC NURSING TEXTBOOKS

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FAMILY-CENTERED NURSING CONCEPTS IN PEDIATRIC NURSING TEXTBOOKS

Does a knowledge base for family-centered nursing exist in pediatric nursing textbooks? If so, what is it? These two questions guided a search of a sample of pediatric nursing textbooks published during the past fifty years.

Need for the Study

Family-centered nursing care is a frequently expressed goal of both nursing education and service. It is generally considered to be a relatively new idea, one which, if known and practiced, will be an answer to many of the problems in health care delivery today. The argument usually goes something like this: if nurses would only practice family-centered nursing then parents would feel less alienated, children would be less traumatized by hospitalization, and so on.

But what is family-centered nursing? How does one "nurse" a family? Is there evidence that a family-centered approach is "better" than another approach? What do nursing students learn about family-centered nursing?

By stating that family-centered nursing is a value, a goal, and a process in various philosophical statements of clinical settings and educational programs the nursing profession implies that this approach can be distinguished from other approaches and that it can be implemented. Experiences with a random sample of health care settings

in a large metropolitan area will almost certainly lead one to the conclusion that some settings do emphasize families more than other settings, although the manner in which it is done may vary considerably.

One way to address the question of why there are differences is to find out what is presented about the concept in the pediatric nursing textbooks. What are students learning about family-centered care?

The Study Design

Pediatric nursing textbooks were examined for references to families, parents, siblings, and the role of the pediatric nurse. In all, forty-eight textbooks and related nursing documents, such as curriculum guides and teaching manuals, were included in the study. This does not represent an exhaustive sample of all published textbooks in pediatric nursing; however, a systematic effort was made to include representative textbooks from the past half-century. In all, three health center libraries, three diploma schools of nursing libraries, and one baccalaureate program library were searched. In addition, several private collections were included in the study. The frequency with which certain textbooks and authors appeared gave some assurance that textbooks commonly used in this geographical area were being included in the sample.

At times the only reference to family was in the preface of a book, and that reference was a general statement about the pediatric nursing role. At other times the view of family could be inferred only from instructions to the nursing student about visiting hours, suggestions for nurse-patient interaction, and discussion about the

effects of separation on the hospitalized toddler. A few books did stress family needs throughout the text.

No attempt was made to compare textbooks that do and do not include family-centered concepts with regard to quality of other nursing and medical content.

Findings and Discussion

Pediatric nursing is a relatively young nursing specialty. It is not mentioned in Nursing of the Sick, 1893, although "District Nursing", "Obstetric Nursing", "Midwifery as a Profession for Women", "Nursing of the Insane", and "Nursing in Homes, Private Hospitals and Sanitariums" can all be found in the Table of Contents.[1]

The earliest reference to a pediatric nursing textbook found was to Sellew's Pediatric Nursing, first published in 1926.[2] A list of reference books in a 1936 textbook included three books specifically for pediatric nurses.[3]

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[1]Isabel A. Hampton et al., Nursing of the Sick, 1893: Papers and Discussion from the International Congress of Charities, Correction and Philanthropy (Chicago, 1983; reprint ed., New York: McGraw-Hill, 1949), pp. xii—xiii.

[2]Gladys Sellew and Mary E. Pepper, Nursing of Children, 7th ed. (Philadelphia: W. B. Saunders Company, 1953), copyright page.

[3]John Zahorsky, Pediatric Nursing (St. Louis: The C. V. Mosby Company, 1936), p. 560.

It has not been unusual to find a nursing textbook written by a physician. In 1933 Dr. Abraham Levinson, in his Pediatric Nursing: A Textbook for Nurses, recommended a child-oriented approach which is cognizant of the extended "family":

> In every phase of nursing there is a human element. In pediatric nursing the human element is all-embracing. The nurse has to consider not only the child who is her patient, but his mother, his grandmother and sometimes even the neighbors. The nurse has to be prepared to handle all concerned to the best interests of the child.[4]

Dr. Levinson, in discussing the decision of home treatment versus hospitalization of the sick child stated that the decision should be based on the condition of the home, the emotional response of the mother, the nature and severity of the disease, and "above all the advice of the physician."[5] He added that the mother's fatigue should also be a factor in the decision.[6]

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[4]Abraham Levinson, Pediatric Nursing: A Textbook for Nurses, 2nd ed. (Philadelphia: Lea and Febiger, 1933), p. 21.

[5]Ibid., p. 258.

[6]Ibid., p. 261.

Zahorsky in 1936 presented guidelines for pediatric nurses, including his definition of the nursing role:

> The pediatric nurse has two parts to play in her field of work: (1) she is an aid and instructor to the mother; (2) she is an assistant to the physician. She may be a substitute for the mother whenever the latter is physically incapacitated or mentally incompetent to care for her child. Her duties are, therefore, that of an intelligent mother. On the other hand, the trained nurse becomes the skilled assistant to the physician in the diagnosis, prevention, and treatment of diseases. It is the latter qualification which distinguishes her from the nursery maid and untrained voluntary helpers, friends, and relatives.[7]

But it is his interest in the importance of the family that is most relevant here. He was a child and family advocate, cautioning against unnecessary hospitalization:

> The practice of nursing a sick child in the home rather than in the hospital should be encouraged. Unless the disease requires surgical intervention, hospitalization of the child is not necessary.[8]

> In spite of the advance in the science of hygiene and the comparative safety of large groups of children assembled in dormitories and dining rooms, pediatrics, more than ever, emphasizes the importance of the family unit in the growth and development of the child.[9]

And Zahorsky advocates a nonjudgmental approach to pediatric nursing practice. He stressed the importance of preserving the family's individuality.

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[7]John Zahorsky, Pediatric Nursing (St. Louis: The C. V. Mosby Company, 1936), p. 18.

[8]Ibid., p. 480.

[9]Ibid., p. 490.

> In recent years students of sociology are paying some attention to family life and are gradually accumulating many facts in regard to the happenings in the home . . . . There are no two families alike, and research has great difficulty in finding common qualities for comparison. Because a family is different is no reason to assume that an abnormality exists.[10]

> An outsider is really incapable of separating the essentials from the nonessentials of life in any home. We must not judge that the child is neglected because we find him playing in the ash heap.[11]

In 1937 the National League of Nursing Education published A Curriculum Guide for Schools of Nursing which stated that, with regard to teaching nursing of children: "The emphasis in this course is on the care of the child as an individual and as a member of the family and of the community."[12] Furthermore, "The best interests of the child demand a parent - nurse relationship in which parent and nurse learn about the child and his needs from one another."[13] The suggested teaching methods included observation of "normal" children, such as in nursery schools, but did not mention family.[14]

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[10]Ibid., p. 490.

[11]Ibid., p. 495.

[12]Committee on Curriculum of the National League of Nursing Education, A Curriculum Guide for Schools of Nursing (New York: National League of Nursing Education, 1937), p. 467.

[13]Ibid., p. 468.

[14]Ibid., p. 470.

Harriet Frost, a nurse, in 1939 published Nursing in Sickness and in Health: The Social Aspects of Nursing. She stated that "the pediatric department aims to care for the child as a whole, rather than to treat some specific complaint or disease."[15] She recommended the use of family studies in pediatrics to teach nursing students about the impact of illness, and gave as an example the work of a second-year student who, without value judgments, questioned the impact of cultural differences on interaction between generations in an immigrant Italian family.[16] And Frost reminded her audience that during the health exam: "Of no less importance than the physical reactions of the children, are the psychological reactions of the parents to these procedures."[17]

In contrast, Taylor, in 1941, published her book on ward teaching. She also advocated pediatric nursing care studies, but her example, titled "Chorea" and written by a third-year student gave a markedly different view of family and the nursing role.[18] The subject of the study was May T., an Italian girl of eleven or twelve years, who has chorea, (a form of rheumatic fever). The student

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[15]Harriet Frost, Nursing in Sickness and in Health: The Social Aspects of Nursing (New York: The MacMillan Company, 1939), p. 195.

[16]Ibid., pp. 51-57.

[17]Ibid., p. 196.

[18]Anna M. Taylor, Ward Teaching: Methods of Clinical Instruction (Philadelphia: J. B. Lippincott Company, 1941), pp. 197-205.

describes May thus:

> When she first came to the ward she would only hang her head and cry and reiterate shrilly, "I want to go home." Throughout her stay here she would get spells of repeating, "I want to go home" in a stubborn, unreasoning way that made me conscious of a part of her that an outsider could not get at. Nevertheless, on the whole she soon became very friendly and co-operative and seemed like one who wanted to be taught and guided . . . . I believe that May also has the intelligence to be workable material in spite of the fact that she is two or three years behind the normal grade for her age in school, being only in the fifth grade, and in spite of the fact that one of the teachers at May's school showed surprise to our social worker that the worker should be helping the T's, implying strongly that they are a backward, worthless family.[19]

The student's value judgments continued throughout the study:

> Certain factors in her physical environment also probably contributed to her illness. In the first place May comes from a family belonging to the class I mentioned as most susceptible to rheumatic fever, the upper poor. Moreover, according to the hospital social worker, the T's live in a small frame house which, in spite of being fairly comfortable, with a good steam-heating system, is only one and one-half stories high -- not very substantial sounding -- and is located in the poor part of Boston near the railroad tracks, where it is probably flat, low, and fairly damp.[20]

When it came time for May's discharge from the hospital her family insisted on taking her home rather than sending her to the Home of the Good Samaritan which specialized in the care of rheumatic fever children, even though Boston Charities would pay the $5.00 a week charge. This was interpreted as a lack of intelligence on the family's part.[21]

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[19] Ibid., p. 197.

[20] Ibid., p. 202.

[21] Ibid., p. 204.

The nursing student concluded from her experience that:

> The factor which makes Italians hardest of all to deal with is their emotions, which so quickly dominate them to the exclusion of reason. It's the natural emotional response for a mother to want to keep her sick child at home with her; but it is not facing facts.[22]

Taylor included this case study as a desirable example of an assessment of a child and her family. In my opinion, the contrast between the approaches of Zahorsky and Taylor is representative of the differences in interpretation of family-centered care that have continued to the present time. Both authors talk about the importance of the family and both advocate taking the family situation into account in assessment and intervention, but the gulf between them with regard to exactly how to do that is vast. Zahorsky saw the family as more knowledgable about their needs than the health professional; Taylor saw it in quite the opposite way.

Both views have continued in nursing literature. The implicit and sometimes explicit assumption that parents are ignorant (and, indeed, may not be very bright) persists. In 1954 nurses learned that:

> In the examining room the mother is questioned by the physician about the onset of the child's illness, his symptoms and his developmental history. This can be a trying procedure if the mother is ignorant, unduly nervous or unable to speak English adequately.[23]

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[22] Ibid., p. 205.

[23] Robert A. Lyon and Elgie M. Wallinger, Mitchell's Pediatrics and Pediatric Nursing, 4th ed. (Philadelphia: W. B. Saunders Company, 1954), p. 143.

And again in 1976:

> A great deal of information about the child and his family can usually be obtained by interviewing the mother. She knows her child far better than the nurse, and even if her views are distorted, she can still teach the nurse something about her child.[24]

And yet again, in 1979:

> The modern nurse recognizes that the family may have a great deal to offer the hospitalized child, and when properly prepared and supported, the parents may be able to help the child during a difficult, but, we hope, also a potentially constructive period in his heretofore brief experience with life.[25]

With this orientation to the family the definition of family-centered care becomes something like this:

> A child's morale will inevitably reflect his parents' outlook. When parents are inadequately prepared, they cannot adequately prepare their child. It is extremely important that the parents have sound information about the child's illness, confidence in their physician's recommendations, and the devoted interest of warm, intelligent, and understanding nurses.[26]

In my opinion it is this orientation which has made family-centered nursing care synonomous with parent teaching in many instances. There is an underlying assumption that parents do not and can not know as much about their own children as do health professionals.

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[24]Dianne Fochtman and John G. Raffensperger, Principles of Nursing Care for the Pediatric Surgery Patient, 2nd ed. (Boston: Little, Brown and Company, 1976), p. 33.

[25]A. Joy Ingalls and M. Constance Salerno, Maternal and Child Health Nursing, 2nd ed. (St. Louis: The C. V. Mosby Company, 1979), p. 235.

[26]Ibid., p. 335.

This viewpoint has not been the only one expressed in the literature, however. In 1967 Broadribb asked:

> Can we honestly say that most parents are ignorant of their own children's needs, either physically, emotionally --- or any other way? Perhaps much of the feeling one encounters against parents goes back to the days when principles of hygiene and sanitation were not as well known as they are at present. Most certainly it was necessary to guard the child against superimposed infection. Perhaps, with typical American enthusiasm, we overdid things. We think that if a certain practice is good, more of the same would be better . . . . We completely lost sight of the fact that the child belongs to his parents and will go back to them.[27]

In 1947 Wolf had stated clearly that "the professional curriculum of basic nursing education is built upon the assumption that the individual patient and his family is the unit of nursing care . . ."[28] But, as Broadribb indicated, it appears that the nursing profession often did "lose sight of" this belief.

Discussions of the pediatric nursing role and activities, in my opinion, also illustrate some of the ambivalence and contradictions in interpretation of what pediatric nurses are to do. For example, in textbooks parents are almost always mentioned during the description of the admission of a child to a hospital. The nurse's role is usually described as one of developing rapport.

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[27]Violet Broadribb, Foundations of Pediatric Nursing (Philadelphia: J. B. Lippincott Company, 1967), p. 23.

[28]Lulu K. Wolf, Nursing (New York: D. Appleton - Century Company, 1947), p. 50.

> The admitting nurse has the responsibility for developing good rapport with the parents and with the child. Her attitude and behavior may well influence the child's (and the parents') reactions to the hospitalization.[29]
>
> The nurse should greet the parents and child by name and spend time with them to develop a positive nurse - parent - child relationship.[30]

But there is little or no carryover into the text about visiting hours, rooming-in, or individual family choices. One could conclude from many books that once the child is amiably admitted, families are superfluous.

Siblings are rarely mentioned. Sellew and Pepper in 1953 stated that "the child as a member of the family group should be considered in relation to his parents and also to his brothers and sisters.[31] To the best of my knowledge this is one of only a very few substantive references to siblings in any of the books reviewed.

Fathers are another relatively forgotten group. Although the textbooks begin with "parent" they almost inevitably change to talking about "mother". One exception was Kalafatich:

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[29]Dianne Fochtman and John G. Raffensperger, Principles of Nursing Care for the Pediatric Surgery Patient, 2nd ed. (Boston: Little, Brown and Company, 1976), p. 19.

[30]Gloria Leifer, Principles and Techniques in Pediatric Nursing, 3rd ed. (Philadelphia: W. B. Saunders Company, 1977), p. 32.

[31]Gladys Sellew and Mary F. Pepper, Nursing of Children, 7th ed. (Philadelphia: W. B. Saunders Company, 1953), p. 14.

> A word must be said about the father of the sick or hospitalized child. He is so often forgotten. Consideration for him as a member of the family unit is an essential part of the care of the patient. Throughout the child's illness the father is expected to carry on his daily routine. He must go to work to earn the family support, but at the same time he is expected to assume the role that many men have in today's families -- that of stabilizer. He must hold the family together, so to speak, in this crisis.[32]

This traditional view of the husband-father role brings up another point. Although many textbooks describe changes in families from a sociological viewpoint, e.g., one-parent families, working mothers, etc., seldom is this carried over into the practice arena. In my opinion, an assumption is made in discussing such activities as the admission of the preschool child to a hospital that all families are nuclear and that mother has neither a job nor other children to keep her from her sick child.

The instructions on how the pediatric nurse can be a "good" nurse are even more vague:

> If the nurse is to be worthy of her position in helping the pediatrician to build a happy, healthy childhood, she must have an inquisitive, receptive attitude toward new ideas.[33]

> With medical training and the knowledge of normal child behavior, the nurse can help treat and prevent disease; detect symptoms of physical, mental, and emotional trouble, and guide the child along pathways of optimum physical and emotional health . . . . The nurse can serve the child and the nation in trying to give every American a chance to be healthy and happy.[34]

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[32]Audrey J. Kalafatich, Pediatric Nursing (New York: G. P. Putnam's Sons, 1966), pp. 35-36.

[33]Gladys S. Benz, Pediatric Nursing (St. Louis: The C. V. Mosby Company, 1948), preface.

[34]Robert A. Lyon and Elgie M. Wallinger, Mitchell's Pediatrics and Pediatric Nursing, 4th ed. (Philadelphia: W. B. Saunders Company, 1954).

> The aim of pediatric nursing is to supplement the goal of pediatric medicine by meeting the physical, emotional and social needs of patients.[35]

> Empathy for her patients will be fostered in the degree to which the pediatric nurse learns to understand and accept her own attitudes and feelings and to appreciate the way in which she handles her problems. With such self-understanding she will be able to recognize and make explicit the origin and meaning of the behavior she observes in her hospitalized patients.[36]

However, there has been change over time. Marlow's work has an interesting evolution. The first Textbook of Pediatric Nursing (which Marlow co-authored with Sellew) states that "it should always be remembered that the child eventually goes home to his family."[37] The authors also observe that "an increasing number of mothers are remarkably able to control their own emotions . . ."[38]

In the second and third editions of the Textbook of Pediatric Nursing the following quote is found:

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[35]Jean Bulger Mash and Margaret Dickens, Armstrong and Browder's Nursing Care of Children, ed. 3 (Philadelphia: F. A. Davis Company, 1970), p. 4.

[36]Florence G. Blake, F. Howell Wright, and Eugenia H. Waechter, Nursing Care of Children, 8th ed. (Philadelphia: J. B. Lippincott Company, 1970), p. 11.

[37]Dorothy R. Marlow and Gladys Sellew, Textbook of Pediatric Nursing (Philadelphia: W. B. Saunders Company, 1961), p. 39.

[38]Ibid., p. 36.

> Good mother - child relations are based not on the amount of time they spend together, but rather on the quality of the relation while they are together.[39,40]

In the fourth edition the quote is changed to:

> Good parent - child relations are based not on the amount of time they spend together, but rather on the quality of the relation while they are together.[41]

And in the fifth edition there is a discussion of the role of the nurse as a family advocate.

Pediatric nurse practitioners and other nurses interested in primary care have developed their own literature. In the Preface of the Handbook of Pediatric Primary Care the authors state:

> The impetus for this handbook came from our discovery that traditional resources are not appropriately directed to the specific demands of PNP practice. There are no resources which combine content on primary care plus management from a family-oriented perspective in a compact and practical format.[43]

The idea of advocacy has also appeared in general pediatric nursing texts.

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[39]Dorothy R. Marlow and Gladys Sellew, Textbook of Pediatric Nursing, 2nd ed. (Philadelphia: W. B. Saunders Company, 1965), p. 7.

[40]Dorothy R. Marlow, Textbook of Pediatric Nursing, 3rd ed. (Philadelphia: W. B. Saunders Company, 1969), p. 13.

[41]Dorothy R. Marlow, Textbook of Pediatric Nursing, 4th ed. (Philadelphia: W. B. Saunders Company, 1973), p. 15.

[42]Dorothy R. Marlow, Textbook of Pediatric Nursing, 5th ed. (Philadelphia: W. B. Saunders, 1977), p. 17.

[43]Marilyn P. Chow et al., Handbook of Pediatric Primary Care (New York: John Wiley and Sons, 1979), p. vii.

> The primary role of the professional nurse is that of advocate of the child and family. By virtue of his longer, more continuous contact with the child and family, his basic knowledge of development, family dynamics, and disease process, the nurse is in the best position to assess the total impact of the illness and hospitalization on the child and family. If the professional nurse is to be a patient advocate, he must be adept in assessing, planning, implementing, and evaluating direct patient care. He must also act as liason, teacher, and consultant.[44]

Pilliteri describes "at least" four ways a family situation may influence the health of a child. The family may be a direct transmitter of infectious disease, the family will certainly affect the treatment and outcome of disease, it is important in determining who will receive health care, and the family's reaction to one member's illness may affect the family's overall unity.[45] The nurse's role then is "to recognize illness as a family problem rather than an illness of a single child."[46] Pilliteri then went on in her textbook to describe ways nurses could assess and intervene in a family-centered way.

In 1974 Chinn described four current trends in child health care. Three of these trends reflect values and beliefs about families:

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[44]Joyce M. Olson and Jo-Eileen Gyulay, "Pediatric Nursing in the Hospital," in Comprehensive Pediatric Nursing, Gladys M. Scipien et al. (New York: McGraw Hill Book Company, 1975), p. 905.

[45]Adele Pilliteri, Nursing Care of the Growing Family: A Child Health Text (Boston: Little, Brown and Company, 1977), p. 12.

[46]Ibid., p. 13.

--The basic responsibility for providing basic needs and protecting the child's health and happiness rests with the family. Society shares this responsibility but also protects the child's and family's right to independence, autonomy, and primary responsibility for their own destiny.[47]

--The basic goal of child nursing, as part of society, is to promote the ability of children and families to attain, retain, or regain health.[48]

--Child health care is meaningful to the extent that it is provided within the family's life style and health state, and to the extent wished by them.[49]

In my opinion, Chinn's statements are evidence of the growth of sophistication and knowledge about family-centered care in nursing. They also reflect back to Zahorsky's statements in 1937 about the uniqueness of each family.

The two predominant themes in pediatric nursing textbooks, family as knowledgeable and competent versus family as the needy recipient of knowledge and care, continue today. Both can be true, and both can be true at the same time for a given family. However, given the conflicts in the literature, e.g., the all or none presentations and the segregation of family themes from nursing care, is it any wonder that there are inconsistencies in practice and in implementation of family-centered nursing care?

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[47]Peggy L. Chinn, Child Health Maintenance: Concepts in Family-Centered Care (St. Louis: The C. V. Mosby Company, 1974), p. 17.

[48]Ibid.

[49]Ibid.

Summary

There is a knowledge - base for family-centered nursing in pediatric nursing textbooks. However, it is often inconsistent, seldom research-based, and has rarely-expressed and often conflicting underlying values.

It is clear from the literature that family cannot be totally separated from the child. It is also clear that nurses do interact with families, regardless of dominant philosophy underlying that interaction.

Therefore, it is logical that nursing address the problems outlined above. Research into the feasibility and value of various approaches to care is needed. Definitions of family-centered care must be determined and subjected to critical analysis. How does one nurse the family when a child has been abused? How does one nurse the extended family? When conflicts between patient/client and family arise, what guides the critical decisions of priorities? The list of questions is virtually endless, and the challenge to nursing exciting.

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PEDIATRIC NURSING RESEARCH:

THE STATE OF THE ART

A Review of the Literature

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Is there a knowledge base of clinical nursing research available to help the inpatient pediatric nurse? This is the question addressed in this paper describing a selection of relevant studies reported in nursing and related literature from 1952 to 1979.

The literature search included the following: Nursing Research, 1952-1979; the Western Interstate Commission for Higher Education's Communicating Nursing Research series, 1968-1977; the American Journal of Maternal Child Nursing, 1976-1979; the American Nurses' Association's Nursing Research Conference series, 1965-1973; and the Maternal Child Nursing Journal, 1972-1978. In addition, articles in general and specialty nursing journals which were identified as reports of studies from 1950-1979 were included.

Nursing dissertations abstracted in Dissertation Abstracts International were reviewed. Time constraints precluded addition of any of the actual dissertations. A selected list of relevant dissertation abstracts can be found in Appendix A.

The 55 studies included in this summary do not represent an exhaustive collection of pediatric studies to date, but, in the author's opinion, they are generally representative of the literature as a whole. Of these 55

studies, 10 (18.2%) are experimental or quasi-experimental studies. There are 44 (80%) descriptive studies; 13 of these included a comparison group of some kind. One case study is included (1.8%).

Studies not included in this summary are those that address issues of normal newborn care and the care of the premature or high risk infant. Also excluded were studies outside of pediatric nursing literature that may be applied to pediatrics, e.g., studies of isolation procedure.

The studies described were not included because they represent outstanding research methodology. In fact, some would be difficult to justify as research in the strict sense of the word. However, the practicing nurse would find all of these listed under "studies" and "research", and the lack of quality control is a current reality of the nursing profession.

Selected studies are described in considerable detail. They represent common research designs included in this summary and in current nursing literature as a whole.

The Current State of the Art

Although plagued with methodological inaccuracies, limited clinical investigations, and minimal attention to

theoretical frameworks, there is an insightful literature in pediatric nursing from which a practicing nurse can gain information to help in his or her practice.

Hospitalization

The issues of psychological distress as a result of the fact of the hospitalization experience itself have been examined extensively by nurses. In 1952 Wilkins reported results of a survey of 135 schools of nursing that had been approved to teach pediatric nursing. Her purpose was to discover what current practices were used in admitting preschool children to hospitals and to show how nurses may assist in reducing anxiety expressed by children as they are admitted; 100 of 135 questionnaires were returned. She found that nurses explained admission procedures to the child, provided toys, gathered personal information about the child from his or her mother, accompanied the mother and child to the ward, and remained with the child during physical examinations, explaining what was happening. A few schools reported that mothers were not allowed to accompany their children to the units; others did not allow children to bring their own personal possessions. No methodology was described and the link from gathering data about what was happening to what could

happen was not made explicit. Recommendations included increasing visiting sessions for parents.

Godfrey (1955) conducted an experimental study to examine what, if anything, the nurse can do to assist hospitalized children, aged 2 to 6, and their parents toward making a more comfortable adjustment when the parents leave at the end of the visiting period. Specifically, the question was: does purposefully planned nursing care during the visiting period and for 30 minutes after the parent has departed make a difference on how the children and their parents feel at the end of the visiting period.

Godfrey presented an extensive literature search related to the effect of hospitalization and separation on the child, the parents and the hospital staff. The documentation provided a rationale for a concern about separation and for the need for positive experiences for families during visiting periods. (It should be noted that, at the time of this study, visiting hours at Vanderbilt University Hospital, the site of the study, were one-half hour daily, 2:30 to 3:00 p.m., and for one hour and one-half on Sundays.) The question was and continues to be an important one for nursing.

The sample consisted of 50 children, aged 2 to 6, and their parents; 23 were in the control group and 27

in the experimental. The age range was chosen because of the judgment that preschool children have the "most" difficulty with separation. Patients were assigned to groups by alternating the collection of data under control conditions with those under experimental conditions in continuous two-week blocks. While no explanation was given of why this approach was used, it may have reduced the possibility of contamination in the ward situation.

The sample was a convenience sample, with control for orientation to the environment, age of children, and frequency of parental visiting. Children were excluded from the study if they were comatose, deaf, or mentally deficient, if they had special nurses, if they slept through the visiting period, or if they were critically ill.

The control group was subjected to usual ward conditions. The experimental group had a nurse providing purposefully planned care to meet the needs of an individual child and his or her parents during the visiting period, at the parents' departure, and for 30 minutes after the parents had left. The goal of the care was to make separation more emotionally comfortable for all of them. Godfrey provided a description of what this care could include and the minimum it would include.

The dependent variables were children's feelings on separation and parents' feelings on separation. The method used to measure responses by children was direct observation of behavior and immediate recording, under both control and experimental conditions, from the beginning of the visiting period until 30 minutes after the parents had left. The method used to measure parental response was a one-question questionnaire: "How do you feel about leaving your child today?" This was asked just after leaving the child and the responses were immediately recorded.

The direct observations were made by ten nursing students; they were also the nurses who provided the experimental treatment. They received training in observation and recording but no inter-rater reliability is reported. Recorders were assigned to observe parents and children whom they did not know from prior clinical work.

The direct observations could be problematic with subjectivity and bias, but a greater concern is the question asked of the parents. In addition to the dangers of relying on only one question for a complex construct, the socially acceptable answer may not be the honest answer.

The responses and behaviors of parents and children

respectively were rated by ten judges with knowledge of behavior and of children. These judges read the child observations and parental responses and indicated on a five-point rating scale, developed by Godfrey, how they thought each child and each parent felt. (The scales went from very secure to very anxious.) Inter-rater reliability for the judges for child observations and parent responses respectively were 0.8133 and 0.7650. Godfrey added the caution that the five-point scale was not as sensitive as a finer scale would be and could have inflated the reliability figures.

Mean scores were reported and compared, and "t" tests used to test significance. Putting aside questions of the assumptions underlying the "t" test in relation to this study, when the total numbers of children in the control and experimental groups were compared, the difference between the groups was in favor of the experimental but not significantly so. The parents of these children felt about the same under the control conditions as they did under the experimental conditions.

Questions of the operationalism of the dependent variables, measurement reliability and validity, and statistical analyses are serious. However, this 1955 study is impressive in what it addressed and the relative

sophistication of its design.

Branstetter (1969) compared groups of young children in the hospital in order to differentiate whether the reaction to separation was due to the child's attachment to the mother, to the stress of the hospital experience itself, or to need deprivation due to a lack of mothering care. The design was a comparison of three groups of children, ages 14 to 36 months, under three conditions of separation from mothering: the mother-present group, the substitute-mothering group in which individuals chosen for personal warmth and an interest in children spent most of the child's waking hours with him or her, and the mother-absent group in which the children received the usual hospital care without a rooming-in mother. (The substitute-mothers were selected and trained by the investigator.) Again in this study the question is a significant one for nursing.

Although Branstetter did not state formal hypotheses, she suggested that the mother-present group, when compared with the other groups, would exhibit signs of the stress of hospitalization. Thus, the two other groups would give information about how much of the reaction seen was due to deprivation of mothering care as opposed to the emotional tie to the mother as a person.

This descriptive study had 30 children as subjects, ten in each group. There is no evidence of a random assignment to groups. The criteria for selection included that the child have no previous separation from mother because of hospitalization, that the family be intact at the time of admission, and that the child not be acutely ill or be scheduled for surgery. The children were all judged to be within normal limits for growth and development. The groups were matched for age and sex; although not matched for socioeconomic status, 85% came from upper lower and middle-class homes. Cultural differences were not addressed.

Data were collected through naturalistic observations in the hospital setting, 15 minutes twice a day, on the 2nd, 3rd, 5th, and 7th days of hospitalization. There was no randomization of observations and the investigator apparently was the observer. The observations were recorded directly on tape and then transcribed.

The researcher developed an instrument of ten behavior categories to code the observed behaviors. It is not clear how she chose the behaviors nor how she assigned numerical values to behaviors. Reliability scores are reported for observations (95% agreement), dividing the observation narrative into units of behavior (98% agreement), and for assigning categories of behavior to

the units (93% agreement). How these figures were arrived at is not reported.

The general results showed behavior differences between the groups. The substitute-mothering group showed behavior similar to the mother-present group, and both of these groups showed much less disturbed behavior than the mother-absent group. The data were analyzed using multivariate analysis of variance; why this method was chosen was not discussed. More appropriate analysis techniques could have been found for this non-experimental study. However, significant differences were found in the mother-absent group in twelve of sixteen behavior categories. Other significant variables were age, sex, age and condition of mothering, day of hospitalization and condition of mothering, and day of hospitalization and sex of subjects.

This was a descriptive study and, as such, was fairly well described. However, questions of methodology arise consistently through the document. The need for more complete information on why and how data were gathered is apparent. Also, a replication is still sorely needed.

Hennessy (1976) looked at behavioral responses of hospitalized toddlers to tape-recorded communications from

their mothers during a brief separation. The children, ages 17 to 30 months, listened to tape recordings of their mother reading a story about a lost kitten, a story of separation with a happy ending. All of the children recognized their mother's voice; an inference was made that they were comforted by this contact. The usefulness of this kind of technique in practice is clear; it is an easy, inexpensive, not very time-consuming technique.

An additional feature of interest in Hennessy's study is the variables she controlled for in her sample. There was no indication of randomization, but she did control for age, developmental level, seriousness of illness, frequency of mother's visits, and for the possibility of child abuse as a factor in the hospitalization. This latter variable is not addressed directly in any of the other studies and is certainly a potentially confounding variable in studies of separation.

Two studies attempted to take a longitudinal look at the effects of early childhood hospitalization and serious illness. Holt (1968) did a five-year follow-up of thirty children who had originally been subjects in a study of the reactions of three, four, and five year old children to hospitalization and illness. (There was no information about how these children were selected for the

first study.) She used play and direct verbal techniques in her interviews with the children, and the use of play is well-described in her study. Data were analyzed using scoring systems and rating scales, but what these were was not included in the study report. (She did use judges to rate the drawings of the children.) The descriptive analysis of the findings indicated that, based on what children included and left out in their recall of the former hospitalization, their knowledge and understanding of their previous illness, and their current perception of self, that the presence of chronic illness should be viewed as an indicator for concern. There are many more implications from the findings of this study, but the overall message is that the hospitalization experience is not easily forgotten.

Fergusson (1976) looked at eighteen children who had survived at least four years after a diagnosis of cancer. She determined that psychological damage does not necessarily follow diagnosis for cancer in early childhood. She reviewed hospital records for information about the emotional distress of the child during the early hospitalization and then interviewed parents, asking for both their recall of the early responses of their children to their illness and for what had happened since

then. She tested the children using projective and interview tools. She found that there was a correlation between healthy post-illness adjustment and a free and open atmosphere about the illness in the family. She also was struck by the fact that even twelve years later some parents still needed to talk about their feelings about the early experiences they had. The lack of randomization, the small sample, and the projective techniques suggest need for replication.

These two studies offer some guidelines for future longitudinal studies in nursing. Regretfully, these are the only two in this summary that even began to address such long-term concerns.

Parent Participation

Do parents wish to participate in their children's care? Morrow and Johnson (1968), MacDonald (1969), Beck (1973), and Jackson, Bradham, and Burwell (1978), in small descriptive studies, found that parents generally wish to participate as much as possible in their children's care. In two of the studies (MacDonald; and Morrow and Johnson) nurses' attitudes were also sought. Generally the nurses thought that parents should or wanted to participate in fewer care situations than did the parents,

from their responses. Dew, Bushong and Crumrine (1977) evaluated parental response to allowing parents in the recovery room after their child's surgery and found that 98% felt better about their child after seeing him or her in the recovery room and that 100% would do it again.

Although none of the above studies are distinguished for their methodological sophistication, they add up to some impressive evidence that, in general, parents wish to participate in their children's care, even to the extent of braving the recovery room. This is a far cry from the one-half hour daily visiting of Godfrey's study. In addition to looking toward an experimental design that examines some of these issues of parent participation and nurses' attitudes, it would be enlightening to look at those parents who may not wish to participate in the same way. Will they become the ostracized group in the future? Will it be acceptable for them to say they do not wish to participate?

Using a different approach to parental responses to the situation of their child's hospitalization, Gardner and Simpkins (1976) compared reactions of parents to three different types of dress worn by nurses in a pediatric intensive care unit. The three alternatives were a traditional white uniform, uniforms with colorful smocks,

and street clothes. Not too surprisingly, perhaps, the results indicated that what the nurses wore was not as important as how they performed as a source of support for the family.

Roy (1967), in an intervention study, found that a mother's level of adequacy in relating to her hospitalized child could be increased by the nurse's introduction of cues about the mother's role in caring for her child. The design was quasi-experimental, with 30 mothers divided into four groups, each group receiving a pattern of cues or no cues according to the design. Assignment to groups was done by the order in which the mothers became available to the pediatric staff nurse assigned to the project.

The cues were defined as overt actions of the nurse in interaction with the mother. The actions were of three specific types: congruent orientation, involvement, and role reference. The theoretical framework for the study was role theory, and it was hypothesized that the specific introduction of role cues would increase the level of role adequacy in the mother.

The two instruments used in this study were developed by the investigator. One was an observation schedule for measuring the level of the mother's role

adequacy on the three days of observation per subject in the study and the second instrument was an interview schedule to cross-check the experimental manipulation of tools. Validity and reliability studies of both instruments are reported.

Data were analyzed by comparing the number of scores from the tools, above and below the median, for each of four relations which the investigator believed critical. Comparing the cue scores for conditions when mothers received cues with the scores of those same mothers when they did not receive cues, the correlated means showed a difference that was significant beyond the 1 percent level. The nurse's introduction of role cues consistently provided the mothers with a higher number of role cues. Going a step further, the second part of the analysis, using chi-square values with Yates' correction for small expected frequencies, showed that the manipulation of cues did affect the levels of adequacy positively, with statistical significance occurring in three of the four selected relationships of cues-no cues at at least the $P<.05$ level.

This study is a good example of a small-scale, but well designed clinical study. It is relevant; parents who do wish to participate in their children's care may need

assistance in translating their normal relationship with their child to the strange setting of the hospital. And, if we do believe that the child will benefit be parental presence and care, then it becomes part of nursing's responsibility to help facilitate that experience. The sampling problems and the need for replication do not diminish the real contribution of this study to pediatric nursing literature.

Rooming-in

The literature reflects another leap from the early and mid-fifties with the studies of rooming-in for parents of hospitalized children. Fagin (1964) compared selected areas of pre- and post-hospital behavior of two groups of children, ages one and a half through three years, with one group attended by mother and the other not. Her results demonstrated regressive behavior in the absence of a mother rooming-in during hospitalization.

McGillicuddy (1977), a student of Fagin, built on this early work. Her problem statement indicated that she was interested in the relationship between mothers' rooming-in during their children's hospitalization for selected diseases and changes in selected behaviors of their children. Considering the complex variables implied

by this statement it would be expected that the attempt to study the problem would be careful to define and limit the study variables and to adequately describe the constructs underlying the problem. Unfortunately, this study did not address these issues sufficiently.

McGillicuddy used a quasi-experimental design with three groups of ten children each. Two of the groups were of hospitalized children, one of which had mothers rooming-in and the other did not. The third group consisted of nonhospitalized children. The choice of a quasi-experimental design was appropriate for this study; McGillicuddy could not ethically or practically randomly assign children to rooming-in or non-rooming-in situations. The group of nonhospitalized children was drawn from volunteers from a local school; the hospitalized groups were taken from three private, voluntary hospitals.

McGillicuddy controlled for age, physical and emotional problems, chronic illness, family situations, length of hospitalization, and reason for hospitalization. The three groups were comparable with respect to sex, number of children in the family, position of child in the family, and social class.

Major concerns arise in analysis of some of the inclusion-exclusion decisions. The age range included

in the study was one and a half to four years. This is a very broad span; by four years of age many children have considerable experience with separation, whether in nursery school, day care, or the like. One would not expect the same reactions as with a younger child. Secondly, the diagnoses acceptable for inclusion were a mixed-bag of medical and surgical problems. Can one equate a herniorrhaphy with "eye surgery" or a tonsillectomy with an upper respiratory infection? Bringing together medical and surgical conditions, and very different surgical procedures makes the question of the meaning of the hospitalization to the child and the parent more problematic.

Another problem is in the definition of rooming-in. All of the mothers of hospitalized children indicated a willingness to room-in with their child but were unable to do so because of hospital policy or some personal circumstances. If, for example, the mother had a job and thus could not stay, would this not have an effect on the child's responses? Rooming-in mothers by definition stayed at least twenty-four hours a day for two days and then at least ten hours for the remaining days of hospitalization. The non-rooming-in mothers did not stay twenty-four hours a day during the first two

days, but only visited the child at some time during the hospital's visiting hours. No information is provided about the usual visiting hours. No information is provided by how frequently or how long at a time these mothers visited. It is feasible that they could virtually equate the time spent by the rooming-in mothers in the long run.

The major difficulty that keeps recurring is the problem of construct validity in this study. Unlike Branstetter, McGillicuddy did not separate out separation, hospitalization, lack of mothering and mother's importance as a specific person. Her literature review reflects this difficulty; there is much of interest, but it does not "hang together".

The dependent variables as identified by McGillicuddy were selected areas of behavior, including dependency, reactions to temporary separations, toilet, eating, sleeping and autoerotic behaviors. They were measured by mothers' reports obtained during prehospitalization and posthospitalization questionnaire interviews. The questionnaire was developed by researchers from the Northwestern University Medical School and all validity and reliability information comes from their work. Insufficient information is given about the questionnaire. Little

indication is available to determine whether or not the tool is consistent with the concepts considered in the research statement.

McGillicuddy and a trained data collecter did the interviews. The problem of bias comes in because of the interaction necessary between the subject and the interviewer. In addition, was there a problem on the part of the mother's willingness to indicate "negative" behaviors on the part of her child? This is not addressed.

The analysis of data section is a very confused and confusing part of the report. The data were analyzed using analysis of variance. Insufficient information is provided to evaluate this adequately. (A summary table of the analysis of variance with F ratios is given but it is inadequately labeled.) McGillicuddy indicates that the results support a main hypothesis of her study, that children whose mothers room-in with them during hospitalization demonstrate changes in a positive direction in selected areas of behavior. That is, a hospitalization not only need not be traumatic, but, in fact, can be a growth-producing experience when mother is able to stay.

This study is a good example of a good idea that lost effectiveness from the beginning from a lack of conceptualization and definition. It is unfortunate,

given the obvious amount of effort and the importance of the general area of study. The meaning of the non-hospitalized control group was lost. And the interesting results, according to McGillicuddy, lack credibility.

What effect have studies of rooming-in and parent participation had on the visiting privileges in pediatric units? Fagin and Nusbaum (1978) conducted a survey of 1,154 hospitals in the United States to try to answer this question. Of 720 returned questionnaires, 636 were usable. Sixty-two percent of the hospitals in the sample permit twenty-four-hour parental visiting. Of those hospitals that do not permit this extent of visiting "many" indicated that under certain conditions parents may stay. Socioeconomic differences do influence visiting privileges. Parents who can afford a private room are more likely to be able to stay than those who cannot.

Fagin and Nusbaum found that in spite of the fact that many places permitted rooming-in, at the time of the survey very few parents were taking advantage of this opportunity. In looking at this the investigators suggest that the attitudes of the staff may be limiting the parents' rights; i.e., the professional staff may be possessive of the patient and give the indirect (or

Topics
suitable
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&
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When Proof
does not
address
living parents
personally

Arthur Kornhaber
Woodward, Ken
Grandparents
Grandchildren
Mrs Mitsl Cox

direct) message to the parents that they need not stay.

Studies about nurses interacting with children in hospitals, with or without parents present, do not indicate much effect of the rooming-in and patient participation studies either. Smith (1976) determined by observation that the number of contacts of nurses with hospitalized children was the same regardless of whether or not their parents were present. Cleary (1973) in a British descriptive study of the numbers and kinds of nurse-patient contacts on an acute children's ward in a provincial general hospital concluded that the task assignment method of staffing was detrimental to meeting children's needs and recommended increased visiting hours and a case assignment staffing pattern. Alcock's (1977) Canadian survey of hospitals with pediatric beds found that many were lagging behind in implementing research findings about visiting hours, sibling visits, pre-admission orientation, child-oriented care, schooling in hospitals and volunteer programs.

And so, the research we have is not being consistently translated into practice.

Pre-operative Preparation

Moran (1963) in a quasi-experimental study found increased parental satisfaction with the hospitalization

experience of their child's tonsillectomy and adenoidectomy when they had received a planned preoperative preparation. Although questionable in design and methodology, the general findings from this early study have been supported by studies by Mahaffy (1965), Thomson (1972), and Cox (1976).

One of the better studies in many respects was done by Wolfer and Visintainer (1975). The hypothesis of this study was that children and mothers who received special supportive care in the form of psychologic preparation and continued supportive presence would show less upset behavior and better coping and adjustment as indicated on ten dependent variables, as compared to a control group of children and mothers. An extensive literature review tied this study to previous work and underlined the lack of systematic investigations, theoretical frameworks, and replication studies in this area. The basis the investigators chose for the nursing intervention was social interaction theory, and in particular, the emotional contagion theory, to explain the transaction between parent and child.

The purpose of this study, then, was to: provide a partial replication of selected earlier studies; operationalize the independent variable, psychological

preparation and support care for parent and child; examine and define the transactional process of communicating with both mother and child; and examine the effects of the experimental preparatory and supportive transactions in relation to the age and sex of the child and whether the mother roomed-in. The ten dependent variables in this study were: blind observer ratings of the children's upset behavior and cooperation with procedures at five potential stress points; pulse rates at admission and before and after the blood test and preoperative injections; resistance to induction; recovery room medications; ease of fluid intake; time of first voiding; posthospital adjustment; mother's self-ratings of anxiety at potential stress points throughout the hospitalization; mother's rated satisfaction with various aspects of the nursing and medical care they received; and mother's ratings of the adequacy of information they received.

A two-group experimental design was chosen, with random assignment of children and parents to either a control or an experimental group. The experimental group received special preparation and supportive care by the same nurse at six different times during the hospitalization. The control group received regular

nursing care. Children's pulse rates, which were taken at admission, before and after the blood test, and the preoperative injections, were treated as repeated measures. The upset behavior and cooperation ratings were analyzed separately for each of four events: admission, examination, blood test, preoperative injections, and transportation to the operating room.

The report detailed a description of the setting and of what consitituted routine care. There were only ten registered nurses to staff a thirty-bed pediatric unit; most of the care was provided by licensed practical nurses and nurses' aides. No preoperative instruction was given and little nursing contact was made unless specifically requested by the child and/or the parent. A licensed practical nurse did all admission in the hospital and the "control" children were included in the general population.

The sample consisted of 80 children, between the ages of three and fourteen. This large age gap was handled in the analysis by dividing the groups into 3-6 years of age and 7-14 years of age, considerably more reasonable in terms of growth and development. The children had not had a prior hospitalization within the last year, they were English-speaking, and were free from

chronic diseases and special medical or psychological problems. They were admitted for tonsillectomy, adenoidectomy, myringotomy, polyethylene tubes (and any combination of these), or inguinal or umbilical herniorrhaphy. Precautions in assigning rooms were taken to prevent contamination of control and experimental subjects.

The experimental intervention of the nurse was well described. In essence, the intervention consisted of accurate information about sequence of events, sensory experiences, role expectations and appropriate responses, previews of procedures through play techniques, and supportive care given at critical points pre- and post-operatively. Those points of intervention were admission, shortly before the routine blood test, late in the afternoon the day before the operation, shortly before the pre-operative medications, before transport to the operating room, and upon return from the recovery room.

The dependent variables were measured as follows: Behavioral ratings were measured using a manifest-upset scale and a cooperation scale, each five-point scales which describe verbal and nonverbal behaviors which correspond to little or no evidence of distress, a moderate amount, and considerable distress. The nurses

observer was unaware of who was in the experimental and who was in the control groups when she rated behaviors. (The scales were developed by the investigators; reliability and validity evidence from pilot work is reported.) Pulse rates, recovery room medications, time to first voiding, and ease of fluid intake were all measured fairly straightforwardly. However, there is no evidence that which anesthetics and induction medications were used might also affect some or all of these physiological measures. And, the tonsillectomy patients surely would be predicted to have less ease of first fluid intake than some of the others.

The posthospital adjustment variable was measured by parent report, using a Posthospital Behavior questionnaire, a list of 27 behavioral items most frequently cited in the literature as sequelae to a child's hospitalization. The parent was asked to compare the child's posthospital behavior with his typical behavior before hospitalization. The questionnaire was given to parents before they left the hospital and on the eighth day post discharge they were contacted by phone and reminded to complete and return the questionnaire. There was an 87 percent return rate.

This particular parental self-report again raises questions about the expected response. Ideally, some home

observations would be helpful.

Parental measures included observations and ratings with the manifest upset and cooperation scales of the parents at admission. In addition, three other measures for parents were obtained from a questionnaire which was administered shortly before discharge. One assessment was the parent's self-rating of anxiety expressed at selected points during the hospitalization. A satisfaction of care score was included in the questionnaire, as was a score to indicate the adequacy of information received during the hospitalization.

The data were analyzed using analysis of variance. Significant differences were found between experimental and control children and parents on ratings of upset behavior, cooperation with procedures, pulse before and after painful procedures, resistance to induction, time to first voiding, posthospital adjustment, and parental anxiety and satisfaction with information and care; these findings consistently supported the hypotheses.

In discussing the limitations of the study the investigators suggest that there is a possibility of observer bias and of bias on the part of the parents. The effect of the special nurse caring for them and their child may have had a halo effect on the hospitalization

experience, and they may have wished to reflect well on "their" nurse and so rated themselves more satisfied than they were. In addition, the contrast between this clinical specialist who came in at specified times to be with the family and the professional nurses who were responsible for the whole pediatric unit must be considered. Had this study been done in a setting with an all-registered nurse staff or one with a little more depth of professional nurses than approximately two per shift (not counting vacations) for thirty patients, the effect may not have been as strong.

Further themes of the interaction between parent and child were explored by Hadley (1968) and Olgas (1974). Hadley suggested that patterns of preoperative parent-child relationships influenced the processes of role change or the relinguishment of the sick role of a child following a curative operation for congenital heart disease. Using a convenience sample of children who were to undergo surgery for such cardiac conditions, Hadley classified each into one of three patterns of relationships, protective, rejective, or adaptive, on the basis of an initial interview. She then used observations and interviews to determine the degree to which the sick role was relinguished and when it occurred. She concluded

that sick role relinguishment was not automatic with the completion of the curative surgery and that socio-emotional environment was more important than medical status.

Olgas, taking a different approach, studied the children of visably disabled parents and of healthy parents and found no difference in body images among the two groups.

Hospitalized Children's Views

Several descriptive studies have been done to try to identify how children perceive hospitalization and how they respond behaviorally and emotionally. In addition to the ones already discussed, Jacob (1953), Pidgeon (1974), Barnes (1975), and Beardslee (1976) described various behaviors of children, all concluding that environment and nursing acceptance of the children as individuals was important.

In attempting to get at children's emotional responses, such as fears and definition of stressful occurrences, nurses have used various techniques. Fuszard (1969) asked adolescents to rank registered nurses on a scale indicating how they perceived the nurses. The results were compared to nurses' scores on an authoritarianism scale. The hypothesis that the adolescents would rank less authoritarian

nurses higher (more positively) was not supported. Fleming (1972) used differences in drawings of human figures and of families to compare chronically ill, acutely ill, physically disabled and well children. (Significant differences were found; interpretation of the meaning of this finding could be strengthened by a stronger conceptual base and additional supportive work.) Menke (1973) developed a game to help identify children's perceptions of stress in the hospital. And Astin (1977) used a checklist of potentially fearful objects to compare fears of hospitalized and nonhospitalized school-age children. In these studies the tools used almost overshadow the results; creative and stronger studies could use the contributions of these researchers.

Procedures

Four studies deal with children's responses to procedures. Riddle (1972) and Mandleco (1976), in small descriptive studies, both described children's reactions to procedures (binocular bandages and percutaneous renal biopsies). McCaffery (1971) attempted to determine the effect of cognitively specific preparation on three and four year old children's observable behavioral responses to rectal temperatures. She used a two-group design, with 13 in the control group and 14 in the

experimental group. The intervention was cognitive preparation. Variables that appeared to influence behavioral responses most, however, were age, physical trauma, the amount and/or type of sensory stimulation at the time of temperature taking, the child's physical activity, and the presence of visitors during the procedure.

One of the most outstanding of the studies in this summary is Johnson, Kirchhoff, and Endress's (1975) study of intervention to alter children's distress during orthopedic cast removal. This study is part of a program of research which Johnson has spearheaded. The theoretical background began with psychological research on the effects of cognitive processes on behavior, including emotional behavior. Johnson's observation and research led her to believe that the intensity of a response that reflects emotion during a threatening event may be a function of incongruency between expected and experienced sensations. Thus, the greater the incongruency, the more intense the emotional response.

The purpose of this study was to build on previous research, in which adults, given verbal descriptions of the sensations they would experience, found threatening procedures less upsetting. This research looked at

children's responses to a threatening event, and the event chosen was orthopedic cast removal among children who had had a cast applied as the result of injury.

The hypothesis, then, was that children who heard a preparatory message which describes physical sensations of orthopedic cast removal will display less distress during cast removal than those children who receive no experimental information. A three-group experimental design was used. Two of the groups were control groups; one group heard a taped message which described the general procedure of having a cast removed and the second control group heard no tape-recorded message. The experimental group heard a taped message which described the sensations during cast removal.

The sample consisted of 89 children, five of whom were excluded from data analysis because of atypical experiences in cast removal. The data were all collected in the orthopedic fracture clinic at Children's Hospital, Detroit, Michigan. Children were accepted into the study if they had not had a cast removed within three months, were at least six years old and no older than 11, and had no obvious neurological or developmental problem. Assignment to information group was by fixed order. This type of assignment was used to allow even distribution

in information groups of younger and older children, boys and girls, and, according to the investigators, removed the possibility of systematic bias. The age range chosen was appropriate for cognitive information to be effective, and there was not yet the adolescent restraint in the face of perceived threat.

Data were collected over a ten-month period. Measures of the dependent variables included stick figures of four children on an equal interval continuum to determine how fearful the children were at different points during the clinic visit. Pulse counts were taken, again at selected intervals, observations were made and recorded of minor and major signs of distress from the time the saw touched the cast until the limb was freed from the cast. (Interobserver reliability was 88.2 percent for minor distress scores and 100 percent for major distress.)

The intervention was made just after the child was settled in an examining room and the determination that the cast would, indeed, be removed was made. To control for changes in voice, inflection, and message, both the tape of sensations and of the general procedure description were done by the same person.

The data were examined for relationships between the characteristics of the children and the distress scores. A two-factor analysis of variance, least squares method

was used. The hypothesis that a preparatory message which describes the sensations children experience during orthopedic cast removal will result in reduced stress during cast removal was supported. Observable behaviors that indicate distress occurred significantly less frequently in the sensation groups than in the no-information group.

Pulse rate changes gave some support for the conclusion that the sensation group was less distressed since only the two control groups had significant increases in pulse rates. Reported fear during the procedure was not significantly affected by preparatory information. Fear admitted prior to cast removal was related to higher behavioral distress scores and reports of fear during cast removal than in children who did not report fear prior to the procedure.

The possibility of observer bias occurs if the observer knew which group the child was in, and in the absence of information to the contrary it remains a problem.

This study is not perfect -- none is -- but it is exciting. The problem is a real one and in busy clinics the intervention tested here would be a practical, inexpensive of time and equipment addition. The study

is generally noted to be logical, consistent, clear, and explicit with regard to theory and design decisions.

Related Topics

Tool Development

Three tool development reports were found that were pertinent to pediatrics. Seidl and Pilliteri (1967) reported on their development of an attitude scale on parent participation. Rodgers, Ferhold and Cooper (1974) discussed their testing of a tool to assess psychological adjustment of school age children with cystic fibrosis. Calkin (1979) reported her initial work with her tool to assess toddlers' adaptation to hospitalization.

Most of the tools used in the studies in this summary have been borrowed from other disciplines. Projective tools are used frequently, as are questionnaires and observation guides. There is a need for tools which are more sensitive to changes in behaviors than some of the larger-scale development assessment tools (such as the Denver Developmental Screening Test). And there is a critical need for tools that can be used by clinicians as well as researchers to assess the effects of interventions. Calkin's tool is an example of one that has promise for the future but that needs rigorous validity and reliability testing before it can be used with any confidence.

Special Populations

Special populations of children such as the chronically ill or dying children have not been extensively studied by nurses. Garlinghouse and Sharp (1968) found a relationship of the self-concept of hemophilic children and family stress with the number of bleeding episodes. Holoday's (1974) descriptive study compared responses of chronically ill children to those of well children using an Intellectual Achievement Responsibility Questionnaire to determine achievement behavior. Payne (1973) described the relationship of alienation and Piagetian concepts with frequency of hospitalization of diabetic children. Eggland (1973) compared locus of control between children with cerebral palsy and nonhandicapped children and found the handicapped children more externally controlled.

Surprisingly, only one study looked directly at the dying child. Waechter (1969) compared four groups of 64 children, 16 per group. These four groups were: children with chronic disease and death predicted, those with chronic disease and a good prognosis, those with a brief illness, and nonhospitalized children. Information was gathered through projective tests, interviews of the child's nurse and social worker, medical records and

and observations. Dying children did evidence increased anxiety. Analysis of her findings prompted Waechter to recommend increased communication with parents to help them help their children.

Parental responses to chronic diseases in their children were examined by Mercer (1974), Gudermuth (1975), Murphy and Pueschel (1975), and Buchanan (1977). The studies ranged in numbers of subjects from 5 to 90, and all are questionable in validity and reliability as they stand by themselves. However, repeated themes indicate the importance of early and continued intervention to deal with attachment, acceptance, and the daily stress.

In a sense, another special population for the pediatric nurse is the well child. Three studies looked at nonhospitalized, healthy children for information about children's views. Swanson (1977) compared responses of 96 mothers and their children about what objects and situations were frightening to the child. Schultz (1971) asked 74 school age children about hospitalization experiences to determine how they perceive pain. Brodie (1974) had 408 healthy school age children respond to a questionnaire on illness and general anxiety, comparing the results with previous similar work with ill and hospitalized children. She found that the healthy, nonanxious children

rejected the possibility that misbehavior caused illness. Previous work has indicated that ill and hospitalized children tend to possess distorted views regarding causality of illness.

Clinical Observations

Case studies are generally not included in research reviews, but Durand's (1975) analysis of a child with Down's syndrome and failure to thrive syndrome deserves mention. This excellent case study gives rise to many research questions and provides a model for additional such studies.

And, Gillon's (1973) collection of information of the behavior of 82 infants with cardiac distress was an attempt to identify information useful to nurses in evaluating the severity of cardiac malfunctioning in newborns. She described specific behaviors under seven categories: respiratory status, feeding behavior, activity, color, posturing, cardiac rate, and cry. This description of her observations, thoughtful and objective, also is a model for clinical contributions from which researchers can design relevant clinical studies.

Summary

Nursing is a practice discipline. If there is any justification for research and education it must be found in providing support for practice. The questions addressed by the studies included in this summary are relevant to nursing practice because that was a major criterion for inclusion. However, there are many "So what?" studies in the literature that would not stand up to the criterion of usefulness and appropriateness for nursing practice, even a couple steps removed.

However, many of the questions included in this summary were not well conceptualized. Conspicuously absent in most of these studies were theoretical frameworks. An ad hoc approach to research questions has resulted in interpretations of results that often seem to lack connection with the study itself.

The vast majority of the studies included in this review are small-scale descriptive studies. Relatively few can be called intervention (experimental or quasi-experimental studies) and, of these, few have attempted any form of randomization. External validity is virtually absent in most of the studies and internal validity is highly suspect.

Sampling in a clinical situation is difficult at best.

Sampling from a pediatric population compounds the problem. In addition to the legal and ethical considerations, there are many issues of age, development and culture. Two three-year-olds may have very different behaviors in the face of a stressful situation and yet both be within normal limits for their age and development. Trying to determine an acceptable age range for a study is difficult, particularly but not exclusively from infancy to school age.

A major issue for nursing research is the lack of criterion measures to identify the effects of nursing practice on patient outcomes. Tools such as physiological measures and projective tests are borrowed from other disciplines and are used, sometimes effectively, to approach the impact of nursing care on patients and families. But development, refinement, and reliability and validity testing of tools specific and sensitive to outcomes of concern to nursing are urgently needed.

Most of the data analyzed in these studies were nominal or ordinal. When statistical analyses were done at all, and often they were not done, they seldom were well done. They rarely addressed issues of limitations of the data or fully explained how they were manipulating the data. Sometimes it can be inferred, most times not.

The use of replication to build evidence for an intervention has been underused in nursing. This is a potentially powerful tool, given the unavoidable problems of using a clinical population.

Another alternative, laboratory research, has potential for nursing. There was no example of its use in the pediatric literature searched for this review.

There are many areas of nursing care and concern for the pediatric nurse practicing in the hospital which are not mentioned in the research literature. The problems range from the most efficient and effective way to give antibiotics intravenously to children with restricted fluid intake, to effective interventions to assist siblings of chronically ill children with prolonged hospitalizations become part of the family functioning. Perhaps the most neglected area is that of procedures, the day to day activities of nursing that are too often practiced by rote or imitation.

The state of research reflected in this summary is reflective of nursing's youth in research. There has been a dearth of experienced nursing researchers committed to investigating nursing problems. And research has not yet been an important aspect of the profession.

However, this review is hopeful. From Smith's one

page summary of nurses' contacts with hospitalized children to the sophistication of the work of Johnson et al. with children's fears during cast removal, it is evident that nurses are questioning their practice. They are asking difficult questions and, with varying degrees of skill, they are seeking answers to those questions.

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Appendix A

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IMPACT OF A CHILD'S ILLNESS ON THE FAMILY:

IMPLICATIONS FOR FAMILY-CENTERED CARE

A REVIEW OF THE LITERATURE

NS 440 Impact of Illness on the Family

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IMPACT OF A CHILD'S ILLNESS ON THE FAMILY: IMPLICATIONS FOR FAMILY-CENTERED CARE

A REVIEW OF THE LITERATURE

The purpose of this review of pediatric nursing literature is to ascertain how that literature would answer several questions:

What does it mean to nurse the family in the pediatric setting? What is the nurse's role with the family? Do we nurse the family? If so, how? If not, why not? Is it always the thing we want to do? Who constitutes the family?

What factors may typically influence the relationship between the nurse and the family?

What is family-centered care?

How has the effectiveness of family-centered care been studied?

In order to accomplish these purposes, nursing journal articles related to family, to emotional care of the pediatric patient, to nursing role with the pediatric patient and family-centered care were reviewed. It was assumed that all of these topics relate to pediatric family-centered care. The major focus was pediatric journals, although general nursing journals and maternal child nursing journals were also included. It was beyond the scope of this review to consult textbooks.

The Concept of Family

Descriptions of pediatric nursing care both directly and indirectly refer to family. However, family is not usually directly addressed or defined. Specific members of the traditional family constellation are likewise often omitted, such as fathers, siblings, and grandparents. Less traditional family relationships are completely omitted. Emphasis is on the mother and the child or on the parents. For instance, Petrillo (1968) very carefully explains how to prevent traumatic experiences in the hospital for the child without ever referring to family although mention is made of parents. When family is mentioned a typical comment by the writer is, "Develop a skillful, friendly approach to the patient and his family." (Webb, 1966) Just how that should be accomplished, what it means in terms of our care of the identified patient, and who comprises a family is not addressed. Atkinson (1976) states that the confusion about what a family is and who all constitutes the family makes her wonder if family-centered care is a myth or a reality.

Family-Centered Care

Family-centered care is generally typified in the pediatric nursing literature by descriptions of environmental conditions and administrative policies that favor family involvement. Like definitions of family, direct definitions of family-centered care are avoided. Overall, parents are either seen as being helpful with the care of their

hospitalized child or the care of their child helps the parents own adjustment to the experience of having their child hospitalized. The nurse is seen as a necessary prerequisite for this involvement (Scahill, 1969). Parental involvement is highly valued as reflected in a question by Baxter (1976, p. 160), "One question especially presents itself: who not let parents be more responsible for themselves?"

Besides involvement of parents, certain environmental conditions are seen as conducive to family-centered care. An overall homelike environment is seen as important (Shope, 1970, p. 32). Facilities to "room-in" with the hospitalized child are seen as important but not mandatory (Fagin, 1978; McElnea, 1971; Shope, 1970). Family-centered care is sometimes equated to rooming-in, however, Mahaffy (1965, p. 19) notes, "Allowing mothers to room-in is not the complete answer - must provide a supportive environment."

There remains a haunting, unanswered question in the literature pertaining to rooming-in. When rooming-in is available, the parents then must choose whether or not to room-in, whether or not to participate in this fashion. All parents do not choose to room-in. The percentage of parents choosing to room-in has been surveyed (Fagin, 1978). If parents do room-in, what are the possible positive and negative results of the practice? If parents do not or cannot room-in, what are the possible positive and negative results of the

practice? This has not been satisfactorily studied.

Other important environmental conditions included in the literature are the attitudes and roles of the family and the nursing staff (Fagin, 1978; Burrows, 1973; Seidel, 1969). The role of the family is typically translated to the role of the parents: such things as parents choosing the objective child care activities they would like to do with their child (McDonald & Jackson, 1978) have been addressed. Shope (1970, p. 32) notes that, "Actively caring for her child under direct medical and nursing guidance better equips a mother to care for her child at home."

Overall, the literature advocates, "nursing care activities need to be family-oriented, individualized and coordinated" (Luciano, 1972, p. 52). Various impediments to this approach includes "geography of the pediatric unit, therapeutic plan for the child, staffing requirements, and the nurse's needs." To implement family-centered care one must be "committed, communicative and creative."

In this process of helping the parents to become involved and to participate the parents' intimate knowledge of their child becomes of secondary importance to the nurse's knowledge of the hospitalization and treatment experience. The nurse is seen as a guide through this experience, who minimizes the harmful psycho-social effects of hospitalization and maximizes on the less frequently mentioned possibly positive psycho-social effects of hospitalization.

Much of the nurse's work with the family in family-centered care is described in terms of assessment. A framework for assessing the family and the identified patient who is the recipient of family-centered care is highly valued in the literature. Luciano (1972a) advocates a goal-directed approach with families that includes assessment, planning, and intervention. No mention is made about evaluation. Assessment is definitely explained most vividly (Luciano, 1972; Tapia, 1972; Macvicar, 1976). For instance, guidelines to assess developmental needs for the individual child are offered but not for the family as a whole or for individual adult members (Wu, 1965; Anyan, 1974; Duran, 1972; Erikson, 1965, Ambler, 1967). Some suggestions for intervention are mentioned. Again, most focus on the individual, identified child who is the patient. Discharge planning (Deakers, 1972), however, is put in terms of the family.

Nursing the Family: The Nurse-Family Relationship

> *What does it mean to nurse the family? What is the nurse's role with the family? Do we nurse the family? If so, how? If not, why not? Is it always the thing we want to do?*

These questions are left largely unanswered in the literature. The literature suggests that the family is going through a completely foreign and alienating experience when they bring in their child for hospitalization. Their feelings about this experience are related to

the child verbally and nonverbally. This is said to effect the child negatively.

Separation is seen as leading to harmful psycho-social results such as regression (Kueffer, 1975; Shope, 1970, Kunzman, 1972; Freiberg, 1972; Bransletter, 1969). Audette (1974, p. 38) states that the resultant regression can be minimized, "It seems desirable to encourage parents to stay with their child, if they are able to control their emotions and support their child."

Parental and child anxiety are seen as inevitable with hospitalization of the child (Bright, 1965, p. 30), "The episode frequently becomes a crisis situation in the parents' view." Bright assumes that, "A most significant source of anxiety in the child is parental anxiety." Sources of possible anxiety are listed.

Toward the end of attempting to meet some of the needs created by this anxiety the role of the nurse in family-centered care has been defined by Eyres (1972) as consisting of the following components: setting the climate, therapeutic use of self, and becoming the ombudsman. "The nurse's role is designed to move all family members forward during the illness situation, through incorporation of the present experience into the family's overall concept of a meaningful and satisfying life experience. The nurse attempts to maintain family <u>functioning</u> in the face of a disruptive experience."

Such professional intervention (Waechter, 1970, p. 207) is seen

to make a difference, "The outcome of the situation is profoundly affected by the manner in which professional personnel, particularly nurses, work with parents during the period immediately following the birth of an exceptional child."

More subtle, subjective, interpersonal issues between the nurse and the family are not directly addressed in the literature. For instance, control issues between the family and nurse are not systematically described.

Assessment of Effectiveness

Several studies have compared a "traditional" approach (control group) and "family-centered care approach" (experimental group) to systematically assess health outcomes of the two techniques. There is certainly not a unified picture that represents significant outcomes, but, most studies showed some areas of benefit (Sonstegard & Egan, 1976; Jordan, 1973; Shea, 1952). These benefits include reduction of anxiety in the parent and child and increased quality of recovery.

Another group of studies examines the impact of an experimental nursing intervention on the welfare of the identified patient. Some studies focused the experimental intervention on the parent (Mahaffy; Skipper and Leonard; Godfrey) and in another study the experimental intervention is focused on the child (Wolfer & Visintainer and Visintainer & Wolfer). In any case, the experimental intervention usually includes some direct or indirect preparation that is geared

towards reducing the child's and parents' stress and increasing their involvement with care. Entire family units are not the targets of the intervention.

Family-centered care is also assessed in the literature by studying the reactions of families to the approach without benefit of a control group. Aufhauser (1967) here equates family participation with planned family-centered care.

Fagin (1978) has surveyed the overall implementation of planned family-centered care in terms of visiting hours, attitudes of nurses and percentage of utilization by parents. In this study it was interesting to note that there were regional differences in the percentage of hospitals allowing 24 hour visiting on pediatric units.

Discussion

Several words reoccur in the pediatric nursing journal literature in relationship to family. When a reference can be found pertaining to family, the idealistically functioning family is prepared, involved, and participating. The nurse is to be an active agent in helping the family maintain or obtain this level of functioning. Family-centered care is typified as a means to accomplish these goals. Discrete elements of family-centered care are used in the literature to describe what constitutes family-centered care: liberal visiting hours, rooming-in, and attitudes of staff conducive to family and patient growth and support.

In many ways, these references to parental involvement assumes that parents aren't naturally involved with their child's hospitalization or can't be without the nurse's assistance. It also assumes that all parents should be involved in the manner prescribed by family-centered care.

Therefore, many of the questions that framed this review of the literature remain unanswered. Something is known about each question, but, not enough is probably known to comfortably operationalize the terms family or pediatric family-centered nursing care. Undoubtedly, those questions need to be answered in part by each particular clinical setting. Nursing as a whole also has some work to do as well.

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FAMILY-CENTERED CARE IN PEDIATRIC NURSING LITERATURE

NS 440 Impact of Illness on the Family

June 4, 1979

Janet Nowlin
Sheila M. Kodadek

OVERVIEW OF FAMILY-CENTERED CARE IN PEDIATRIC NURSING LITERATURE

These two papers were designed and written for different purposes. One paper examines pediatric nursing textbooks from an historical perspective for evidence of family-centered care concepts. The other paper examines pediatric nursing articles in order to identify the state of the art of pediatric family-centered nursing. Although these two papers can stand on their own, it is clear there are recurring themes. (We anticipate combining these papers in the future after further study and analysis.)

It is clear that there has not been an absence of reference to family in pediatric nursing literature. In our historical analysis we found sensitive and sophisticated discussion of family needs when a child is ill as far back as the 1930's. In both reviews the problem appears to be of inconsistency in implementation and in emphasis. For example, a textbook may have a chapter on family life and never again refer to family responses to a child's illness. Or, one article may emphasize family needs, while another in the same year (or even journal) will not refer to the family. If the family is referred to it is only in an "expert to the needy" fashion. The nurse is the expert. The family is the needy.

We have come to the tentative conclusion that one major reason that family-centered care has not had broader acceptance is that the

literature is inconsistent. We further believe that this inconsistency exists, at least in part, because there has not been a concentrated effort to systematically study family-centered nursing care.

Our own values and clinical experience lead us to believe that family-centered nursing care in pediatrics is a valuable approach. We further believe that the basis for implementation of family-centered nursing care is the provision for alternatives in care in that families may be given the opportunity to become involved to the degree that they wish and can. This implies a nursing responsibility for information giving, support, and facilitation of this process. We plan to explore this further in the future.

Janet Nowlin
Sheila M. Kodadek

APPENDICES

Field Notes
September 14, 1979

Card 546

I was asked by Joanne to see a family who had written to the hospital concerning the care of their child. The letter that they wrote is as follows:

"Dear Sir,
I would greatly appreciate it if you would refer this letter to whoever could help me answer some questions as quickly as possible but also as frankly as possible.

I am a former Shriner's Hospital patient. I was in many times as a child and received excellent care from a concerned and capable staff. I had severe bilateral clubbed feet. Now people would never know it.

We have a 4½ year old daughter, Christine, who inherited the bilateral clubbed feet. Hers, too, were very severe and coupled with extremely tight achilles tendons.

At her birth our physician referred her to Dr. Jay C. Alameda from Peoria St. Francis Hospital. She has been in his care ever since. We have, though, taken her to several other doctors for other opinions. All said to stick with him. Some said he's the "best in the state".

My parents often told me how they used to have to take me to Shriner's on Fridays for check-ups and often would have to wait till 4 or 5 to see the doctors.

They told me about how I was in the hospital more than I was out till I was six and how hard that was on them.

We took Christine to a Shriner's Clinic in LaSalle a couple years ago. They had us fill out forms and took a picture of Christine's foot. They said we'd have no trouble getting her in. But after considering the things my folks had told me, I decided to stick with Dr. Alameda. Since then I discarded the Shriner's forms.

Card 547

Please let me give you Christine's medical history. Perhaps an orthopedic surgeon on your staff could look it over and tell me whether there would be any advantage in bringing her there.

(Cont. on next page)

Birth - Severe bilateral clubbed feet with very tight achilles tendons.

11 Day to 5 Months - Casting

5 Months - Surgery - schilles tendons. He could not bring them up as high as he had hoped because they were so tight. Exercise 6 or 7 times a day - outflare shoes - with night brace.

7 or 8 Months - Brace worn between feet night and day.

14 Months - She started walking. The brace was dropped.

(Continued)

Page 358

Card 547 (Con)

Shortly After That - One foot turned in. She was fitted for a leg brace to her knee - placed on the outflare shoe - wedge at the side because she started to walk on the outside of her foot.

18 Months Or So - Other foot fitted for leg brace same as above. She wore these for 3 years.

4 Years - Her feet dragged in badly from the weight of the braces - so just outflare shoes with wedges were used.

4½ Years - July 25, 1979 achilles tendon surgery done again. It was not successful. The cords would not budge anymore.

Later - He feels that at this time no other major surgery will be done until she reaches the age of 10 or 12.

She has been in the hospital only 2 days at the age of 5 months - and 2 days this last week. In both cases she was released the afternoon that she had surgery.

Card 548

My questions - We wouldn't send her there unless we could get some reply to these particular questions. We live on one income. My husband can't affort to take another day off work to go and talk to someone if there's a pretty good possibility she would be just as well off sticking with Doctor Alameda.

1. Do you feel it would be to Christine's advantage to be evaluated by the doctors at the Shriner's Hospital?
2. Is there anything that can be done for the deep scar at the back of her legs?
3. What day are evaluations given? Would it mean an all day wait?
4. How often can parents visit the children in the hospital?
5. Are parents allowed to be with the children before and after surgery?
6. Is a good school still provided? With kindergarten?
7. Approximately how long would a child be in the hospital for an achilles tendon lengthening?

For the surgery done at 12 years of age on a child with clubbed feet I think it is called triple archedesis?

I know the facilities are excellent. I'm sure the staff is extremely capable. But, I would appreciate your answering the above questions and letting us know what procedures we might to through to get her admitted. Thank you."

Patricia Moore Hopkins
2400 Circle Drive
Ottawa, Illinois 61350

(815) 433-1180

The letter was responded to by Dr. Millar. Then I also called the woman who had written the letter. She stated that they were going to be bringing their daughter up to be seen as a new exam and that they would contact me when they came up. When they arrived at the

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Card 549

hospital they told the people in the clinic that they were going to be seeing me. I talked to Mr. and Mrs. H. and to C.H., their daughter. In talking to them I stated that my purpose was to gather background data on individuals who had been hospitalized for long periods of time in our more traditional setting. Mrs. H. was the original identified patient and now in September of 1979 she is 34 years old. She stated that when Dr. Millar saw her daughter, C.H., that Dr. Millar had gotten Mrs. H.'s old records out and that she had been hospitalized at Shriners for 5 to 6 admissions. For instance, during one admission she was here for some 126 days. When I asked her about what kinds of things ran through her mind about being here again and about seeing the hospital again and bringing her daughter here, she stated that a lot of things are so different. When she was here the visiting hours were from 2:00 P.M. to 4:00 P.M. on Sundays. Parents never knew about surgery until it was over with. Parents would receive a letter stating that their daughter was doing fine and that surgery was performed. She said she can't remember what it was like when she was here at a younger age - that is, 6 years old. She was not hospitalized that much between 6 and 12 years of age so she does not remember her earlier hospitalizations. But, at 12 years of age she remembers a lot of pain. She said that hospitalization was indeed very traumatic. She stated that it was not so much because her parents couldn't come but because of the pain involved in the triple arthrodesis that she had done on her ankle. By that time she stated, however, that her parents could come on Sundays and Wednesdays so the visiting hours had been expanded. When Mrs. H. asked her mother about her recollections of bringing her daughter here it sounded like it was a very painful experience for the family - not so much for Mrs. H. in particular but for the family as a whole. She said that the lack of visiting hours and not knowing when surgery was occurring was very painful although they felt that this is where their child could get the best care. So, this is where they had brought her and they still felt good in that part of their decision even today. She said one of the things that her parents remember specifically is that they got a card stating "your daughter had her first tooth today. She's growing by leaps and bounds. You'll never know her." Mrs. H. said that this is not what you want to know as a parent. She said another thing that her parents really resented in coming was the fact that they were given an appointment at 9:00 A.M. for a clinic and were here until 4:00 P.M. or 5:00 P.M. It was the waiting involved and not really having an appointment and just being herded in with a group of people. It was very difficult especially after driving 2 or 3 hours to get here. But all in all she still repeated that they felt that this was the best alternative for care. Mrs. H. does remember again . . . her parents seem to have many more negative memories of the hospital than she does - - - Mrs. H., in my opinion, seemed to respond to the home-like environment of the institution and felt very much at home. She said that she had been in many of the pictures on some brochures that Shriners had of crippled children and she was always smiling on the pictures. Her mother always asked her how she could be smiling so much since she was away from home so much. She said that overall the hospitalization experience for her was not that cruel. She remembers in particular her experience with school and how excellent the school was here at that time. I asked her what kinds of ways she feels that the hospitalization experience really changed her.

Card 550 (cont on next page)

Card 550. (Cont.)

She said that one thing in particular was a greater understanding for people that do have handicaps and not to look down on a person with handicaps. In college she had a friend who had a roommate who was an amputee and the person who was the amputee's roommate stated to the amputee that she didn't want her for a roommate and that she couldn't stand the fact that she had an amputation. It was very hard for Mrs. H. to understand how people could look down on people with handicaps. She said another thing that she felt did change her was missing her brothers especially and also her family as a whole. But she said she is also a very family minded person at this time. She doesn't know if it's because of the long separations from her original family but that she is very family minded and her husband, who was present at the interview, also did reinforce this. She felt all in all that it was just probably true that the family was more affected than the individual child. She said that this was true except at 12 years old for that surgery . . . she felt that she had been affected by the trauma of that experience. She hopes that her daughter, who has a similar anomaly, will not have to go through that experience. I asked her what she did as she grew up and she said that she taught school for 5½ years.

Card 551

She taught music. In talking to her husband about her growing up . . . I mean as a teenager and as a young adult . . . her husband thought that the most important thing besides being he felt more family minded because of her experiences being hospitalized so extensively that she had more appreciation for health and sort of using people that she had known here with more handicaps than she has as kind of negative comparison groups. He remembers that when their daughter was born with a handicap that the general practitioner came in and said "Well, let's tell your wife tomorrow. She just had the baby and it might be too much right now." The husband said "Oh, no. My wife knows all about it so why don't you just go ahead and tell her now." Mrs. H. stated that the first thing that she thought of after she found out about her daughter's handicap is that it is correctable and it is something that can be fixed. She said that when she looks back on her experiences of being here for such long periods of time, one thing that she really does think about extensively is the comradery that she had with other patients. For instance, she gave one example of really being a great religious person and not having a chapel here so a bunch of the kids would get together on Sunday and pretend like one was a priest and one was another member of the clergy and they would just go ahead and form their own chapel program.

NEWS AND VIEWS ....

SHRINERS HOSPITAL CHICAGO

THE BEGINNINGS OF ALL THINGS

ARE SMALL

CICERO

AN IDEA SHARED.....

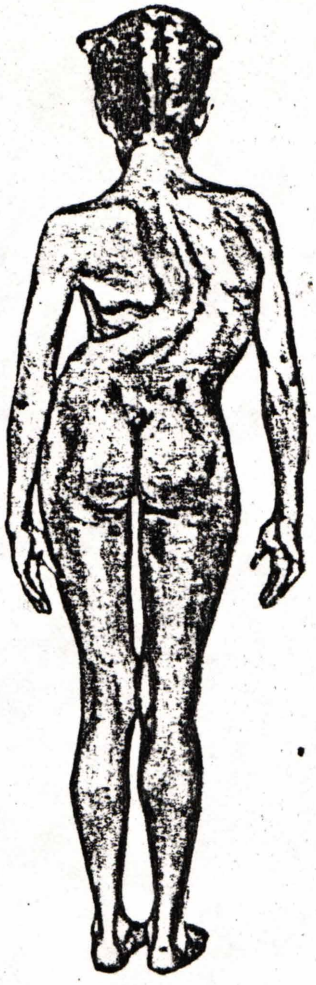
Upon occasion we are asked a question about one of our Shrine Units. In particular people ask us to compare our hospital with that of our sister Units. Often a Department head or hospital employee will inquire as to how a particular program is conducted in the other Units. Not surprisingly we find it rather difficult, if not impossible, to provide any accurate information as to what is happening elsewhere. Once a year the Administrators share program ideas at their meeting - but, beyond this meeting, there is little or no contact during the year. Miss Eleanor Baird, Executive Administrator, will often share her knowledge of what is being done in other Units but the time she has to do this is limited.

We take great pride in being associated with the Shriners Hospitals organization. In the operation of our particular Units or hospital departments we have common goals and interests. The manner in which we achieve these goals may be very similar or quite different. Certainly, we must be confronted with similar problems and concerns.

There should be a great deal of information we could share which would be helpful both to Administrators and Department heads.

We hope that the Chicago Unit Newsletter will be the beginning of the sharing of ideas which might be of help to you. Perhaps some idea or thought is the one you have been trying to come up with. Or, perhaps as you read about how we are doing a particular thing, you may have a suggestion that would be helpful to us. We would welcome your suggestion and look forward to your ideas shared in your Unit Newsletter.

June, 1974



SCOLIOSIS

Scoliosis has been with us since man first assumed the erect posture. Cave drawings even before the days of Hippocrates, and woodcuts attest to its significance to patients and physicians alike.

For centuries man has been baffled by the etiology of scoliosis and the management of the scoliosis patient. Hippocrates was the first to use the name "scoliosis" for any curvature of the spine and used crude methods of treatment. A thousand years later, Paul of Aegina attempted gradual scoliosis correction by bandaging the body to corrective splints. In 1582 Ambroise Pare instructed armorers in the development of iron cuirasses which were bent about the torso of the scoliosis patient. Then progress stopped until this century when the first spine fusion was performed in 1911 by Hibbs and the Milwaukee brace was designed by Blount and Schmidt in 1946.

Reprinted from Clinical Symposia
Vol. 24, No. 1

The Shriners Hospitals have been treating scoliosis patients since the hospitals first opened. Usual treatments have been Milwaukee bracing, body casts and surgical correction with a posterior fusion.

The Chicago Unit has embarked on a new and exciting scoliosis program through the efforts and leadership of Dr. Edward A. Millar, Chief Surgeon. Dr. Ronald DeWald, orthopedic surgeon who developed the halo hoop apparatus, joined our staff as Assistant Orthopedic Surgeon in 1973, and at the beginning of this year an orthopedic Fellow joined our staff. We are treating more severe scoliosis patients by means of halo femoral traction, the halo hoop apparatus and subsequent anterior (Dwyer) fusions and posterior (Harrington rod instrumentation) fusions. The type of spine patient being seen is the idiopathic scoliosis patient, muscular dystrophy patient. Marfan's Syndrome, osteogenesis imperfecta and the chondrodystrophies.

During the past three years we have averaged 20-22 spine surgeries per year. From January to April of this year we have already treated 11 patients. Three of these have been anterior (Dwyer) spine fusions; two have had the halo hoop apparatus; two have had halo femoral traction and one has had Crutchfield Tongs femoral traction. This indicates an anticipated increase for 1974 of from 40-50 surgically treated severe scoliosis patients, or one per week. The following articles will describe in more detail the procedure for anterior spinal fusion and the halo hoop traction device.

AN ANTERIOR APPROACH TO SCOLIOSIS

The principle of the operation is to shorten the long or convex side of the scoliotic spine.

A brief outline of the operation is as follows:

1. The surgical approach to the convex side of the vertebral bodies in a scoliotic spine is far easier than the approach to a normal spine. In a scoliotic spine, the great vessels like on the concave side, and it is simple to carry out a disk excision.

2. The actual approach varies with the level of the curve and it is always important to remove the rib right back to the transverse process.

3. The intervening intervertebral disks in the curve are first removed by excising the anterior and the lateral portions of the annulus and then curetting out the nucleus.

4. Into each vertebral body in the curve a special type of titanium screw is inserted on the convex side.

5. Each screw holds down a titanium plate which hooks over the ends of the vertebral body to increase the strength of the attachment.

6. A titanium cable is threaded through the screw heads and then the distance between them is shortened by a special tensioning device. (Figure 2)

7. Before the Tensioner is removed the screw head is fixed firmly to the cable by a swaging clamp.

8. By repeating this process step by step down the length of the curve, the bent column becomes straighter.

9. After the last screw has been swaged, an extra button is placed on the cable, and it is also swaged, to increase the grip on the lower end of the cable where more force could be expected to fall. The redundant cable is then cut off.

10. After the cable has been fixed, the rib is cut into chips and these are placed on the convex side of the curve between the vertebral bodies to promote fusion.

11. The pleural flap is now sutured back to cover the screws and the cable, and the chest is closed. The pleural cavity is drained by an underwater seal for a few days.

There are several advantages to this type of surgical approach:

1. The operation is conducted through largely avascular areas and blood loss is not a problem.

2. The mechanical fixation is sound with the load spread evenly over every spinal segment.

3. The internal fixation is capable of standing up to any necessary post-operative nursing measures.

4. Convalesence is relatively short and comfortable.

5. Very little bone is necessary for grafting purposes and the rib obtained is usually adequate.

FIG. 1. Model representing the vertebral bodies of a scoliotic spine. The convex side of the upper 2 vertebral bodies is gripped by special screws and plates.

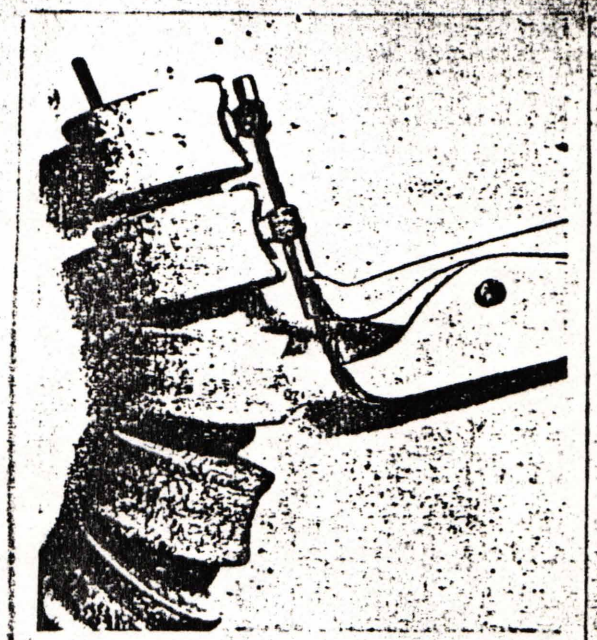


FIG. 2. A cable with fixed end-button is passed through the screw heads. A tensioner is fitted to the cable, and as it is tightened the screw heads

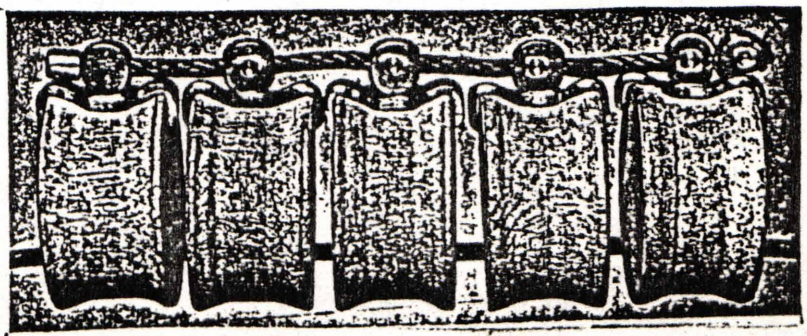


FIG. 7. The model, showing correction at each interspace with each screw head firmly swaged on to the cable.

NURSING CARE - ANTERIOR FUSION

I. PSYCHOLOGICAL:

A. Pre-Operatively

1. Reinforce doctor's explanation of surgery when questions arise. Answer as honestly as possible without frightening child, according to level of maturity.
2. When indicated explain the various treatments and equipment the child can expect, such as chest tubes, two IV infusions, Foley Catheter, hemovac.
3. Demonstrate and explain purpose of blow bottles and Bennett Respirator.
4. Teach and practice coughing and deep breathing.
5. Circle-Electric Bed - place child on bed and give pre-surgical "ride" (or demonstrate turning sheet).
6. Parents - explain all the above so they can give the child the necessary support.

B. Post-Operatively

1. Patient may be frightened and in pain. Reassure and keep as comfortable as possible.
2. Explain all procedures. Keep a calm manner.
3. Special nurses are assigned the first four days.

II. GENERAL:

A. Check vital signs as ordered.

B. Check IV's as to rate and arm for possible complications.

C. Observe drainage in pleur-vac (water-seal drainage) as to amount and color. Check to see that water seal is maintained.

D. Milk chest tubes every hour to prevent clotting.

E. Central venous pressure - take recordings as ordered.

F. Check dressings for bleeding or drainage.

G. Turn patient as ordered. Good skin care.

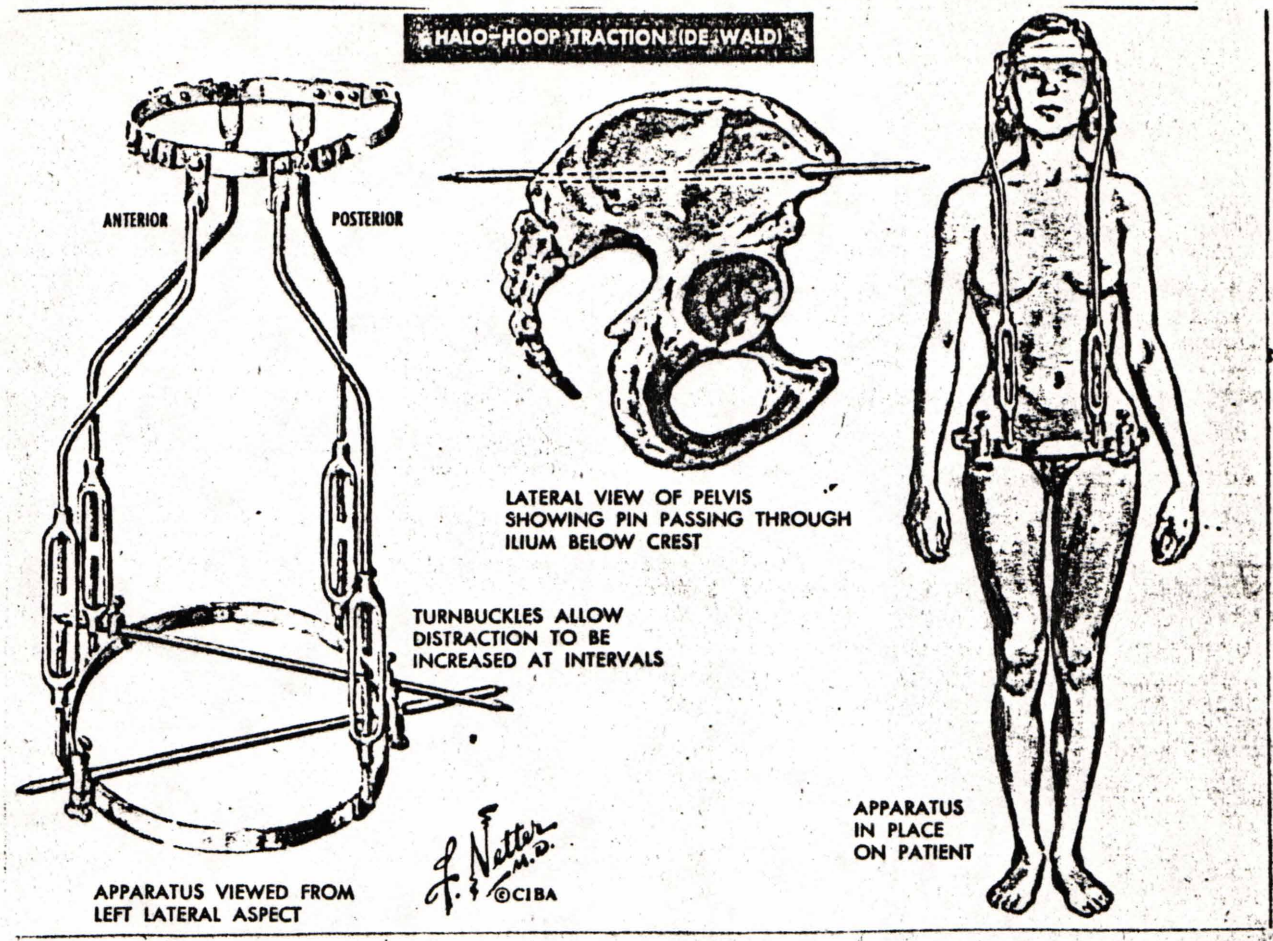
H. Oral hygiene.

I. Proper positioning of extremities should be maintained to prevent contractures.

J. Keep patient as comfortable as possible.

K. Maintain accurate intake and output. (Foley Catheter care)

HALO HOOP TRACTION



Reprinted from Clinical Symposia
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PURPOSE:
1. To provide traction to the spine before surgery.
2. To provide support to the spine after surgery.

INDICATIONS:
1. Paraplegia with anesthetic skin.
2. Spine tumors where the vertebral bodies need to be removed and there is a need for a good external splint.
3. Severe kyphosis.
4. Pelvic obliquity.
5. Fracture dislocation of the spine.
6. Poor pulmonary capacity.
7. Severe scoliosis where other methods have failed.

ADVANTAGES:
1. Respiratory capacity is not impeded by a restricting cast.
2. Decreased incidence of decubitus ulcers from pressure.
3. Decreased incidence of muscle and soft tissue contractures.
4. Pelvic rotation and obliquity can be controlled.
5. Patient is not confined to bed if ambulatory.

COMPLICATIONS:
1. Pin tract infection.
2. Arthrodesis of lumbo sacral joint with location of iliac rods.
3. Sliding of pelvic on iliac rods.
4. Neurological problems.
5. Psychosis.
6. Obtaining iliac bone grafts.
7. Penetration of bowel.
8. Dilated duodenum.

NURSING CARE - HALO HOOP

I. PSYCHOLOGICAL NEEDS:

A. Before application:

1. Answer all patient's questions as honestly as possible without frightening patient.
2. Explain purpose and post-op nursing care. Show empathy.

B. Post-Application:

1. Apparatus is confining at first, so plans should be made for recreation, school, etc., so patient won't feel isolated.
2. Pins in the hip are painful so patient should be prepared before he is turned or moved.
3. The apparatus can be frightening. Therefore, the patient should be praised and supported. He should not be scolded or humiliated for his fears.

II. PHYSICAL:

A. Cork should cover the ends of the pins of the hoop. The patient should be turned carefully with a turning sheet and not pulled by the apparatus. Care should be taken so pins do not get caught in the bed linen.

B. Meticulous inspection of his back and bony prominences should be made frequently to prevent bedsores.

C. Skin around the pinsites should be closely inspected for drainage, odor and redness. If ordered by the physician, the pinsites are cleansed with Betadine solution and covered with sterile dressings.

D. The bars of the apparatus should be covered with sheepskin to prevent rubbing against the skin. He should have frequent back rubs.

E. When the patient is turned to his side, his back should be supported with pillows. Pillows should be placed between his legs and positioned so contractures are prevented and not increased.

F. Observe neurological signs for possible complications:

1. Cranial nerve damage.
2. Change in motor power - upper and lower extremities.
3. Loss of bowel or bladder control.

G. Patient may be allowed up on a stretcher after a few days and included in hospital and ward activities.

PHYSICAL THERAPY ..... HALO HOOP

The Physical Therapy Department becomes involved with the patients immediately after application of the halo hoop. The activities vary with different patients depending upon their level of physical activity before application of the apparatus. Those who were ambulatory are gotten out of bed as soon as possible so they can resume their previous ambulatory and functional activities. Many of the children, however, are non ambulatory and with these patients care must be taken to assure that ROM exercises are carried out on the lower extremities daily to prevent hip and knee flexion contractures, since while lying in bed after application they tend to assume that position which is most comfortable. Isometric quadriceps exercises and active hip and knee flexion and extension exercises are also done in cases where the patient's abilities allow.

A few days before their surgery the patients are instructed in diaphragmatic lateral costal and upper intercostal breathing exercises. The primary objective for pre-op breathing instructions is to maintain full chest expansion and good diaphragmatic motion to prevent,atelectasis and for accumulation of excessive secretions in the lungs, thus helping to prevent respiratory tract infections after surgery. These pre-operative sessions also provide an opportunity for us to talk with the patients and develop a good rapport with them, as the children will often express their fears and anxieties about surgery at this time.

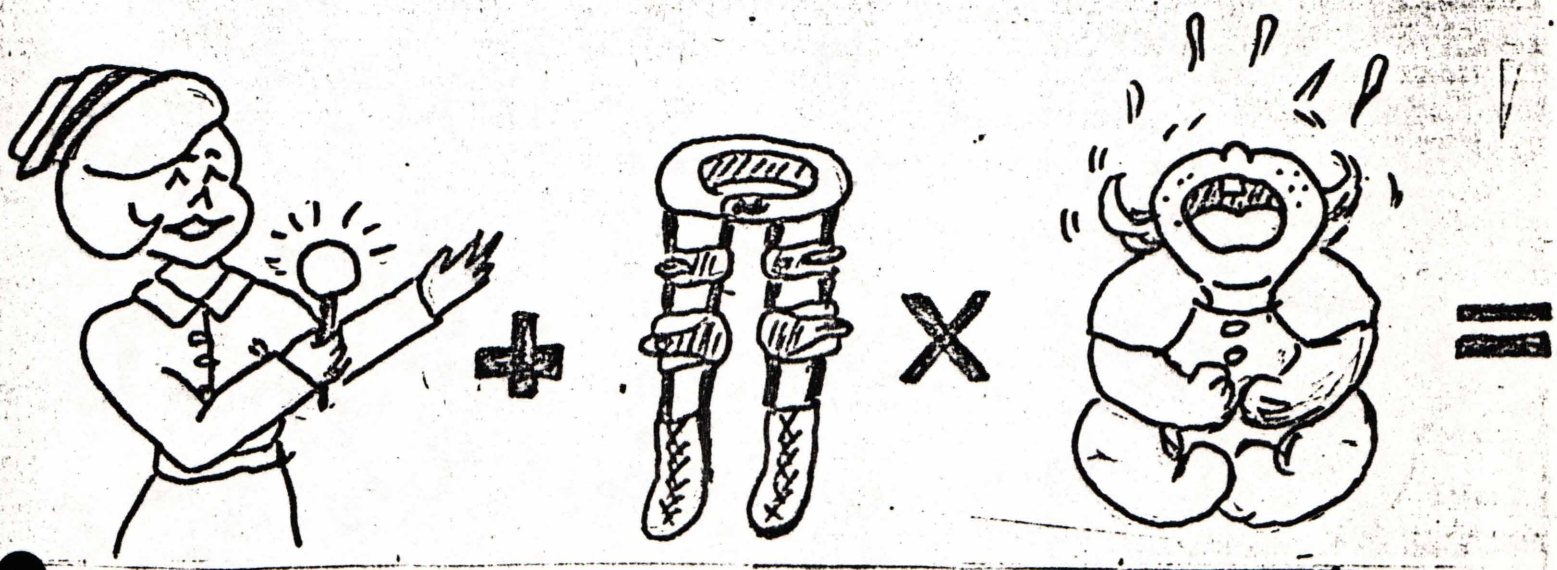
After these are discussed the rationale for the breathing exercises are explained to the child with the result that he is better prepared psychologically to participate actively in his post-operative breathing and coughing program.

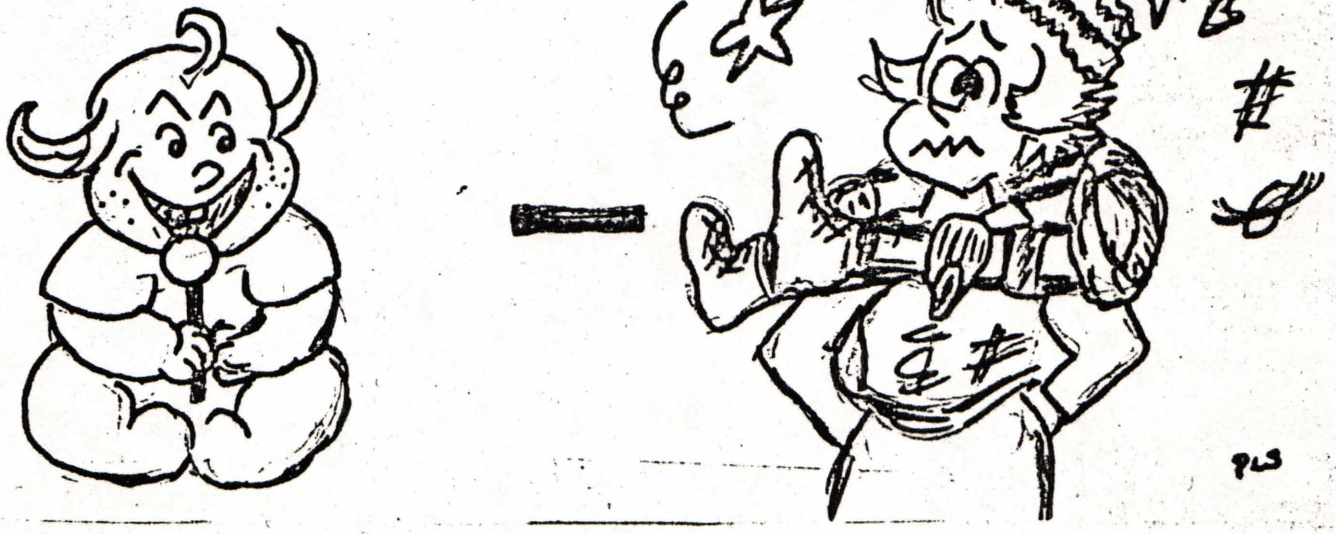
Breathing exercises are resumed one day post-operative along with gentle ROM exercises to the LE's. The length of treatment depends on the patient's condition and how quickly he tires. Those who tire quickly are done 3-4 times per day, while those who can tolerate it are done for longer periods of time twice a day. Goals of treatment at this time include obtaining full chest expansion, a good dry cough, a willingness on the part of the patient to carry on the exercises thruout the day without supervision and adequate ROM of all joints.

After 3-4 days most of the patients are ready to begin with conditioning exercises in the form of manually resisted exercise and weight lifting to maintain their strength while lying in bed. Quad setting and active ankle exercises are also done with our patients during this time.

After the spinal fusions the patients are sometimes placed on a Circ-electric bed. In 2-3 weeks they are allowed to sit up in bed and those who are ambulatory usually begin walking at this time. As you know, however, it is of paramount importance that they have support for the spine whenever doing any of these activities.

MODERN MATH ...





BRADFORD FRAME VS. SOFT GOODS

The Bradford frame is widely used in many institutions to keep a hip spica cast clean and dry. We have very limited use of the frame! We feel that meeting the emotional and psychological needs of the child are just as important. Therefore, since our goal is to keep the child as active as possible, out of bed, and held frequently, our procedure is as follows:

PURPOSE:

1. KEEP CAST DRY AND INTACT.
2. MEET EMOTIONAL NEEDS.

POINTS TO REMEMBER:

1. CHECK AND CHANGE DIAPER FREQUENTLY.
2. NURSING - HOLD CHILD FOR MEALS.
3. PARENTS - HOLD CHILD DURING VISITING HOURS.
4. ALLOW UP IN FRACTURE CART OR BUGGY.

PROCEDURE:

1. INFANT.
   - (a) TUCK PERIPADS IN FRONT AND BACK OF CAST.
   - (b) COVER WITH PLASTIC DIAPER.
   - (c) HOLD IN PLACE WITH BIKINI TRIANGLE OR LARGE PINNED DIAPER.
2. CHILD - NOT TOILET TRAINED.
   - (a) FOLD SMALL CLOTH DIAPER TO FIT IN OPEN AREA OF CAST.
   - (b) COVER WITH PLASTIC DIAPER.
   - (c) TUCK UNDER FRONT AND BACK OF CAST.
   - (d) HOLD IN PLACE WITH BIKINI TRIANGLE OR LARGE PINNED DIAPER.
3. CHILD - TOILET TRAINED.
   - (a) ELEVATE UPPER PART OF BODY WHEN USING BEDPAN.

RESEARCH

Dr. Edward A. Millar, Chief Surgeon, presently has two research projects under way. For the past five years, in conjunction with Dr. Clive Solomons, Ph.D., University of Colorado, the Chicago Unit has been the center of a major study of Osteogenesis Imperfecta. By means of a symposium on this subject, conducted in our Unit in June, 1973, communication has been established between scientists and medical men throughout the country who are investigating this problem.

A second program of research initiated this year is concentrating on children with severe cerebral palsy in an attempt to discover a method of improving spastic conditions by implantation of electrodes on the cerebellum. The effect of various frequencies and intensities of applied current upon spasticity will be evaluated.

ALPHA KERI LOTION

We've evaluated a number of skin lotions and find Alpha-Keri Lotion and Bath Oil works best. Used daily in the bath water, Alpha-Keri Oil softens the skin and removes dry skin quickly and without excessive rubbing after cast removal.

AS LONG AS THE SUN SHINES
ONE DOES NOT ASK FOR
THE MOON.
Russian Proverb

INTENSIVE CARE NURSING

The Nursing Department has also gone through some dramatic changes. With more sophisticated traction methods and the anterior spinal fusion has come the need for intensive nursing care. Inservice classes and doctors' lectures were mandatory to prepare us to give specialized care.

Post operative care of the anterior spinal fusion patient requires "special nurses" around the clock for a period of four days. Our "special nurses" are our staff nurses who are assigned only the one patient. They monitor vital signs, central venous pressure, chest tubes and Emerson Pump, hemovac, Foley catheter, intravenous fluids and IPPB therapy. They give a lot of Tender Loving Care and they are great.

Initially there was apprehension and discontent. With education came knowledge, with knowledge came confidence, and with confidence came pride in what we are doing!

NURSING FUNCTIONS INCREASING

With 6-7 pre and post spinal fusion patients in the hospital at one time, the need for increased nursing care is quite evident. No longer are we only checking the color and temperature of toes or petaling casts.

Caring for children in skeletal traction, Circle Beds and Stryker Frames is requiring more RN hours than ever before. The apprehension and frustrations these children have must be handled with patience and TLC. This takes time . . . and when a nurse has 30 other children to care for she doesn't always have this time.

Our immediate goal is to evaluate our present needs in order that we may continue to provide the optimum in nursing care.

Two caterpillars were crawling across the grass when a butterfly flew over them. They looked up and one nudged the other and said: "You couldn't get me up in one of those things for a million dollars."

- Anonymous

NURSING AUDIT

The Joint Commission on Accreditation of Hospitals' new requirements of a Nursing Audit as a means of accounting for the evaluation and improvement of nursing care has brought many questions to mind. How? When? Where? Why? We are all faced with developing a functional audit system. How about helping each other? We are all specialized in the care of orthopedically handicapped children and certainly our goals and our criteria for nursing care must be similar if not the same. I'd like to share with you our progress thus far.

We began by attending two workshops which dealt with the Nursing Audit. I would highly recommend the J. C. A. H.'s Nursing Audit Workshop above all others, for it is quite thorough and tells you exactly what it is looking for in respect to meeting accreditation standards. One of our staff nurses who was highly motivated in the area of quality control was appointed as Committee Chairman. She chose her Committee members and upon completing the workshop proceeded to orient the Committee to the philosophy and goals of the Nursing Audit. One of our secretaries was appointed to the Committee and will be doing the data retrieval and documentation before it goes to the Committee for evaluation and further investigation. Meetings followed which formulated our philosophies and criteria for good nursing care.

We are starting with the 10 most common admitting diagnoses. One classification will be audited monthly until all conditions are audited and then the cycle begins again. THE JCAH has a workbook which describes in detail the Audit Procedure and the necessary forms which may be duplicated for individual use.* On the next page is a copy of the criteria we have formulated for Congenital Dislocated Hip and the form that we are using. We hope this may be helpful to you either as a comparison to your criteria or in assisting you to formulate your own.

The 10 most common diagnoses here are Congenital Dislocated Hip, Spastic Muscle Contractures of C. P., Perthes, Talipes Equinovarus, Scoliosis, Myelodysplasia, Osteogenesis Imperfecta, Burn Contractures, Arthrogryposis and Hemimelia. We certainly would appreciate hearing from you on the criteria you have formulated for these conditions.

*JCAH Retrospective Patient Care Audit Procedure (Third Edition, September 1973), $ 10.00. Order from: JCAH Publications, 875 No. Michigan Avenue, Chicago, Illinois 60611.

NURSING: I. OUTCOME AUDIT CRITERIA AND INSTRUCTIONS Audit Topic: Congenital Dislocated Hips Date:

	A. Elements	B. STD 100%	0%	C. Exceptions	D. Special Instructions
Discharge Status	1. Afebrile	X		Discharge with a communicable disease	Temperature below 99.6° F. rectal for 24hrs prior to discharge Graphic sheet, Nurses notes
	2. Free of escessive pain	X		None	Medication sheet Nurses notes
	3. Parental teaching of home care	X		None	Nurses notes
Complications	4. Skin breakdown		X	NURSING MANAGEMENT: 1. Unwrap traction & check circulation every shift 2. Check circulation of casted legs 3. Petal cast prior to discharge 4. Chart any reddened areas and/or foul odors & notify Dr.	nurses notes Medication Sheet Doctors progress notes Graphic sheet
	5. Impaired circulation		X	1. Unwrap traction & Check circulation 2. Check circulation of casted legs 3. Note discoloration, temperature change, edema, or insensitivity & repott to Dr. 4. Elevate limband apply ice bag	Nurses notes Medication Sheet Doctor progress notes
	6. Upper respiratory infection		X	1. observe temperature elevation, nasal congestion, coughing, Notify Dr, 2. Postural drainage	Nurses notes Doctor Progress Notes
	7. Other		X		Nurses notes Doctor progress notes

REFLECTIONS OF AN ORTHOPEDIC NURSE

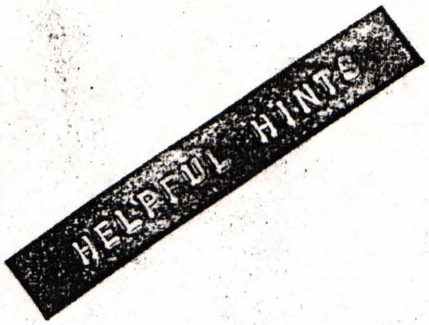
It's a little hard to remember just when I began noticing how Orthopedic Nursing was influencing my life . . . Maybe when I raised my arms to roll up my hair and was suddenly reminded of ARM & HAMMER BAKING SODA . . . or Indian hand wrestling with a strapping teenager; and winning?! Something happened to that voice with the dulcet tones of medical nursing and intensive care days . . . Was it the competition of high pitched cast saws, countless rolling wheelchairs and stretchers, groaning weights and pulleys, that changed it to the timbre of a long-shoreman's call? Do high-heeled shoes vaguely suggest shortened heel cords remedied by bilateral TAL's? Could that stranger with the limp have been benefited by an intermedullary rod procedure such as a "SOFIELD's STRATEGY" or "MILLAR's MANUEVER"? Have I become a sensuous woman of ORTHO because my pulses race and respirations quicken to trace a beautifully outlined and highly developed muscle to its insertion?

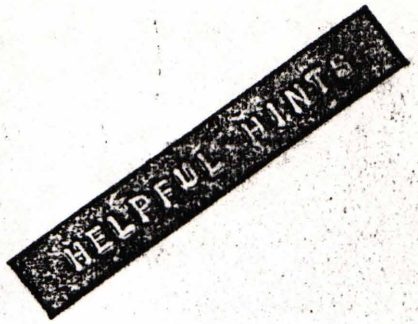
But there's another facet of Orthopedic Nursing in my career. Perhaps an accomplishment. I have survived all those embarrassing situations! Situations such as: laboriously lacing up club feet shoes (16 to 20 eyelets!) on the wrong feet . . . Finding out the periosteal elevator doesn't go to the 2nd floor (or any other floor for that matter) . . . A Steinmann pin doesn't necessarily mean membership in a Women's Lib Organization.

Or in the Dilemma Department: A hip spica cast trimmed too conservatively to meet the call of nature - noticed after you've panned the patient . . . That fun circle-electric bed that somehow got rotated in the wrong direction (why is your face so flushed, dear?!) . . .

Let's not forget the Challenges of Orthopedic Nursing!!!!! confrontations with a houdini who can escape from his bilateral long leg braces with pelvic band in 7-3/8 minutes . . . but at meal times hasn't the strength or coordination to lift a spoon to his mouth . . . The Enfante Terrible that screams and spits out his candy flavored medicine shortly after he's placidly devoured half of the sheet wadding lining his cast . . .

But now my reflections are fading and the present closes in . . . my coffee break is suddenly over and it's time to head back to the ward with the rest of my orthopedic brethren . . . perhaps to face new challenges and crises?! Fortified with sensible shoes, good body mechanics, and a tremulous smile, I face the future and someday perhaps that GREAT WHITE CAST ROOM IN THE SKY!!!!!





BUBBLE TOP CRIB RESTRAINT

2, 3 and 4-year-olds love to challenge your intelligence and ingenuity by escaping from just about every restraint you put them in! The crib net is no exception, for somehow they're able to untie those restraint straps and pull the net into bed with them. Aside from not working too well, crib nets look horrible to patient and parent alike and convey to all concerned the feeling of being imprisoned.

We've tried the new Bubble Top Crib Restraint and we love it! It's made of plexiglass and fits all standard cribs. Because of the plexiglass there is optimum visibility for the child when he stands in the crib. The top slides back and forth when a special lock is released by the nurse. This feature permits the nurse to work or play with the child with ease and without having to stoop or bend under the top to reach the child. (The Bubble Top is available from American Hospital Supply.)

PHARMACY - COLOR CODES

Replacing outdated medications from the pharmacy was always a chore. Checking each medication date took hours. Now it takes 10 minutes.

We've started color coding each medication according to expiration date when it is delivered. We use plain square stickers that come in a variety of colors and attach to the medications easily. Black has been designated 1974, red - 1975, green - 1976 and yellow 1977-1978. Each month all we have to check are the medications with black stickers!!

CRIB (BUMPER)

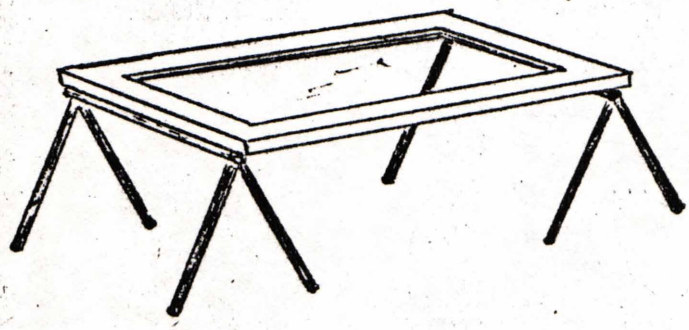
Our engineering department made a plexiglass crib bumper from old materials that works beautifully. The plexiglass is 6 inches high from the bottom of the mattress, extends around all four sides of the crib, and is attached by screws and bolts. It prohibits the small or spastic child from accidentally pushing his feet or arms through the crib rails and also permits visibility for the child when confined to bed.

HELPFUL HINTS

DECUBITUS DEMONSTRATION TABLE

The following idea was conceived after viewing a filmstrip on Alpha-Keri Lotion. It was made by our engineering department. A clear piece of plexiglass (5 ft. x 2-1/2 ft.) was framed in wood and set on metal sawhorses.

A child can be placed on this plexiglass top and by looking underneath the pressure points are clearly outlined. This visualization does more than any amount of instruction on the prevention of decubitus ulcers.



MOTIVATION FOR THE KIDS

We have found that the children work harder and enjoy doing their exercises more when given small rewards at the end of their treatment. Our rewards consist of stickers (found at most variety stores) such as these:

The children find many enjoyable uses for them, such as decorating shoes, braces, casts, personal items or making their own stationery. The children enjoy going to therapy and the sticker serves the purpose of giving the child a small token of physical evidence for any accomplishments they may have made in therapy that day.

IV CARD

BOTTLE #	DATE	SOLUTION & AMT.	FROM	TO	MEDS ADDED

Never enough room on the Kardex? One of our nurses designed this 4" x 6" card that inserts into Nursing Kardex whenever IV's ordered. Works great!

SOCIAL SERVICE

To begin with, I should tell you a little about myself and my Department. I am the fourth Social Service Director to serve the Chicago Unit. In general my job is to work closely with the patients and their families, providing emotional support and assistance in securing medical and educational services outside the hospital. I work, on many occasions, as an advocate of our patients and their families in dealing with other hospital staff members and various community agencies. For every child admitted to the hospital I prepare a pertinent social history containing family and educational information which is entered into the child's chart to be used as needed by the medical, teaching and recreation staff.

Mine is a unique position within the hospital in that all my time is spent getting to know our youngsters, their parents and families on a personal and essentially non-medical basis. I meet with many agency representatives and parents contemplating care for their children at Shriners Hospital and share with them the special care we are able to give to our youngsters. I talk with every new exam and interview each new admission and their parents, and, in each case, explain what they can look forward to during their affiliation with or stay in the hospital. As each child is admitted I make out a new social history or update existing information for the permanent files.

I attend all patient rounds and new admissions medical conferences and keep parents informed of their child's status in regard to surgery, discharge or major tests planned, or any unusual treatments such as traction, body casts or the need for isolation.

For the parents of outpatients I provide referral services in education, medical care, orthopedic equipment, physical and occupational therapy, psychology and family counselling, public assistance, clubs, camps and residential facilities.

My greatest curiosity, of course, is to find out who and where you are and how you spend your days, so I am most excited by the prospect of meeting you through our newspaper.

RECREATION

Our Recreation Department is staffed with a full time Director and uses about sixty volunteers weekly. These volunteers participate in a multitude of activities. The 9:30 to 11:00 a.m. volunteers function in the pre-school classroom as aides to the teacher as well as working on the wards in a recreational capacity. Many are assigned to specific children to work bedside with a patient who may have to be bedridden because of traction or surgery.

One of the classrooms has been set up to serve a dual purpose. During the day it is a pre-school classroom and during the evening, 5:30 to 6:30 p.m. volunteers work with children from the ages of 3 to 8. This room is set up with a number of interesting toys, games and equipment. One of our newest additions is a sand and water table, which the children really enjoy.

Our older children have a recreation and craft period from 6:00 to 7:30 p.m. daily. We try to accomplish some interesting crafts. We do some pottery work, decoupage and various other projects. One of our major problems is finding interesting crafts and ideas for our growing number of cerebral palsy children. Any suggestions?

Another problem we have is convincing the patients to finish one project before they begin another. Our only solution has been to withhold new supplies and ideas until the previous projects are finished.

WHAT IS YOUR OPINION

RECREATION ASKS:

Any suggestions about activities or toys for the cerebral palsy child?

NURSING ASKS:

Do you have any formalized plans for patient or parent teaching?

Any ideas for Inservice Education Programs?

Do you have any criteria for nursing audit that you might share?

PHYSICAL THERAPY ASKS:

Included in our physical therapy program for patients with scoliosis are stretching exercises for spine mobilization. These include traction exercises and lateral bending exercises. The particular exercise we would appreciate an opinion on is the following:

The patient sits on the floor with the therapist holding tightly around her pelvis; the patient bends sideways at the waist, first to the right and then to the left. The patient's arms are held straight and she keeps her chest close to the floor. When the patient bends to the (R) she corrects a right curvature and vice versa. If the primary curve is to the (R) and the secondary curvature to the (L) we have the patient bend twice to the (R) for every one time she bends to the (L).

The question we are presenting involves those children with double primary curves. In these cases do you feel that when the child bends to the (R) she is aggravating the (L) curve and vice versa, since they are of equal or very nearly equal magnitude? We would appreciate any comment you may have on this subject.

BOOKS...PERIODICALS...REVIEWS

1. CLINICAL SYMPOSIA, VOL. 24, NUMBER 1, 1972, SCOLIOSIS.

   This is a thirty-two page pamphlet devoted to scoliosis treatment. It includes Anatomy, Etiology, Classification, Evaluation Techniques and Treatments. The illustrations are exceptional in quality and include Halo-Femoral and Halo Hoop Traction. Excellent for Nursing Staff. (Available from CIBA Pharmaceutical Company, Summitt, N. J., $ 1.50)

2. ONA MANUAL OF ORTHOPEDIC SURGICAL PROCEDURES AND HOME CARE MANUAL.

   Excellent reference guides for ward libraries. (See ONA Newsletter for order form).

3. FILMSTRIPS AND RECORDINGS (Robert J. Brady Co., 130 Que St., N. E., Washington, D. C., 20002, $ .25 each).

   These are used routinely during orientation of RN's and Aides. A good visual aid in addition to lectures. "CAST CARE", "TRACTION CARE", "ISOLATION TECHNIQUE".

4. A ward Library has recently been added to each ward. We find it a must for reference and educational purposes. We found the following texts to be quite complete for our needs:

   "TEXTBOOK OF PEDIATRICS", Nelson, Vaughn and McKay, W. B. Saunders Company.

   "ORTHOPEDIC NURSING", Larson and Gould, C. V. Mosby.

   "COMMUNICABLE AND INFECTIOUS DISEASES", Top and Wehrle, C. V. Mosby.

   "NURSING CARE OF THE CHILD WITH LONG TERM ILLNESS", Steele, Appleton-Century-Crofts.

   "TABERS CYLOPEDIC MEDICAL DICTIONARY", F. S. Davis Co.

   "THE MERCK MANUAL", Merck, Sharpe and Dohme.

   "ORTHOPEDIC INSTRUMENTS AND PROCEDURES", Zimmer.

   "PHYSICIANS DESK REFERENCE".

   "PHARMACOLOGY AND THERAPEUTICS", Musser and Shubkagel, MacMillan.

   "WEBSTER'S NEW WORLD DICTIONARY", World.

Annual Business Meeting and Installation of Officers Held July 1, 1964

Harold A. Sofield, M.D.
President

Noel G. Shaw, M.D.
President-Elect

Francis W. Young, M.D.
Secretary

Allison L. Burdick, Sr., M.D.
Immediate Past President

The Annual Business Meeting of the Chicago Medical Society was held on July 1, 1964. The meeting was followed by an informal reception and open house in the offices of the Society at 310 South Michigan Avenue.

The retiring President of the Society, Dr. Allison L. Burdick, Sr., presided. The following were installed as the Society's officers for the year 1964-1965:

HAROLD A. SOFIELD, M.D., President. Dr. Sofield, as President-Elect, has served as Chairman of the Council during the past year. He received his M.D. degree from Northwestern University in 1929. Dr. Sofield is Professor of Orthopedic Surgery, Northwestern University Medical School and Chief Surgeon, Chicago Shriners Hospital for Crippled Children. In addition to service on several of the Committees of the Chicago

REPORT OF THE ELECTION COMMISSION

Dr. S. M. Goldberger, Chairman, is pleased to announce that at the Annual Business Meeting on July 1, 1964, the following officers were elected for the year 1964-65.

President-Elect
Noel G. Shaw

Secretary
Francis W. Young

Councilors-at-Large
Paul L. Bedinger
Edward A. Piszczek
John L. Keeley

Alternate Councilors-at-Large
J. D. Majarakis
William M. Lees
John J. Brosnan

Past Presidents
Frank H. Fowler
H. Close Hesseltine
James H. Hutton
J. Roscoe Miller
T. R. Van Dellen
Arkell M. Vaughn

AUX PLAINES BRANCH

President
George R. Chobot

Vice-President
Martin W. Green

Secretary
Allison L. Burdick, Jr.

Treasurer
Joseph B. Moles

Councilors
E. Allen Joslyn
Robert F. Sharer
John S. Hyde
Joseph C. Sodaro
William F. Ashley

Alternate Councilors
Roland A. Kowal
Everett E. Nicholas
Philip E. Cocagne
John W. Tope
Thomas H. Mercer
Charles B. Thrift
Gustav A. Hemwall

CALUMET BRANCH

President
Vice-President
Secretary-Treasurer
Councilors
Alternate Councilors

DOUGLAS PARK BRANCH

President
Edward A. Razim

Vice-President
Raymond W. Nemecek

Secretary-Treasurer
Otto Pacold

Councilor
L. S. Tichy

Alternate Councilor
Raymond W. Nemecek

ENGLEWOOD BRANCH

President
Vice-President
Secretary
Treasurer
Councilor
Alternate Councilor

NORTH SUBURBAN BRANCH

President
Robert A. Snyder

Vice-President
Raymond H. Conley

Secretary-Treasurer
Howard C. Burkhead

Councilors
Raymond H. Conley
Edson F. Fowler
Frank Pirruccello
Donald E. Hansen

Alternate Councilors
William H. Harridge
Edward F. Scanlon
Seth E. Brown
Arnold Wagner

IRVING PARK SUBURBAN BRANCH

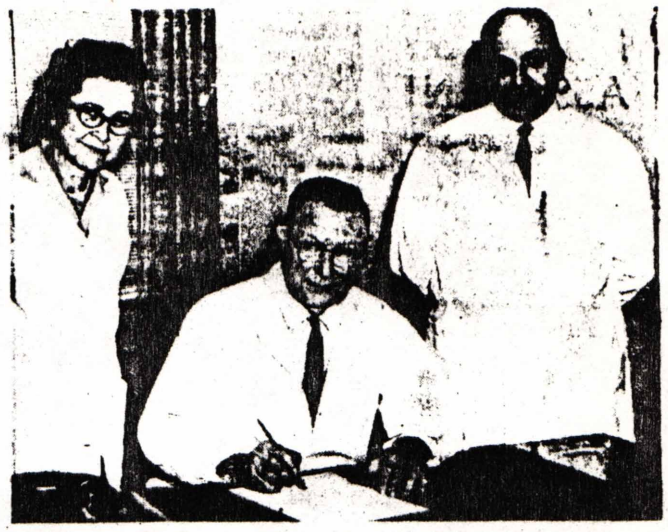
President
Arthur T. Haebich

Vice-President
John R. Orndorf

Secretary
David O. Dale

Treasurer
Alfred Faber

DR. SOFIELD RETIREMENT NOTE INSPIRING



Dr. Harold Sofield (seated) with Mable Ramspeck, R.N., administrator, and Dr. Edward Millar, who is to succeed him as Chief Surgeon at the Chicago Unit, Shriners Hospitals for Crippled Children.

On April 1, Dr. Harold Sofield, for 38 years associated with the Chicago Unit of the Shriners Hospitals for Crippled Children, retired. He is being succeeded by Dr. Edward Millar as chief surgeon.

Prior to his retirement, Dr. Sofield received a letter from Illustrious Harold Lloyd, former Imperial Potentate and President of the Shriners Hospitals. His reply was such an inspiring summation of the work, hopes and accomplishments of our hospital that it is being printed in full, with his permission. It should be an inspiration and a source of rededication to every Shriner. Here it is—and take the time to read it:

Dear Mr. Lloyd:

Your thoughtful letter to me evokes a measure of appreciation far beyond that which you are apt to realize. I know that I speak for all of the members of the Chicago Shriners Hospital Staff in expressing thanks for your evidence of interest and kindness.

On April 1, 1965, I will be retired from the hospital staff after 38 years of service. This is as it should be and I am pleased to know that the position of chief surgeon will be filled by a dedicated, able, devoted surgeon, Dr. Edward Millar. I could think of no one more capable or more deserving.

While it may to some extent be true that I have left my mark on our hospital, to a far greater extent the hospital has left its mark on me and fashioned my life. Starting in 1927 at the hospital as a financially dependent extern, needing a job to provide food and lodging in order to finish medical school, I have been of the hospital family ever since.

After my residency at the hospital, where I lived full time and grew to know and love the children, I was appointed assistant chief surgeon in the early thirties. Except for a leave of absence during overseas service in World War II, I have from the very start of my association averaged more than 20 hours per week in our hospital tasks.

To say that the work has been rewarding would be to belittle it—it has been my life. Perhaps the 15 years I served as assistant surgeon, without pay at that time, seem even more comforting from a service standpoint than my 20 years as chief surgeon. Many of the surgeons have enjoyed long periods of activity in our hospitals; I believe that I have probably been privileged to serve the longest period.

Now as I leave the work I must express to the Board of Trustees, the Board of Governors, and to all my friends in Shrinedom my heartfelt thanks for the opportunity granted me. As the hospital has grown in professional stature it took me with it, so that I have enjoyed honors and offices far beyond my qualifications or my most optimistic expectations. I owe the organization far more than I could ever repay.

Over the past years Chicago Shriners have seen five presidents of the British Orthopaedic Association visit the wards to observe our teaching and research—not to lecture. Surgeons of equal stature in their native lands have come from Japan, Australia, India, Austria, and many other climes.

While the patients continue to knock on our doors in increasing numbers for service, the surgeons come for observing, research, and teaching.

These three functions of any worthwhile hospital have been developed to the fullest at our institution.

Now we have the largest list of patients awaiting admission of all hospitals in the Shrine system, and we have the largest volunteer staff of recognized orthopaedic surgeons providing professional skill.

Service must continue to be the keynote. That through the other functions we have been able to add a bit to the knowledge of the treatment of crippled children we appreciate. Our institution has been able to develop new methods of surgery and treatment that are now aiding in the relief of suffering and which have found worldwide adoption to help solve some of the difficult problems confronting the crippled child. If we had only added one brick in the tower of knowledge our time would have been well spent.

And so with pride and humility and with a sense of gratitude that overshadows all other feelings, I leave an institution that is strong, active, and progressive. I know that progress will continue and the hopes of many unfortunate children will be realized.

Sincerely yours,

HAROLD A. SOFIELD, M.D.

SHRINERS' HOSPITAL FOR CRIPPLED CHILDREN

CHICAGO UNIT

2211 N. OAK PARK AVE. — CHICAGO

Phone: ME 7-9170

◇MABLE A. RAMSPECK, R.N.
Administrator — Shriners' Hospital For Crippled Children — Chicago
A.M.C. No. 54

NEW CHIEF SURGEON

On April 1, 1965, Dr. Harold Sofield retired as Chief Surgeon of the Chicago Unit, Shriners Hospital for Crippled Children. His retirement marked the end of a thirty-nine year tenure of service to this hospital. During the years under his leadership, the medical reputation of this institution was increasingly enhanced until the hospital now is considered one of the outstanding of its kind in the world.

As in all things that Dr. Sofield did, he anticipated his mandatory retirement at age 65, and years ago started grooming a likely successor. However, whoever the man selected, he must meet the most stringent qualifications. First of all, he must be a skilled surgeon and an outsanding orthopod. He must have qualities of sound administrative ability and outstanding leadership. He must thoroughly understand the philosophy and objectives of the Shriners Hospitals for Crippled Children and be devoted to the work being done in these hospitals. He must understand, love and be sensitive to the needs of children, especially physically handicapped children. Ideally he should be a family man with a wife who could meet the social and professional demands placed upon the person holding the high position of Chief Surgeon.

The Chief Surgeon of a hospital such as this should have an awareness of the public relations aspect of the position. He should be an effective public speaker, as well as an able professional teacher. Naturally he will be an active participant in professional medical associations and a significant contributor to medical literature. If he is to be eminently successful in the position of Chief Surgeon, he must be a diplomat, organizer and soundly well adjusted in both his personal and professional life. Above all, he should have compassion couched in courage, humility made secure by strength and drive tempered by patience.

And so, when the mantle of Chief Surgeon was placed upon the shoulders of a younger man, it was decided that it would fit best the shoulders of Dr. Edward A. Millar. His appointment was recommended by Dr. Sofield to the Board of Governors, who, in turn, made the recommendation to the Medical Advisory Board of the National Board of Trustees. The application was passed on favorably there and the National Board of Trustees gave their approval early this year.

Dr. Millar would scoff that he could possibly meet all of the above qualifications. However, having worked with him for the fourteen years he has been associated with this hospital, first as a Resident, then as an Associate Surgeon, Assistant Surgeon and now as Chief Surgeon, I personally can attest to the fact that he does qualify in all these things to a very marked degree. He is well known to many of the hospital staff here, all of whom are delighted with his appointment.

By way of statistics, he was born on May 3, 1920 at Woodward, Alabama. He is the youngest of five children. His father is an engineer and he has two married sisters and two brothers, one of whom, his twin brother, is a Captain in the United States Navy. The other brother is Assistant General Superintendent, South Works, United States Steel Corporation. He graduated from the University of Alabama in 1941 and finished Medical School at Northwestern University in 1945. His internship was served at Evanston Hospital, Evanston, Illinois 1944-45. His Residency training was at Hines Veterans' Hospital 1947-1950 and Shriners Hospital for Crippled Children 1950-51. His military service was with the United States Navy, 1945-46 and 1954-56. He holds the rank of Commander, U. S. Naval Reserve. He has membership in the following: American Academy of Orthopedic Surgeons, Chicago Rheumatism Society, Chicago Orthopedic Society, American Medical Association, Chicago Medical Society, Advisory Board United Cerebral Palsy and Easter Seals, Shriner, Medinah Temple.

He was married to his lovely and charming wife, Dorothy, in 1946. She is a delightful person who looks as if she couldn't possibly be the mother of their ten children. We are sure she has been an asset to her husband in all his accomplishments and will continue to be so. The Millar's are a happy family. Both parents evince pride and a warm sense of humor as they speak of their children.

Dr. Millar has a busy practice and is on the staff of two other hospitals, Evanston and Swedish Covenant. But, this has never prevented him from spending a great deal of time here at Shriners Hospital. As Chief Surgeon, he will be spending even more time at this hospital. Nonetheless, we will wager that he will still manage to find time to pursue his hobbies — electronics and farming on the small acreage where he lives with his family in Northbrook, Illinois.

Our congratulations to him for this new appointment. We are sure he will continue to build upon the firm foundation established by our two previous Chief Surgeons, Doctors Beveridge Moore and Harold A. Sofield. As were his predecessors, we are also certain that he is conversant with and firmly committed to the act that through the teamwork of the Board of Governors, the hospital staff and the medical staff, the success of the future is assured.

CHILDREN GIVEN BONES OF STEEL IN OPERATION

Technique Is Described at Medical Parley

Brittle bones of some child victims of an unusual bone condition have been literally transformed into bones of steel by means of a new surgical technique, members of the American Academy of Orthopaedic Surgeons were told Sunday in the Palmer House.

Dr. Sofield

Dr. Harold A. Sofield and Dr. Edward A. Miller of the Shriners Hospitals for Crippled Children, Chicago, said the operation saves the victims from the need for amputation and enables them to live more normal lives.

Bones Break Easily

The condition is called osteogenesis imperfecta. The fragile bones of the victims fracture in trivial accidents.

In the new treatment, the physicians remove the fractured pieces of arm or leg bone from their bed and thread them on a straight, round steel rod, approximately the diameter of the bone marrow canal. They said:

"The pieces are threaded on the rods in the manner that seems to bring them into the straightest possible line."

Some of Benefits

The bone fragments eventually unite solidly, the frequency of fracture is reduced, pain is diminished, and deformities are corrected and frequently prevented, the surgeons said.

One unexpected boon of the technique, they said, is that some stimulation of bone growth has occurred.

Brittle Bones in Children Strengthened With Steel

CHICAGO, Jan. 25 (AP) Brittle bones of some child victims of an unusual bone condition have been literally transformed into bones of steel, two surgeons reported today.

The operation saves the victims from the need for amputation and enables them to live more normal lives.

The condition is called osteogenesis imperfecta. The fragile bones of the victims fracture from trivial accidents. The mere act of lifting an infant suffering from the condition can break his arms or legs.

Drs. Harold A. Sofield and Edward A. Miller of the Shriners Hospital for Crippled Children, Chicago, appraised their technique at the annual meeting of the American Academy of Orthopaedic Surgeons.

In the treatment, the physicians remove the fractured pieces of arm or leg bone and thread them on a straight, round steel rod approximately the diameter of the bone marrow canal. They said:

"The pieces are threaded on the rods in the manner that seems to bring them into the straightest possible line. Some fragments may be turned end for end, and others may rotate 108 degrees. When the shaft is realigned on the rod, it resembles a shish kebab (chunks of meat impaled on a pointed stick)."

The bone fragments eventually unite solidly, the frequency of fracture is reduced, pain is diminished, and deformities are corrected and frequently prevented, the doctors said.

One unexpected boon of the technique, they said, is that some stimulation of bone growth has occurred. Generally the condition results in one leg or arm being shorter than the other.

The doctor said that some children, who previously would have had to wear an artificial leg from childhood on, now may look forward to two vital legs of normal, equal

Victims of Bone Condition Strengthened by Steel Rods

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The doctors said some children, who previously would have had to wear an artificial leg from childhood on, now may look forward to two vital legs of normal equal length.

Chicago Medicine

CHICAGO MEDICAL SOCIETY • THE MEDICAL SOCIETY OF COOK COUNTY

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Dr. Sofield makes his rounds at Shriners Hospital for Crippled Children, Chicago.

Dr. Harold Sofield Wins CMS Public Service Award

Dr. Harold Sofield wins CMS annual public service award

He's traveled and taught all over the world, but renowned orthopaedic surgeon Harold Sofield, M.D., has spent more than 50 years volunteering his services to Shriners Hospital for Crippled Children in Chicago.

Dr. Harold Sofield provides some encouraging news for orthopaedic patient at Shriners Hospital.

He stands at the top of his profession, enjoying the warmth and respect of his colleagues, patients and friends. At the age of 80, orthopaedic surgeon Harold Sofield, M.D., could write books about his life in medicine. And the list of honors he's received would take up pages.

His most recent honor, the third annual 1980 Chicago Medical Society Public Service Award, makes him feel "real good," he tells a colleague in the halls of Chicago Shriners Hospital for Crippled Children, where he's on his way from the Department of Surgery.

"But you keep on living long enough, and you'll get an award for that, too," he laughs. Two nurses walk by, affectionately kiss him on the cheek and wish him a happy birthday. As they walk away, he calls out to them chuckling, that his birthday isn't until next week, "so you'll have to kiss me again."

Dr. Sofield bustles down the hall and into a classroom full of children recovering from their orthopaedic operations. He stops for a few minutes to visit, and then drives off to downtown Chicago to do medical work for the Armed Forces.

Dr. Sofield has virtually volunteered his professional services at Shriners ever since he served his clerkship there in 1927.

He was chief surgeon there for almost 20 years, before his official "retirement" in 1965, but has kept active ever since, helping out in surgery and teaching.

The Shriners organization recognized him in 1955 as an "Outstanding American." Asked about the occasion, Dr. Sofield recalls that the award ceremonies took place in Soldiers Field, where other honorees included TV personality Art Linkletter, Fighters Jack Dempsey and Gene Tunney, and director of the Lincoln Park Zoo, Marlin Perkins, among others.

"We were each driven up to the center of the field in a white Cadillac," he said. "Those Shriners really love to put on a show."

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"He stands at the top of his profession, enjoying the warmth and respect of his colleagues, patients and friends... And the list of accomplishments goes on..."

While the Shriners hospital has been his main activity in public service work, over the years he has been active in many other volunteer efforts. (This in spite of a regular professional schedule that saw him serve as chairman of the Department of Orthopaedics at West Suburban Hospital for 45 years.)

For example, he was chairman of, and now serves on, the advisory board of Orthopaedics Overseas, a volunteer organization of surgeons serving under Medico and CARE in underprivileged lands. Through this organization he volunteered his time and paid his own way to perform surgery and train native medical personnel in such countries as Tunisia, Columbia, Peru, Viet Nam. "We had a nice program going in Afghanistan too, but we pulled out just at the right time," he said, referring to the current problems in that country.

There was also time for work on the WTTW-TV Medical Advisory Board, the committee that organized and started the Rehabilitation Institute of Chicago, the Connie Tingley State Hospital for Crippled Children in New Mexico, the Illinois Association for Crippled Children board of governors, the Medical Division of the Community Chest of Oak Park, and the chairmanship of the research division of the Easter Seal Foundation Board of Trustees, a position which he utilized to maintain liaison between the Easter Seal Society and orthopaedic surgeons.

In World War II, he served in the South Pacific Theater as the orthopaedic surgery chief of the 25th Evacuation Hospital, an affiliated unit of West Suburban Hospital. After one year, he was appointed the consultant in orthopaedic surgery to all Army forces in the South Pacific Area. It was during this period of service that he was elevated to the rank of colonel. For his services, he was awarded a Bronze Star Medal, Legion of Merit Medal and five Battle Stars.

A brief look at Dr. Sofield's role in organized medicine shows an equally strong dedication. He co-founded the Orthopaedic Research and Education Foundation which collects monies and awards for research and education in orthopaedic surgery.

In 1934, he invented the "Sofield pin," a device used by orthopaedic surgeons to mend fractured hips.

In the late 1940's, he reported the "Sofield shish kebab" operation for osteogenesis imperfecta. In early 1950, this technique was modified to correct congenital femoral shortening, congenital fibular absence, and congenital tibial pseudarthrosis.

In 1946, as a professor of orthopaedic surgery at Northwestern University Medical School he chaired and incorporated six health care institutions into the Orthopaedic Residency Program at the VA Hospital, Hines, IL. He trained more than 130 orthopaedic surgical residents.

Dr. Sofield served as president of the Chicago Medical Society from 1964 to 1965, and was active on the CMS Board of Trustees for 10 years. He also served as president of the American Academy of Orthopaedic Surgeons and Chicago Orthopaedic Society, and was elected secretary of the American Orthopaedic Association.

In 1971, as a delegate to the American Medical Association, he was the leading proponent of a law ordering drugs dispensed in "child-proof containers."

And the list of accomplishments goes on and on.

"Hal" Sofield, the man from medicine to out-door living

A few more words here, however, help reveal a little more about "Hal" Sofield, the man.

Born in Jersey City, New Jersey, March 27, 1900, he first developed a feel for medicine watching his dentist father at work. He joined the navy at age 17 and served in World War I. He took his premedical education at Columbia University and medical education at Northwestern University, earning his M.D. in 1929.

He served a year's internship in San Francisco, and then began resident training in Orthopaedic Surgery in Chicago at Shriners Childrens Hospital and at St. Luke's.

Dr. Sofield married Ruth Robinson in 1934, and had two children, David, who is now professor of English literature at Amherst College, and a daughter Julie (Mrs. Otis) Tholander. There are also five grandchildren. And the Sofields have friends all over the world.

Dr. and Mrs. Sofield live in Oak Park but spend weekends in Michigan in their country home overlooking a wooded area. He says he likes going up there so he can go fishing, chop wood, and utilize his skills as an amateur photographer to photograph his grandchildren when they visit. "I'm always busy," he says, and he bustles off to another project. □

SHRINERS HOSPITAL FOR CRIPPLED CHILDREN
2211 NORTH OAK PARK AVENUE
CHICAGO, ILLINOIS 60635

Friday, December 12, 1980

"A LOOK AT YEARS PAST"

Christmas: Honoring the Past and Looking Toward to the Future

On this evening of celebration, we salute the past and look toward the future with great anticipation. In order to preserve the best of the past, it is believed that we must fully appreciate the accomplishments and joys of the past. This is the purpose of this gift of the past to you - those who have made the past accomplishments possible and will make future plans into realities.

The information in this gift was gathered as a part of a project that describes how care of the child and the family in the Shriners Hospital for Crippled Children, Chicago Unit, has changed over its history. A complete copy of the project will be housed in the Professional Library in the new hospital. Specific questions that the study will attempt to answer include:

1. How have institutional, technological, and social changes produced changes in the interface between the hospital and the family and the child?

2. What have been the reactions to these changes by staff? By families? By children?

3. How have these changes in care delivery affected outcomes of care given at Shriners Hospital?

Interviews were conducted with Dr. Harold Sofield, Edna Travers, Mr. Gene Yeazell, Dr. Edward Millar and Joanne Woiteshek - a group of leaders who have spearheaded the work of the hospital over the years. A few historical facts will be presented first, then parts of the interviews will be quoted.

This research was supported by the
Joint Board of
Shriners Hospital for Crippled Children

Janet A. Nowlin, R.N., M.S.N.
Chairperson, Department of Nursing Research

HISTORICAL LANDMARKS

Present Hospital

- Land Donated by the Medinah Temple	$ 44,000
- 17½ Acres; Building Takes 7 Acres	$400,000
- April, 1925 Groundbreaking	
- June 20, 1925 Cornerstone	
- February 20, 1926 Building Completed	
- March 20, 1926 Building Opened	
- March 18, 1926 Seven Patients Admitted	
- 1956 Remodeling	$ 95,000
- 1963 Remodeling	$375,000

NEW HOSPITAL

- June 11, 1978 Groundbreaking
- May, 1981 Target for Completion
- June, 1981 Target for Occupancy

Interview with Dr. Harold Sofield, Chief Surgeon Emeritus

Well, of course, 1927 most of our cases were cases of poliomyelitis. 60% of the census was poliomyelitis. We took them in the really subacute stages but we had some in the acute stages. Later on when the iron lung came into use we had two iron lungs here in the hospital and so we took them in the acute stages as well as in the subacute stages, and then in the stages later on after the subacute when a great deal of surgery was done.

60% of our census was polio. The other part of the 40% was primarily made up of osteomyelitis in general and staphylococcus and streptococcosis and so forth and then a good part of the other part of osteomyelitis was tubercular joints such as tuberculosis of the knee joint, tuberculosis of the spine, of the elbow and so forth. So that the entire hospital population has changed almost 100%. Now we don't see any in this hospital. We don't see any acute, subacute or chronic polio at all. That's good.

Now that's what we saw back in the early days. Now you'll see none of those three. Once in a while you may see a TB joint, but very seldom. So the entire census, the entire hospital population of this hospital and of most Shriners Hospitals has changed 100%. Also, at the same time there were great social changes. Back in the late 20's and early 30's, particularly in the early 30's, after the great depression came along when the stock market fell, we had many, many, many cases who were very sad in that from an economic standpoint. In other words, the parents did not have money enough to feed their children and we had many malnourished children brought in. This added to the polio and TB and so forth. It meant that these children. . . many, many of them were in pretty sad shape when they came to the hospital. It's different now. Now that we have welfare. . . the welfare state we seldom see these malnourished children in a hospital like these. You see more. You see some that are malnourished, not so much from an economic standpoint but rather from the standpoint of ignorance in knowing how to feed them.

Not only that but in order to use the child as an economic asset we had certain cases that were rather sad cases where we had to step in and take the child away from the parents.

Dr. Moore who was the Chief Surgeon. . . the original Chief Surgeon. . . here. . . had not had a great deal of formal orthopedic training. He had a little during World War I when he was assigned for a relatively short time to Boston Children's Hospital and then when he came out of World War I he decided he wanted to go into orthopedics and at that time they had not formal residency training and he went and worked in a clinic over at the County Hospital. He also worked with the Rush Medical School Clinics. . . there just weren't any trained orthopedic men available in Chicago to take this particular position.

I was in my third year at. . . no, I was in my fourth year. . . I started my fourth year of medicine at Northwestern. . .

Dr. Sofield (continued)

Well, I was starting in my fourth year and I had been in Chicago for my third year. . . and it was October and when we were starting and I was assigned to the orthopedic clinic at Northwestern and Dr. Moore was running the clinic at the time. He approached me and said after I had been with him with all of the other members of the class. . . there weren't too many who were assigned to orthopedics. . . and asked if I would be interested in coming out here as an extern because they needed another body here to cover. They only had one resident and he wanted to get away occasionally. . . and would I be interested in coming. There was another man who was a resident. . . rather an extern. . . I will see him at our 50th class reunion. He name is Rideout. . . William Rideout. He was then serving as an extern here. So I came and joined him and we had two externs and one could then cover one time and one could cover at another time and let the resident. . . who at that time was Dr. . . . he did not go into orthopedics anyway after he finished his residency. . . So that's how I came here in 1927. I assisted in surgery because there was only one other man assisting and that was the resident and as an extern we were allowed to assist in surgery and then we would go to medical school. We took the trolley car down Grand Avenue to Northwestern. It cost 5¢. We got out. . . we weren't paid anything but we got our meals and board. At that time those were two very necessary things for me because I was putting myself through medical school so I was very happy and I was very much interested in the work here. Dr. Moore was a man that you would properly call a gentle man. He was extremely gentle and a very lovable character. There were no boards and no one was certified or anything like that and people that came here for a residency. . . at least half of them in the first ten years did not continue in orthopedic surgery. They put a year in here as a resident more less to bone themselves a little better for general surgery or general practice. The first resident that went into orthopedics here. . . and he was the second resident here. . . the first resident was Dr. Husang. He developed a massive pulmonary hemorrhage here in the hospital and was immediately moved out to a TB sanitarium and died there. The second resident became. . . went into orthopedics. . . Dr. Garceau. . . and be became an outstanding orthopedic surgeon. . . the head of orthopedics at the University of Indiana. . . professor. . . and the head of the Riley Hospital for Crippled Children. . . outstanding man. The third one was Dr. Riddle. He did not continue in orthopedic surgery. I worked here with him then as an extern. . . with Dr. Riddle. Then when I left to take my internship in San Francisco the fourth resident was Dr. Pappenhagen who ended up out in Idaho. Then I came in as the next resident. . . the fifth resident. From then on practically all the residents stayed in orthopedic surgery, although many of our assistant residents didn't. The mix of patients changed gradually over the years so that more and more. . . and as polio gradually came under control tuberculosis, of course, we never did. . . there was nothing like a serum of any preventive medication or chemical that conquered tuberculosis. Tuberculosis was conquered primarily by good nursing. And, also by the fact that it gradually wore itself out so that now we practically never see a case of bone or joint tuberculosis but as I have traveled in

Dr. Sofield (continued)

South Africa I find many, many, many cases in the hospitals there among the Bantus. This is true in all the underdeveloped countries. As a country becomes more developed, more sanitation, better food, better living conditions, tuberculosis drops. This is true all over the world. So, we didn't conquer tuberculosis by any great discovery. Tuberculosis was conquered by economic conditions and by education rather than any great discovery like the Salk Vaccine.

Let us start with the head personnel in nursing, namely the superintendent as the head person, the administrator person, who was then called. This was Miss Duning. Miss Duning was from Boston Children's Hospital. She was the first superintendent.

She had one assistant but the assistant who was also a trained nurse worked on the wards and helped out in the hospital more than she did any administrative work. It was very seldom that Miss Duning ever left the hospital. At that time the boys' ward and the girls' ward were completely separate. They never mixed or almost never. At that time the only time they really mixed was at the Christmas play which was really quite an event and which was supervised by one of the chief nurses of the hospital. At that time they mixed. They never played together. We really didn't have a schoolroom for a number of years to start with. The schooling was all done on the wards. So there are the two chief nurses. We had a nurse supervisor of the girls' ward and a nurse supervisor of the boys's ward and then we had a Miss Blizzard. These are the trained nurses. Miss Blizzard was a very pro temed person in that she filled many shoes. She was the x-ray technician. She took all the x-rays. She took all the photographs. She gave all the anesthetics and helped on the ward in addition. She was a very independent character. She is one of the few that is still alive and I saw her not too long ago at the dedication here. She was of Indian extraction. She was very proud to have had some Indian blood from Oklahoma. She was really a marvelous person to be able to fill so many shoes and fill them well.

Next, the girl in the operating room. . . the supervisor of the operating room was Miss Hanson. She was a Norwegian girl. I don't remember her first name although I should. She was a very fine operating room supervisor and she was the only trained nurse there. She scrubbed on everything and had been here so long that she was really a very good teacher to the younger men who came up to scrub for surgery. She and Miss Blizzard were great friends.

On the boys' ward we had another trained nurse, Miss Busk. She was an excellent nurse and surprisingly enough even though all of us were here at the time, apparently there was a romance that went on between Miss Busk and the resident whose name was Norman Riddle, an older man. When Riddle finished his year here, and as we have noted before, he married Miss Busk and they left. It was a great surprise to everyone here. On the boys' ward. . . that was on the boys' ward. On the girls' ward at the moment I don't remember the first nurse that had the girls' ward and then there was only one other trained nurse

Dr. Sofield (continued)

in the whole hospital and she more or less floated substitution on either the boys' ward or the girls' ward or scrubbing in surgery. Coming to the next one on the hierarchy would be the attendants. These were not practical nurses. These were girls fresh from the country and when I say the country, I mean the country. Very few of them, if any, came from around Chicago. Most of them came from down around Plano or south of Peoria or other places out in the country. They came here fairly young and knowing nothing about a hospital. They were called attendents. They helped on the wards and the good ones, of course, became good practical nurses. If they liked children, as most of them did, when they worked out very well and they did the feeding and they did the cleaning and so forth. . . of the children and many of them were very good. They had real country names. I remember one was named Miss Turnipseed.

And the others had good country names that I don't recall. They were good. They all lived in the hospital. All the trained nurses lived in the hospital. They had to live in the hospital and the rule was that none of them could be married and still keep the job. As a matter of fact Miss Blizzard had been married for some time. . . Jean Blizzard. . . but no one knew it. I didn't know it even though she was a very good friend until after I had left here and then it turned out. . .

She was married but as I said she was a rebel. No one knew that she was married, of course. Otherwise she would have been fired by Miss Duning. These were the first four, five, six years.

So this is the way it went in the first few years. Now outside the next hierarchy in the members of the hierarchy down of course were the workmen and women who did the maintenance work around the hospital. They came and they stayed for years. They became part of the family. One that is best remembered is the engineer, Bernie Arnold.

He would always come first thing in the morning and put on his overalls and take the largest wrench that was ever made, which was almost as big as a broomstick, put it over his shoulder and walk around the hospital. This gave the impression that he was working. Actually he did a very good job in keeping the boilers going and doing the maintenance around the hospital. He was well up in the Masonic order, having been the head of the local lodge here in Montclare. So he fitted in very well and he stayed for quite a long time. We had a few that came in and out.

We had a minimun number of trained persons in the hospital. Dr. Moore came every single day and would drive out from the south side. He lived down near the University of Chicago. He always drove a Packard car. After I had finished my residency here he asked me to go in the office with him and to live in his home. His children had grown up and left home. So I lived in his home for a matter of about four to six months until I found out that the depression of the 1929, 30's, was so severe that Dr. Moore was making no money either and so he could ill afford to pay me the few dollars that I needed to exist on. So I decided I would go into private practice. It was impossible to go

Dr. Sofield (continued)

into orthopedic practice at that time. The specialists were getting nothing because the depression had hit the doctors so badly that anyone that would refer cases would do them in common times. . . would do them themselves in order to get some money. They couldn't make a living in it nor could I. So that just taking myself as an example of what happened was that I went into family practice. . . general practice. . . and I borrowed $100 from my aunt and opened an office about three blocks from here on Grand Avenue. Walk upstairs over a real estate office. I lived in the office. I had a day bed.

So I went into general practice and the first patient I had was a diabetic. Then I started delivering babies in the neighborhood. I started mainly with the nurses in the hospital who had married and were having babies. I took care of many of them in the homes. . . not in the hospital because nobody could afford to go to a hospital. I would charge nothing, of course, for those cases. However, I then got on the W.P.A. (Works Progress Administration) Program and I was paid $35.00 for every home delivery that I did. I was not even associated with any hospital at the time except here at Shriners Hospital where I continued as assistant chief surgeon. That started in 1931.

Here only in this hospital was I able to practice orthopedics. Oh, I got a few broken wrists or broken fingers that would come in but it was just general practice. The population around this hospital at that time was primarily of two distinct nationalities. They were either Italians or Polish. I understand that the Polish population around here is pretty well diminished although the Italian population in the area of Montclare has increased. But at that time there were many Polish people living here. In the meantime I stayed at the hospital under Dr. Moore and of course a new resident came every year and they are listed in one of the lists that we have here that I went over not too long ago. I would work with Dr. Moore almost every day here. We had an enormous cast clinic on Wednesday. We had many, many congenital dislocations of the hip because at that time the pediatricians were not trained to recognize a congenital dislocation of the hip in a newborn. . . nor were the obstetricians. So, these cases were neglected and it was late when we got them.

Dr. Moore, as he grew older, was advanced at Northwestern Medical School to assistant professor. In 1930 when I had finished my residency here and had gone with him in his home for a while, he managed to talk with the people at Northwestern University and I was put on in the lowest position in the orthopedic section. That meant that I had to attend clinics and run a clinic in conjunction with one of the men, an older man, who was better trained than myself, twice a week. So I ran it with Dr. Moore on Monday mornings and with Dr. Crosland of Gary Campbell Clinic trained on Wednesday mornings.

I was busy because I had very little private practice. I lived right in the office which is practically on the trolley car tracks on a cot that was in the office and where the patients sat. . . what patients I had. Then I would roll down the thing and sleep there at night.

Dr. Sofield (continued)

I kept my clothes in a rolltop desk that someone had given me. I took my baths over here at Shriners Hospital.

Well, of course, it was easier to have a family atmosphere here in the old days when the nurses and the attendants lived in the hospital. They had no family nearby. Most of the families, not all of them, were at a distance from Chicago so that per chance this had to be the family for them. So at Christmas and Thanksgiving and other celebrations. . . were celebrated here as a family would at home. For example, my home was in New Jersey and I was here in Chicago which meant that I didn't get home for Thanksgiving or Christmas all the time or other holidays. So they were all celebrated here. We knew each other imtimately. We shared each other's family problems. Some of the younger nurses would be like sisters and others perhaps would be like. . . And so this carried on to the children, too, because many times these children that we were taking care of would be about the ages if we had children. The children were away from their families. Their families didn't get here very often particularly when we were hospitalizing a member from South Dakota and from other outlying states. So they looked to us as they would look to their parents. And, as I have mentioned before, many times when I was making rounds I would say. . . ask someone a question. . . you know, one child a question and he would answer or she would answer and say "Yes, father". Well, it was difficult for me to tell whether they meant daddy of whether they meant a priest because we never have had any written statement in any of these hospitals as to what form their religion took. This was of little interest because we had a piano down on each ward and always there was one of the attendants or one of the nurses that could play the piano and a number of times I would wander down. . . they'd all be gathered around the piano singing hymns, regardless of what their religion was. They all enjoyed singing and they all seemed in a short time to know the hymns that were being played. I thought it was excellent.

And, someone would get married and everybody in the hospital would go to the wedding. And, to emphasize how close the family relationship was among the staff, is the fact that when these attendants or the nurses got married and I had graduated from the hospital in just recent years and was here as an assistant chief surgeon and I was doing general practice I would have the job of delivering them of their children. So it all kept in sort of a family way that way.

Now let's talk a little bit about the Board of Trustees over the years. The attitude of the Board of Governors of the hospital has, of course, changed over the years. When it started the local Board of Governors had a good deal of autonomy. The problems that came up were settled primarily. . . were settled locally and everything didn't have to go to the Board of Trustees which is a national group. This is pretty much like state's rights in which problems that seem to be able to be handled more equitably locally where all the different angles of the problem are known, were handled that way. I presume that there must be a very good reason for it changing because one hospital might be able to attract a great deal more money than another hospital and it would have to be equalized. This was best found in a fund that

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was started here called the Crutch and Cast Club. This was money that was donated locally to be used locally and used to good purposes. If we wanted something here that was. . . that we thought was good for the children and for the hospital in general, we were able to go to the local Crutch and Cast Club. I recall one set of circumstances that illustrates how valuable this fund was. At one time, we had a very fine Chairman of the Board of Governors. I think the Chairmen have been excellent.

Let's talk about the Board of Trustees and how they changed over the years. This hospital started. . . the Chairman of the Board was a man named Bill Wade. . . and he was a large man physically. He was blessed with a marvelous Board of Governors. This was a new project and it was a project that was being watched really all over the country by other fraternal organizations. It attracted the top level of men to the Board of Governors. Men such as Ken Rice, Art Vincent, Arthur Bullock and a man whose name I can't remember who was very prominent in Sears, Roebuck and owned a very large house in River Forest and others of that quality. These were top men - top men in the big organizations and big corporations of the time. They were devoted to the hospital. They practically never missed a meeting. They would give of their time and of their effort and many times of their money.

Also, I would report on cases that were unusual when we started doing roddings for osteogenesis imperfecta at the meetings. I did the first one in 1946 on a patient named Adams and the first report that we made was in 1949 and another in 1951 at the American Academy of Orthopedic Surgeons where we demonstrated by slides and by photographs the technique we used for rodding of osteogenesis imperfecta. We had a little article printed and distributed but we never published it nationally. . . Associated with me at that time were Dr. Newton Meade who later became a Chairman of the Orthopedic Department at Evanston Hospital, Dr. Manley Page who stayed with me all through my professional career almost. . . he retired a few years before me. . . and he became the Assistant Chief Surgeon here when I was Chief Surgeon. He was not the first Assistant Chief Surgeon. Dr. Newton Meade was the first Assistant Chief Surgeon and Dr. Manley Page was the second Assistant Surgeon. Also, we had with us one of the residents at the time. . . Mortimer Eiger. . . who was a resident at Hines Hospital. We were rotating the residents through from Hines over here in Shriners Hospital. One resident at the time. . . later two. We never got beyond two residents and we frequently would have 80 patients in the hospital. But they lived in the hospital. They were not married and they lived in the hospital and they knew every case intimately. That was the first public announcement of the operation and later on. . . ten years . . . Dr. Millar and I, who had come in later in the day on this because he was a resident at the time. . . coming four or five years later after we started doing it. . . Dr. Millar and I published a more definitive article on a ten year survey. It's interesting that at this particular operation, which is a salvage operation. . . I mean the disease is such that eventually the big breakthrough will be prevention

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of the disease the same as it is for polymyelitis. . . and just like in poliomyelitis all the operations that we did will fade away once the cause is found and proper treatment instituted in trying to prevent it. However, at the present time it's interesting. . . . starting in 1946 with roddings here and up to the present time 1979, nothing new has taken the place of the roddings that were started and they are now done universally all over the world. When visiting in England or Canada or South Africa. . . English speaking nations. . . when I'm introduced to someone frequently someone will say "Oh, you're the Sofield shish kebab man" because the operation became known as the shish kebab operation.

I instituted it and perfected it. I did it first on rabbits which we kept down in the morgue. We don't even have a morgue in the Shriners Hospital any more. We never used the morgue. It's of interest that during the prohibition days when the mob of gangsters was very active in Chicago in alcohol. . . we used to get our supply of alcohol for this hospital in barrels that were confiscated by government agents tested to see that it was pure ethyl alcohol and it would be given to this hospital. Alcohol cost a lot of money in those days. It still does. We had barrels and barrels of alcohol given to us. We had so much alcohol that we were afraid that if we stored it all downstairs it really was a menace. . . a hazzard. . . so a little building. . . a little brick building was built in back of the hospital to store these barrels of confiscated ethyl alcohol. I don't know but maybe they're still using it. We got so much of it. But it cost us nothing.

We've started to run short of patients from around the Chicago area although we had at one time a waiting list of close to 300 and it would take two (2) years to get an elective case in. That meant that cases that were urgent we took in and the ones that were elective as is true now in most all of the countries that have nationalized health are put off for two or three years. For example, if you have an interval appendix that needs surgery. . . in England or in Canada or many other countries that have nationalized health. . . you may not have that taken out for three or four years. Your turn won't come to a hospital. The same thing happened here in which we had a number of cases that were not emergency cases and so they were put off. So we ran. . . sometimes we would run up to 80 cases. . . that was the upper limit of our beds here at the hospital. It ran between 60 and 80 all the time. The Board of Trustees has changed tremendously and the last time that I attended the Board of Trustees meeting here which was a number of years ago it was running beautifully and Dr. Millar tells me that it's going along very well and knowing the succession of Chairmen of the Boards in which Mr. Roberts serves for a while and then Mr. Green serves for a while then Mr. Roberts serves for a while and then Mr. Green serves for a while you have continuity that. . . of two dedicated people who are very excellent.

So let's talk about the physical part of the Hospital. The building, of course, was much smaller than it is now. The girls' ward and the boys' ward were extended. At first they didn't have the extensions on from the central portion of the building and then they were extended

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out. Of course it had no air conditioning and upstairs in surgery it was absolutely hell because at that time and up until relatively recent years the idea in surgery was to have natural light only coming in so the entire west wall of surgery was one great big window with small panes. . . almost from the floor to the ceiling. So you can imagine how the sun would beat in there on the second floor right under the roof and all this sunshine coming in. Now many of the surgeons, particularly Dr. Edwin Ryerson who came here and operated while I was in the service and who perspired tremendously. . . he would have an oil silk, almost like a gown. . . that he would hang from his neck and it would go down almost to his feet. . . and then his operating gown would be over and the perspiration would gather in pools. It was just hellishly hot up there. This went on because the idea was that you had to have natural light. . . that you wouldn't be able to recognize structures properly in artificial light. Well then when they did over the operating room they closed it off completely so there was no light at all coming in from the west. . . none at all. None from any of the other three directions either. Well, I objected to that because we were used to looking out. . . while we were operating or in between operations or monitoring an operation. . . looking outside and seeing what was going on and seeing a little bit of the outside. So, on my recommendation they tore out some of the bricks and made a little narrow. . . about a one foot length of window that now goes across so that you can look out when you're monitoring an operation. . . and see what's going on outside and what the weather is. This was a concession which we felt very grateful for and it's that way now. However, many of the modern operating rooms had no sunlight at all in them. They're all artificial light. . . down at St. Luke's and many of the others. . . Presbyterian St. Luke's. . . I always speak of St. Luke's first because I was on the staff of the old St. Luke's. The present idea is not to have any daylight coming in because it varies so much. . . a cloud goes across the sky and your light is varied at your operating table. . . even when it's accessory light coming in, in addition to the artificial light. So now practically all the operating rooms, of course, have no daylight at all. It's all artificial light. So that was changed. The back room where the school room is now. . . although the school room has been expanded tremendously. . . there was a small suite of rooms back there. . . on the ground floor. . . and this was our contagious ward for serious contagion like diptheria which was the only killing contagious disease of childhood that we had. We had several cases of diptheria there and we lost at least one. This was considered so contagious and it was. . . that none of the nurses that worked in the hospital ever went back into those wards at all. We had nurses hired from the outside who would come in and just go back there and do their work and then leave for home. They would never mix. Those of us that were doctors on the staff were residents and attending surgeons would change completely before we would go back and then we'd see them and then we'd change completely before we mixed around again. So, we observed that thing very, very completely. Of course, the funny thing about contagious diseases is the way that they

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gradually ameliorated in that they're not nearly as fatal or severe as they were. Chicken pox was one of the greatest examples. Chicken pox used to be a communicable disease that was quarantined and we'd have a red sign on the front door here and whenever we had a chicken pox case. . . and they were quite sick with chicken pox. . . and of course, the incubation period if fairly long for that disease so that we'd get children in who had been exposed to it and we didn't know that they'd been exposed to it. . . their mothers didn't know either. ... although they would always be asked. . . and they'd come down with chicken pox. Then we'd be quarantined completely.

Well, as soon as they got over the chicken pox we'd send them home you see. But then another one would come up with chicken pox so that it just kept going on and on and on and we'd have to wait until it ran its full length of time. . . when our hospital would maybe be half full before we could admit any patients. But this was with measles and scarlet fever also. So that has changed tremendously. No, we don't mind if a kid comes in and has chicken pox. We operate with the pox on him and everything. It has become such a minor disease that we don't hesitate at all. Well, of course, this has been the history of communicable diseases in childhood. For example, if you took measles and go over to the South Pacific Island and give measles to. . . as had been done by missionaries in particular. . . and they'd get measles. . . they'd die. They would die from measles. Die from scarlet fever. Great numbers of them because they had never built up a resistance as a race to it. So that made a great change here. Then when air conditioning came in and I've forgotten when it came in but I would say in my lifetime relatively recently. . . it was such a change. Now fortunately, they put in a big enough unit so it would really keep us cool which was something that I in particular talked about because every other hospital I worked in. . . in order to keep the costs down they would put in a unit that was supposed to just barely cool the hospital and the operating rooms. The operating rooms in most hospitals are up on the top floors where it's the hottest and the air conditioning never was adequate. So here they put one in that was really adequate and so that we really enjoyed operating then and it's much better for the patient of course. The old idea that you had to keep a patient real warm with blankets and everything after they came out of surgery was one of the things that has been changed completely now and now we try to keep them at just a normal level of temperature and not put heavy blankets on post-operatively. So far, as these rooms that we're sitting in and I'm sitting in the room that has the name Chief Surgeon on it but it's no longer the Chief Surgeon's room. . . this is where the residents used to interview the families when they came in. They were allowed in on Sundays from 2:00 P.M. to 4:00 P.M. and that's the only time of the week they were allowed in. Of course, that was more for contagion than anything else. . . and they would. . . and also for the fact that it would interfere with our work if they were around all day. And so they would line up outside in the hall and then come in one by one and I would have a file card here that I would look at. . . flick over. . . with the name. . . and I would add

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written on it and we kept it all up to date so when Mrs. Brown came in with her husband about little Johnny Brown, I would have the card and I would talk to them and tell them about what was going on and what they could expect in the future. That's the way we ran visiting hours. There hasn't been much change otherwise in the downstairs layout of the hospital. It has been redone, as I said, for air conditioning and there have been some changes back in the clinic. There never was a clinic there at all. We just had the cast room. That was as far as the hospital went. Later on that part of it was expanded and made larger, you know.

The children who came back for a follow-up visit were seen back in the cast room. . . in what little area we had back in the cast room. It was about that time. . .of course, we had no dictating machines at all, so we had to write long hand on the thing. Well, Dr. Moore and I would commonly be the only two people here and since we would run between 60 and 80 patients in the hospital at that time. . . the hospital first was designated as a 60 bed unit and then later as an 80 bed unit. . . we had very large clinics on Friday afternoon. Wednesday afternoon was plaster day. Friday afternoon was clinic day. Frequently we would get so far behind that we wouldn't write them up as we saw them. So that they could get out by 6:00 P.M. to go home. Then we would sit and write, trying to remember the various things we had seen in these patients. . . and we'd write long hand. . . and if you look at the old records you could see that at that time I was writing with a fairly legible hand. . . much different than I am now. . . and we would write until 8:00 P.M. or so before we ever took time off to have dinner or go home. We didn't have. . . we had one assistant surgeon beside myself. His name was Frederick Test and he was old. . . he was as old as Dr. Moore or a little older. He was very faithful about coming and he helped in clinic too. So, frequently there would be the three of us but very often just the two of us. The other physical changes to the hospital, of course, were upstairs where the nurses lived and the attendants lived. They all lived in as I've said before so that they would entertain their boyfriends in the parlor upstairs and, of course, lights had to be out at I think 10:00 P.M. It was Miss Duning who was the original superintendent then was, as I've said, was very strict. But they had to be out at 10:00 P.M. The girls had to in, I think, by 12:00 P.M. or perhaps even a little before. The door would be locked and they couldn't get it. Of course, the same rules applied to the residents. We had to be in too. However, the residents living on the first floor, just in back of where we're dictating, they had nice windows and they were at ground level so you could very frequently flip up a window and get in. Once in a while some of the nurses came in late and I would hear a tapping at the window and I would open the window and just help her in through the window and she'd get upstairs.

It was more like a family at that time. They were all living together. I, having no family here at all, my family was back in New Jersey. So it became a substitute surrogate family for me. The other physical changes of course, were in lighting and so forth. We had very poor lights. See we didn't have this flourescent lighting at that time and

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so the operating lights were very poor and they were hot. . . . flourescent lighting is cool. But you can understand. . . we'd have these great big lights just pouring out heat and in the summertime that added to the sunlight coming in through the windows. That was about most of the physical changes. Outside. . . where the. . . now, as I've said before the children used to be outside practically all day and they'd play baseball. . . the boys' ward. The girls' ward never had a great big yard like the boys' ward, of course. The girls were not supposed to be as athletic as the boys. But they would play in the little playground they had, while the boys would have a diamond out there and would play baseball. And, to see a boy with a hip spica cast hitting the ball out through the infield and then hiking himself down to first base with a hip spica cast on was really quite a coo. I've even seen them try to slide with a hip spica cast on. The casts took a real severe beating in those days. Of course, the isolation frequently would be so much like. . . if the little boys' ward had a case of chicken pox, then that whole ward would be isolated from the other wards in the hospital. . . so that they never mixed you see. Really the little boys and big boys and the little girls and the big girls they never mixed much except that the big girls. . . many of them were, you know. . . actually I think our limit was 15 then. . . but many of them were quite mature and had come from big families and they would enjoy going in and feeding the little children and taking care of them, you see. So, again, it was more of a family setting than it is now because of necessity and because of the length of stay that they would be in. We had big flower beds out on the lawn on both sides. . . very big flower beds. Also, outside we had a barbeque pit outside the boys' ward and so the nurses would make up a barbeque and in the evening we'd go out and have a barbeque there. There was a tennis court and many of us would play tennis out in the. . . that was also off the boys' ward. I even made a little pitch and put golf course out there with tin cans set in the lawn and would practice golf. Of course, the girls were never allowed on the boys' side and the girls never did have. . . but they'd be lined up outside in wheel chairs and things. . . out in the sunshine. Sunshine was believed to be more curative then, than it seems to be around here now. Even in the winter time. . . and it was a great chore putting heavy winter clothes on these kids and getting them out but it was believed that was the thing to do and so they did it. Now that's about the main physical changes that we've had. We had more trees out on the grounds and with the flowers and everything it really looked quite beautiful. Of course, we were in a setting that was isolated back in the late 20's and early 30's. On a rainy day you couldn't go from this hospital over to North Avenue along Oak Park Avenue. It was mud. You'd have to go down and go across Narragansett and then come up North Avenue to get to Oak Park if you wanted to get to Oak Park. Trolley cars were running on Grand Avenue and the main way that we went downtown was by trolley car. It cost 5¢. There were no buses running back and forth so we were a bit isolated here. We used the railroad a great deal. Fortunately we were close to the railroad and if we were going downtown we'd either walk to Grand Avenue and take the trolley car which took a long time or we'd

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go over and take the railroad downtown. Not everybody had automobiles in those days.

Animal experimentation really was done surreptitiously because we were never set up for animal experimentation here at all. But at that time the laws and the rules for taking care of animals were much more lax than they are now. Well, the first animal experimentation or the only animal experimentation done here was just on two projects that I had. We had noticed that. . . I don't know if I've covered this before or not. . . but we had noticed, Dr. Moore and I, that a number of the children that came in with congenital deformities. . . missing a part of an arm or part of a leg or something. . . had been misdiagnosed. The mother, in her pregnancy, had been misdiagnosed as having a tumor and at that time the way that you treated tumors was by x-ray radiation and they'd been radiated rather heavily. Well, then they found out, of course, that the tumor disappeared when the child was born and it was a misdiagnosis. We didn't have the fancy diagnosis with frogs and things then to tell about a pregnancy. So we got the idea that perhaps radiation had something to do with these malformations that we were getting so many of. So I decided that I would. . . I was brought up on a little farm in New Jersey and I knew about raising chickens and we had a brooder and everything and an incubator. . . and at that time we had an incubator here at the hospital in the little laboratory for incubating blood cultures and things. . . which you could vary the temperature. . . so I stepped that incubator up to 103 degrees which is the degree that you use for raising. . . for chicken eggs. . . for hatching chicken eggs. . . then my problem came in finding fertile eggs. There were a lot of chickens around but most of the people didn't have roosters with them. There was some strange idea that chickens that had a rooster with them. . . that the meat was going to be tougher. Finally I found a place out on River Road. . . quite a long way from here that had roosters in with the hens so I bought the eggs there and I brought them in and we raised a number of chickens. I would roll the eggs over every day and keep the temperature at 103 degrees and then we started shooting little doses of x-ray. . . and I would handle the eggs to find out where they were. . . we knew where the heads and the tails and everything would be. . . and then, Miss Blizzard, interested in all sorts of things so we would wrap a piece of lead around the chicken egg and make a little hole about where we thought a wing or a leg would be and would shoot a certain dosage of x-ray through. . . just by chance. . . just by guess and by God, as to how much you were going to give. Well, by doing it we found out that we had. . . we were able to get chickens born without a wing or without a leg and I was enthused because it seemed to me that this was proof in itself that heavy radiation of a woman who was pregnant had those malformations. I had one chicken with one leg who used to make rounds with me and he would hop all over the place and I was making rounds and he became a great favorite of the children, of course. Well, I was about ready to publish a paper on it when a most beautiful paper came out from the New Jersey Agricultural. . . the State Agricultural Department at New Brunswick, New Jersey. . . where thousands of eggs had been hatched you know and then proving that this was so. So the paper never got written. Well, then the next and only

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other animal experimentation we had here was when I was fooling around with osteogenisis imperfecta and the rodding of bones and seeing if they would heal if you took them entirely out of the body and turned them around and put them back in again. Because at that time it was expected that the bone would die being away from its blood supply, you see. In fact, there still is some question about it and more work still needs to be done on that problem. But I would take. . . so we got rabbits and I kept them down in the morgue. . . at that time we had a morgue. It was dark and it was down in the basement. Well, of course, you would never be allowed to keep rabbits now in a place like that at all. Then I would anesthetize them and break up the bone and put a little thin rod down it and see whether the bone would live and we found that it would live very well. That's about the only experimentation we did there so that we had chickens for a while and we had rabbits for a while. Then, of course, the laws got much stricter and you would have to have a very separate place for the rabbits. The rabbits would have to be kept in conditions a little better than the average person lived under. So that was the end of it because we never had any more. I might say that the supervisors that we had here helped a great deal with the experiments . . . like Miss Blizzard. . . she would give the the anesthetic to the rabbits. Sometimes I would do them here at the hospital and sometimes I would take a rabbit to my office which was up on Grand Avenue and after hours we would work on it there. One time I worked on a dog up there that Miss Blizzard had found. . . it was a Dachshund. . . one of the sway-backed animals, you know. . . and they're the only animals that get disc disease and get a paralysis from it. . . from the ruptured disc . . . protruded disc rubbing up against the nerve root and pressing it. I operated on this dog up in the office and Miss Blizzard gave the anesthetic. Fortunately. . . very fortunately, the dog got well so it worked. But, that's about the limit of our animal experimentation.

The educational conferences that are once a month which are called the Loyola/Hines meetings started right at the beginning and we had conferences every week. Every week we had a conference on Thursday which lasted two hours to the dot. We ran a very strict, very tight residency program and very tight conferences out there every week. They were very well attended by all the residents. All the residents had to come and they had to take their turns in presenting cases. They had to have themselves organized so that they. . . in thirty minutes they were through and they were well organized.

Our meetings here started with Dr. Millar. I suspect shortly after. You see it's tied in with the Hines thing. He started the meetings here in lieu of meeting out at Hines. Now he will continue this even though the meetings at Hines are being discontinued. Those same meetings are being moved over to Loyola. Loyola, quite naturally, is reaching out to take in as much as it can. This is natural.

Back in about 1928 or 1929 they had formal meetings of the Chief Surgeons at the hospitals. These were held at various hospitals. They rotated. Dr. Moore was Chief Surgeon then. He went to them from here. Later on,

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for some other reason or another, the next year or two, the Board of Trustees, as I understand it, decided that the Chief Surgeons should pay their own way to these meetings and that they would no longer be paid by the trustees or by the Board of Governors. So they became a little bit informal and not too well attended because at that time in the late 1920's and early 1930's, money was very, very tight. So these Chief Surgeons, when they had to go on their own to these places like down in St. Louis or far away from Chicago. . . farther away from Chicago. . . they just didn't go. So, the thing kind of folded up. The meetings weren't held every year and they just didn't amount to an awful lot for quite some period of time. They drifted along and there would be a meeting once in a while and then there would be another one. They weren't regular. Well then in 1946 when I returned from the service, they were having, at that time, the Academy Meeting in Chicago every year.

The Academy of Orthopedic Surgeons, which was the big one and still is the big one. They would have it in Chicago every year at the Palmer House. All the Chicago Orthopedic Surgeons would help out in the various categories as needed to put the meeting across. I had a home in River Forest at the time and it had a big basement and it had a bar in the basement. So, at the end of the Academy Meeting in 1946 I invited all the Chief Surgeons who had come to the Academy Meeting, and most of them had. . . to come to my home the evening that the Academy closed its meeting. So they would come and bring their assistants and we would have refreshments in the basement. ... all of the Chief Surgeons that were at the meeting and practically all of them came and brought their assistants. Then we would go out to dinner for a banquet someplace. Frequently we would go to the Czech Lodge down in Berwyn and there would be a bit of merriment..

We would always meet over here at the Chicago Unit and that was really the rebirth of the Chief Surgeons' Meetings. They were not formal in the sense that there were any programs at all but the residents would pick out interesting cases, teaching cases, to present. Then all the Chief Surgeons would comment on them. I would lead the discussion as Chief Surgeon here. These meetings became very popular so that more and more of the Assistant Chief Surgeons were attending until we had quite a group that would come over to our home for refreshments and then go to the banquet. Then, of course, eventually the Academy started moving to other places, but before that the Board of Trustees and Board of Governors reinstituted the meetings around various hospitals. I don't know just exactly what year that was because it must have been, I would guess, toward the end of the 1950's or at the beginning of the 1960's. Up to that time every year it would be held at my home and here at the Chicago unit. So the Chicago Unit really revived the meeting of the Chief Surgeons and after that it was held around different places.

There are only three or four of us that are still alive from the ex-chief Surgeons. We go to the meetings. . . about four us probably. I always enjoy them and we're always very well received by the present Chief Surgeons.

Interview with Edna Travers, past Assistant Administrator

We were the first hospital that hired a social service worker of all the Shrine hospitals. Mabel Ramspeck finally got permission to hire one on a part-time basis. She was here three days a week and from that the outgrowth was continually on the upgrade and you could see a great difference. . . the doctors and all spoke about it. . . parents were more satisfied and the children were more satisfied.

The social worker would come to me if somebody had a little problem . . . even to the place where they didn't have any money to go out for a bite to eat. . . we did not feed them at that time. . . and we would help arrange it so they could get up to Harlem Avenue for lunch while waiting around for their child to be admitted or examined.

The social worker would find out little quirks of the children. . . feeding habits. . . potty habits, and she would give me this information in the evening. I could give it to the head nurses on the ward and then they had their morning consultation; she would explain these different things. . . it would make the child feel more at home.

The parents couldn't stay as much then, but we gradually increased that too, but at first they were only here on Sunday. It was always a tearful parting from parents, and the children were here for several months at that time. It was Dr. Sofield's feeling to get as much done as possible to help them over a period of time instead of an in and out patient as is done now. . . so you knew their whole background. . . you could talk to the parents over the phone. . . help the kids write letters home. . . so it was a close contact that way. And the kids did not want to go home when it was time to go.

They had been with us for so long. . . and, we had recreation for them, movies on Saturdays, school for them, and we had volunteers who came and played with them in the evenings. We put on little plays with them . . . you know I think they were more hidden at home in those days, because so many of them were kind of grotesque in looks and all and as well as the child, the parents were just a little bit embarrassed about it, so they didn't have the freedom that they had here.

It didn't take long for them to get back, but you know it made all of us feel good that we were able, while they were here, to take the place of their parents and make it a happy time for them.

Where the residents live now was my quarters and Mable was here. . . it was very much of a family. I came from St. Luke's Hospital and that was family from A to Z. Anybody who was ill or hospitalized, or down on their luck or things like that. . . it was all over the hospital before you could even say scat, and everybody was willing to help and some of the old-timers still keep in touch.

Well, I have always loved children. . . I did a little private duty. . . but most of my time was spent in OB and supervisor of the OB Department. I saw the Shriners ad in the paper and came over and was interviewed for the position of afternoon supervisor.

Edna Travers (continued)

I wasn't here quite a year when the Director of Nurses. . . we called them Superintendent of Nurses in the old days. . . was going to leave and Mabel called me into her office and I said "I don't want any part of it. . . it it is going to take me away from the children and I don't want any part of it." Well, she finally talked me into it so she and I ran the hospital. I did everything where they now have three or four people doing the things I used to do. We did just everything.

I took care of the scheduling of the nurses. . . the hiring of the nurses . . . I made rounds on the ward every day and I was on call twenty-four hours every other day. I ordered all the drugs. . . kept the pharmacy up. . . Betty would give me her orders. . . I ordered all the solutions, all the instruments. . . just a little bit of everything.

The kids were very free. . . they would stop at the office that Kelly has now and say "What are we going to have tonight?", and you could hear them all the way down the hall saying "Oh brownies and pizza". They would come into the medical records office and the girls would hold them on their laps and in a few minutes they would try to use the typewriter. It was just a wonderful feeling. . . you could see why the kids hated to go home. Because you see, they were the main thing in our lives. . . all of us. We even had a cleaning man here who had puppets on his broom. The kids would be yelling "Oh, Chester what have you got today?." . . things like that.

On the holidays one of the turkeys would be taken to the ward on a cart, all decorated up and the kids could have one of the apples, oranges, plums, whatever. . . . they could see the turkey before it was cut. So you see it was very much like a family affair. . . what you couldn't do nowadays.

Part of my philosophy for the hospital was that there should not be a hierarchy or division. . . the maids and cleaning men on the wards gave their heart to the children, as did the nurses and aides. . . it was very close. Our anesthetist at that time would come down and talk to the kiddies. . . we took the children up to tour the operating room, showed them the mask and the gowns and even let them put them on. We did this the day before they would go to surgery so they would know what they would be seeing when they went to surgery. There were no strangers to the children at all. Even the people who worked in the offices. They would wheel their wheelchairs into the medical records office and chat for a while. . . they knew everybody by name. I don't know if you still have the picture or not, but one of the typists had this child on her lap and here she was just a going away at the typewriter and singing.

Now, this is another thing. . . somebody would call in sick and before I would go around and ask. . . one of the things I will never forget as long as I live. . . Barbara would come in and say "I hear Margaret is sick today and she won't be in on the afternoon shift, I'll take it." I said "you know my policy, I don't like you girls to work sixteen hours a day unless I can't find somebody else." I had a lot of girls who lived in the neighborhood and could do part-time. Now Pat Dolan was one of my part-time people.

Edna Travers (continued)

I think she is going to work on the adolescent unit in the new hospital. She talked to me about it.

Pat is a marvelous person and dependable as the day is long. We had a little child dying one night and I had to go out to an all night drug store at Austin and Irving Park to get some medicine. Dr. Sofield came in and we worked on this child for hours. I would get the medicine out and give it to Pat and she would put it in the syringe, so nobody could tell me that she wasn't an excellent nurse. But the child died. . . the parents didn't get here in time, but Dr. Sofield stayed and talked to the parents. It was a spastic child. . . we didn't know what happened. I was sitting with her at different times and one time she said to me "Ms. Travers, I am not going to make it this time". She had been operated on several times. . . I said to her, "You are going to be up jumping around in no time. . . you know I have always called you my jumping jack." She evidently had a premonition of what was going to happen.

After the morning work was done we always had conference over coffee. . . we didn't have it in the dining room then; we had it at the little tables on the wards. I would go to the girls' ward one morning and the boys' ward the other morning, and they would each recite what problems they were having. . . or why was something being done the way it was. . . so it was a close relationship. . . I liked this. . . there was a closeness between their work and finding out the reason for what they were doing.

I agree with a lot of the loosening of the old regimentation ways of hospitals because we are treating the patients more like human beings, not like. . . this has to be done at 6 P.M. and this at 7 P.M., and you have to be here by 5 P.M. to have your prep and enemas, etc. . . that sort of thing.

Another thing that we had. . . the social worker worked with the psychiatrist every Thursday. . . we had one child who had been a problem. The nurses would be seen by the psychiatrist and even the family if it was serious enough and then between the social worker and the psychiatrist, it was presented to the nurses.

Over the years I noticed the admiration that all the men had for Dr. Sofield. One of the doctors from St. Luke's sent me the Chicago Medical Society Bulletin that had it all in and I had forgotten some of the honors he had gotten. He had got so many and delved into so many different things. I enjoyed it very much.

I met with a lot of resistance to loosening up the regimentation here at the hospital. Part of it was going out of a regular routine when we made changes that you get into. . . I think that is the main thing back of it and they felt, I think, in the back of their minds. . . felt just a little bit that having the parents under their feet so much that they were losing a little contact with that patient without realizing that they were being just a little bit jealous.

Edna Travers (continued)

The nurses would say, "We want to do so and so at so and so time, and we can't with the parents here", and so we got to the place where we were letting the parents stay and feed the children their supper and the nurses would say "They just mess around. . . the child doesn't get anything to eat. ... "Now you know the mother wouldn't do anything like that. . . maybe the child was just trying to show off that day". I think it was the background of it and the changing of the routine. It wasn't like it used to be when at 4 P.M. you washed their hands and got their bibs on and they were ready for their supper at 4:30 P.M. When the parents were there they were asking questions all the time you were getting the trays ready in the kitchen and saying "Johnny doesn't like that. Can I get him something else?" Before that, Johnny would eat it because it was a stranger feeding him. I had a niece like that; anything I gave her she would eat, but it wasn't like that when her mother fed her. But it was surprising how the nurses came to me afterwards and said "Gee, you know that helped a lot."

Interview with Mr. Gene Yeazell, Administrator

When I came I replaced an administrator who had been with the institution for 13 or 16 years. Then following her, an interim administrator had been here for 1½ years. The institution's commitment at that time was pretty plainly supporting the orthopedist in his work and I think what we saw was a situation where that kind of. . . you know, they provided that support in the way of being there when the doctor needed them. But, after about a year we began to make some little changes and first of all it was visiting hours. We did that piecemeal. There were several steps that we took in expanding the visiting hours. There was a lot of opposition to it. Yes, there certainly was a lot of opposition. It was about 1972 when we began to really start examining this. Part of this came out of our interplay with individuals involved in the early planning of the new facility. The whole planning process for our new building began in 1969. Dr. Millar and myself and the Director of Nursing at that time, sat down every Monday morning and had a session where we started to put together the functions of the new facility. I think some questions came out of these meetings where we started looking at the whole thing in terms of changes that we might make or might need to make. I believe it was about that time or maybe in 1973 where we committed ourselves to what we called parent participation. I think it was was in 1973 or 1974 at the administrators' meeting that I made a report of what we were doing in this area. We still didn't have the whole concept or idea put together but we were working at it piecemeal. We started attacking the idea. We started attacking the visiting hours. That was the first thing that we started working on. Some of the other elements of the concept came along later. Then I think we made a real strong commitment in that direction when our former Director of Nursing left. We were looking for a new Director. At that point we made a real commitment to look for somebody who had a commitment and had a concept in mind as we saw it. That's when Joanne came into the picture. From that point on, there was a full commitment to the program.

I'm sorry we didn't diary along the way or document the changes that came about because today we take everything for natural. I guess one event really struck home with me. A good friend of mine and his wife had one of their children admitted. I had a lot of interplay with them after hours and they started throwing some criticisms at us. Of course, I was very sensitive due to the fact that they were good friends.

The staff at one time felt that visiting hours should be limited. I don't know what they feared. It was just the idea that the whole program as it was, seemed to them to work well. I guess, unfortunately, our parents, at that time, hadn't complained or hadn't voiced this concern either. In fact, I can see a big shift in parents from that period of time. At that time they were pretty satisfied to get what they did get because they were receiving a gift that didn't cost them anything. I think a lot of them felt that they couldn't complain. I'm not sure what they feared specifically. There was certainly a lot of rebellion there though. I think we moved from 1 1/2 hours to 3 hours that first step.

Mr. Yeazell (continued)

At that time you would think that the world was caving in. Then it got easier as we went along. We lengthened our visiting hours in 5 or 6 steps over a period of 5 years. Now when we make a change like that nobody says boo.

One of the concerns may have been germs. I think there was one concern that with the lengthened hours there would be more visitors here also. What they soon realized was that really the same number of people came but they just spread themselves out.

Pennies were pinched then. Everything was tight. We didn't use very much in the way of disposables back then. Everything had to go upstairs and was sterilized.

I think we became more concerned about. . .. you know, the primary concern in 1970 was the child to function orthopedically. . . you know, the bones and muscles and looking at support of the child that way. It wasn't a wholistic view of the child at all. We really didn't start looking at the child at all. We really didn't start looking at the child as a whole until after Joanne came. Even through this period when we were talking about parent participation maybe there was some feeling in that area but it was more of trying to meet the needs of the parent at that point.

INFORMATION GIVEN BY MR. YEAZELL

EVOLUTION OF NEW HOSPITAL BUILDING

In Chicago, a new $12 million Shriners Hospital to replace the present 54 year old building is now under construction. The dreams and plans of many are now becoming a reality. Few appreciate the time and effort that go into the planning and creation of a new building. Lest we soon forget the history of the new Chicago facility, let's review the process of development from the very beginning.

Back in 1969, Dr. Edward Millar, Chief Surgeon of the Chicago hospital placed his concerns regarding the inadequacies of the old hospital building in the form of a letter to the hospital Board. In many ways, the old building did not meet the needs of modern medicine. More and more work was being required on the building to meet the changes in program and to correct code violations.

For the next few years, the need for a new hospital in Chicago was the subject of conversations at Local and National Board and staff levels. During the period of 1970 to 1975, Gene Yeazell, Administrator of the Chicago Unit and Dr. Edward Millar, spent a great deal of time looking at the programs and functions of the hospital in determining what was needed for the future. Out of this interaction and future meetings with staff, came a detailed plan listing the many elements desired in the new facility.

Mr. Yeazell (continued)

During this time period, the National Board of Trustees were evaluating the orthopedic hospitals, both in terms of program and buildings, to determine the priorities for the replacement of facilities. In 1975, and 1976, visits were made to the Chicago hospital by Board of Trustee members and National staff to consider many programs and site options.

In early 1977, the National Board of Trustees decided to recommend to the Imperial Council the development of a new hospital for Chicago. Action was taken by the representatives in July 1977 in New York City to appropriate $11 million for such a purpose. It was announced at that time that the Walter Olsen Foundation was giving $5 million for the construction of the hospital with a stipulation that it be located at the present site.

A special Chicago committee was appointed to oversee the development of the new facility. Imperial Sir Dr. Hogan H'Doubler serves as chairman of that committee. He has worked closely with Mr. Woodrow Bennett, Past Imperial Potentate, Chairman of the Board of Trustees - Building and Grounds Committee, and Thomas C. Roberts, Chairman, Chicago Unit Board of Governors and Building Agent for the project.

A consultant architect, Mr. Rod Henslin, of St. Paul Minnesota was retained in early 1977 to develop preliminary drawings. In December, 1977 a permanent architect was selected from some 90 interested firms. In January 1978, a contract was signed with the firm of Loebl Schlossman & Hackl, Chicago, to complete design and working drawings.

On June 11, 1978, a ceremonial groundbreaking was held at the time of the Chicago hospital annual Hospital Day Ceremony. At that time, Mrs. Ella Pelz of the Olsen Foundation announced an additional $2 million gift to the hospital.

Throughout the year of 1978, numerous meetings were held between architect and the hospital staff to develop and perfect a plan. In December of 1978, plans were at the final stage and the selection process for a contractor was begun. Six contractors were invited to bid on this project and bids were let in February of 1979 and opened the latter part of March 1979. In April a letter of intent was signed with the George Sollitt Construction Company.

Construction was begun in May of 1979. Completion of the new building is anticipated by early Summer 1981.

In 1981, many years of planning and building will be completed as the new edifice is occupied and dreams are realized. It will in some ways be a sad time, as the old building is razed and becomes but a memory. The old will become new, both in building and program, but there will remain a dedicated Board and staff, building on the past and recommitting themselves to greater service in the present and future to a most deserving group of young people.

Mr. Yeazell (continued)

PARENT INVOLVEMENT AT THE CHICAGO UNIT

As a parent of two children, I've had the unfortunate experience upon several occasions of having to hospitalize them for short periods of time. Fortunately, they do not have any of the disabilities we deal with daily at our Shriners Hospitals so that my sojourns with them to the hospitals have been brief. However, these experiences, I believe, have helped me in a small way to emphathize with the many parents who must see their children hospitalized for long periods of time. I have felt resentment when my child was cared for in a manner which said to me that I was not an important part of that care. Conversely, I have felt good when I was consulted and informed and made to feel as though I was needed during the hospitalization of my child.

The same holds true for any parent who loves and is concerned about his child. Unfortunately, I think for too long we have only tolerated parents, rather than recognize the need they have to be a part of the child's care, not just an observer. My impression is that we have attempted to protect the child from the parents, rather than use to advantage the unique role the parents can play as a part of the team of persons caring for that child.

Progressive hospitals and pediatric care units began recognizing some ten to fifteen years ago the need to more fully involve parents. This involvement has taken many forms and in some instances has developed into the provision of "live in" facilities for parents. Boston Floating Hospital for infants and children has its FAMILY PARTICIPATION UNIT. Children's Hospital of Stanford and Henrietta Egleston Hospital have similar units where parents may participate in the child's care around the clock.

Historically, at the Chicago Unit, and I am under the impression the same holds true for other Shrine Units, we have had a rather restrictive attitude in our dealing with parents. We did only a minimum to accommodate them and involve them. Our visiting hours were short, we provided a very brief time every week when the parent could converse with the doctor, and the parents that "stayed out of the way" seemed to be the most desirable. We have always been rightfully proud of the fact that ours was a special place where we really get to know the parents. But knowing them, is not necessarily involving them.

Some five years ago, we began a program to more fully accommodate parents and to become more involved with them in supporting them and making them feel more a part of the care of the child. I briefly share with you some of the things that have happened at the Chicago Unit, not knowing where you are at in this area of concern. Perhaps rather than being progressive, as I think we in Chicago might be, we may be far behind. I would welcome your ideas and suggestions and would like to know what you might be doing to accommodate and involve parents.

Without going into a great amount of detail, let me outline some of the steps that we have taken at the Chicago Unit:

Mr. Yeazell (continued)

I. VISITING

1. Regular hours: 1970 - 1½ hours a day, 3:00 to 4:30 P.M.
1971 - 1:00 to 4:30 P.M.
1972 - 1:00 to 7:00 P.M.
1973 - 11:00 A.M. to 7:00 P.M.
1975 - 7:00 A.M. to 7:00 P.M. - small wards

Rather than more visitors, as was expected, there has been a spread of visitors throughout the day and especially this has enabled fathers to come in the evening.

If the child is in school, the parent has the option of having him brought back to the ward for visiting.

2. Pre-surgical visit - 6:30 A.M.

Parents may come in and join the child on the ward and accompany the child up to the surgical suite. In most cases, the parents want to be here with their child at this anxious moment.

3. Surgical lounge: A quiet lounging area, apart from the regular lounge, with TV and coffee. The receptionist takes them there the first thing in the morning, they are visited throughout the day by our social worker and recovery room nurse, and the resident immediately following surgery.

4. Post-surgical: Parents meet the child as they leave the surgical suite and accompany them back to the ward as they are returning from recovery.

II. PATIENT CARE:

1. Mothers are encouraged to help provide bedside care for the child and with extended visiting hours come in early to help bathe and diaper.

2. Parents assist in transporting children to and from physical therapy and recreation and cast room.

3. With more time to visit, parents become more involved in play activities.

III. COMMUNICATION

1. A social service interview, if needed, is held at the time of first exam.

Mr. Yeazell (continued)

2. A social service interview, in all cases, upon admission. (Manual)

3. Medical staff is now available at any time to answer questions and parents are encouraged to ask questions.

IV. EDUCATION

1. Meetings over coffee are held with special interest groups (CP and OI) during clinic period.

2. Nurses now have check sheet to assure that parent has been seen by all members of the health team when needed before discharge.

Further involvement of our parents is restricted due to our space and building limitations. When needed, we would like to be able to provide for 24 hour accommodation of a parent of a small child at the time of admission and during the immediate pre and post-surgical period. Strong evidence points to the benefits of this type of involvment of parents, especially in the case of pre-school children. At such time as we may be able to build a new hospital, we would like to advance the concept of minimal care with private rooms, allowing, in selected cases, for a parent to live-in with the child.

The parent would provide a great many of the daily care needs of the child with minimal supervision by hospital staff. Many of our children, other than at the time of surgery, do not require the extensive nursing now provided. As such, a child could certainly be adequately cared for by a parent with minimal support from staff.

This would, in certain instances, provide a parent's needs to be involved and at the same time allow an opportunity to more adequately educate the parent in the care of the child. Furthermore, there might be a real cost savings if a number of children were regularly cared for in this fashion.

As hospitals and health care institutions appear to be directed to a more and more impersonal approach to the patient, I believe our future success lies in the area of the provision of more personal care. The care of a child is incomplete and impersonal unless every effort is made to provide for the accommodation and participation of the parents.

Interview with Dr. Edward Millar, Chief Surgeon

1950 was the first time I was here permanently, but I first visited here in 1943.

I was in medical school and I visited again in 1944. I take that back . . . my first visit was here in 1944 and then I visited briefly in 1945. Then I started my residency in 1947 at Hines and we used to come back and forth but I wasn't here in the sense of being assigned to this hospital. I was a resident although I was a resident over at Hines and we always had our meetings over there. Then as far as being here in the sense of being on the staff, I started in 1950. Well, I would say this . . . first of all there has been a dramatic change in the type of patient that we see. In one sense when we started a large majority of our children were polio's and we still had a considerable number of congenital abnormalities like we have now. The other thing was club feet. We didn't have near as many as cerebral palsies in the hospital. We had them in the clinic to some extent but I think the reason for that is that we were filled with polio's.

So this is quite different. As a result, our transportation back in those days was quite different too. Parents couldn't come back and forth and so these kids stayed for much longer periods of time. I'm sure Dr. Sofield informed you of the same thing. The turn-over was smaller and we actually ran more patients in the hospital than we do now. We didn't take care of as many patients and so more emphasis, at that time, was on inpatient care. We would keep the child until, in essence, their treatment was completed and then they would go home as opposed to what we do now where they are here for only a very short period and then are treated in an outpatient manner and the families are able to go from here to Cleveland or Detroit in an hour and, of course, the tollways and everything weren't in at that time. So, these are the big differences that I see as far as patient population and the manner in which the hospital in general operated things as a result. We would have fewer admissions but we were always full. I don't know that we treat things dramatically different than we did back then in some aspects. I think we're able to do, perhaps, more critical surgery than we were because of anesthesia . . . but here again, we did spinal fusions but we did them in two procedures rather than one.

We did them in segments and the children did very well. We weren't using Harrington instrumentation and this sort of thing as we are now.

We weren't doing anteriors. We weren't going through the chest and that sort of thing. So, that was different. We really didn't have a recovery room as such. Well, we had a small one up there but then the kids were brought downstairs.

The children were more or less segregated in glass cubicles on the units when they needed to have segregation. So those are the basic differences I see. We had fewer residents than we do now and we have a much smaller outpatient department in the activity . . . I would say that but we had clinic on Fridays . . . that was a journal clinic and covered everything and this we continued up, I'd say until the late fifties or early sixties

Dr. Edward Millar (continued)

and then we started doing some specialization and then the other aspect of the clinic; we did have plastic surgery . . . even that goes back way before my time. We didn't have specialty clinics like neuro-surgery and this sort of business. We would just have to get people to come in to see the patient. We did that. So I think this is a big change.

I think going along with the transportation is that the parents, way back when, this goes much further back than my time . . . perhaps in the sense . . . since they didn't have too many alternatives were willing to leave the child here. Whereas now the transportation being what it is, they're just unwilling to do so whether they have transportation or not. I think in a sense you'd say the present population of parents is much more sophisticated and I think they are. Maybe we all were, but I don't know that there were any differences and I don't really know in the long run that the patients' outcome, for given things that we were treating similarly or dramatically different.

The children were here for a longer period of time where there was a slower turnover so the children, as per se, became more individuals to the medical staff and the nursing staff because they were here longer and they got to know them much better. We have some now that still carry on but you can see that, numberwise, that there are so many more now and they're here such a short period of time that you really don't get to know the child as well, say where they stay five days or a week as compared to staying here three months or six months or a year.

So we were family-centered care back then, but we were the family.

I don't think everyone looks on this with horror. They used to have visiting yours for a few hours on Sunday afternoon. I don't think that the very few kids that went through this, at least in my opinion, have really suffered significant psychological trauma from that.

Of course the mothers . . . and naturally they still do . . . sometimes got upset when they left their child here. But the child usually adjusted himself or herself in short order and many of them didn't really want to go home. Now part of this was because some of them did come from deprived families and they didn't have as much at home as they did here. Perhaps it's a little less so that way now. Many of them looked on this as really being part of their home because they spent so much time here . . . even now.

There's one simple answer to that and that is you have to take a personal interest in each child. That's all it amounts to. It's the only way you can do it. You have to have a personal concern for each child. There's no way you're going to get to know them as well as we did before.

You have to genuinely have a concern and interest in that child's problem . . . and this is on all levels. That's the only way to do it. If they don't have a personal concern, it's not going to work.

The technological innovations are really hallmarks. I wouldn't use that at all; that's all mechanics. Something that has evolved here, of course, is the fragmentation of rodding in O.I. We've tried other things here I think, that for example, the implant business . . . we're still

Dr. Edward Millar (continued)

working on it. It seems like in a sense it doesn't have a great deal of promise but it's the first step and I think it's an important step and over the long run it may prove to be much more important than the cerebral palsies . . . than all the operating we've ever done. It's not there yet.

Dr. Sofield did his first fragmentation rodding back in 1946. I'm pretty sure the name of the first kid he operated on was Adams.

Actually we did our first implants in about 1974 or 1975.

I think some of our radiographic techniques and this sort of thing have been a great deal of help. Some of the instrumentation for fixation of osteotomies and leg lengthening, for example, have been improved on. I don't think there's been a dramatic change, but I think they've been improved on. I think that these things are a help. They were doing leg lengthenings almost thirty, forty, fifty years ago.

The individual mechanics may have changed some. You know, for example with scoliosis, we used to hang them in a fish net to bend them and every-day that used to be a job we hated to do. One resident had to take them down, hang them in this net and stretch them out. Well, actually it was pretty effective.

Same principles; just applied a little bit differently. Then we would put them in body jackets with hinges on them and wedge them over and then we'd do the fusion and try to wedge them a little more. Our objectives were the same; the manner in which we were getting there was somewhat different perhaps in the sense more cumbersome and took a lot more work than they do today. On the other hand, in one sense, it may have been a little safer.

Obviously, antibiotics made a significant difference. Actually, it's before my time in the sense of . . . well, not completely before because penicillin was coming out and sulfa. These had been available since the early forties and so we didn't see a lot of osteo on this sort of thing. We did see some, but not near as much as Dr. Sofield saw say in the thirties and the late twenties. So this is again a dramatic difference. Actually, the thing that made the most dramatic difference in these hospitals . . . there's no question about it . . . <u>is</u> polio vaccine.

There isn't any question about it because: (1.) it prevented a lot of polio so we didn't have the patients per se in polio and, (2.) not having the polio patients, it gave us the opportunity to take over all these other patients that before we just kind of pushed to the side.

This probably was the single most dramatic thing that has occurred that isn't peculiar to this institution . . . all Crippled Children's . . . The next most dramatic thing that has occurred was, of course, the antibiotics. I don't think anything we've done from surgical technical skill changes can match that in orthopedics.

Again, as I mentioned in the past, I think the other things that have made significant differences as far as surgery goes are anesthesia and blood transfusions. Anesthesia I think could improve or at least be more dependable than it has been in the past. . . at least more control.

Dr. Edward Millar (continued)

In a sense, you know Bliss was here for 25 years, from 1927 until 1952/53. She never lost a patient.

They were half awake sometimes when we did them but it doesn't mean it couldn't be done and some of it was done very well. We had a few scares but she never lost a patient and yet it was a very simple sort of method. We have intubation so in a sense there has been progress but in another sense it doesn't mean necessarily that very good work wasn't being done.

You can tell some of these fellas that we did spines, face down, without intubating and they have all sorts of horrors and they weren't as safe as they are now. There were certain individuals like Bliss who was extremely bright and extremely capable and we just were most fortunate to have her. We just worked right through.
I think there's been a dramatic change in better underatanding of genetics. I believe that we are doing, thanks to Dr. Salafsky, a much better job in that area. I think that we are doing a better job in children's neurology than we did. If you look at it overall, we're doing a much better job sorting these things out than we used to. So from that standpoint, I think that there has been significant improvement. I wouldn't say it was dramatic but we understand more things now and understand them better than we did. These things were looked on with curiosities and they're no longer that.

They are better than the metabolic things and are better understood now. I shudder to think, for example, about the vitamin D resistance to rickets. We did the best we could do at the time and in some sense it's just as good as we're doing right now but we understand it better now and probably have more of a chance of doing a better job than we did in the past.

There's been a good change in congenital dislocations of the hip because . . . not because we're really better in treatment but because we've treated earlier.

By we I'm talking about the orthopedic community and so this has been a significant improvement. I think other neurological conditions . . . that we can recognize them . . . would be of help. I think it would be delightful, for example, with myelomeningocele . . . if somehow we could give those children bowel and bladder control. I don't mean the orthopedic community is going to do it, but if the medical community did it somehow . . . had a better answer even than we have right now . . . I think this would make a dramatic difference in their lives.

The other less common are muscular dystrophies and metabolic diseases. I would look forward . . . even those that are understood to some extent . . . that we would really come up with real solutions for them and there are a lot of things that need to be understood better that we see commonly . . . Perthes' disease for example. I don't know if we really understand a lot more about Perthes' than we have in the past. I'd like to see that. Club feet are still looked on as primarly a mechanical thing and in a sense they are but we have lots of room for

Dr. Edward Millar (continued)

improvement in club feet. Sure we end up with a good foot usually but it's those few bad ones.

We still don't understand the mechanism. Way down the line, talking more basically, if we found out some ways to turn on and turn off local growth of tissues. This would be tremendous and yet it's possible because we see nature do it. We've just got to learn how she does it.

In the future the mechanics of the operating room and of surgery would depend much more on electronics than upon chemistry to achieve the results. Scanning technology would improve in the future. The biggest breakthrough, which will come in the next ten to twenty years, will be grasping through the scanning device's three dimensions. For instance, not only the bone but the cartilage and soft tissue and actually being able to construct a model whereas . . . a model would be made of a person so that model would be able to be manipulated and so the best type of surgical intervention would be able to be tested in that way before testing it upon that person.

Interview with Joanne Woiteshek, Director of Nursing

I think a lot of changes were really obvious, like bathing the kids on admission. The principles of pediatrics tell you that; that is real traumatic for children. Increasing visiting hours . . . we did not get much pressure from consumer groups like many institutions get pressure. When I came here initially, Illinois Masonic and Children's were getting pressure from consumer groups, but we didn't.

I have included the parents' concerns about hospitalized children in some of the planning but their input was minimal. Mrs. Kuebel was on that committee and I didn't see a whole lot of pressure from them.

Even though I think the parents have appreciated the changes, I don't think they have put much pressure on us to change one way or the other. The minute that some of it occurred I think they felt more comfortable with pediatric changes. As far as turnover in staff because of that, I lost one head nurse. Other than that the turnover was really very minimal. As far as making those changes, I think that people probably enjoyed them more.

The people thought the changes were their own. I don't think they remember some of the trauma . . . just simple things, like changing the evaluation form or mailing out the evaluation form . . . that had come from research really. They forget what Fridays used to be like.

I think the staff just feels more comfortable. I think initially they felt a little uncomfortable because everything was very regimented and ruled and they knew which way to go, but as things became more flexible, they probably had more questions . . . but now they would never want to go back. I think they like it being flexible, which a pediatric institution has to be. It has to have some flexibility. I remember that used to be the hardest thing . . . in supervisors' meetings they always wanted me to make a rule, and you know, I couldn't make rules.

I think the pre-op holding room was a real big change, and it was very simple. It didn't cost much money. It just required people to think differently about things.

When I came here there was no committee structure. There was a Professional Activities Committee which was mainly infection control at that time . . . but we have done a lot by committee structure. We started the Family-Centered Care Committee . . . did all of that growth and development. They never looked at growth and development of the kid and even though that is a continuing process I don't think we can stop and say "Okay, we have looked at growth and development. We don't have to do it any more."

I think the other thing that has probably improved over the last three years is the school teacher situation . . . including them as part of the team. I think they are more attuned to the whole philosophy of the institution so that has been helpful.

Clinic has probably changed the most. When I came, Judy Wood worked here. She was the only one who worked back in clinic; well, Helen

Joanne Woiteshek (continued)

came down from surgery after she was done with surgery. With Parent Talk Times, we didn't have playback in clinic; we didn't have information for the parents. Now we will be going to three nurses in clinic which will really make a difference.

So I guess those changes were the easy changes and the hard changes are ahead.

I think education is the other area that we need to work on as we move into the new facility and then working on our community which really needs a lot of help. I think people are now more accustomed to going out of the institution; we do a lot more home visits. We do a lot more community work than we have done in the past, so I think there is a whole network of things that we could be doing that we are not doing which can be stimulating for staff. I think they need that but it can also, hopefully, help bring more patients in; but on the other hand it will also help the community and help the name of the Shrine.

Everyone wanted to live by the rule; no matter what level you were on, there was some rule. I think by giving nurses more accountability and responsibility they have been much happier. When I take a look at some of the programs . . . like Terri is doing now and Merry picking up urology . . . that gives them really a lot of responsibility.

I think that we have made some changes and I think you always have to constantly be on those changes. So we were willing for the nurses to go down and play with the kids or Steve to set up a schedule for the nurses to go down and play with the kids . . . you always have to revitalize those things, like you have to do your own values and everybody else's.

Sometimes I am amazed at some of the situations that occur . . . like where have they been the last three years. I think the nice thing here has been that we prepare people well for change. With some of the changes I am sure it was kind of radical for them initially, and as I look back, those were probably minute changes. The next year we are going to have a lot of changes and I think people are pretty geared now for change.

I think they see a lot of benefits to having the new building. It should be interesting because I think we have to keep people stimulated over the next year and I think that is going to be the hard part . . . keeping them stimulated when you don't always have a large patient census, because it means then you push them to read more. I think another nice opportunity is that we will see more people going to school and I think the tuition reimbursement helps. Again, I think it is a very small thing that institutions can offer, and yet people going back to school seems to help them a little bit to identify what they want to do.