NEW ASPECTS OF CHILD CARE*

ALAN MONCRIEFF, *C.B.E.*, M.D., F.R.C.P., J.P.

Nuffield Professor of Child Health, University of London; Physician, The Hospital for Sick Children, Great Ormond Street, London

The last 10 years in Britain have seen a remarkable development in many aspects of child care. Living in a revolution often means that what is going on around is not completely appreciated, and this paper is an attempt to look back on the decade and to try and sort out what has been happening. In the social field of child care the Children Act of 1948 marked a major development in the community's responsibility for the care of children deprived of a normal home life and today the innovations of even 5 years ago seem already out of date. Better methods for the prevention of the break-up of family life are being widely urged and a Government Committee is considering legislation for this purpose.

Paediatrics in the Medical Curriculum. In the more strictly medical field the fundamental advance has been the recognition of paediatrics as a major subject. All the Universities

* A paper read in plenary session at the South African Medical Congress, Durban, September 1957.

in the United Kingdom and Northern Ireland have established Chairs (except Oxford and Cambridge), which are usually termed Chairs of Child Health, to emphasize the new outlook. This is also seen in the close association in many instances between the university department and the local health authority. Social medicine has also come into the curriculum as a modern approach to the study of environmental factors in disease, and undergraduates can often grasp the importance of this more clearly in the field of paediatrics, which therefore gives them a good introduction to the wider aspects in adult life. The exact placing of paediatrics in the medical curriculum is still subject to varying views, but it is usually closely linked with midwifery. Similarly, the place of paediatrics in the final examination takes different forms in different universities. I should be quite prepared now to see it left out altogether, for paediatrics has a popular appeal with students and some simple class examination would keep the slackers up to scratch! It was, however, necessary to press for a share in the examination in the early days, because deans would only yield adequate time and supply adequate staff if the subject was one to be faced at the 'final'. Probably the use of paediatricians as part of the team of examiners in medicine is the right answer, especially as nowadays they are often the only general physicians left! With the better education of the medical student in child health there is a growing number of family doctors well equipped to look after sick children at home (to be discussed later) and with better knowledge of the preventive services available.

COOPERATION WITH HEALTH AUTHORITIES

The development of a closer association in many centres between the children's hospital (and university departments) and the local health authorities, including the school health service, has been achieved in varying ways and is perhaps better seen outside London. The exchange of staff has made for better understanding and is a valuable training method. At the hospital for Sick Children, Great Ormond Street, there is an arrangement with the London County Council whereby one of the registrars takes one of the child welfare clinics or school health clinics each morning while the Council's medical officer takes an out-patient session at the Hospital as part of the team of one of the physicians. In addition, the staff of the Institute of Child Health takes charge of a weekly toddlers' clinic at our own Province of Natal Centre and I very much enjoy my monthly return to this type of preventive work. At the administrative level, medical officers of health often serve on hospital boards or committees, and again from the Institute staff there is a member of the appropriate divisional health committee of the London County Council. The advice of the local medical officer of health is freely available for all problems of hospital epidemics, although probably he is not called in as often or as early as he should be in many instances.

There is, however, one aspect of this close association between hospital and community work which must be watched with care. The medical officer of health has a first duty to prevent spread of disease and he therefore thinks in terms of the isolation hospital—often only too truly isolated from all contact with the children's hospital services. The hospital physician, on the other hand, thinks first of the welfare and treatment of the individual patient. The conflict is especially well seen in regard to poliomyelitis, which the health authorities would like to see always treated in an isolation hospital, whereas although not necessarily willing to admit children with such a disease to a children's hospital (for it may disrupt the ordinary work) it is not always in the child's best interest to transfer him to an isolation hospital with a possibly long journey when the disease is developing. Clearly the solution is to improve all the facilities at the isolation hospitals and put hospital paediatricians on the staff together with well-trained children's nurses. This is already happening in a few centres but the days of the 'medical-superintendent fever hospital' are not yet over!

CHANGES IN THE CHILDREN'S WARD

Another very remarkable change in child care today is seen in the whole atmosphere of a children's hospital or ward. In my time as a resident and registrar most of the children were in bed all the time and the death rate was high. Today with modern drugs and modern methods of surgery, children are less ill and for shorter times. Children with pneumonia, for example—only rarely admitted incidentally—are convalescent in a few days, and even after major cardiac surgery I have seen a child running about after a week. It is true that certain long-term conditions are still with us. Tuberculous meningitis, for example, has taken the place of rheumatic fever. Nephrosis presents novel problems. Leukaemia seems to be on the increase. Reparative surgery for congenital deformities is taking an important place. Nevertheless children are often up for longer periods than they stay in bed and it is necessary to provide education, occupation and recreation. There is a 'school' with 3 teachers at Great Ormond Street paid for by the local education authority even although we are an 'acute' hospital. Occupational therapy is available. The wards have to provide a playroom, with television, of course. Nurses have to understand the recreational needs of the child.

With modern drugs to control infection and with more children less knocked out, so to speak, by illness it is necessary to give careful thought to the psychological side. Some years ago the public was told that hospitals were doing serious harm to children by refusing to allow visiting and thereby enforcing a separation of mother and child which, it was alleged, might do permanent harm. Some of this talk was largely theoretical on the part of psychiatrists who had not been at the bedside of an ill child since their student days, and the potential harm done by separation was probably exaggerated. The effect of the child's illness upon the subsequent behaviour has to be remembered. None of us is quite so sweet-tempered in convalescence as before an illness. Moreover, the child's background and family life play an important part in his reaction to a period of hospitalization. Children from secure and happy homes are better able to face adversity than when they come from broken and insecure homes where affection, positively expressed, is lacking. Mothers who complain that hospitals have harmed their children should search their own hearts to see if some of the blame may not rest with them. It is often possible to prepare a child for hospital, if time permits, and on no account should the hospital be talked of as a

place of correction for naughtiness as I have heard it done by a distracted mother in my out-patient clinic.

Child Psychology

There is also some degree of psychological tangle which still needs unravelling. If a child 'settles down' well and appears not to be unhappy in hospital it is said that he may well be brooding secretly and will be upset on return home. On the other hand if he exhibits grief and rage this is also said to be a bad thing, so that the psychological school seem to be trying to have it both ways. It is clear that the superficial reaction of the child is not the whole story, and it is necessary to look below the surface if the true reaction of the child is to be understood. Here I would like to pay tribute to my own colleagues in our department of psychological medicine for their enormous help. Our psychiatrist does a weekly round with the medical registrar to discuss with them the psychological aspects of any of the patients, and we also do a monthly joint teaching round for the benefit, we hope, of our postgraduate students as well as of ourselves.

There is no doubt in my mind, however, that separation of the child from his home may inflict a serious blow to his emotional state. This seems to be especially likely at the vulnerable age of about 9 months to 3 years. Before this, babies present special problems, which are mentioned below. After this age memory of home is stronger and there is more comprehension of what is going on and appreciation of the recreational facilities provided. There are also probably vulnerable children who, as already stated, come from unstable homes and who have already experienced threats to security and loss of affection in other ways. It is therefore necessary to seek ways of mitigating the separation experiences of a child in hospital. This leads to the subject of visiting.

Visitors and Cross-infection

Up to some 10 years or so ago all in charge of a children's ward were constantly worried by the fears of cross-infection. Children came in for some simple operation, for example, and died of infectious diarrhoea. It was widely and sincerely held that some infections were brought in by the parents, and hence visiting was largely restricted. It was also sincerely felt (and still is by some) that visiting so upset a child that it is better not to permit it. The green light came in an accidental way. Towards the end of the last war the British Paediatric Association in an optimistic mood set up a study of the architectural aspects of the new children's hospitals which it was hoped would be built. (It is an interesting reflection on the changes of the past decade that there are possibly too many children's hospital beds available today!) A 12 months' study of all the factors thought to be contributory to the central problem of cross-infection was undertaken and the results submitted to a careful statistical analysis. It was clearly shown that there was no correlation between visiting by parents and the incidence of cross-infection. Fortified by this, some of us began to experiment with more frequent visiting than had hitherto been permitted. Daily visiting became the pattern in my wards, at first at a set time of day but now almost unrestricted. Many of my colleagues have also been led to make changes and, although the practice in Great Ormond Street is not uniform and there are still certain practical difficulties in certain departments, the change in outlook has been enormous.

The Mother in the Children's Ward

But merely to allow visiting more frequently is not the whole story. I still maintain that visiting shall be at the discretion of the medical staff and ward sisters and very occasionally we may decide to ban it for a period. The knowledge that frequent visiting is permitted at once increases parental confidence, and this is possibly one of its main values. Easy and frequent contact with their sick child and those looking after him lessens parental anxiety, and such anxiety is no longer transmitted to the children to contribute to their possible unhappiness. This 'confidence trick', as I sometimes call it, begins of course when the child first comes to hospital—even before, in a sense, if the hospital's reputation stands high. It must be fostered in the out-patient department by courteous reception and every endeavour to reduce frustrating delays by an appointment system. It must be continued through the process of admission. Sometimes, when a child's name is put on the waiting list and the parents are reluctant to allow admission, I send them all up to the ward to see what goes on and meet the nursing staff.

At the time of admission the old custom of a bath in the admission unit with cleansing of the head and the discarding of all links with home in the shape of clothes and the favourite toy is no longer continued. The child goes up to the ward where his mother may help in putting him to bed—in attractive clothes and with his favourite teddy bear beside him if requested. From that time onwards mothers may come, usually in the evenings, to my wards. They are encouraged to be active visitors and not sit passively at the bedside in a depressed frame of mind! They may help to settle the child for the night, giving the evening wash, helping with his supper, reading a story, saying his prayers with him and tucking him down to sleep—which often follows before mother leaves. (Occasionally we cheat with a sedative to achieve this when parting has seemed especially upsetting.)

When mothers cannot come every day it is often possible to provide substitutes and share the visiting. If the mother of a child in a neighbouring bed is introduced as 'Aunty' by the child's own mother (and this is important) it is often accepted as similar to the custom of neighbours at home. For parents at a distance we sometimes find a relative near at hand, or a pupil teacher in training, or a substitute mother from a small selected panel of volunteers, who often have had their own children in my ward. Fathers are encouraged to visit when they can—especially for little girls, who miss them a lot—and they frequently get in for a few minutes in the lunch hour. With all this, and especially when parents live at a distance and cannot visit often, links with home can be kept going by postcards, books, hair-ribbons, and even the use of the telephone in certain circumstances!

The confidence thus engendered can be greatly helped by easy access to the 'chief'—the member of the staff actually in charge. I do not think it fair or right to leave all the explaining to the nursing staff or to the residents. Indeed, I think it part of my work to train my resident how to talk to parents about what has happened, what we are trying to do, what is the likely outcome, and even bringing in preventive medicine by attempting to show how further trouble may be prevented. Some parents have to be specially

asked to see me. Others do not want to trouble me. All, however, whether they use the service or not, have more confidence if they feel that they have the chance.

The Young Baby in the Ward

For young babies the difficulties of separation are different and, indeed, I suspect that it is the mother's emotional state which is more upset. It may be ideal to consider admitting all mothers with their babies but it is not always practical and not always necessary. What the baby needs is probably not too many strange faces and case assignment among the nursing staff may minimize this. It has been suggested that the use of masks may help in this respect by making everybody look the same! One of the most successful baby nurses that ever worked for me came from West Africa and some of the success, I feel sure, was due to the ease of recognition by the little patients. An important part of the care of small babies in hospital is to secure easy transition from hospital to home. If they have not been living in, mothers are encouraged to come in by day (or, if necessary, to live in) for several days before the child is discharged, so that all details of feeding and care are understood. The mother's confidence in herself is fostered and an abrupt change avoided.

Some agree, however, that the difficulties we make for ourselves might be largely avoided if more children were kept out of hospital—cared for in their own homes.*

PREVENTIVE SERVICES

Finally in relation to child care today, here are a few random thoughts on the preventive services. It seems important to decide what diseases and disorders it is nowadays planned to try and prevent. Infant mortality rates are at a low level. Gastro-enteritis as a serious menace to health has virtually disappeared in Britain as a national problem, although local outbreaks in children's nurseries and newborn baby departments indicate that complacency is unwise. Nevertheless the standardization of safe feeding methods has largely mastered the main reason for the development of the infant welfare movement.

There is still scope for the better care of the newborn, and especially of the premature infant, although important reductions in mortality and morbidity have been made. After the newborn period respiratory-tract infections now head the list in mortality rates of the very young, and we need to know more about household infection and how to prevent the common cold of the adult, merely a nuisance, from becoming a fatal pneumonia in the young baby. Congenital malformations present a great challenge in the study of their causation and to the surgeons in the alleviation now so ably carried out in safety in regions previously inaccessible.

Some organization is necessary in the growing programme of preventive inoculation. The usual list now includes vaccination against smallpox, immunization against diphtheria and vaccination against whooping cough, to which may be added tetanus prophylaxis, B.C.G. and the use of the poliomyelitis vaccine. Quite apart from the administrative problems of timing all these 'shots' there is scope for study of antibody formation, interferences, reinforcements and so forth. (The young child who goes abroad may also have yellow-fever inoculation and T.A.B.)

Two outstanding problems in child health seem to need urgent consideration. One concerns the rise of '*accidents*' as a cause of death in early life—now causing a higher mortality after the age of infancy than any of the infectious diseases. The term comprises poisoning, home accidents (including burns) and deaths on the road. The second is the possibility that the child welfare movement, which must receive credit for much of the improved physical condition of children today, might turn its attention to the psychological side. Could not the infant welfare centres do more to prevent the development of behaviour problems, to detect early the unsatisfactory mother-child relationship, which may lead on to delinquency in the child and neurosis in the mother? Already this possibility is being explored in some areas. In London, seminars and case conferences for health visitors and the medical staff of welfare centres are being led by child psychiatrists, and it is hoped that such training on the job may lead to the emergence of preventive mental hygiene as an important part of what the infant welfare movement has to offer. The time is ripe for a radical review of methods used in the infant welfare centres and in the school health services in terms of 'job analysis' and methodology. To a large extent there has been little change since 50 years ago. It is now being asked whether the services provided really equip a child physically and psychologically to face life in industry, for example, or to be a good parent. This is the ultimate test of child care—what is the finished product like? The present amount of juvenile delinquency and adult neurosis suggests that there is still a lot to be done.

* See Gairdner, D., page 981 of this issue.