The family as the unit of health : papers presented at a round table at the 1948 annual conference of the Milbank Memorial Fund, November 17-18, 1948.

THE FAMILY
AS THE UNIT OF HEALTH

PAPERS PRESENTED AT A ROUND TABLE AT THE
1948 ANNUAL CONFERENCE OF THE MILBANK
MEMORIAL FUND, NOVEMBER 17–18, 1948

•

MILBANK MEMORIAL FUND
NEW YORK
1949

MILBANK MEMORIAL FUND

•

Board of Directors

MORRIS HADLEY

JAMES G. AFFLECK, JR.
GEORGE BAEHR, M.D.
CORNELIUS N. BLISS, JR.
BARKLIE HENRY
FRANKLIN B. KIRKBRIDE
SAMUEL R. MILBANK
FREDERICK H. OSBORN
GEORGE A. SLOAN

Officers

MORRIS HADLEY, *President*
SAMUEL R. MILBANK, *Vice President*
FRANK G. BOUDREAU, *Executive Director*
CATHERINE A. DORAN, *Secretary*
UNITED STATES TRUST COMPANY OF NEW YORK, *Treasurer*

Technical Board—1949

FRANK G. BOUDREAU, M.D., *Chairman*
GEORGE BAEHR, M.D., *Consultant to the Fund*

ROWLAND BURNSTAN
DEAN A. CLARK, M.D.
HARRY S. MUSTARD, M.D.
HERMAN E. HILLEBOE, M.D.

CLYDE V. KISER, *Secretary*

Technical Staff

DOROTHY G. WIEHL
CLYDE V. KISER
JEAN DOWNES
H. D. KRUSE, M.D.

CONTENTS

		Page
FOREWORD		5
OLD-AGE PROBLEMS IN THE FAMILY	*J. H. Sheldon, M.D., F.R.C.P.*	9
A PLAN FOR HEALTH SERVICES FOR THE FAMILY	*Thomas D. Dublin, M.D. and Marta Fraenkel, M.D.*	23
PREVENTIVE MEDICAL SERVICES FOR THE FAMILY	*Henry E. Meleney, M.D.*	36
DISCUSSION	*E. M. Bluestone, M.D.*	44
	John H. Dingle, M.D.	46
THE MANITOBA HEALTH PLAN AND ITS EFFECT UPON THE FAMILY	*F. W. Jackson, M.D.*	50
HOW THE HEALTH CENTER SERVES THE FAMILY	*Harry S. Mustard, M.D.*	56
HOW PUBLIC HEALTH SERVES THE FAMILY IN A COUNTY	*Hugh B. Robins, M.D.*	64
THE FAMILY AS A UNIT FOR PUBLIC HEALTH	*Marion W. Sheahan, R.N.*	72
DISCUSSION	*V. L. Ellicott, M.D.*	79
	V. A. Van Volkenburgh, M.D.	81
	Marie L. Johnson, R.N.	83
WELFARE MEASURES AND THEIR EFFECT UPON THE FAMILY	*George F. Davidson*	87
DISCUSSION	*Bailey B. Burritt*	101
THE CHILD HEALTH INSTITUTE IN ROCHESTER, MINNESOTA	*Benjamin Spock, M.D.*	104

THE IMPORTANCE OF THE FAMILY IN THE PREVENTION OF MENTAL ILLNESS — *Kent A. Zimmerman, M.D.* 111

DISCUSSION
George S. Stevenson, M.D. 120
J. H. Sheldon, M.D. 123
George F. Davidson 125
Martin Cherkasky, M.D. 126
George Baehr, M.D. 127

LIST OF PARTICIPANTS 128

FOREWORD

INSTITUTES and chairs of social medicine have multiplied in recent years; the subject is discussed and dissected increasingly in medical societies and medical journals, and it exercises a more and more important influence on medical practice. The origin of this new interest in the social environment as a factor in the etiology of disease processes lies beyond the scope of this foreword; it is enough to know that the interest is real and wide spread; that it bids fair to change the character of the practice of medicine and to make practicing physicians into more effective agents of preventive medicine.

Surprisingly enough, interest in social medicine has not penetrated very deeply into public health practice, although the development of the concept of social medicine owes much to the epidemiologist-statistician and the socio-medical surveys which they have carried out.

John A. Ryle, Professor of Social Medicine, has stated that[1]

> Social medicine and social pathology should, as their names suggest, be considered respectively as the medicine and pathology of families, groups, societies, or larger populations.

These considerations led those who prepared the program of the Twenty-fifth Milbank Memorial Fund Annual Conference to seek to focus interest at one of the two round tables[2] into which the conference was divided on the family as the basic social unit of health and pathology. Respect was paid to the need for cross fertilization by inviting as participants leaders from the fields of medicine, public health and social medicine, and the idea was also carried into each of these groups, so that among the medical participants, for example, the points of view

[1] The New York Academy of Medicine: SOCIAL MEDICINE: ITS DERIVATIONS AND OBJECTIVES. New York, the Commonwealth Fund, 1949, chapter on "Social Pathology," p. 55.

[2] The subject discussed at the other was "Problems in the Collection and Comparability of International Statistics," the proceedings of which will be published separately.

of psychiatry, pediatrics, internal medicine, and nutrition were presented.

A feature of the round table program was the contribution of Dr. J. H. Sheldon, Director of Medicine at the Royal Hospital, Wolverhampton, England, the author of a survey of a random sample of aged persons in that city.[3]

Just as the concept of social medicine is beginning to influence medical training and practice, so it will eventually have a strong impact on the programs of schools of public health. It might be suggested cautiously that these schools have suffered from the success of public health work, for when public health practice yields such high dividends, schools are not likely to depart from the traditional program of teaching. Yet all admit that the ageing of the population and other changes in the nature of health problems, make it imperative to review existing practices in the light of new conditions.

The public health of the future will undoubtedly concern itself with chronic diseases and the health problems of the aged. Its success will depend more largely than at present upon the work of practicing physicians. Its practitioners will need to keep in closer touch with practicing physicians on the one hand and with workers in the field of social welfare on the other. For the practice of social medicine calls for greater team work than ever before from the practitioners of all these three professions whose efforts are focussed upon maintenance of the public health.

Such team work will be facilitated when schools of public health and public health workers accept more fully than at present the concept of social medicine and the idea that the family rather than the individual is the unit of health.

The Milbank Memorial Fund owes a debt of gratitude to the participants of this round table, to whose efforts the success of the program is due.

Doctor George Baehr, the Chairman of this round table, and

[3] The Social Medicine of Old Age, published by the Trustees of the Nuffield Foundation, Oxford University Press, London, 1948.

the speakers and discussion leaders who spent long hours in preparation, merit a special word of appreciation.

This volume contains a full account of the proceedings of the round table.

FRANK G. BOUDREAU, M.D.
JEAN DOWNES

August 1949

OLD-AGE PROBLEMS IN THE FAMILY

J. H. SHELDON, M.D., F.R.C.P.[1]

THIS discussion of old-age problems in the family can be divided into two parts. In the first place, I want to give a factual description of the actual state of affairs in old people that I found in the course of a survey conducted in Wolverhampton; and in the second place, I want to put forward a few thoughts and generalizations on the importance of the family which I think arise from that survey.

Some four or five years ago when I was sitting on a committee of the Nuffield Foundation dealing with old age, I realized that although a great deal was known about the state of old people living in institutions, virtually nothing was known about the state of old people living at home, and in particular, nothing was known of what one may call their social biology. And so I thought it would be worth while to make a survey of the old people in my home town, Wolverhampton, which is a manufacturing town with a population of approximately 150,000.

We did that by taking an absolutely random sample of the old people. Officially in Great Britain you are old at sixty if you are a woman. Why, I don't know; but that is a fact—a legal fact. And you are old at sixty-five if you are a man. So I took a random sample of one in thirty of the old people above those ages. The sample was easy to get because we are rationed, and having obtained permission from the Government to inspect the registers we took every thirtieth ration card and we had then a sample which bore no relation whatever to income. Two investigations were made. In the first similar samples were studied by a team of social workers in a series of representative towns—Lutterworth, Oldham, the Rhondda, Wolverhampton, and two London boroughs. The results were studied by a Committee of the Nuffield Foundation presided over by Mr. B. Seebohm Rowntree, C.H., and published by

[1] Director of Medicine, The Royal Hospital, Wolverhampton, England.

the Oxford University Press in a book entitled OLD PEOPLE. The second investigation was of a medical nature, and was confined to Wolverhampton, but the same sample was used. The results were published by the Oxford University Press for the Nuffield Foundation in a book entitled THE SOCIAL MEDICINE OF OLD AGE.

I now want to give you the facts dealing with the social life of these old people.

The first point: Of the 477 people who formed the sample, only 2 per cent were living in institutions, and 98 per cent were living at home. Clearly the problems of old age are fundamentally domestic rather than institutional problems. Statistics available in Great Britain dealing with the proportion of old people who are ostensibly living alone, show figures which vary from place to place from somewhere about 10 per cent up to as much as 20 per cent. But I had not gone very far with the survey before I realized that these figures were of limited value if one's attention was restricted to the house in which the old person was living, and much of the true mode of their existence in the community would be missed.

An account of the actual instance which drew this to my attention will illustrate the point.

Quite early in the survey I called on an old man of seventy-five, a retired carpenter, a nice old boy, living in a small workman's house. I called on him on a Saturday afternoon and sat talking with him in the kitchen, and through the kitchen you could see his garden, a small garden, very nicely kept, full of flowers. What struck my attention so much was the fact that on the table was a bowl of flowers and on the mantelpiece there were two vases of flowers, very nicely arranged. Now, that is not an occupation that a man normally does himself, and no ordinary man goes into his own garden with a pair of scissors. It is a feminine instinct. And so I thought it was a point worth investigating. It appeared the flowers were arranged by a married daughter living next door, and that he had another married daughter living further up the street. What was the family

structure? He lives alone; he is a householder. He appears in the old-age figures as an old man living alone. Yet one or other of the daughters comes in at midday and prepares his dinner. He goes every Sunday to one or other of the daughters. He goes out every night with one or other of his sons-in-law for a drink. And when he is ill, one or other of the daughters comes to him and looks after him. When either of his daughters is ill, he does all the shopping. Was he living alone? From one point of view, the architectural point of view, he was. But in actual fact it is equally clear that he was part of a human unit, a family unit, which spread over two or three houses, and bore no relation to architectural limitations. It was a unit which functioned quite loosely in times of peace but became more and more closely knit in times of stress.

I was very lucky to come across that case right at the beginning of the survey, because a series of questions were framed in order to find out if this was a frequent mode of existence for old people. I think the results were surprising. I am going to give you a series of percentages, and remember that each new percentage will include all that has gone before.

In Wolverhampton 4 per cent of the old people, 1 in 25, have children actually living next door. Ten per cent of the old people have children actually living in the same street. Twenty per cent of them have relatives living within half-a-mile, or within such a distance that a hot meal can be carried from one house to the other without needing re-heating. I use "relatives" instead of the word "children" because this group includes the small extra class of old persons who have no children but who are living close to a sister-in-law or a brother-in-law or other relative of the same generation. But they only account for about 10 per cent, 90 per cent of the relatives being children.

Twenty per cent of the old people, then, have relatives living within half-a-mile, so that approach from one house to the other is very easy. Forty per cent of the old people had daily visits from one or more of their children regardless of the distance away at which they lived. I think these figures show very

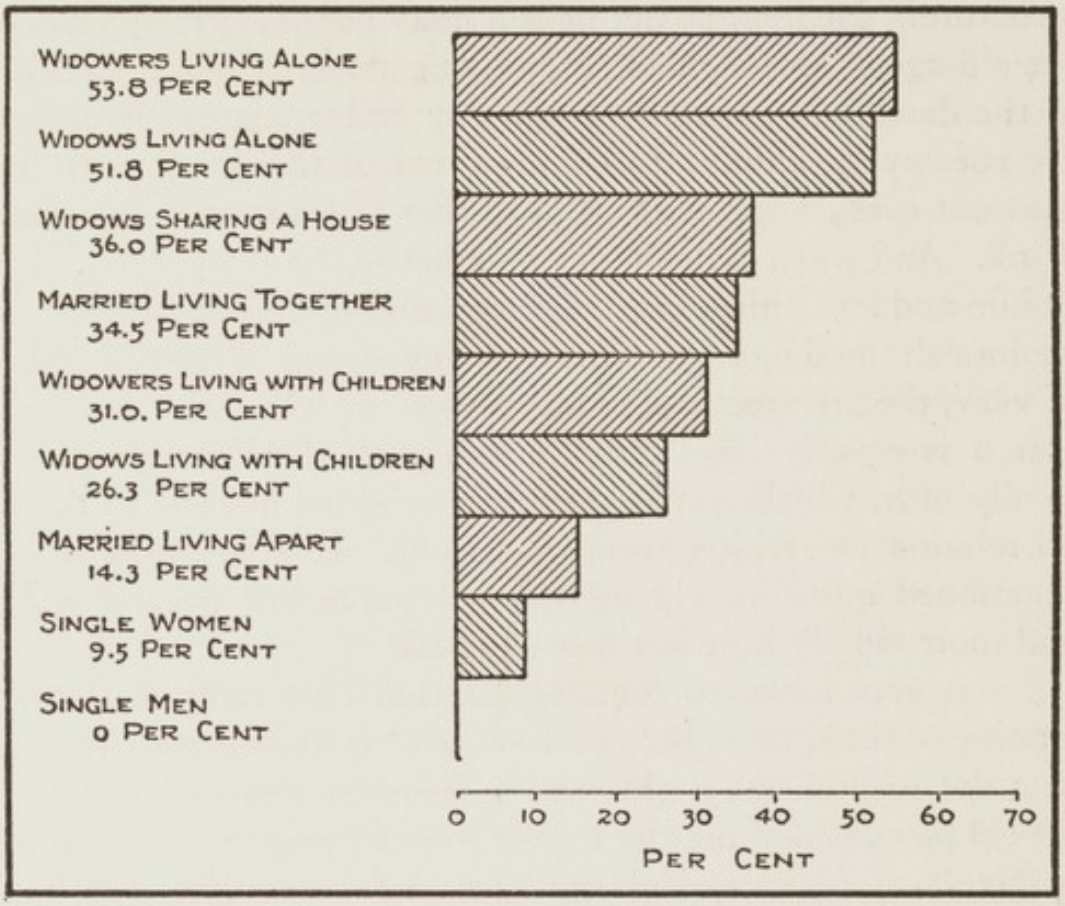

Fig. 1. Old people with relations living near. (Data from Sheldon, J. H.: Some Aspects of Old Age. *The Lancet*, April 24, 1948, ccliv, No. xvii. Reproduced by permission of *The Lancet*.)

clearly the fundamental part played by the family in the life of the old people. I think they show it even more when you attempt to break up those figures into the different social states, which is shown in Figure 1.

You will see that in the case of widowers who live alone and also in the case of widows living alone, over 50 per cent of them have children or relatives living close. In other words, the decision of an old man or an old woman, after the partner-in-life has died, to go on living alone in the old house is contingent upon whether or not children are living near. If children are living near, that is how they prefer to live.

Then as you go down through the other groups, the proportion decreases. Take the case of widows sharing a house—they are widows who, after their husband has died, have either set up a lodging house or have joined forces with another widow or

with an old friend and share the house; even here they are not content, but like to be near their children, for 36 per cent of them have children living close by.

When you come to old people who are married and both are still living, 34.5 per cent of those have children living close to them.

Those figures, I think, illustrate beyond any shadow of doubt the fundamental part played by the family and by the younger generation in the life of the old people.

You see it also in the very interesting group of single women. Almost 10 per cent of those have relatives living close to them. These are in nearly all cases relatives of the same generation, so that the single women, in 10 per cent of the cases, like to settle somewhere close to a relative.

The single men fascinated me because they are such a complete contrast. Not one of those had any relatives close by. They formed the most interesting psychological group. Obviously, there was something wrong with them from the start, because I presume they all could have gotten married if they wished! But they had no relatives living near whatever. They lived completely lonely lives without any trace of loneliness, and although they don't need our sympathy, they are worthy of much more psychological study.

These figures show clearly that in the life of the ordinary old person it is essential to take into consideration not merely the house in which he or she lives but also to take the whole family structure into consideration, because the family functions as one unit. It would, however, be wrong to leave it at that. Really, old people live as part of a human group in which the family is the most important but is not the whole.

Before we go on to that subject, which I am going to deal with in a minute, there is one small point of interest that came out of this question of relatives living near which I want to show you because I think it is quite important (*See* Figure 2). I was very interested when I came to work out the findings of children living in the same street to discover that when the

children were living either next door or within three houses, which meant that they would have lived next door if they could have but somebody else had got into the intervening house—of those, eight were sons but twenty were daughters. In other words, 71 per cent of those living next door to the old people were daughters. When you came to the children who were living up at the other end of the street from their parents, you found the reverse: 58 per cent of those were sons and only the smaller proportion were daughters. In other words, the daughter is very glad to settle down near her parents where she can be a constant standby for them, but the son apparently is quite willing to live in the same street so that he can be a standby in time of trouble but he is not going to be so close that there is any chance of interference with his own married life. That, I presume, is one explanation. Another explanation may very well be that some of those sons had only jumped out of the frying pan into the fire because they had gone from one end of the street to live with their in-laws at the other end of the street. That may not be the case, but it is an interesting little facet of social structure which obviously is worth inquiring about.

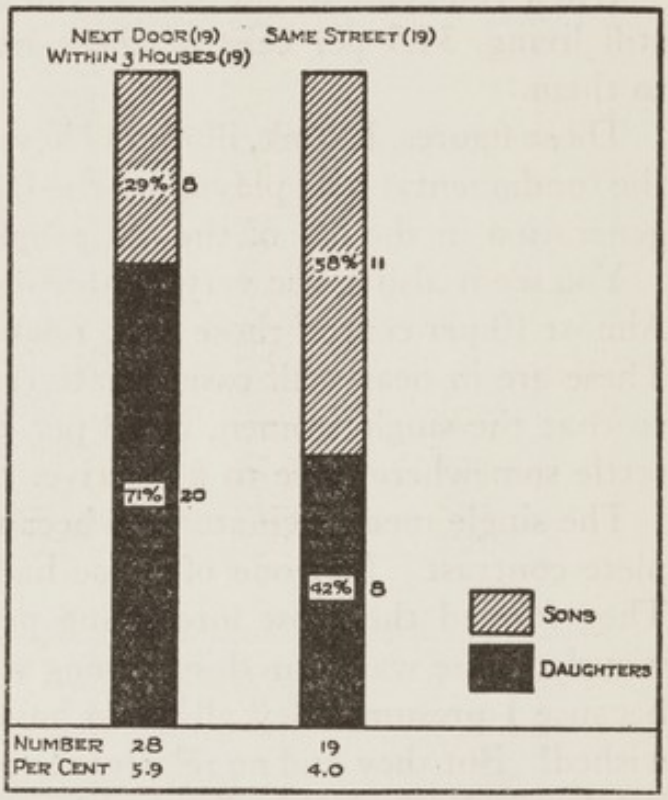

Fig. 2. Children in same street.

Now we go back to the previous point that old people form part of a human group of which the family is the most important but is not the whole.

Figure 3 deals with the care of illness in old people in their

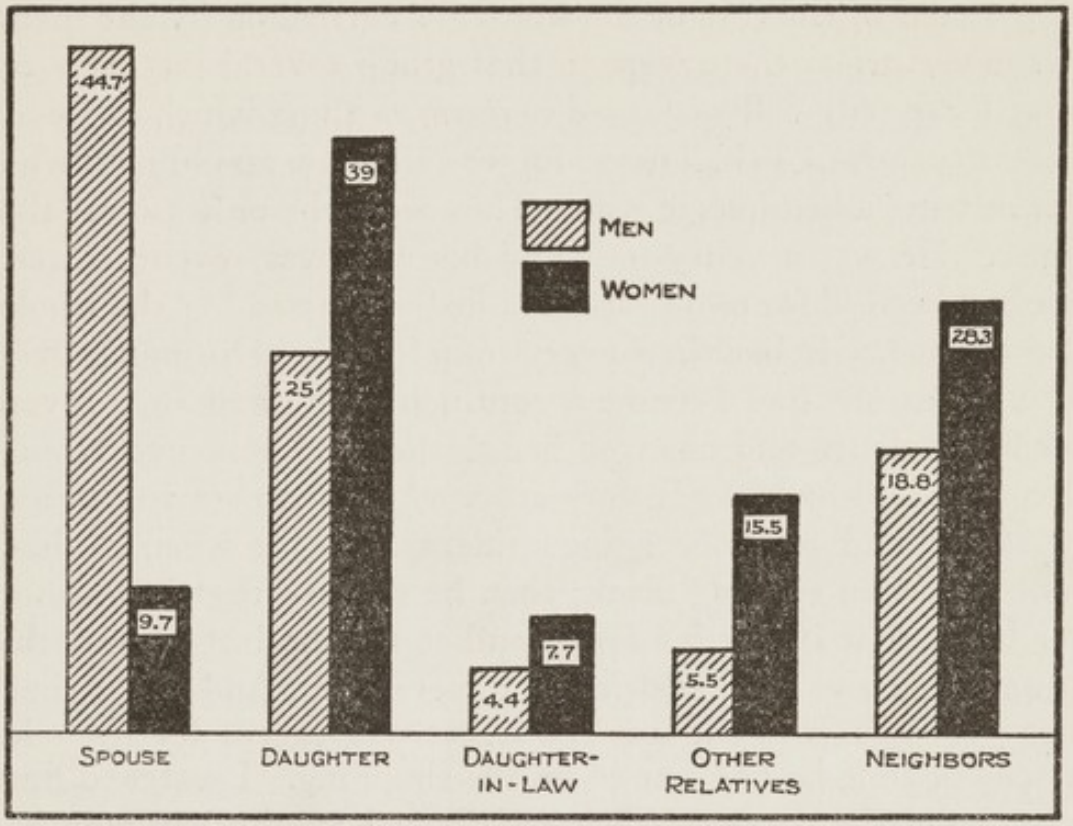

Fig. 3. Nursing of old people in illness.

own homes, where the illness was one in which the old person had to be nursed at home. Let's see who looks after the old people. You will see that when the man is ill, 44.7 per cent of the nursing is done by his wife, 25 per cent of the nursing is done for him by his daughter, only 4.4 per cent is done by daughters-in-law, and 5.5 per cent by other relatives, like sisters-in-law. That, of course, is due to the operation of social taboos and so on. But no less than 18.8 per cent of the nursing of men at home was carried out by their neighbors, and those neighbors were doing full nursing. They would be quite willing to give the old man next door a bedpan, change his bed, and things of that type. And I think that it is a remarkable thing that so big a percentage as nearly 20 of the nursing of old men should be carried on by the neighbors.

What happens to the old woman when she is ill? Husbands, I am afraid, do not occupy such a prominent place in the care of their wives as the wives do of their husbands, because only

9.7 per cent of the care of the woman is carried on by the man. But nevertheless there were in that group several instances of what I can only call sustained heroism, a thing which came as a great surprise. I shall never forget calling on an old man who was nursing a hemiplegic wife. They were the only two in the house. He was seventy-four and his wife was seventy-three. She had been ill for two years, and he had nursed her the whole of that time. He had done everything for her. During the last six months she had become incontinent. He had then given her her bedpans and changed her clothes and done everything else. He said he had got very cross with her to start with because she had often been incontinent at night when he had gone to get an evening drink; then he realized that it was not her fault, that it was his fault; and so for the last six months he had even given up his drink in the evening. And at the time I got there, he was indoors the whole day except for the odd snacks of time he had out to do the shopping. I watched him after I did the survey. That wife lasted another six months, and it was not until the last fortnight of her life, when she was beyond hope, that he thought of getting a district nurse. He said, "I married her for better or worse, and I am going to look after her and nobody else shall." That is a magnificent spirit, and that sort of thing is present in old people if you give them a chance to develop it.

Nine and seven-tenths per cent of the care of the wife is carried out by the husband; but a very large percentage—nearly 40 per cent—is carried on by the daughter; 7.7 per cent by the daughter-in-law; rather more than in the case of the man by other relatives, such as sisters and sisters-in-law; but 28 per cent is done by the neighbors.

These figures show the relative contributions made by the family and by the neighbors in the nursing of illness at home, and they establish the point that the old person lives as part of a human group, in which the family, though certainly the most important part, is not the whole.

It is not to be imagined that old people can live in such close

contact with the community as that without causing severe strains, and in the conduct of the survey I took particular notice of every case where there was strain. I graded the strains into three groups: an easy strain, which wasn't really very much; a moderate strain; and a severe strain. By severe strain I mean the sort of strain which turns the life of the person who is bearing it into that of a mere drudge. No less than 7.7 per cent of the old people were causing strains of that degree of severity on the younger generation.

What does it mean to the younger generation to bear that strain? In the first place, the strain is borne nearly always by daughters. The precise figures are these: 76 per cent of the younger generation carrying severe strain were daughters; 16 per cent were daughters-in-law; 5 per cent, to my great surprise, were nieces—nieces who were looking after old aunts; and 3 per cent were friends. So that the strain on the younger generation in looking after the old people is borne mainly by the daughters, and the effect on the daughters shows itself in two main ways: they can't get out except to do shopping and things of that kind, and 50 per cent of those daughters had restricted movement, and they can't get away for a holiday.

I well remember such instances as these: one daughter had only been to the pictures eight times in fifteen years because she could not leave the house where her old mother was. Another one had had no holiday for twenty years; she had been a slave and a drudge in that house, doing the washing and everything for an old father for twenty years without a break.

The actual distribution of the strain (shown in Figure 4) in age is very interesting. After sixty-five, the proportion of old people causing severe strain of the type that I have mentioned slowly increases until seventy-five, when it steepens; after eighty, it steepens more, and at eighty-five is rapidly steepening. And I have no doubt that if you could have figures for the centenarians, it would be 100 per cent, because I cannot imagine a centenarian who is not a burden to somebody.

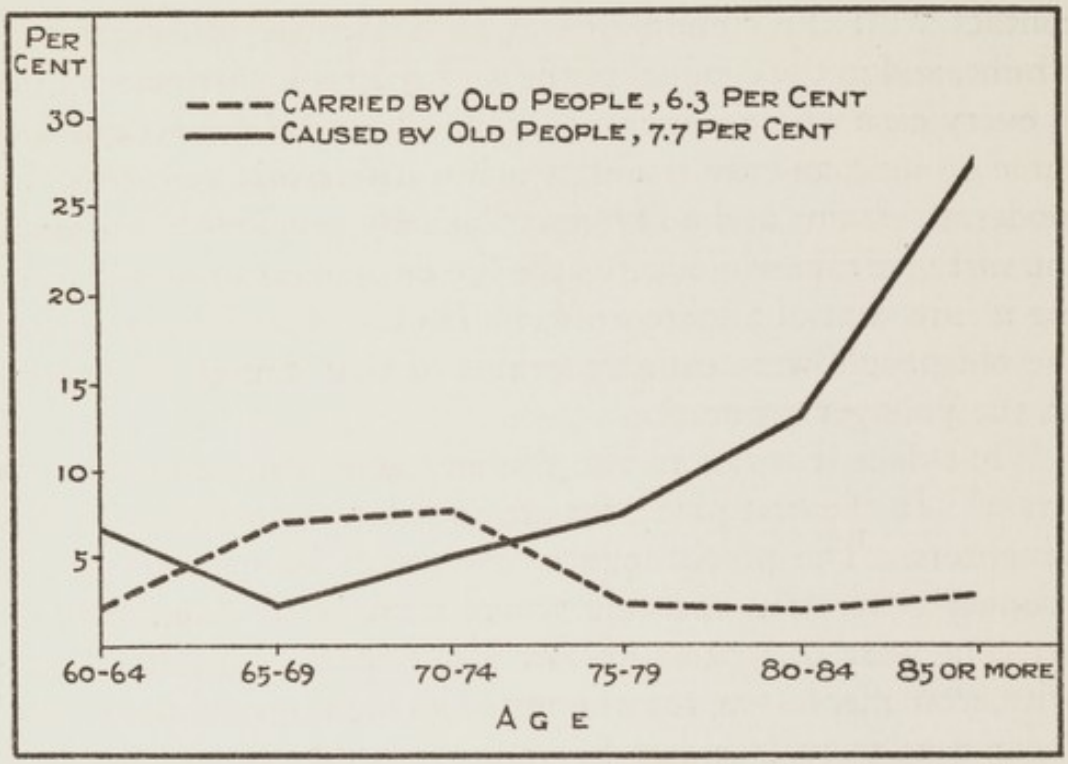

Fig. 4. Strains carried by and caused by old people. (Data from Sheldon, J. H.: Some Aspects of Old Age. *The Lancet,* April 24, 1948, ccliv, No. xvii. Reproduced by permission of The *Lancet.*)

But it would be unfair to leave it at that; to think only of the strains that are caused by old people. It is essential to remember that they carry, themselves, on behalf of the community, equal strains. Six and three-tenths per cent of the old people were carrying strains of the same degree of severity, but they can only carry them up to the age of about seventy, and then age begins to tell and the proportion decreases.

What sort of strains do the old people themselves carry? Well, they are really of three types. There is the strain of the old person who looks after a defective child, the old woman of eighty who has got a mentally defective son of fifty and still surrounds him with care and affection. There is the case of the old woman who is forced to bring up her grandchildren. I remember one woman of seventy-five bringing up four grandchildren, which was obviously a frightful strain for her. But far beyond any of those is the strain where one partner in life has the nursing of the final illness of the other partner; and that usually, of course, falls on the woman who is nursing a dying

husband. He may take some years to die, and she carries the whole strain.

So that those two curves, I think, illustrate from a different point of view the same sort of points I was making at the beginning: that old people form an integral part of the community; they must not be looked upon as living isolated lives; they cause strain, but they also carry it.

Those were the essential facts that I found in Wolverhampton of the social structure of old people.

Can we learn anything from those? Well, I should like in the few minutes that remain to me to put forward a series of propositions which may help to focus discussion.

In the first place, it is self-evident that old people form part of a family. To look on them as leading purely isolated lives is to miss the whole point of their existence. In the second place, I would postulate that there is a human tendency—I don't really think it is an instinct, it is rather a sense of responsibility, but "instinct" is perhaps an easier word to use—I think there is a human instinct which makes younger people feel that they have got to care for the older people. And the third point I would make is this: that if there be such an instinct, it is our duty as doctors to subject that instinct to the fullest possible study; and when we know more about it, we have got to give it the maximum possible encouragement in our measures for dealing with old age.

Why is that?

Well, as I walked into this building this morning, I was very interested to see the Latin inscription on the wall, and I should like to give you another one which is always in my mind, those famous lines from Lucretius: "Naturam furca expellas, tamen usque recurret." Those words when uttered were merely a bright but a deep thought; now at this moment in 1948 they are a sober reality; but in twenty to thirty years' time they are going to provide us with a terrifying spectre. What do they mean? You cast out Nature with a pitchfork, but it doesn't matter, she is going to come back on you in some other way.

And you see, we in our profession are casting out Nature with a pitchfork. We are controlling more and more all the natural checks which in the past Nature has imposed on the density of her population. And if that process goes on and nothing is done about it, two major disasters are going to face our civilization. One is the pressure of population on a limited food supply; and the other, which is equally serious, is the internal pressure in our own civilization of the burden of the aged and of the younger people who are infirm. If conditions continue, the burden imposed by those is going to be such that it will be more than our civilization can bear.

And so I think that it is essential in dealing with old age to get away from the purely caretaker attitude, the aspect of providing an increasing number of homes for them. We have got to find out more about the natural social biology of old age in the community, and then encourage its help along those lines.

Two more points: (1) Why do I say that if there be such an instinct, it deserves study?

I can't overemphasize the importance of that. Obviously, it is not an instinct in the sense that the maternal instinct is one, an overpowering state of mind, because it shows such extreme variability. Look at its anthropological aspects. From what one reads of China, at any rate in the old days, ancestors were worshipped, and old people were looked upon with the very deepest respect. But there were some South Sea Islanders who ate their old people. The Eskimos, so I have read, put the old people, when they can no longer support themselves, out in the Arctic night. Even more interesting, look at British Guiana—which contains the second or third biggest waterfall in the world—it is called Kaieteur, and "Kaieteur" I am given to understand, is the Indian name for an old man; and it is called that because it was the habit of the Indians, when their old men could no longer support themselves, to put them in a canoe without paddles and send them adrift to die. This sense of responsibility for the care of the aged appears to range from zero in some human races up to the maximum possible in others,

such as the Chinese. I would say that the difference is probably based on economic factors. A civilization that is agrarian, such as China, can apparently support its old people and manage to get away with it; a civilization whose economy is that of hunting obviously cannot, and the old people have to be slaughtered.

(2) Where do we stand? We are neither. We are an urban civilization, and I think we just don't know yet the extent to which that instinct is strong in different places, because I am quite sure that it does vary from place to place.

So I think that instinct varies, in the first place, with the type of economy; in the second I think it varies from place to place very largely because of architectural differences. The slide I am showing you now is a picture of Wolverhampton taken from the Hospital roof, and I am showing it to you because it illustrates one type of housing that we have. There you don't have the type of housing that I see so much of here, where each house is standing in its own garden, but there are rows upon rows of streets of workers' houses, all of which are contiguous. Each house has a front door which is never used except on state occasions, and there is a common entry every five or six houses which takes you round to the back of the houses. The people therefore go in and out of their back doors, passing by the back doors belonging to the other houses. That is the type of architectural structure that is common in a British manufacturing town. I have shown you this picture of part of Wolverhampton because there you see the conditions under which the family instinct can thrive. People are living next door to each other; they have got common back entries; it is rather like a rabbit warren, and the people are living all the time, in a sense, as part of a communal structure.

My friends say that may be true of Wolverhampton but it is not true of London; in London the younger people have not got the same affection for their old ones. If this is true, I think the reason is architectural. I think the Londoners are born with the same amount of affection, but the old people tend to

live more in tenements, single rooms, and it is very much more difficult under those circumstances for that instinct to flourish.

There are therefore many variable factors of that kind, that need to be taken into account; but I do feel that it needs the fullest possible study. This instinct, if it be such, is a tender plant, and we have got to find out what are the economic conditions, what are the social conditions, what are the architectural conditions and so on, in which that instinct has the maximum chance of development. And when we know that, then I think it is essential for us in the future to adjust all our schemes for the care of old age along those lines. Instead of going on buying more and more homes for caring for old people, we have got to do our best to encourage the family to look after them, and to do nothing which makes it unnecessary for the family to look after them, because that is the best thing for the health of the old people themselves. Then they are still in the family, they can still contribute to our civilization; and at the same time the younger people, by looking after them, can save us from the burden.

That is all I have to say. I can only sum it up by stating that I think in the future, with the increasing number of old people, if we merely take the line of least imagination and least resistance, which is that of just simply having a caretaker policy, building up homes for them, we shall end in disaster. But the experiences in Wolverhampton do show that the family, under suitable conditions, has a sense of responsibility toward their old ones, and that the old people can themselves contribute to the welfare of the family. And knowing that, it is our duty, I think, to make all the inquiry and study we can of that aspect of old age and model our plans for the future on it.

A PLAN FOR HEALTH SERVICES FOR THE FAMILY[1]

THOMAS D. DUBLIN, M.D.[2] AND MARTA FRAENKEL, M.D.[3]

IN HIS thoughtful and inspiring analysis of medicine today, Kershaw (1) has written: "In the past, the imminent threat of death has been more important to man than the prospect of a fuller life; medicine needed to conquer disease before it could go on to foster positive health. It is not unduly optimistic to suggest that that conquest, in so far as it concerns the major killing diseases of the civilized world, is within sight, for most of those diseases can now, in favourable circumstances, be either cured or controlled. Medicine may, therefore, regard itself as in the position of an army which, having consolidated its defensive position, can begin to think of taking the offensive.

"Pure medicine is conceived in terms of concrete processes of disease occurring within the human body and specific procedures for their arrest or cure. In such a conception, health is something which is capable of only a negative definition as the absence of detectable disease. If we try to move over to a more positive viewpoint and regard health as the realisation of the fullest potentialities of the human mind and body in the living of a complete life as a member of the social community, so that disease or disability becomes a recognisable departure from that full realisation, we see that this shift demands a very full integration of medicine with social life."

It is with such an aggressive concept of health and with an equally positive approach to the "full integration of medicine with social life" that a group with which we have been associated has attempted to develop a plan for a practical demonstration in family health maintenance.

[1] This paper is a resume of a report entitled "A Demonstration In Family Health Maintenance" by Dublin and Fraenkel prepared for the Long Island College of Medicine under a grant to the College from the Community Service Society.

[2] Executive Director, National Health Council; formerly Professor of Preventive Medicine and Community Health, Long Island College of Medicine.

[3] Director, Medical Record Service, New York City Department of Hospitals; formerly Research Associate, Department of Preventive Medicine and Community Health, Long Island College of Medicine.

At the outset we would like to emphasize that we have drawn generously from the observations of those pioneers who have devoted years of painstaking effort to the study of man as a "healthy whole" rather than as an aggregate of organs and systems highly susceptible to pathological processes. We have in mind such workers as Gessell at Yale, Keyes at Minnesota, the staff of the Grant Study at Harvard, and Williamson and Pearse at Peckham. We have attempted to synthesize a plan which would not only take into account the health problems of the individual and of the group in their proper social setting but would take advantage of some of the currently developing patterns for the provision of medical care as a social service. We refer here to the concepts of medical group practice and of prepayment for medical care, concepts which already are beginning to exert an important influence on the methods of practice of the physician and of his professional colleagues.

Our efforts have been stimulated and encouraged by one of this country's outstanding social agencies, the Community Service Society of New York. At one of the three symposia commemorating the hundredth anniversary of that Society, Mr. Bailey B. Burritt, its former Executive Secretary, first announced to the public that they planned to sponsor such a demonstration in the near future. (2) We would like to acknowledge our personal gratitude to Mr. Burritt and to the other members of his Health Maintenance Committee for their patient guidance and generous support. We wish also to express our appreciation to Dr. Jean A. Curran, President of the Long Island College of Medicine and to the Board of Trustees of that institution for the opportunity to conduct the studies we are briefly to summarize. It is our hope that the full report of our efforts will be published in the near future and thus be made available for evaluation and criticism to all those who are interested in this new phase of medical endeavor. This brief resumé of program and procedure, however, represents the thoughts of a small group of individuals and does not necessarily reflect the policy or plans of any institution or agency.

As a starting point for our project we have studied a small segment of the population living within a well defined geographic area of New York City in order to obtain a preliminary though careful estimate of the overall medical needs of this group in health as well as disease. Since our objective is health maintenance and health promotion we have felt it desirable to define some of our terms:

As a goal of medical care the term "health maintenance" has for us a specific meaning which is partly derived from a new comprehensive concept of health. Health in this concept is no longer only negatively a state of "absence of detectable disease" but positively a state of well-being and of optimal adjustment of individuals and of groups to their environment with its physical, psychological, as well as social demands. Health must be conceived structurally, i.e., in relation to a person's body and mind; functionally, i.e., in relation to the various activities in which the individual is engaged; and socially, i.e., in relation to the groups of which the individual is a part.

Health maintenance, then, requires the application of every effort which will secure a maximum of physical and mental fitness and which will enable each person to live "a complete life as a member of the social community." Measures towards this end include those of maintaining and improving health as well as those of attending to the "recognizable departures" from the state of health, to disease and disability.

A program geared toward the goal of health maintenance, therefore, has to be all-inclusive; for diagnostic, therapeutic, and rehabilitative services are as much a part of it as are those traditionally considered as preventive.

The demarcation lines between preventive and remedial measures in a program of health maintenance are difficult to determine. The time in which it was proper to teach and practice two distinctly separate disciplines is past; we are clearly approaching the time when preventive medicine must be considered a part of the practice of every physician. It is such a concept of integrated health services that some medical edu-

cators have been attempting to teach. The availability of a "health maintenance" program in operation should prove of invaluable assistance.

Our focus of interest has been as much upon the basic social unit, the family, as upon the individual—for in our opinion health maintenance calls for a program in which individuals are seen not isolated but within the family. It cannot be overemphasized that if we are to foster health we must concern ourselves with the satisfactory adjustment of the individual in all his social relationships, and, in the complex society in which we live, the adjustments to which the individual citizen must make for healthful living are increasingly difficult.

It is within the family where basic adjustment to social living is required. Success or failure may affect the health of the group as well as of the individual. Is it not remarkable how long medicine has paid only scant attention to family health? Only recently has the family been recognized as the "unit of illness" and have attempts been made to consider the family as the "unit of treatment." (3)

This new approach has proven sound for diagnostic and curative measures. There is need of extending it: the family should be considered as the "unit of health." The Family Health Maintenance Project takes this extended point of view; all phases of its program in which preventive and remedial services are integrated are geared toward the family.

We would like to dwell momentarily on the concept that health is a collective as well as individual characteristic. The acceptance of the family as the unit of health leads to the concept of "family health." "Family health" is not just an arithmetical mean of the health status of the various family members. It is something more. It is the aggregate of the physical, mental, and moral well-being of all members including their adjustment to group life and to other environmental and biological conditions which the family must meet as a unit. A family with a seriously handicapped or chronically ill member might occasionally have to be considered as "healthier" than one without any mem-

ber suffering from overt disease. In striving for "family health," unity and "esprit de corps" are strong assets; disharmony and tension—often concomitant with life in a social unit as a family—equally strong liabilities.

"Family health" can be appraised only by a diagnostic study of the family as a group. If persons are seen not isolated but within their family, it may be possible to recognize tensions, anxieties, maladjustments, and other emotional conflicts as elements common to various conditions manifest in one or several members of the group. The diagnostic study of a person within his family group may permit the correct evaluation of specific characteristics and sometimes the detection of conditions in a preclinical state. Only through this type of an approach can we hope to understand better such significant associations of illness in both husband and wife as found by Downes in her recently reported studies of chronic disease among families living in the Eastern Health District of Baltimore. (4)

The Pioneer Health Center in London, which subsequently became widely known as the "Peckham Experiment," was the first group which clearly recognized and defined the problem of "family health" and boldly launched a new service to approach it. (5) Even though its procedures are not directly applicable to conditions in this country, its philosophy has been a source of inspiration for all those concerned with "family health."

In our concept of "family health," the term "family disease" acquires a connotation far beyond its traditional scope. In addition to familial infections and conditions of hereditary and dietary origins, it includes a large variety of other "diseases." Many conditions appearing in different family members may be found to have a common etiology, even when the manifestations of illness are completely different. The hypertension or the asthma of a parent and the enuresis or the stammering of a child may be manifestations of common "etiology," symptoms of one "family disease." It is these underlying causes that must be attacked to prevent spreading of the "family disease" and

to secure safe cure of those already affected. Clinical treatment of a duodenal ulcer or of hypertension is only one phase in the proper attack of a "family disease," just as the clinical treatment of the tuberculous patient is only one phase in the combined preventive and curative attack on tuberculosis in the patient's family. Diagnostic and preventive measures must be applied to the whole family.

Richardson summarizes his discussion of the relationship between the individual illness and the family in the general statement that "the family is part of the individual and the individual is part of the family." (6) This concept of the family as part of the individual is one of the basic principles of family health maintenance.

A Program for a Family Health Maintenance Service

The concept of family health maintenance calls for a program in which all health and medical services are integrated. These include not only services traditionally provided by the physician but also those offered by the growing army of professional workers now active in fields closely associated with the practice of medicine. Disciplines which have been practiced separately must be merged; professions which have functioned independently must be coordinated. The significant advances which have been achieved when physicians, public health nurses and medical social workers have joined forces in attacking specific socio-medical problems of their patients, are most encouraging in this direction.

The Main Elements of the Program. The application of the program starts with the "initial health inventory" of the family, the "unit of health." In this inventory account is taken of the biological and the social characteristics of the family as a group as well as of the physical and psychological characteristics of each individual member.

The findings of the health inventory determine the health maintenance schedule which has to be worked out with each family as a group. They likewise determine the procedures to

be followed by its individual members. Curative and rehabilitative measures are, as described earlier, just as germane to a true health maintenance program as those traditionally considered as "preventive." Separate programs for "preventive" and for "curative" services are as unreconcilable with health maintenance, as we define it, as are separate programs for persons grouped by their age, by common disease, by occupation, or by economic status.

"Maintenance of health" calls for its periodic re-evaluation. The cycles in which the members of a family should be re-examined, as well as those in which a family situation as a whole should be reviewed, have to be decided on a case basis. The scope of the periodic health examinations, as at present performed in progressive health programs, may serve as a guide but not as a model: a more flexible, more individualized procedure seems necessary.

Health education, increasingly recognized as an indispensable factor in health care, will play a major role in the program, not as a special feature but as a thread inseparately woven into its total pattern.

Premises for Operation of the Program. For the successful operation of a family health maintenance program it is essential that several basic premises be established.

1. Broadly trained and experienced general physicians, "family physicians," must continuously be available in adequate numbers. If a physician attends patients exclusively or predominantly during the emergency of illness, continuity in relationship, though desirable, may be of secondary importance. But when the supervision of a family's health and the guidance of long-range health measures are at stake, continuity is of all-decisive significance. The term of "family physician," it seems, never was more justified.

Seldom has the physician had a more challenging responsibility than in this program: the findings of the initial health inventory of the various members of the family group have to be fused into a coherent picture of family health; conversely,

the family group as such must be studied and the effect of group peculiarities on the well-being of each member must be evaluated. The general physician, moreover, has to tie together the pictures of family health as obtained in subsequent examinations, taking simultaneously into account the various factors that may have influenced family health in the meantime, be they growing or aging processes, inter-current diseases, occupational or other environmental changes. All these phases require the utmost in medical skill, psychological and sociological understanding, as well as genuine mutual confidence between the physician and each member of the family.

2. Since a health maintenance program, as we have defined it, includes diagnostic, therapeutic, rehabilitative as well as preventive services—all satisfactorily integrated into a unified scheme—an equally important premise is that the whole array of modern medical services is readily available and is rendered by a closely organized and properly balanced medical group. Thus the staff must include not only general physicians but specialists in the various branches of medicine. We have used for our pattern of group composition the plan proposed and now being tested by more than twenty-five medical groups actively associated with the Health Insurance Plan of Greater New York.

If our plan varies from existing medical group patterns it does so primarily in two respects. We insist, for example, that the place of the family or general physician be strengthened both numerically and strategically, for in our opinion he is and must be the focal member of the medical team, the coordinator of all services and the interpreter of the program and its services to the family. Secondly, we envision the actual incorporation into the staff of our group practice unit representatives of associated professions as, for example, public health and educational nurses and medical and psychiatric social workers. Physicians are only now beginning to learn how to utilize effectively the knowledge and skills of a growing army of co-workers. At present we see the need of the physician practicing even more closely with those workers mentioned above, and yet we hold the view that there

remain a host of others, still unidentified with the provision of medical care—sociologists, psychologists, anthropologists, educators, to single out a few—who, we are convinced, could help solve many of the problems of medicine which thus far have escaped solution.

3. The mounting costs of medical services have often been deplored as a barrier to the proper distribution of medical care, especially of early care and of preventive services. Generous contributions by physicians of time and services and the acceptance of public responsibility in many communities have resulted in the provision of essential services for the indigent population, including the "medically indigent." But many people who pay the costs of treatment of illnesses out of income and savings or, if necessary, loans, are unable or unwilling to tap the same sources for preventive and health promotional services. To avoid "unnecessary" expenses, they often postpone the appeal for medical care to advanced stages of illness. For far too many people, especially in the wide layers of the middle-income groups, "medical care" is still identical with "medical care during serious illness."

The third premise for the operation of a health maintenance program, therefore, is that the program is financially within the reach of families and that they are able to budget its expenses. Prepayment for medical services appears as the best workable solution of this problem: regular payments are made by all during periods of well-being and earning, instead of the accumulated expenses being borne during periods of illness by those unfortunate enough to be sick when decrease or interruption of income frequently occurs. It is necessary then that the families be members of voluntary prepayment medical care plans providing comprehensive services under financial arrangements acceptable to them. Today more than fifty-two million Americans defray their medical expenses in part through such plans and in New York City as elsewhere voluntary health insurance plans are extending their coverage of services to more closely approximate the comprehensive type of medical or

health program which we envision in our family health maintenance demonstration. Lest our comments be misinterpreted we are well aware of the fact that our proposed project, particularly during its testing and demonstration period, will require financial subsidy beyond the contributions made by subscribers. We are confident, however, that its costs will ultimately be brought down to levels which the average wage earning family can well afford to pay.

4. The fourth, and not the least important, premise for the successful operation of this program is that individuals and families wish to remain well and to improve their health; given the opportunity to do so, they will enroll voluntarily and cooperate wholeheartedly with the staff in an intelligently planned health maintenance program. More and more people are realizing that good health is "not a gambler's luck," as Dr. Alan Gregg has phrased it; nor is it only a privilege—but a challenge and a responsibility.

For many families it may, in the beginning, be difficult to comply with the various demands of the program as, for example, the initial health inventory, the periodic thorough health examinations, consultation on family problems of which they have not previously been aware, and therapeutic procedures of a new and extended character. Some people may not be ready to accept such a service, others may become indifferent or develop hostile attitudes in the course of time. Much careful and patient interpretation on an individual-family basis may be required to build up a steady, continuously cooperative clientele.

In concluding, may we add a few words about the magnitude of the demonstration we would like to initiate. Earlier we have mentioned that the operation of the demonstration postulates that the program be incorporated within the framework of a voluntary prepayment comprehensive medical care plan with the services rendered through carefully organized groups of physicians and professional co-workers. Theoretical considerations and the practical experience of several organizations op-

erating in different parts of the country have indicated that such group practice units providing comprehensive care on a prepayment basis, operate most efficiently when they serve a clientele of not less than 20,000 persons or between 6,000 and 8,000 families. It is a project of this size with which the program of family health maintenance should be associated.

We recognize, however, that a clientele of this magnitude would be too large for the testing of the program particularly since the solution of many of the problems it will pose can only be found through experience. It has been proposed, therefore, that the health maintenance demonstration be inaugurated with an arbitrarily determined fraction of families assured of medical care on a prepayment basis by a group practice unit.

A variety of elements will have to be considered in deciding upon the size of this fraction; limitations of available physical accommodations and of operating funds may favor a relatively small clientele of say 300 families, whereas from the point of view of composition of the medical group and of efficiency of operation, a clientele of 1,000 or 1,500 families may seem more advantageous. For purposes of discussion, the estimates prepared in our report have been based on a clientele of 1,000 families—but these lend themselves to alteration according to whatever size group is ultimately decided upon.

In addition to a restriction in size, it has seemed advantageous, for successful operation of the demonstration and for meaningful interpretation of the findings, to place some reasonable limitations on the types of social problems introduced by member families. The demonstration would doubtlessly be facilitated were the three main adversities to health mentioned by Ryle (7) due respectively to low economic, environmental and educational standards comparatively limited. The area selected for the demonstration should, therefore, be a residential district populated by stable families of moderate income, to whom the health maintenance program should appeal, and from whom the necessary intelligent cooperation can be expected.

Summary

In this brief presentation it has been possible to offer only a superficial and very incomplete outline of our plan for health services for the family. We would like to emphasize, however, that our plan has been formulated as an experiment—an experiment in social medicine, if you will, where the application of the experimental method so highly developed in other branches of medicine is long overdue.

As a research project it is imperative that we list the objectives of our study. This we have attempted to do and briefly they may be summarized as follows:

1. To test in operation a new program of medical care which involves the provision of comprehensive health maintenance services for families;
2. To test in operation a new scheme of group practice of physicians together with members of related professions to provide the services required by such a family health maintenance program;
3. To determine the type and amount of additional services and staff required by such a program and to ascertain how these services can be integrated with medical care as currently rendered and coordinated with the programs of existing community agencies;
4. To determine the costs of adequate family health maintenance services and to explore whether the costs can be included in voluntary health and medical care insurance contracts;
5. To study the attitudes of families toward the program as offered, their reactions to the services received and, particularly, the objective effects of the services on the health of families;
6. To test the training potentialities of a family health maintenance program for medical and other professional students;
7. To study the incidence and prevalence of diseases and disorders in family groups and the interrelationship of biological and social factors in the etiology of disease.

The supreme objective of this as of any other demonstration project is to pave the way for a routine service. The operation of the Demonstration Project in Family Health Maintenance then should succeed in establishing the patterns for effective family health maintenance services as regular features of progressive medical care programs.

References

1. Kershaw, John D.: An Approach to Social Medicine, London, Balliere, Tindall and Cox, 1946.

2. Burritt, Bailey B.: Maintenance of Health: Exploring in New York. *In* The Family in a Democratic Society, pp. 183–193. New York, Columbia University Press, 1949.

3. Richardson, Henry B.: Patients Have Families. New York, The Commonwealth Fund, 1945.

4. Downes, Jean: Chronic Disease Among Spouses. The Milbank Memorial Fund *Quarterly,* October, 1947, xxv, No. 4, pp. 334–358.

5. The most recent description is—Pearse, I. H. and Crocker, L. H.: The Peckham Experiment: a study of the living structure of society. Yale University Press, 1945. The basic ideas of the Peckham program were developed earlier in—Williamson, G. S. and Pearse, I. H.: The Case for Action. London, Faber and Faber, 1931; and Williamson G. S. and Pearse, I. H.: Biologists in Search of Material: an interm report. London, Faber and Faber, 1938. For a summary report *see* Baehr, George: The Peckham Experiment. Milbank Memorial Fund *Quarterly,* October, 1944, xxii, No. 4, pp. 352–357.

6. Patients Have Families. (*See* 3).

7. Ryle, John A.: Social Medicine: Its Meaning and Its Scope. The Milbank Memorial *Quarterly,* January, 1944, xxii, No. 1, pp. 58–71.

PREVENTIVE MEDICAL SERVICES FOR THE FAMILY

HENRY E. MELENEY, M.D.[1]

IF there is any contrast between Dr. Dublin's subject of "Health Services for the Family" and mine of "Preventive Medical Services for the Family" it is one of definition. "Preventive" is so often used in the purely defensive sense of warding off disease that we may forget its original meaning of "coming before." By this definition Preventive Medicine is the service which comes before disease appears, and it connotes the promotion and maintenance of optimum health.

Our discussion will be directed toward services to the family as a unit. The Peckham Group has called attention to the simple but oft-forgotten fact that individual men and women are not complete biological units, and that only when this union has produced the child is the biological unit complete. This biological unit should also become a functional unit, and that is what the facilities and spirit of the Peckham Health Center aim to develop. In contrast to this, most of our public health programs are aimed at accomplishing certain specific goals with certain groups on a mass scale, and only incidentally related to the family as a unit. This system has been developed to accomplish administrative economy, but it tends to make public health work impersonal and to encourage the attitude that people are specimens of health or disease rather than persons and members of family units. This is the attitude which we deplore in clinical medicine. To overcome it we are teaching our medical students that they should be like the good old family doctor who knew all his patients' personal problems, and that they should practice preventive medicine in its broadest sense as well as high quality curative medicine.

My discussion will deal with the preventive medical services which can be rendered by a physician or group of physicians having supervision of the health of the entire family. It is undoubtedly advantageous for the family to have a single physi-

[1] Hermann M. Biggs Professor of Preventive Medicine, College of Medicine, New York University.

cian who can both guide the family in health practices and treat its members in illness. But this physician should have available laboratory and specialist services such as those provided in a group practice unit.

In discussing these services one must start at some point in the life cycle of the family. It seems most appropriate to start with the premarital period. If the physician has had close enough contact with the family he is likely to know when sons or daughters are contemplating marriage, especially if he has told the family that he would like to give marriage counseling when the time for it arrives. Counseling of premarital partners can usually best be done by seeing them together. The conference should be aimed at an understanding of the physical and psychological aspects of marriage, the requirements for a healthy family, and especially the self-sacrificing adjustments necessary for the continuation of harmony and the development of mature love. A careful history and a thorough physical examination, blood tests for syphilis and the Rh factor and an x-ray of the chest can be supplemental to this conference.

The importance of planning for parenthood is emphasized by our thesis that the family is not a complete biological unit until a child is born. That this event is important in making the family also a complete social unit needs to be emphasized in view of the alarming increase in the proportion of marriages that end in divorce. The possession of children apparently has some deterrent effect upon divorce, but unfortunately too many of the children grow up in an atmosphere of marital strife and become the victims of broken homes. Planning for parenthood should therefore include planning for the permanent adjustment of parents to each other and to their children. This goes back ultimately to the proper selection of a mate, education for which can certainly not be a responsibility of the physician. But he can give information and advice on the physiological and psychological adjustments of marriage in his premarital counseling. He can present the advantages and disadvantages of child-spacing, and, either at this time or after marriage, can

give instruction in the methods of accomplishing this if it is desired. The earlier such instruction is given the more likely it is to be effective in preventing maladjustments, but the practical experience of married couples will often require further counseling at a later time. The family physician should also have available psychiatric, gynecological and genito-urinary specialists who can share with him the responsibility for special problems, such as personality conflicts and sterility, as they arise.

We now move on to the preventive medical services which should be available after conception has occurred. The practice of obstetrics is largely a preventive medical service. Adequate prenatal care includes not only the usual physical examination and interval visits and a blood test for syphilis, but also examinations and instructions for the continued health of the mother and for the production of a normal child if possible. The mother's nutrition must be supervised carefully, any deviation from her normal metabolism must be noted early and adjusted, and special precautionary examinations such as a chest x-ray should be made. Since prematurity is the chief cause of neonatal deaths, instruction should include all known precautionary measures to avoid its occurrence. Preparation by the mother for the arrival of the child, with equipment and instruction in the details of care and feeding, are equally important. Lastly the prospective father must also receive warning as to the physiological and psychological changes of pregnancy, as to patience and equanimity in the waiting room of the hospital, and as to the neglect which he may suffer in the new family program.

Preventive medical services for children have become the chief goal in the practice of pediatrics. The pediatrician in private practice often makes financial arrangements for the supervision of the child in health and sickness on a yearly basis. This should serve as a model for medical service to people throughout life. In addition to periodic check-ups, immunization against smallpox, diphtheria and tetanus must be administered, and reimmunization at appropriate times. Gamma glob-

ulin is an established agent in the prevention or modification of measles. Active immunization against other diseases is also indicated when environmental conditions or residence in endemic or epidemic areas makes exposure a possibility. Tuberculin tests are an essential part of preventive services to children, both to indicate whether infection has occurred and to direct attention to sources of infection. The increasing interest in BCG vaccine may lead before long to its wide use in minimizing the probability of the development of clinical tuberculosis. Dental supervision is also an important part of preventive medical services for children. Orthodontia and periodic check-up for caries should be urgently recommended by the physician, and recent information indicates the wisdom of the local application of sodium fluoride to children's teeth in areas where the water supply is deficient in fluorin.

Nutrition is one of the most important elements in preventive medical services. It begins with birth and extends throughout life. It can follow general principles but must be adapted to each individual, because of differences in metabolism, activity, allergies, availability of foods, religious and family customs, climate and season. In the adolescent period the onset of menstruation in girls has been shown to increase the demand for certain food elements such as protein and calcium, and their deficiency is apparently associated with the development of clinical tuberculosis in infected girls. (1) This also emphasizes the importance of periodic x-ray examination of the lungs at and after puberty.

Recreational counseling may seem to be outside the province of the physician, but in dealing with emotional and behavior problems of both adults and children he can make recommendations which may be of importance. Before the advent of the automobile and the motion picture, recreation in the home, guided by the parents, was more common than it is today. Today parents have difficulty in limiting the leisure activities of their adolescent children to reasonable hours and places. To compete with extremes of unsupervised excitement

and pleasure requires ingenuity and planning by the family, and the physician can cooperate by early guidance and by redirecting unfavorable tendencies. Many behavior problems have a physiological basis, such as reading difficulties in children and alcoholism in adults. Careful observation can frequently discover these conditions early and prevent the development of serious or even tragic complications. Such problems are in the field of mental hygiene, which has become increasingly important in preventive medical service. The beginnings of psychoneuroses lie in physical or mental strains and conflicts, which become exaggerated by repetition and which can most easily be eliminated if detected early. We know less about the fundamental basis of the true psychoses, but it is generally believed that their development can at least be postponed by early recognition of the tendency, and by adjustments of habits and environment.

Vocational counseling is also an activity in which the physician can share an interest with parents and teachers. By his familiarity with the physiological make-up of the adolescent children in the family and by observation of their interests and talents he may help them choose a suitable type of vocation and avoid one which might lead to physical or mental illness.

Little can be accomplished in preventive medical service without the intelligent cooperation of the family. The physician rendering such service is therefore primarily a health educator. Although health education in the mass has been adopted by schools, health departments and industries, individual and family instruction is the most effective approach. Every health examination from the prenatal period to old age should be a session in health education, with simple explanation of the reasons for various tests, favorable comment on normal findings and instruction on how deviations from the normal can be overcome or held in check. Such procedures are paramount in winning the confidence of the individual and family in the skill and personal interest of the physician.

In sex education the physician has a function wider than a

mere statement of the "facts of life" and the dangers of promiscuity and venereal diseases. The Kinsey Report (2) is of value in demonstrating the wide range in sexual behavior from the unrestrained satisfaction of the animal instincts to the natural or self-controlled limitation of sexual activity. But it does not and is not intended to show how sexual behavior may influence physical and mental health or the happiness or fate of the family unit. I believe the physician has a function here in judiciously guiding youths and adults into a point of view which will be conducive to their well-being, without developing repressions which will lead to neurosis. The diversion of some of this animal energy into productive avenues of physical and mental activity is surely beneficial. Indeed the advancement of our civilization toward peace and culture is in proportion to the wise control of our animal instincts.

Safety education is another field to which the physician can contribute. A recent report of the Bureau of Medical Economic Research of the American Medical Association (3) shows that in 1945 accidents were the most important cause of death in the United States from the point of view of working years lost, and the second most important in life years lost. This does not include the tremendous amount of temporary and permanent disability caused by accidents. Physicians must keep this in mind in their instructions to mothers and in attempting to promote and maintain health at all ages. They can be especially helpful in studying the habits and reactions of accident-prone individuals and in suggesting precautions against the repetition of such occurrences.

We have now completed the life cycle of the human family, but it is necessary to follow the life line of the adult members during and after the time when they actually participate in the cycle. Their continued health is important in maintaining the family unit until the children whirl off into their new orbits, and after that in maintaining their own place in the social and economic structure of society. If they have learned the value of the periodic health examination they may seek the continued

guidance of the physician, but usually they will require encouragement to do so. The periodic health examination of adults has never achieved popularity because its benefits have not been generally demonstrable. To be effective it must be thorough, instructive, and performed with interest and enthusiasm. The so-called "negative" findings must be translated into positive findings of health. The inventory must show a large credit to the investor. Age landmarks for the development of diseases of later life must be recognized, and special examinations performed to exclude them or accomplish their early detection. Prevention must be aided by advice as to the adaptation of activities to the declining reserve and resilience of the human machine. Not only the aging adult but also the younger members of the family must become familiar with the physical limitations imposed by time, so that they may cooperate in maintaining the integrity of the family unit.

The attainment of this Utopia in preventive medical services to the family is a problem of considerable magnitude. It involves the shifting of emphasis by the medical profession from the diagnosis and treatment of illness to the diagnosis and treatment of health, and the education of medical students in the importance and opportunities of practicing on well people. Our system of solo practice and the tendency toward narrow specialization is not conducive to advancement along these lines. It is said that even in group practice only a special type of physician is interested in the examination of well people. If the pediatricians can take interest in the normal development of children it would seem that proper orientation and techniques could stimulate the practitioners of other specialties to broaden their interests and enjoy the recognition and encouragement of health as well as the cure of disease.

The demands and overhead cost of solo practice are not conducive to the thoughtful and time-consuming work of providing all these preventive medical services to the family. The assumption by public health agencies of the responsibility for an increasing number of preventive activities, and the assumption

by schools and voluntary health agencies of the responsibility for health education have placed these activities on an impersonal basis which does not fully meet the needs of the family as a unit, or of individual members of the family. I would not decrease these activities by public agencies but I would supplement them by more active participation of practicing physicians, and I would encourage the organization of physicians into groups so as to increase their ability to meet a wider variety of family needs and to facilitate a more leisurely approach to family supervision.

A beginning has been made toward providing these facilities in the establishment of fairly complete family coverage by prepaid health and medical insurance plans on a group practice basis. For instance, in connection with the Health Insurance Plan of Greater New York, Dr. William A. Davis, at the invitation of Dr. Boudreau of the Milbank Memorial Fund, prepared a brochure entitled "Preventive Medicine in Group Practice," (4) which presents to the group physician the concept of practicing preventive medicine, and outlines methods by which it can be done. Although this brochure has not yet been distributed to the groups participating in HIP some progress has been made by these groups in providing preventive services. In a preliminary analysis prepared for me by Miss Neva Deardorff, Director of Research and Statistics of HIP, 13,000, or 5.8 per cent of the 224,000 services rendered by group physicians during the six-months period beginning November 1, 1947, were classified as preventive. They included health examinations and immunizations. Of the 5.8 per cent about four-fifths were given to persons who were found to be in good health and one-fifth to persons who were found to have a condition which needed attention. This is recognized as only a beginning in furnishing preventive services. Education of subscribers is necessary to encourage them to seek these services for themselves and their families. Miss Deardorff reports that the Painters' Union, during the first three months of participation in HIP, persuaded 20 per cent of its enrolled membership to receive health ex-

aminations. This was half of the total members who were brought under medical observation during that period. Mr. Irving S. Shapiro, Director of Health Education for HIP, reports that eleven of its Medical Groups are now issuing to their subscribers periodic informational bulletins which emphasize prevention and encourage periodic health examinations.

I recognize that such a service as I have outlined is perhaps far in advance of our expectations for the near future. Some of my ideas may be impractical, and I have probably omitted items which might be incorporated in an ideal program. Such a program will require more and better facilities than are now available, a broader education of physicians, the organization of more medical groups and health insurance plans, the accumulation of experience, and above all, wise leadership. When these things have been accomplished a broader, more constructive and I believe a more attractive field will be created for the family physician, and a gap will be filled in the practice of preventive medicine which will be of benefit to the family and to our civilization.

References

1. Johnston, Joseph A.: The Relation of Nutrition to the Development and Course of Tuberculosis in Adolescence. In Press

2. Kinsey, A. C., Pomeroy, W. B. and Martin, C. E.: Sexual Behavior in the Human Male. Philadelphia, W. B. Saunders, 1948. 804 pp.

3. Dickinson, F. G. and Welker, E. L.:What is the Leading Cause of Death? Two New Measures. Bureau of Medical Economics. American Medical Association, Bulletin 64, 1948. 25 pp.

4. Davis, W. A.: Preventive Medicine in Group Practice. Unpublished manuscript.

DISCUSSION

Dr. E. M. Bluestone: When I listened to Dr. Dublin I was reminded of my days in high school when I sat in the chemistry class and the teacher taught us the Periodic Law of Mendeleef. I remember the diagram on the blackboard showing each one of the elements that had been discovered up to that time in its proper relationship to the others according to atomic weight and so on. Then in the

years that followed, elements were discovered and put into their proper places, and the table seems to be fairly complete by now.

What Dr. Dublin has told us this morning fills in another one of those spaces in the field of social medicine, something that we could very well have predicted but have not been in a position actually to carry out. It all seems very logical; and when you listen to it, you say, "Why not? Why can't we proceed with all these things at once?" We have a hospital at Montefiore which is, to my knowledge, the only voluntary hospital of its kind in existence, a hospital that deals with prolonged illness. Let me remind you that if you solve the problems of prolonged illness, you have solved almost all the problems of medicine. We deal with prolonged illness, and we also have a group practice unit in our hospital. We also have a home care program, because we believe that the patient must be treated not only on an intramural basis, when that is required, but also on an extramural basis when he can be taken care of safely and just as well, if not better, at home. A health maintenance program fits very well into these projects in social medicine.

No matter where a health maintenance project, such as that described by Dr. Dublin, is tried out on a demonstration basis, I hope that the institution will be permitted a certain amount of experimentation. There are, beyond a doubt, a great many obstacles which will have to be overcome and they cannot be overcome if one is too dogmatic on the subject.

I have found that in our home care program and our group unit, the experimental point of view has been extremely valuable to us. We have been able to alter the original plan and adjust it to changing needs and to needs that could not have been foreseen by those who did not come in actual contact with the problem in the hospital and in the home.

Serious consideration must be given to the personalities of the men and women who are chosen to carry out such an experiment. With similar projects our experience has been that where you have the right sort of personalities, your battle is half won. When I brought the home care program to Dr. Cherkasky I felt that his personality was going to mean a great deal in the success of that program. Those of you who are familiar with it will, I think, agree that the point concerning his personality is well made.

Dr. Baehr spoke about the medical schools and about the importance of raising up a generation of medical graduates who will see the value of just such programs as these. I want to remind you that the doctor is still being taught in the medical school how to make a living, and that he makes a living by writing a prescription. Unless you find some substitute for a living for the practitioner, you may come to grief with a very human and very valuable experiment like the one proposed.

The education of the medical student is a very fundamental consideration. It means that we will have to establish the full-time principle in carrying out such things as home care, group practice units, health maintenance, and so on. Here we come up against the graduate of the medical school who is organized in county medical societies, medical societies which are unfortunately still trade-unions that protect the economic interests of their constituent members more than they do their scientific interests. We will also have to find a way, therefore, of reorganizing our medical curricula and also of reorganizing our county medical societies in such a way that we will get support for these projects.

Also, the medical student has to be taught that he is going to deal not only with sickness—and this is a fundamental point—but with unhappiness generally, and discomfort, because this is the essence of the social point of view. And when he learns to deal with sickness, unhappiness, and discomfort, he is a much better physician and certainly in a better mood to receive such projects as we are discussing here.

The point was made that it is not sufficient for a physician during the course of his practice to be "on call." A physician has got to be tenacious in his interest, he must make every effort, unremittingly, to solve the problem before him; and that, of course, I remind you again is dependent on fees. If we can find a way by which the physician will be able to stick to his problem and never let go of it, I think we shall have done a great deal to further the progress of social medicine.

Dr. John H. Dingle: I have been asked to contribute to this subject today on the basis of our experience in a study of families in Cleveland, a study which has been carried on by a group of us, in-

cluding Dr. George F. Badger, who is here; Dr. A. E. Feller; Dr. R. G. Hodges; and Dr. C. H. Rammelkamp. I shall outline briefly some of the objectives that we had in mind when the study was initiated, and indicate the present status of it.

The ultimate objectives of the study approach those which have been outlined in the excellent papers of Dr. Dublin and Dr. Meleney. Our actual work is on a far lower level. We can perhaps state it this way: that we are attempting at the present time to assess the total illness problem in families.

You are familiar with the several similar surveys that have been made in the past. Our approach differs from these in one important respect, which is that we plan to follow the family units over a greater period of years. We set our sights at a ten-year period in initiating the study.

At the present time, we are concerned with the problems of episodes of illness as they can be defined clinically and epidemiologically, and with the problem of determining their causes in so far as is possible by the aid of laboratory technics now available. Perhaps I can illustrate our approach better by presenting to you the development of our ideas along this line.

During the war we were fortunate in having an opportunity, under the auspices of the Army Epidemiological Board and General Simmons, Chief of the Preventive Medicine Service, to carry out an investigation of various respiratory diseases as they occurred in the Army. There were tremendous advantages in dealing with a military population. First of all, we knew what the denominator was in terms of population. Secondly, there were a variety of ways in which the numerator could be determined for any particular problem which was under investigation. For example, on the basis of severity of a given disease, the numerator could be obtained quite readily. Patients were admitted to the hospital with relatively standard criteria, so that hospital admissions provided one level of severity of cases. By going to the dispensary, we could obtain another level of severity; and by going out into the field and interviewing groups of men, which we did for a number of years, we could obtain still a third level of severity. Taking influenza as another example, it was relatively easy to recognize the clinically apparent infections. By obtaining blood from large population units, we could determine

serologically the number of persons who experienced clinically inapparent infection.

As the war drew to a close, we wondered whether it would not be possible to set up a somewhat comparable population group in civilian life, because there were disadvantages as well as advantages to the Army experience. The disadvantages were: first, the Army provided a selected population of limited age; and second, the period of observation of any given individual was generally short, a matter of weeks, or at the most, of months. We were interested in approaching, in a civilian population which must of necessity be stable, such problems as the epidemological behavior of influenza over a period of years and its occurrence in all age groups of the population.

As we considered it further, we realized that there was, even in the Army, a major problem of minor illness, which was brought out by interviewing men in the field. This problem of minor illness, its effect on people, and its occurrence in families or in civilian populations, was one which we thought to be complex and yet important enough to warrant detailed study. On this basis, we decided that perhaps the family unit would be the place to initiate these observations.

A little over a year ago studies were begun with a pilot group of five families. There was at least one child in each family. The parents had a cooperative attitude toward the study and a reasonable expectancy of continued residence in Cleveland. This obviously means that we had a highly selected population group in the middle or upper economic level. After a period of four month's observation, it seemed to us that the approach was feasible and that the occurrence of illness was sufficiently high to provide adequate data. The families were interested; they were cooperative. And so the study has been expanded until now we have sixty families in the group and a total population of approximately 250 individuals. We plan to limit the group to this size for a period of a year, so that we can get more experience and learn what the job involves on our part, as well as to obtain the reactions of families to this sort of procedure.

Briefly, the procedures that are carried out on admission of a family to the study are as follows. The medical history of the family and of all individuals in it is determined. A complete physical examination is done. The usual laboratory examinations of blood and

urine are carried out. In addition to that, a sample of each individual's serum is stored for future use. The children in the family study have periodic examinations every six months; the adults have examinations at yearly intervals.

Each family is visited once a week by a nurse or a physician who obtains a throat culture from each member of the family. The throat culture is for two purposes: first, to give us a reason for going into the home; and second, to follow the spread of bacteria through the family.

The mother is instructed to keep a record of the occurrence of symptoms in individuals of the family when they are ill. That record is kept only during the time when the individual is ill, however, and is not a matter of constantly questioning each individual in the family unit. At our weekly visits we check these records with the mother, and that is the really important part of the weekly visit from our present point of view.

We are notified whenever illness occurs, even though it is so minor that the family physician would not be called. One of the physicians in our group sees the patient, evaluates the illness clinically, and attempts to define and describe the epidemiological behavior of the illness as it occurs in the family: who introduced it, how it spreads, and so on. In addition, laboratory studies are done, in so far as they are feasible, to determine the cause.

I shall not try to summarize the results except to say that the illnesses have been far more frequent than we had anticipated. The episodes of illness in the individuals, in the families, and in the entire population have been quite frequent, and as time goes on we hope to be able to define some of these problems of illness and their subsequent effect on these family units.

THE MANITOBA HEALTH PLAN AND ITS EFFECT UPON THE FAMILY

F. W. JACKSON, M.D.[1]

FOR many years in the rural areas of Western Canada, there has been a growing demand for better health facilities. Every organized farm group has stated, on many occasions that one of the prerequisites of a satisfactory rural environment is the same opportunity for health services which now only urban people enjoy. Such demand has found expression in the passing of health legislation by the Provincial Governments of the three Prairie Provinces, including provision for the establishment of state-supported local health units.

In January of 1945, the Manitoba Government announced the Manitoba Health Plan and provided for its implementation by passing the Health Services Act.

In preparing the legislation, four objectives were kept in mind:

1. The most urgent needs of our people.
2. That the required technical personnel will have working conditions conducive to a high quality of service.
3. That the health facilities provided should have a reasonable chance of being maintained despite any change in the economy of our Province.
4. That the scheme should be so organized that it will readily fit into any plan which may be inaugurated at the Federal level of government.

With these objectives in mind, the legislation made provision for four services:

1. A complete preventive service covering all the Province by setting up state-operated and supported local health units;
2. The organization of prepaid diagnostic facilities;

[1] Director of Health Insurance Studies, Department of National Health and Welfare, Ottawa, Canada.

3. Financial subsidy to local communities for the provision of general practitioners' services; and
4. The building of complete modern hospitals in rural areas.

Through the generosity of the American Public Health Association, the Commonwealth Fund, and the Kellogg Foundation, much planning was done in our Province prior to the passing of the Health Services Act. The most noteworthy studies were two in number:

1. A general survey of our health resources; and
2. As recommended by this first study, a two-year detailed study of the hospital facilities of the Province, particularly those in rural areas.

As a result of the first study the Province, outside the City of Winnipeg, was divided into twenty-five local health unit districts with populations varying from 16,000 to 35,000, depending upon the size of the area being covered. This service is considered the only foundation upon which any worthwhile plan could be evolved. It is a prerequisite in any community before that community can apply for and have brought into operation either the prepaid diagnostic facilities or a subsidy for prepaid general practitioners' service. Both local health service and diagnostic facilities are wholly tax supported, one-third of the cost being raised by the community, and two-thirds being provided by the Provincial Government. All full-time employees in the health units and diagnostic services are employees of the state and are civil servants. Each health unit is operated by an advisory board consisting of local representatives, nominated by the local governments as well as certain persons appointed from the community by the Minister of the Provincial Department of Health and Public Welfare. The medical officer of a local health unit becomes the administrative officer of the diagnostic facilities as and when these are brought into operation in his district.

The staff of a rural health unit consists of a medical director

with special public health training, a public health nurse for each 5,000 population, a sanitary inspector and the necessary clerical staff, usually two in number. The diagnostic services consist of complete x-ray equipment and adequate laboratory facilities paid for from Provincial tax funds. Each diagnostic unit is staffed with the necessary specially trained licensed technicians. Consultant radiological and pathological service is made available on a part-time basis, depending on need.

It is realized, of course, that no adequate health service can be provided in any rural area unless there is some well-developed hospital plan. This was made possible by the implementation of the recommendations of the Hospital Survey already mentioned. The Province was divided into four hospital areas and each area further divided into several hospital districts. The final outcome of this study indicated that we required four types of hospitals:

1. The small outpost hospital, nursing unit, doctors' workshop or health center;
2. The district hospital varying in size from 30 to 100 beds, with reasonably complete diagnostic facilities and capable of caring for most types of illness including ordinary major surgery;
3. The area hospital of at least 100 beds, which will provide all types of service;
4. The teaching hospitals at the Medical Centre in the City of Winnipeg, where the most difficult cases will go from any area or district hospital.

This, briefly, is an outline of the Manitoba Health Plan and, in its operation, the family, in most instances, is the unit through which services are rendered.

The extension of full-time health units to cover all the Province is only limited by the lack of trained personnel. Since the passing of the legislation in April, 1945, approximately 50 per cent of Manitoba's population, outside the City of Winnipeg, has been provided with a full-time preventive service. The people in two health-unit districts have in operation prepaid

diagnostic facilities. Eighteen communities have general practitioners' service, one on a fee for services rendered basis, and seventeen by the employment of a salaried physician.

Eleven communities have voted in favor of raising by debenture issue the money they require for new hospital construction. Four have raised the money they need by voluntary subscriptions and six districts are in the course of organization which, within a six-month period, will result in a vote of the ratepayers to decide whether or not they will take on themselves the financial responsibility of building and operating new hospitals for their people. Because of this activity in the hospital construction field, three modern rural hospitals have been constructed and are in operation. Seven more are under construction and all should be in operation within a year. In five, where the money is already available, construction will start within the next six months, or just as soon as materials and labor can be obtained.

All plans for hospital construction in Manitoba have to be approved by the Hospital Division of the Department of Health and Public Welfare and in each instance we insist that provision be made in new rural hospitals for doctors' and dentists' offices and the necessary space for carrying on the preventive service for the people of the area being served. So we will now hope to obtain, in all our rural communities, a Health Center where all the health activities in the district will be under one roof.

The provision of services under each part of the Plan concentrates on the use of the family as the most satisfactory unit for the provision of health care. The public health nurse, the backbone of any worthwhile health effort, through her home visiting must consider her duties and responsibilities from the standpoint of the family. Prenatal care, postnatal care, infant care, school health services, and general health education are integrated to form a family service. The sanitary officer, particularly in a rural area, is concerned with the family environment, because, with the widespread electrification of rural areas, complete modernization of farm homes is rapidly

increasing and this emphasizes the family and its home as a unit in health administration. In diagnostic facilities, it is the head of each family who gets the necessary card of identification that entitles him and all members of his family to the services available. The same applies, of course, to the prepaid medical care program. Even in the taxation under medical care, the rate of taxation is usually decided on the number of families in the area being served.

In respect to hospitalization in our Province, the Blue Cross now covers approximately one-half of our total population with a wide coverage of rural families.

We have in Manitoba a combined Department of Health and Public Welfare and decentralization of welfare services is being brought about by placing in each health unit a qualified social worker. This is proving to be a great asset in both fields of endeavor, as a complete family filing system pertaining to both health and welfare is now being developed where we have been able to combine both services at a local level. In one district a new Health and Welfare Center has been built and is now in operation. A common filing system and a common clerical staff are in use. Consultation between health and welfare workers, including administrative heads, is accepted practice. The families of this community now have all the services they may require in the health or welfare fields under one roof.

Manitoba's Health Plan is neither health insurance nor state medicine. It provides health services to the family as a tax-supported community utility, with citizen participation. It does not denounce or destroy or replace. Improvement in health facilities is not a matter of making good what is bad but of making better what is already good.

The recently announced National Health Program will make it possible to extend without too much delay the complete implementation of the Manitoba Health Plan. The grants for professional training, general public health, and hospital construction will be of particular importance in this connection. These and grants for health studies, tuberculosis, venereal dis-

ease, crippled children, mental disease, cancer, and public health research will provide ample funds for every Province in Canada to establish adequate services in these various fields. In the words of the Minister of National Health and Welfare, the Honourable Paul Martin: "This program prepares the way for Health Insurance by putting into effect those steps that are essential prerequisites to any adequate National Plan."

When health insurance becomes effective, it should mean that every family in Canada, no matter where that family resides or what its economic status may be, will have everything medical science has to offer for the promotion of health, the prevention of disease, and the cure of illness.

HOW THE HEALTH CENTER SERVES THE FAMILY

HARRY S. MUSTARD, M.D.[1]

THE preceding discussions have all been interesting, some of them for reported actualities, others for described plans. This distinction is made because there is always some danger of assuming that proposed plans are already in operation, and that the goals described in the plans are already facts accomplished. Only time and experience will determine if the underlying premises and assumptions are sound and whether or not the plans will have led to the envisaged goals. To strike a pessimistic note of this sort is always embarrassing, but occasionally desirable, for it would be unfortunate if there were a too-ready acquiescence in conclusions that have not yet been proven.

It would be a great satisfaction, and certainly in keeping with the spirit of this conference, if it could be reported that health centers in New York City operate completely and satisfactorily on a family basis. This assurance cannot be given, for such is not the case. As to whether health centers of the kind operated by the Department of Health of New York City should serve on this basis, or whether this is practicable for the future, is a matter upon which the Department of Health must wait for more light and experience.

It is not to be assumed, from the above frank admission, that no consideration is given to the family in the health services that arise from the health centers. As a matter of fact, many of these services, or rather many of the problems which the services attempt to solve, are of a nature that demands either investigation on a family basis, or coincident service to other members of the family, and sometimes both investigation and service. This, however, is not exactly the same thing as beginning with the family, studying it as a unit, determining its problems, and serving each member, not so much as an individual, but as part of the whole family.

[1] Commissioner, New York City Department of Health.

Obviously, if one group is to give service and another is to receive it, there must be something in the nature of a two-way agreement, inasmuch as there are two parties to the undertaking. On the one hand is the health center with certain programs, resources and policies and, on the other, the families to be served, families with varying constitutions, needs, and mores.

So far as concerns the party of the first part, the health centers, one finds that New York City is divided into thirty health districts and that these districts are served by twenty health centers. Necessarily, in these circumstances, some of the health centers serve more than one district. In addition to the health centers, many of the districts have substations. The latter render specialized or limited service. One might be a child health station; another a clinic for eyes or for rheumatic fever in children. In none of the substations is there a full complement of service.

The population of the health districts vary. The average district has a population of about one-quarter of a million. The largest population served by a health center is 438,000 and the smallest, 130,000.

The professional and auxiliary staffs in the health center reflect, to some extent, the size of the population to be served. The median number of people on the staff of the health center, including all types of personnel, is sixty-one. The range is from 20 to 145.

The services rendered are what might be designated as conventional public health services. These do not include medical care. Thus, in each health center there is provision for child health, dental, chest, venereal diseases, eye, school services, plus health education, public health nursing, nutrition, certain aspects of communicable disease control, and sometimes specialized services. Reporting of births, deaths, and communicable diseases is indirect, insofar as concern the health center, as are activities related to environmental sanitation.

In general, any one of the above mentioned services is instituted to meet a specific need of an individual at a given time.

The particular service rendered may be of such a nature that it will naturally lead to inclusion of other members of the family, but a study of performance does not indicate that the institution of a service by or from the health center is primarily on a family basis.

The services thus rendered by a health center are, inevitably, somewhat impersonal. In the center itself, one is given service at a place rather than by a person. In spite of every effort to offset this institutional atmosphere, there is a tendency to production-line pressure in a tuberculosis clinic, or one in child hygiene or venereal disease; there is need to proceed swiftly and accurately, to take history and make records, to synchronize the preparation and progress of a patient with the fluoroscope and x-ray, with the clinician and the nurse. There is not much time and, after a long session, not much inclination, to indulge in casual conversation or to be thrilled by the social significance of the work that one is doing.

In spite of recognizing these things, and in spite of efforts to offset them, it cannot be said that the health centers in New York City have developed in the people they serve, that warm allegiance and personal faith that patients once had to and for their family physicians. And it seems not inapropos to question whether governmental health centers, generally, have established for themselves any more personal relationship than that just described. In some rural or semi-rural services, where things are simpler, clinic patients know the names of the doctor and nurse and regard them as helpful friends; in some centers, as at Peckham, where health service is only one part of a family club, of which doctor and nurse are members and ever present, acquaintanceship and personal reliance will develop. However, the health center in metropolitan areas does not possess these collateral and cementing relationships, and though, as will be described presently, it serves the family to some extent, it is organized primarily to serve individuals.

But in addition to the above, account must be taken of the multiplicity, even competition, of health agencies in a large

city, and the sometimes highly specialized approach of each such agency. One finds them specialized in terms of the kind of service rendered: maternity; crippling in general or by a particular type of nervous lesion; disturbance or loss of special senses; ill nourishment in general or by a particular metabolic disturbance; organ affected; kind of invading organism. There are other health agencies differentiated by the kind of personnel employed. One may employ and give only the services of a doctor, another only a nurse, a third a health educator, and the fourth a nutritionist. Again, there is always the division between voluntary and official agencies. Sometimes, too, there is a health facility operated from a particular church or faith, or by neighborhood, and even by race. And never to be forgotten is the fact that in the community are physicians in private practice. There is a tradition that they once served as family doctors.

So much, at the moment, for the party of the first part in a possible two-way agreement for health service between health center and family. But the characteristics of the party of the second part are also important. Here it may not be amiss to point out that the "family," as the term is ordinarily used, has roots in both biological and sociological ground. The degree to which the biological influence or the sociological influence predominates appears to depend to a considerable extent upon social pressures in the culture in which the family exists. To say this is neither to condemn the one influence nor to commend the other. It is intended, however, to caution against confusion between the characteristics of the family as a biological unit and its constitution as a social phenomenon. There is probably danger that this is being done; danger that one will ascribe to the modern family those elements of leadership, cohesiveness, submission to common authority and decision, that are to be found in the biological family unit, consisting of a mated pair, living with their young, in a comparatively simple society. Possibly the primitive biological family itself was not as tight as romance or tradition might lead one to believe. Perhaps even

in Victorian families there was insubordination when the young commenced to feel the surge of adolescence and the psychological necessity of establishing their respective self-sufficiencies. Nor may one assume that it was sweet reason which kept the head of the family in authority. It was rather the fact that, for generations, succeeding heads of families had the physical strength and the inclination to beat the daylights out of any wife or child who challenged his will; and that only as a gentler culture developed was this fear of the family head transformed into the honoring of the elders, and the concept that father or mother knows best. If this is so, one might entertain the heretical thought that, as abuse and physical discipline became taboo, the unity of the family deteriorated.

It is of some importance, too, to recognize that the family as a social unit has been and still is undergoing change insofar as concerns its unity. It is not today what it was a century ago, nor is it the same in rural circumstances as in urban. Families are now smaller, and there is a higher proportion of adults; thus in numbers and make-up there is a change in the family itself. The social milieu in which the family finds itself is at sharp variance with that of 1850. Part of the difference between urban and rural families appears to be due to variations in the complexity of this social environment.

The urban family lives in an organized, articulate, and complex community, where resources, amusements, and services are abundant, diverse, and highly specialized; where tradition is likely to be suspect because it has a past, where serious question is raised as to whether parents are, after all, people, and where baby sitters come in one door as a visiting gerontologist goes out the other. Many of these things are doubtless desirable and commendable, some of them necessary, and a few essential. They will, in all likelihood, redound to the benefit of society as a whole and to each individual in society. It is to be seriously doubted, however, that the old family unit of a simpler society will survive insofar as concerns common and sustained allegiance to one physician, one political party, one lodge, one

grocer, one set of aesthetic values or morals. The new may be better than the old, but in the very nature of things urbanized family unity is more and more disrupted by the very benefits and arrangements that society has made for the individuals who make up that family.

The metropolitan family, such as served by health centers in New York City, tends, in one sense at least, to be a sophisticated one. The members of the family, by experience or information, know that there are many sources, mentioned above, from which assistance and guidance may be obtained in matters of health. With this wide choice they are not inclined, as individuals or as a family, to consider themselves clients of a given health center.

Finally, in relation to family and at the risk of heresy, it may not be amiss to inquire whether or not there is a touch of nostalgia in the recent emphasis given to "the family approach" and "the family as a unit." Is it possible that in this emphasis there is a tinge of yearning for the old ways; that because it would be easier to render health service to the family as a unit, there is an envisaged family receptiveness that did not exist in so pure a form as retrospect tends to picture it? In any event, it seems a hard practical fact that comparatively few New York families recognize any necessity or desirability of serving as a unit for the reception of health service from a health center. In these circumstances, the aforementioned party of the second part cannot be considered as an eager client.

It is quite obvious that a certain amount of the above discussion represents speculation, and should be so considered. But regardless of factors that, theoretically, might serve to deter or promote the provision of family service by a health center, or its reception by the family, it would seem worth-while to examine what has actually happened in the New York City situation. Here experience indicates that some services, initiated for an individual, tend more than others to ramify among members of the family.

To a very great extent, investigation and control of acute

communicable disease are on a family basis because the physician or nurse concerned knows the possibility of origin of the disease in the family itself and its potentialities for spread in the household. Further, the family knows these dangers vaguely, and recognizes that certain legal restrictions may be placed upon them. Those in the family, therefore, tend at least to be acquiescent to a unit approach when there is an acute communicable disease.

A quite similar state of mind and receptivity in the family is found in relation to tuberculosis. Even if the family still has the idea that tuberculosis is an inherited disease, it is regarded as a family problem; and those who know how tuberculosis is spread, recognize that they have on their hands a situation that involves the entire family. They will therefore respond to a service reaching much further than the individual who is ill. On the other hand, there is the reverse of this attitude in regard to venereal diseases. This is no family matter from the standpoint of the infected individual.

Infant and preschool services tend to reach or affect other members of the family, for the mother must always be present, with the child, at clinic or in the home, and she and one child constitute at least half the family of average size. Good advice for the child must be translated into action by the mother and, if the child is to receive the benefits of common-sense mental hygiene, both the mother and father must participate.

To a lesser extent but still significantly, dental services to school children are appreciated by the family, and that part of it relating to nutrition tends to change and benefit nutritional habits of the whole family. Similarly, the work done with school children, although done quite largely out of the home in its first phase, does help to bring health education indirectly to the family, and probably influences its hygienic habits to a very considerable extent.

These examples are sufficient to indicate that there is some spread of health service from individual to family. Further, it seems worth-while to record that, of all those in the health

centers, the public health nurse, by the nature of her work, by her training, by opportunity, and by preference perhaps, is the one who most nearly serves on a family basis. An individual may go into a given clinic and the physician may initiate follow-up work, but it is the nurse in the home who really exhibits and puts into effect an interest and service for the whole family. She is the cementing substance, insofar as concerns the metropolitan health center which follows a conventional program of activities.

In summary, it may be said that neither the attitude of members of the metropolitan family nor the circumstances of urban life, encourage allegiance of the family as a whole to any one particular health agency. Health services from centers operated by the Department of Health include the conventional activities but provide neither the inducements of a club nor the financial attractiveness of a medical care agency to which the family has made prepayments. In the circumstances, the health center serves some of the individuals of the family in specific ways rather than the family as a whole in all health matters.

In spite of these deterrents to health service on a family basis, many of the activities of the health center, beginning with one individual, tend to ramify in the family and to reach other members.

HOW PUBLIC HEALTH SERVES THE FAMILY IN A COUNTY

HUGH B. ROBINS, M.D.[1]

THE health department serves families by becoming a member of the team of community facilities that includes the doctor, the dentist, the nurse, the hospital, the teacher, the minister, the many official and unofficial agencies, lay organizations, neighbors, and friends, who are concerned with family health and well-being. It is our purpose to back up the other members of the team, most of whom were playing the game long before we "joined up," and occasionally to "run with the ball' when our signal is called. Since we are a very small group, and are anxious that our assistance be given where it will do the most good, we attempt to find out what health problems the families have, how well they are meeting these problems themselves, what facilities as noted above are available to help, and how well these facilities are being used.

In making this family diagnosis we utilize morbidity and mortality reports, do surveys, develop record systems, compile registers, fill in evaluation schedules, make home calls, join organizations and talk to people. From these data we make a tentative diagnosis that requires daily, weekly, monthly, and annual revision. We attempt to calculate trends.

We formulate plans and develop programs. These plans and programs are entirely dependent upon the problems existent, the degree of adequacy of the health department staff, the amount and kind of community resources, the degree of understanding the families have, and their desire and willingness to do something to solve those problems.

Having just recently attended the Michigan Governors' Conference on Children and Youth, where we were repeatedly told that we must consider the "whole child," it is with hesitation that I speak of anything but the "whole family." Nevertheless,

[1] Director, Calhoun County Health Department, Michigan.

I find it convenient to think in terms of communicable disease control, maternal and child health, etc., etc.

How do we help our families in the matter of communicable disease? What do they require of us? First a word about facilities.

My community has a population of 112,000 which includes 125 physicians, 560 graduate nurses, 308 practical nurses, seven general hospitals with 423 beds, one of which accepts acute communicable disease cases; and another will take poliomyelitis cases. Our public health nursing staff consists of eleven field nurses, including supervision. We have a public health laboratory with a personnel of three, two of whom are bacteriologists. There is one health officer, two public health engineers, one sanitarian, seven clerks, and a statistician.

Our families expect and get public health nursing care in all cases of major contagion; minor contagion cases are visited only upon specific request of the attending physician. Laboratory diagnosis is freely available to physicians for suspected pertussis, diphtheria, streptococcus, and enteric diseases. Diagnostic consultation by the health officer is available. Our joint policy with the county medical society provides for school clinics for protection against smallpox and diphtheria, whenever less than 80 per cent of the children are known to be protected. Pre-school children over 2 years of age are included. The public health engineer in much of his work is concerned with this problem of communicable disease. His work will be discussed later under the general heading of environmental sanitation.

To meet the problem of tuberculosis the health department developed a coordinated plan together with the county medical society, the county sanatorium, and the county tuberculosis association. Under this plan the department operates a portable X-ray unit which is owned and financed by the tuberculosis association. Over 17,000 persons are being screened annually by this method. "Retake" X-rays are done by local roentgenologists or the outpatient clinic at the sanatorium. Our

laboratory provides sputum examinations by smears and cultures. Out of eighty-seven reported cases in 1947, the director of the sanatorium decided that fifty should be hospitalized. Forty-eight of these were hospitalized within sixty days, largely due to the assistance of the public health nurse.

Much of our tuberculosis is concentrated in one urban community of 9,000 people. Here the death rate is much higher than the county average of 24 per 100,000 population. The nurse in this district gives top priority to tuberculosis and devotes approximately one-fifth of her entire time to this activity.

The private physicians are again caring for the vast majority of cases of venereal disease in our community. The health department maintains a daily clinic for persons of low income. The private physicians are slowly but steadily increasing their referrals to us particularly for diagnosis. They have been slow to adopt the routine use of cultures in the management of gonorrhea. On the other hand, we have reason to believe that we are having referred nearly half of the cases of syphilis that have lesions requiring darkfield examination. With the development and availability of the Michigan Rapid Treatment Center, an increasing percentage of patients from our clinic are being sent there for treatment. Within the past eighteen months partly by reason of our public education program our largest high school has developed a required course in "Basic Living." This course includes instruction concerning the venereal diseases.

In reviewing the problems of maternal and infant health we find that during war years the infant mortality rates increased in our area to a peak of 57 per 1,000 live births in 1944, and since then have steadily declined to a rate of 27 per 1,000 live births in 1947. Because of the great importance of this problem a high priority was given to this program, and a community plan was developed with emphasis upon helping the family physician, the hospital, and the expectant mothers. An institute was held for nurses on the care of the premature infant. A committee in the Medical Society accepted the responsibility of trying to improve the practice of obstetrics. Since time did

not permit adequate instruction in prenatal care, attempts were made to form classes for group instruction. The hospitals reviewed with consultants from the State Health Department the physical arrangements, and the practices in their nurseries. With a declining number of public health nurses available, we are now faced with the problem of being unable to assist but a very small percentage of the expectant mothers through visits to the home. Program emphasis by the nursing staff is now being given to the premature infant and the further development of group instruction. Together with the physicians and hospitals we have developed a referral system that is reaching a majority of the prematures. The Health Department has available the two incubators for use in the homes.

In the field of child health we formerly gave much attention to normal child growth and development. Our services consisted of discussions with mothers at home, in group meetings and indirectly by helping teachers to improve their health program. General policies were worked out by committees from the County Medical Society and the School Masters Club. During the past year we find ourselves being limited more and more to those families whose children have special problems, such as orthopedic defects, visual and hearing defects, cardiac conditions, spastics, and the like. Our county register lists 584 children with these handicapping conditions. We have attempted to organize School Health Councils in all school districts and the teacher is assuming an increasing share in help with this program. For example, during the past spring with the aid of a team from Michigan State College, over 4,000 children in the rural schools were examined for speech and hearing defects. In the follow-up, approximately 90 per cent of the speech difficulties are being worked out by the teacher and parent. In approximately 10 per cent, medical and dental care seem indicated and the nurses have assumed responsibility for interpreting these needs to the parents in order that the children may actually receive medical attention. We found that thirty-three were in need of psychometric examinations and the health

officer has been able to arrange for examination of these children at a Children's Center in an adjacent County. We expect that by December 1st nearly 90 per cent of those in need of medical and dental care will be in the process of receiving it.

The amount of bedside care available by our nursing staff is very small. It has been limited after much discussion between community groups and our staff to emergency situations, cancer cases, and special requests from physicians. In this connection I am not thinking of nor including ordinary demonstrations and instructions such as is given at calls on infants.

State Criteria Misleading

Referring back to the problem mentioned earlier of treating the families as a whole, the voluminous records in our Department bear eloquent testimony that our nurses have made a great effort to provide a generalized service when making a home call. It is an unusual family folder that does not show several kinds of services to the various members of the family. It is in this situation where the nurse has discussed many of the problems with the mother that we have made our best contribution in the field of maternal hygiene. In an earlier day the old-fashioned family physician took the time to visit a little with his patients. He developed better understanding and was able to apply better what aids he had as a result. The physician of today apparently cannot give the time that is needed.

When I went to Battle Creek in 1937, the Kellogg Foundation used the term "family health counselor" for the public health nurse and had been using that for approximately six years. That was a good term. Educators, such as Dean Sanders from Syracuse, told us we should keep it, but we regarded it as unorthodox. When the city and county were combined, Battle Creek had six different categories of specialized nurses. So that term has conditioned the thinking of all persons who have worked in our department and it is a good thing.

Under the general heading of environmental health we include water supply, sewage disposal, food and milk control,

accident prevention, and housing. The services of the engineer as it relates to water supply, sewage disposal, food and milk control are basically for the purpose of preventing communicable disease. Families are increasing their requests to the engineer to check their water supply in rural areas. The plans for all houses built with F.H.A. loans are checked by the engineer before the loan is completed. Our rural people and those in villages not served by a common sewer system are taking increasing advantage of our engineering assistance in the installations of their septic tanks. The rural school teachers are greatly assisting in the knowledge of sanitation by developing school-participating programs for the children. In nearly a third of the rural schools in our county this year the first unit of study was one on school sanitation in which the children themselves, together with the teacher, with a little assistance occasionally from one of our own engineers, did their own surveying. In three schools they decided to bring water samples from home. The pay-off on that is considerable. The families now are wanting a lot of services, and some of the school board directors are becoming more interested.

Milk products in our rural area is big business. It required continuous pressure on the part of the Health Department over a period of eight years to secure pasteurization of all market milk. Coincident with this program we conducted a campaign for home pasteurization. Typhoid fever is quite rare in our county and dysenteries in the rural area are not common, but 6 per cent of the cattle and 22 per cent of the herds have been found to be infected with Bangs disease. Three years ago when the leaders of the County Farm Bureau asked us to recommend three of the more important rural health problems for their discussion groups, we listed infant mortality, accident prevention, and Bangs disease control. We had numerous requests to discuss Bangs control, occasional requests to discuss infant mortality, but no requests for accident prevention. This is a curious thing when one considers that accident and infant mortality are both in the first ten chief causes of death.

In the summer of 1947 our Department conducted a housing survey in the metropolitan area of Battle Creek. This survey was planned with the assistance of the committee on housing of the American Public Health Association. It included not only areas of the worst housing in the City but also those in the suburban areas. A report has been made to the sponsoring community organization and a summary of the findings and recommendations will be published in the near future. How did we come to develop this survey? It came as a direct request of the Board of Health that the Health Department take the leadership in trying to do something to improve housing in the City of Battle Creek. Nobody else seemed to be doing anything about it. The Board was aroused as a result of the disclosure of a most insanitary situation in a small apartment where sixteen families were crowded together. The common toilet facilities on two of the three floors were not functioning. We discovered that there was no way in which the Health Department directly could correct this situation, but we were obliged to bring in the State Fire Marshall and condemn the building as a fire hazard. Since partial publication of the housing survey, with articles in the newspapers, we were surprised that the first group to develop action were those people living in a small rural slum. As a result of their irritation at being designated the worst spot in the Battle Creek area, they have developed a community organization, petitioned the township for a zoning law, have petitioned the township for paving, have started a clean-up drive, have employed counsel to search their land titles for restriction clauses and have reorganized a dormant Boy Scout troop. That has had a tremendous impact on the family life of the people in that small area.

In conclusion, it seems to me—and I like to think of my associates' and of my own function in this field of public health, a little bit like that of the family doctor of another era—it is our function and our responsibility to be concerned with every health problem that our families have. We do not regard it as our responsibility to provide all of these types of assistance

needed, but it is our function to coordinate all that exists, so that the family may get the utmost out of what our community has to offer.

THE FAMILY AS A UNIT FOR PUBLIC HEALTH

MARION W. SHEAHAN, R.N.[1]

SINCE so much has been said of public health nursing by previous speakers, it might be well for me to point out how, over the years, these testimonials have been earned. This discussion will concern the development of public health nursing; why the family *is* the unit with which the public health nurse must work; problems which grow out of the health organization pattern in our average community and lastly areas for consideration by official public health administrators and others if the family as a unit for health service is to be a reality.

DEVELOPMENT OF PUBLIC HEALTH NURSING

It has not been entirely the result of purposeful planning on their part that public health nurses have gone ahead of health officers and other program administrators in realizing and demonstrating the inevitability of considering the family as a unit even though the solving of one problem of one member be the immediate purpose of the contact with the home. If this appears to be critical of health officers, the fact is none the less true, for as a group neither through pronouncements nor administrative procedure have these key officials given evidence of full appreciation of the obligations which are implied when a public health nurse enters a family home. The health agency's program might be directed to one area of health such as tuberculosis control. The immediate *family* concern for health may revolve around an acutely ill three-year-old, a pregnant mother, a school child in need of glasses as well as the father who is a tuberculosis suspect. The last mentioned individual may be the immediate concern of the health agency. In terms of the family in order of urgency the acute illness of the baby blacks out consideration of himself by the father; and care for the wife through her pregnancy and provision of glasses for the school child will prove problems which must be dealt with before the

[1] Visiting Professor in Public Health Nursing Administration, University of California School of Public Health, Berkeley, California.

index case in the family in terms of the health department can be placed properly on the road to treatment. By sheer necessity the family becomes the focus of attention.

I was interested in Dr. Sheldon's discussion this morning of the family unit. The people who comprise a group closely enough related that what affects one member will affect another is in a sense the family with which the nurse must work. This group may be the natural family of man, wife, and children; or a mother alone with her children; a grandmother with grandchildren; or any combination of persons who have come together to live in a group. Recently a public health nurse had to deal with a unit made up of five students who had been sharing an apartment during their college life. One student had been diagnosed as a tuberculosis case. The other four students were the immediate family contacts. So the family for the purpose of public health nursing may be defined, in accordance with the United States Census, as a group of individuals who are living in close enough proximity forming a group dependent upon each other in some way and whose actions influence each other.

Early Development of Family Nursing

It was ninety years ago (1859) that the first nurse was employed for family visitation. The philanthropic man, Sir William Rathbone, wanted to give his tenants some measure of the comfort and help his family had received from a nurse trained in the best tradition of that period. He employed her to visit among the sick tenants on his estate. After three months she wished to leave, for the job seemed futile. Babies became ill over and over again from poor feeding and poor care. She saw no good purpose in the work she was doing. Sir William urged her to remain for another period to do the best she could.

With the purely empirical knowledge she had of prevention of disease she began to teach the fundamentals of good housekeeping and proper preparation of food as well as the fundamentals of infant hygiene. By force of circumstances she be-

came a *teacher* of the homemaker as well as a nurse, herself giving certain care.

History tells us that at the end of the second three months she had recognized the possibilities for helping families to live more healthful lives. Soon there were other nurses employed to work with her and gradually the visiting nurse movement was to spread throughout the world.

In our own country it was not until 1885 in Philadelphia that the first nurse was employed to follow the pattern of work started by the Sir William Rathbone's visiting nurses of Liverpool. A group of citizens in the Quaker State added another concept to his. They wished to offer the nursing service for the sick in their homes to people who could afford to pay for it as well as to the poor. So a fee for service was established for those who could pay in whole or in part, or service was given free for those who were in need. (Later this led to the acceptance of contracts with insurance companies for care to their insured clients.)

In Boston a year or two later a third concept of service was added making an agency objective of the spontaneous teaching aspect of the Liverpool nursing. Families in the Boston Nursing Agency were to be helped to understand better ways of securing and maintaining health. The approach to the home was made through the need for nursing of a sick patient, the diagnosis and treatment was outlined by the physician in charge and it was with his approval that the agency did its work in a given family. These nurses gradually added a social service to assist the families by utilizing community resources of any sort available to provide their needs.

Another significant development was in Baltimore in 1899 when Dr. William Osler acted upon the thesis that tuberculosis was a family problem. Voluntary money contributions made possible the assignment of a nurse to the visiting nurse association for the purpose of visiting the homes of tuberculosis patients who were attending Johns Hopkins clinics. According to the definition of her duties she was to find lost cases and re-

turn them to clinic; teach nutrition; how to control sputum to prevent the spread of disease and give general instruction to parents in relation to the nutrition and health of the family. Within a few years several nurses were employed for this work and were transferred to the Baltimore Health Department. Two community health agencies now engaged nurses for home visiting both giving health instruction but using different approaches to enter the home—one through a voluntary agency and the medium of acute illness, the other through the health department to control a communicable disease.

New York City added nurses to its health department for scarlet fever and measles control, tuberculosis, follow-up of school children with defects, and later for ante partum service and syphilis. The widespread interest in health and the advance of medical and social science prompted the organization of many voluntary agencies with special interests and these too employed nurses for home visiting if their programs depended for success upon action from individuals.

Whatever can be said for the finished work of nurse specialists in the health field, the fact remains that where they meet through the family door the separateness which seems reasonable in the health office immediately becomes artificial. The problem becomes a family one even though there are specific points of need and attack. General nutrition, sanitation, housekeeping, application of immunization procedures, general home and personal hygiene, home nursing skill, and attitudes in general all influenced the management of a specific health problem of one member of the group. It soon became evident that the specialized approach was uneconomical and in long range not effective. It left the homemaker to sort out the values of teaching and advice from several persons. The classic illustration is the story that six workers from community agencies or possibly from the health department visited one home in one morning, inviting rebellion from the mother. This may not be exaggerated, for I myself was the fourth on one occasion, two being from my own agency.

After preliminary studies and some experimentation, health departments began to assemble their nursing programs into one coordinated service which has been called generalized. It has been well demonstrated that a well-prepared health nurse can interpret the programs of the health department and obtain good results measured by such specific evaluations as: number of children immunized at the desired ages; number of pregnant women referred for early medical care; number of babies breast fed, or the number of tuberculosis patients hospitalized. Well-defined objectives, good supervision, and the advice of well-equipped special consultants are the aids to successful general public health nurses. The gradual formation of good health departments following the standards of good public health administration has demonstrated the methods to utilize good consultation in the various phases of health which the nurse must use in her home instruction. Specialized nurses, physicians, nutritionists, medical social workers, health education specialists are now available resources open to her in many situations.

A summary of a case record of a nurse in a rural health department program will serve to point up the relatedness of the family problems to the specific purpose of the visits.

A hospital requested a nursing visit to help an aged patient to care for herself at home following a colostomy. The resume below describes the situation as assessed on the first visit of the public health nurse, from a county health department and the initial needs as the nurse summarized them.

This case summary does not depict an unusual combination of problems. It does show a favorable combination of circumstances with every possibility of accomplishing some definite preventive measures, on the one hand, and helping the family to a better understanding of their health problems in general. The direct quotations of the mother's statement are evidences, reasonably objective, to validate the nurse's "on the spot" judgment of the immediate points of approach to the meeting of the major needs. The record itself with its abbreviated observations obviously is the starting point in supervision; every nota-

Family Situation	Resources	Nursing Plan
Maternal grandmother the patient with colostomy Mother—tired—complained of backache—"losing grip" "the family is out of hand" "worried about my brother who has just been sent to the hospital in home town where we lived until 10 months ago" "I miss my friends back home" Father—working—"my husband is afraid of cancer. He's a good man—works steadily—never earned a lot but gives his family everything he has" Baby—5 months. Fretful. Mother tries her best "to feed baby by the clock" Two preschool children 3 and 5—neither immunized	Cooperative attitude Mother realizes her need to manage her family better Grandmother not rejected Steady income—$45 a week House adequate even though small Grandmother has small room alone Bathroom in house Preschool children appear bright and quickly friendly	Assess home. Help grandmother plan for dressings, irrigations, etc., with least disturbance of family routine Discuss diet and general health regime Look into cost of dressings (Cancer Society if needed?) Change attitude re cancer Encourage mother to select physician and go to him for physical examination Baby to C.H.C. (Child Health Conference). Teach mother new concepts of infant care. Loan S.B.C. next visit (Spock's Baby Care) Stimulate parents to secure immunization for children Entire family chest examination and X-ray (Possibly mother would like "Parents' Class." Might help her loneliness)

tion is meaningful, and while subject to change during the period the nurse will visit that home, her plans are safely based upon the objectives of the health department. If a new nurse took over the home she should have a comprehensive understanding of the family and a knowledge of the approach of the first nurse. Continuity would be assured in the transfer of nursing work from one to another.

I trust the above case record will convey to you how the nurse contributes to sickness care, to prevention of disease and promotion of health and how she works harmoniously under the prescription of the patient's physician in the nursing care aspect of her work and simultaneously follows the program of the health department.

After preliminary studies and some experimentation, health departments began to assemble their nursing programs into one coordinated service which has been called generalized. It has been well demonstrated that a well-prepared health nurse can interpret the programs of the health department and obtain good results measured by such specific evaluations as: number of children immunized at the desired ages; number of pregnant women referred for early medical care; number of babies breast fed, or the number of tuberculosis patients hospitalized. Well-defined objectives, good supervision, and the advice of well-equipped special consultants are the aids to successful general public health nurses. The gradual formation of good health departments following the standards of good public health administration has demonstrated the methods to utilize good consultation in the various phases of health which the nurse must use in her home instruction. Specialized nurses, physicians, nutritionists, medical social workers, health education specialists are now available resources open to her in many situations.

A summary of a case record of a nurse in a rural health department program will serve to point up the relatedness of the family problems to the specific purpose of the visits.

A hospital requested a nursing visit to help an aged patient to care for herself at home following a colostomy. The resume below describes the situation as assessed on the first visit of the public health nurse, from a county health department and the initial needs as the nurse summarized them.

This case summary does not depict an unusual combination of problems. It does show a favorable combination of circumstances with every possibility of accomplishing some definite preventive measures, on the one hand, and helping the family to a better understanding of their health problems in general. The direct quotations of the mother's statement are evidences, reasonably objective, to validate the nurse's "on the spot" judgment of the immediate points of approach to the meeting of the major needs. The record itself with its abbreviated observations obviously is the starting point in supervision; every nota-

Family Situation	Resources	Nursing Plan
Maternal grandmother the patient with colostomy Mother—tired—complained of backache—"losing grip" "the family is out of hand" "worried about my brother who has just been sent to the hospital in home town where we lived until 10 months ago" "I miss my friends back home" Father—working—"my husband is afraid of cancer. He's a good man—works steadily—never earned a lot but gives his family everything he has" Baby—5 months. Fretful. Mother tries her best "to feed baby by the clock" Two preschool children 3 and 5—neither immunized	Cooperative attitude Mother realizes her need to manage her family better Grandmother not rejected Steady income—$45 a week House adequate even though small Grandmother has small room alone Bathroom in house Preschool children appear bright and quickly friendly	Assess home. Help grandmother plan for dressings, irrigations, etc., with least disturbance of family routine Discuss diet and general health regime Look into cost of dressings (Cancer Society if needed?) Change attitude re cancer Encourage mother to select physician and go to him for physical examination Baby to C.H.C. (Child Health Conference). Teach mother new concepts of infant care. Loan S.B.C. next visit (Spock's Baby Care) Stimulate parents to secure immunization for children Entire family chest examination and X-ray (Possibly mother would like "Parents' Class." Might help her loneliness)

tion is meaningful, and while subject to change during the period the nurse will visit that home, her plans are safely based upon the objectives of the health department. If a new nurse took over the home she should have a comprehensive understanding of the family and a knowledge of the approach of the first nurse. Continuity would be assured in the transfer of nursing work from one to another.

I trust the above case record will convey to you how the nurse contributes to sickness care, to prevention of disease and promotion of health and how she works harmoniously under the prescription of the patient's physician in the nursing care aspect of her work and simultaneously follows the program of the health department.

The possibility of approaching the family as a unit as described above is simplified where only one agency provides the public nursing. In rural areas for the most part it is possible to develop one nursing service under the organized health department, and while sickness care is limited it is given to some extent and the way is clear as staff and budget permits and policy is declared.

In large centers there will usually be found a visiting nursing service to which sickness care is referred by every other health agency; a school nurse who visits the homes in the interest of the school-age child and the health department nurses who visit for the purposes of that department. Inter-agency relationships and a true effort to coordinate service to the family in recognition of the unity of health problems, has brought about a system of referrals, scheduled conferences, exchange lists, etc. but at best a multiplicity of agencies all with the same broad purpose, each dealing with segments of a whole is bound to bring about problems in coordination. There is apt to be a wasteful use of personnel, all too scarce, and may leave urgent health needs uncovered since no one agency assumes the coordinating function. There is a conflict between our patterns of community organization and the consideration of the family as a unit.

Considerations of Importance—Summary

A few factors might be considered of primary importance in the promotion of good public health nursing for a family, some of them on the way toward accomplishment and others needing decision.

1. Well-organized health departments adequately directed and staffed are basic. Comprehensive nursing for a family cannot be provided for any community where a strong leadership is not given by a health department. An assessment of the work of community agencies providing nursing wherever multiple agencies exist should be made with the best interest of the family in mind. Re-alignment of functions, elimination of

agencies if need be, and a reorganization if need be are not impossible accomplishments.

2. There is need for a clear-cut definition of the goal for family nursing service by health departments, that definition embracing the three-fold function of promotion of health, prevention of disease, and instructive visiting nurse service to the sick. Only in the light of this definition can decisions as to organization and coordination be made. A structural adaptation should be possible to accomplish a desired goal even in view of our complex community patterns for health.

3. There is needed a consistent and persistent program of public education to bring about understanding and support of a new pattern of nursing education to the end that professional nursing education incorporates the preventive aspects of nursing and the bases for public health. Such graduates would be ready for staff positions in health agencies without further preparation.

4. The present demand for public health nurses makes imperative increasing subsidies from federal and state sources for education at the undergraduate level as well as the advanced.

5. There is great need for pilot studies to test established ratios of nurse to population; to study the types of personnel needed in the light of added services and to study methods of practice and teaching.

6. There should be serious consideration given to methods of financing this service of such potential growth if the nation is to be covered to utilize all the resources of official and voluntary support in such a way that unified approach is made possible to the family.

DISCUSSION

Dr. V. L. Ellicott: These excellent papers describe health services in Manitoba; New York City; and Calhoun County, Michigan—three areas blessed with services far above prevailing standards. Our country as a whole presents an uneven picture of public health. Many places have almost no services. Even where there is an organized health unit, the services are usually limited and scattered with

many gaps between them. Many small communities still have only a health officer, about two nurses, and a clerk. Even if the area can boast of a good rating in conventional health services, as listed in the American Public Health Association's Evaluation Schedule, such services, as mental hygiene and care of chronic illness, which are not listed on the Schedule, will probably be quite deficient or non-existent.

The important question is, What health service does the family receive? If a health unit is functioning in the area, family health service will be derived from it in the form of public health nursing and clinic services. Families will, of course, also receive private services from hospitals and from doctor's home and office calls. Better coordination between the health department and the private services is much needed.

In my own County we had to start with a health officer, three nurses, and a clerk. Over a period of sixteen years we gradually obtained more funds, principally County funds, and now we have a staff of sixty-one. This process of expanding the under-sized local unit must be accomplished primarily from local funds. Rarely, if ever, is a local health program so nearly complete that no further expansion is needed. The principal responsibility of the local health administrator is, therefore, to place his program on an expanding basis. This in turn will be possible only through strong support from citizen cooperation.

The public health nurse is one of the best persons to use not only for family health service, but to enlist citizen cooperation. Nurses can recruit volunteers to serve in health department clinics, and these volunteers, under the leadership of the nurses, can become a most important group in securing citizen cooperation and interest.

The public health nurse is in a key position in respect to family health service because she is the one to bring the family and the facilities together. Her efficiency, therefore, increases as more facilities become available. The nurse of twenty years ago could accomplish much less because she was forced to recommend services which were hard to obtain. The nurse's efficiency also increases as she acquires through experience many of the skills of the medical social worker in solving medical and social problems.

The way to serve the family best is to begin by finding out the specific health needs. This may mean a diagnostic examination in

a clinic or doctor's office. The examination should include mental and social health as well as physical. After this examination or study, the family should have the benefit of any needed therapeutic or rehabilitation service.

The wise public health nurse will strive to help those who can least help themselves. This means the underprivileged group. In rural areas it includes particularly the remote families. These families present a transportation problem. Frequently they cannot get from their homes to the health center clinic. In our County our Public Health Lay Council has solved this serious health problem by providing two station wagons and drivers for clinic patients. These are busy almost every day and they bring in the type of patient who is in greatest need of health service.

To summarize, the approach I suggest is that of building up in the community the services which are basically needed for maintaining good family health. Public health nurses and other health workers should at the same time be made available in order to bring the families and the services together. Finally, a plan for diagnostic examinations should be made so that the specific health needs of each family can be ascertained and used as a basis for any treatment which is needed.

Dr. V. A. Van Volkenburgh: There can be no disagreement between the planning group and the health-program administrators as to the significance of the family and particularly "family health" in its broad concept as of fundamental importance in obtaining desired health objectives. Those in public health practice have accepted it as a truism requiring no elaboration. However, the family group is only one of several population units with which the administrator must concern himself. The over-all objective of public health is universally recognized as total community health, the community consisting of families. On the other hand, the medical practitioner is primarily concerned with a specific illness in a specific person. Those of us accustomed to public health "jargon" may be at fault since we speak glibly of venereal disease control, tuberculosis control, etc., as if our public health concern began, was centered, and ended in controlling a specific disease entity and that we are blind to other health situations in the family. If this is so, we have no

business in public health. However, nothing could be further from the fact. The listing of the various health projects comprising the health program as a whole indicates only one thing, namely, these are specific conditions about which something is, can be, or should be done to improve family and community health. As additional personnel and new preventive knowledge become available, other projects may be added to the list.

In executing a broad public health program, a start must be made somehow to gain access to the home. One may knock on doors. A pertinent and personal reason is desirable. Such reason is usually a report of a specific health maladjustment received in routine fashion, by the health department, a neighbor's remark, or the result of mass case-finding efforts. Once entry is gained and confidence established, it is not only expected of the health worker but a routine practice in good health departments, to place in effect those measures which will result in optimum health for every member of the family. In this connection the resources of all public and private agencies are called upon for assistance as needed even to the extent of job placement. This was gone into in some detail by Miss Sheahan.

Perhaps as a result of Miss Sheahan's remarks, she has given the impression that the nurse is the only person conscious of, concerned with, or having anything to do with "family health" as such. I do not believe this was her considered intention. The health officer is not, of course, a nurse and is not expected to act in such capacity. He is responsible for the work of the department, for program planning, and for directing the work of the department and its employees. I do not need to go into further detail except to state that one of his jobs in obtaining optimum community health is to see to it that each of the various nurses employed to assist him renders as complete a family health service as facilities and priorities permit. To obtain the objective of "family health," the health officer is concerned with every family and member thereof carried by each of the several nurses. He makes available the services of himself and of other health department employees according to their respective skills and responsibilities when in his judgment their services are needed.

One underlying reason why family health services are now seriously curtailed is the lack of trained public health workers. Competing with the personnel needs of existing health unit services is an inten-

sive promotional campaign for new health units by such agencies as the National and State Health Councils, Parent-Teacher Associations, etc. Personnel shortages in public health have been discussed at various governmental levels without visible results. The problem should be tackled afresh. Some agency, such as the Milbank Memorial Fund, could render a significant service by calling the "best minds" together to discuss the problems until success is achieved.

Marie L. Johnson: In any discussion of public health nursing in relation to the family as the unit of health, one must keep in mind the fact that everything we, as public health nurses, work for is part of the larger program of health and social welfare, the objective of which is better health for all citizens of the community. In order, therefore, to gain success we must integrate our service with that of other professions working toward the same goal—first, with all branches of the medical profession since our service is, in reality, an extension of medical care; second, with that of representatives of the allied professions which are closely related to our own field, such as nutritionists, physical therapists, occupational therapists, medical social workers, health educators, etc.; third, with the teaching profession since it, too, is vitally concerned with health factors which improve or disturb the natural pattern of child growth and development; fourth, with all branches of the social welfare profession since the result of our efforts hinge directly on social betterment, whether this be in the field of material relief, social case work, or recreation. In all these professions, including our own, there is an interdependence of each upon the other, and only through integration of effort can maximum results be achieved.

Because the public health nurse, more than any other worker in the health field, establishes personal contact with the families in her community, she is frequently the initiator of concerted action on the part of all the professions involved in the problem.

Whether she enters the home to give care to an individual already under medical care or to give health instruction, the public health nurse is afforded an opportunity to observe the total health situation in every family visited over a period of time. When she enters the home to give direct assistance on health problems which are of concern to the family, she readily gains their confidence so that they discuss their health and social problems freely. In addition, the ob-

servant nurse cannot fail to observe tension, fears, and conflicts if they are present in the home situation. An awareness of the bearing these may have on the treatment of the individual's illness enables the nurse to render invaluable service to the physician in his diagnosis and treatment of his patients. Often, too, the nurse can, through interpretation, gain the family's cooperation for tests and other procedures which may have been advocated, but which the family has resisted because of fear of the unknown. Also, many health problems which have not been recognized by the family are uncovered by the nurse. Frequently she succeeds in securing the family's cooperation in seeking medical care.

Often the problems uncovered by the public health nurse are not confined to organic disease. They are related, however, to the newer concept of health which includes the social and psychological factors likely to disturb the health of the individual and his family. As Dr. James Plant said in an article: "The public health nurse usually sees the gathering cloud of the storm long before the family recognizes it as a storm."[1] To handle these clouds before the storm successfully may require the services of other community agencies. In that case the public health nurse can render an important service by interpreting the programs of these agencies to the families and later, by synchronizing her efforts with that of other workers with specialized skills in the overall program for the solution of the problem.

As an illustration of this I should like to quote from a case story submitted by one of our nurses who is employed in a community where there is a lack of social case workers. Due to this it was necessary for the nurse to do the follow-up work usually handled by social workers.

> The nurse was called to the Adams home because three-months old John was having difficulty with his feedings. In the course of a few visits, here is the story which unfolded before the nurse:
>
> The family consisted of the father, the mother, and three children, Ted, aged 12, Matt, aged 9, and three-months old John. The father was an electrician and worked nights. The mother was extremely tense and nervous. She was a poor home manager, keeping her house in a constant state of confusion and uncleanliness. Both the father and the mother showed faulty judgment in han-

[1] Plant, James S., M.D., The Public Health Nurse as a Medium for Mental Health. *Public Health Nursing,* January, 1947.

dling the family funds, and, not surprisingly, evidence of a poor relationship with each other. Ted, the 12-year old, was the chief source of worry to both parents. He had several petty larceny charges against him. Matt the 9-year old, seemed to be a normal child except for overweight. The baby, in addition to inability to retain his feedings, had a severe body rash. He had obviously had inadequate care for some time, although his mother showed grave concern for him, concentrating her attention on him to the exclusion of the other children.

Baby John was the first concern. Because of lack of funds, the mother felt it was not possible to consult a private physician, but she agreed to take him to the Infant Welfare Station. The physician in charge gave Mrs. Adams a formula, with instructions on how to prepare it, and instructions on skin care. The nurse made a follow-up home visit to demonstrate the preparation of the formula and care of the skin. She continued home visits for some time. Sometimes she met with encouraging signs of improvement in the mother's care—always reflected in the baby's condition. Sometimes the mother had reverted to her old carelessness, and the baby's troubles revived. Each time this happened, the nurse again reviewed the instructions for the baby's care.

The next step the nurse took was to discuss with the parents the desirability of some group activity for Ted, possibly with a nearby Boy Scout troop, and the need to consider an overall plan for him including more attention and recognition from his parents. Ted's problems were then discussed with the Scout Master who agreed to help the boy. Later swimming arrangements were made for him at the Y.M.C.A. and a plan for three weeks at camp in the summer was made, with expenses borne by the local Kiwanis Club. In spite of this, Ted's behavior continued to be a problem. A conference was then arranged between the nurse, the Scout Master, the guidance teacher and the nurse at Ted's school. Plans for more concentrated effort for helping the boy were made.

Meanwhile, in her vists to the family, the nurse discussed the family's nutrition problems and food budget, with special reference to efforts which would bring Matt's weight down to what the school physician said it should be.

The plan for the family was modified and adjusted as circumstances indicated, but always oriented to help the family toward self-direction. The success of this teamwork might be measured by contrasting conditions on the nurse's last visit with those of her first visits.

The baby was gaining, was clean, and his skin was clear. The family's diet had become more nearly what it should be, and Matt's weight had come down to normal. Ted was attending Scout meetings regularly. His behavior had improved to the extent that he had been made a junior policeman at school. The father had switched to day work and was taking a more active interest not only in Ted, but in painting, repairing, and rearranging the long-neglected home. The mother's nervousness had decreased as Ted's problem lessened, and as the baby responded to better care. She was doing a better job all around.

All these observations indicated that a start, at least, had been made by the Adams family toward greater security and a more stable home life.[2]

To get results like this, a public health nurse must have a sincere interest in, and sympathetic understanding of, the people with whom she works. She must have, too, a maturity of judgment which enables her to help the family toward self-direction. Her share in any solution of health problems embodies the gaining of the family's confidence, the art of skillful questioning, the faculty, as Dr. H. B. Richardson says, of "Listening with a purpose,"[3] patience in repetitious health teaching, skill in interpretation of community resources, and an ability to work with, and through, representatives of all agencies in the community. Perhaps all public health nurses need to equip themselves to fit the description given by Dr. Cameron, Deputy Commissioner of National Health in Canada, who in an article writes, "Public health nurses are expected to have the wisdom of Solomon, the patience of Job, the tirelessness of Superman, and the ubiquity of rain."[4]

[2] Stanborough, Grace: The Nurse as a Resource Guide. *Quarterly Bulletin for Metropolitan Nurses,* April, 1948.

[3] Richardson, Henry B., M.D., PATIENTS HAVE FAMILIES. New York, Commonwealth Fund, 1945.

[4] Cameron, G. D. W., M.D.: We Pull Together. *The Forum,* Victorian Order of Nurses, June, 1948.

WELFARE MEASURES AND THEIR EFFECT UPON THE FAMILY

GEORGE F. DAVIDSON[1]

I WILL start off by saying a word of praise for the very orderly arrangements that have been made in connection with the planning of this program. I don't know whether or not it has escaped your eagle eye that there is a very particular pattern in the arrangement of the program. If you will look at the program for yesterday morning's discussion, you will find that it was started off by an Englishman and wound up by a representative of the United States of America. Yesterday afternoon Dr. Jackson, my colleague from Canada, started off and the Americans came on in force in the latter part of the program; and the order for this morning is the same. All of which is simply to prove that it takes the British Commonwealth to start the trouble and the American Republic, not only the Marines, to clean it up. I reserve judgment, however, on whether we shall be in more or less trouble at the end of this discussion than when we started.

You have given me a very embarrassing and difficult assignment, Mr. Chairman, in asking me to discuss in brief compass the whole field of "Welfare Measures and Their Effect Upon the Family." Others of you have taken specialized segments of the health field and have discussed those to your hearts' content; but I will have to do what I can to give you some observations on welfare measures and their effect upon the family.

I must say, first of all, that there was a little while yesterday when I had some doubts as to whether or not it would even be necessary for me to appear upon the program. As I listened to Dr. Meleney and Miss Sheahan, in particular, taking unto their respective professions all the functions that God has given to man or woman here below—functions belonging to counselors, vocational guidance experts, matchmakers, preachers, teachers,

[1] Deputy Minister of Welfare, Department of National Health and Welfare, Ottawa, Ontario, Canada.

and social welfare workers—I began to feel that I represented just about the most unnecessary profession here upon this earth. I began to think that if we could only find the kind of people fit to be trained for a calling such as they described, then we would have certainly come to an end of all our dilemmas and of all our difficulties.

I think, however, if we were to accept in their entirety the conclusions to which they pointed, that we would find ourselves in a most embarrassing difficulty. We would have a fine course of education set up, a fine profession set up, but no professors capable of instructing the students, and no students who could possibly qualify by their personality or their preparatory work for admission to such a course.

I am therefore going to assume that for a while at least the noble profession of social worker will still be necessary. I am going to proceed on that assumption and give you some observations from the point of view of the social welfare worker.

First of all, I will begin with the usual platitude that prefaces most discussions of social welfare. I will begin with the statement of the basic purpose of welfare programs, the principle upon which it is founded, namely, that the family is the unit of society, and that everything we do in the welfare field must or should be done to maintain the family unit intact.

Now, I say that is a platitude. It is obvious that that should be the directive of our welfare program. I think that most social workers go around thinking to themselves and explaining to their friends that that, of course, is the objective and the avowed purpose of everything they do in the welfare field. I am going to examine for the next few minutes the validity of that principle in so far as it is carried out in practice in our welfare programs, because I think the answer to the question that has been posed to me, namely, the effect of welfare measures on the family unit, is to be found in the examination of this principle that I have stated with a view to determining how far it is carried into effect in our actual day-to-day operations.

Probably you would expect me as a welfare executive proud

of my own profession to argue, in all I have to say, that our welfare measures do tend to achieve this objective, that they are true to their purpose, and that in every conscious step we take in legislation and in practice we keep in mind the direct objective of maintaining the family as the unit of society and of keeping that entire family unit intact. I will therefore begin my argument by giving you some of the ways in which I think we *can* show that the approach of the welfare field is the approach to the maintenance of the family unit as the unit in society. I am afraid, Mr. Chairman, however, that before I come to the end of my time I will be running out of arguments. I may be obliged, in fact, to make a few embarrassing admissions which tend to point in the other direction, which tend to suggest that at times, in our concern with legislative programs and also with practice, we lose sight of our objective and, while our desire may still be to maintain the family as the unit of society, the things that we do do not altogether support that as a purpose.

I think the area above all else in the welfare field in which one can say with complete truthfulness and honesty that the family is the case unit, the unit of approach—that area is, above all, the family case work field. That is an area where essentially, as I think most of you know, private welfare agencies rather than governmental agencies operate. Our family case work services, represented by our typical family agencies throughout the country, certainly have as their avowed objective the maintenance of the family as the unit of society. Their entire program centers around the desirability of holding families together where there are any family strengths that are worth maintaining and where it is not actually to the detriment of the individual members of the family unit that it should be held together.

The purpose of these family agencies is, through discussion with the families, through developing an awareness of the entire family situation, to find out and remedy in so far as possible the causes of family discord. Their objective is to mend and

restore broken homes wherever that can be done on a basis that is fair to all the participating members of the family. The family service agency concerns itself with each and every member of the family unit as an individual; but more important than that, it concerns itself with the structure of the family as the unit in society. The family service agency, therefore, I would argue, is the best example that we can put forward from the welfare field of the approach that we have discussed today and yesterday—the approach of the family as the basic unit of treatment in both the welfare and in the health fields.

The family agency has a twofold purpose, a twofold objective, in approaching any individual family. First of all, as a voluntary agency, it does not, strictly speaking, approach the family; the family or the individual member of the family approaches, rather, the family agency. It presents a problem to the family agency. It is usually a problem that looms large in the mind of one individual member of that family unit. That individual brings to the family agency the problem that is uppermost in his or her mind. From that point on, the family agency has two alternatives: It has the alternative of saying, "This is a problem that this person wants help on. We will solve this problem and do nothing more. We will deal with the problem as it is presented to us." Or it has the alternative of saying, "Here is a symptom of a family difficulty. Here is a sympton of a family situation in which there are probably several difficulties, several problems. Therefore we will follow the approach which traditionally the medical profession has followed throughout its history. We will take that individual, that family situation, and complete an examination of the overall situation, and arrive at a diagnosis at the end of our examination."

No medical men, I take it, would accept the patient's word for what ails him or try to prescribe treatment on that basis. Self-respecting social workers, particularly those operating in family service agencies, have for some time taken the stand that when an individual presents a problem to the case worker,

the responsibility of the case worker is to use that stated problem simply as the avenue of approach to the entire family situation. The case worker then attempts to find out, through inquiry and discussion with individual members of the family, what the total problem is. The worker then treats that total problem, treating incidentally also the problem which the individual has brought originally to the case worker's attention.

In so far as it has been possible to carry out this concept of case work treatment of individual and family problems, I think it is fair to say that this is the best example that we have been able to develop in the welfare field of the treatment of the entire family as a unit.

I am not myself an expert in the case work field but I think that I should add to what I have stated, that there are some difficulties that develop out of that approach—difficulties that you probably do not encounter to quite the same extent in the medical and nursing fields. You health workers have a mystery that you have woven about the public imagination for centuries, a sort of hocus-pocus which some of us see through but a large portion of the public fortunately do not. You can somehow convince the individual that the problem he thinks he has when he comes to you is not necessarily the problem that he has at all. Therefore, with your little black bags and your stethoscopes and these various instruments of torture that you have devised throughout the years, you have been able to lay out a patient on a diagnosis table, even with an ingrown toenail, and have been able to justify to that patient your taking him apart and putting him together again. When he leaves your office, he thinks you have done him a favor.

Unfortunately, we cannot do that in social service work. Our clients object, and sometimes object violently, to this detailed examination of all their family difficulties that seems to arise out of an innocent request for help by an individual to a family agency. Most individuals come to a family agency with the request, let's say, for financial help. They think they have an economic problem. When the case worker proceeds to take

them apart and put them together in her tactful way, trying to probe the sources of family discord, the personality and behavior problems in the total family—the reaction of our client at times when that is not properly done can be pretty violent. The individual feels that he is not getting treatment, not getting attention for the problem he brought, although he may be getting attention for a lot of problems that he did not think he brought with him. He becomes restive under that approach and begins to insist more and more that he be given service for what he thinks his problem is rather than for the whole series of problems which the case worker finds in his situation, and of which he himself was not aware.

I am exaggerating the position. I am doing it deliberately.

But I think it poses a dilemma for the social worker which I think does not exist to the same degree in the health field in so far as the treatment of the family problem is concerned.

We have met this difficulty to some extent in the family case work field by developing latterly a new type of practice to which we have attached the usual jargon; we call it the functional approach to case work. And in so far as I understand the distinction—I hope Mr. Burritt will correct me if I am wrong—between the over-all generic approach and the so-called functional approach, which is relatively new, it is this. In functional case work you deal with the problem that the individual has brought, you give him service with respect to what he has asked for, and when that is done you leave the rest to its own good devices. I am oversimplifying that, but I think it does represent the distinction between the practice that has been carried on traditionally and this more specialized approach which in some respects is more what the individual client himself wants, and consequently in some respects perhaps more satisfying. None the less, I think it holds the seeds of certain dangers, because it represents in my opinion a distinct departure from the approach which has had very real strength in it, namely, the approach to the entire family situation, and the diagnosis of family strengths and weaknesses on the basis of

that total examination. If the functional approach to case work is carried through to its logical conclusion, we will arrive at the extreme position which to some extent has been reached in the field of private medical practice where there is extreme specialization and extreme concern with individual ailments and individual parts of the body but no awareness, no concern with the total man or the total family.

Apart from the family case-work agencies themselves, we have, of course, a host of other types of welfare work being carried on in the private as well as in the public welfare field. Even as I mention these, you will begin to see the extent to which we have failed to keep to our objective of the total family as the basic unit. The minute I say "child welfare agencies" you can see that to the extent child welfare agencies are true to their name, they represent an off-center approach to the consideration of the total family problem. The child welfare agency, obviously, is concerned essentially with the problem of child welfare, the problem of the children in the community; and while a good child welfare agency will, of course, concern itself with the total family situation in which a child is found, or to be placed, its very title, its stated objective indicates that its concern is primarily with one individual in a family situation rather than with that total family situation.

One thing, of course, that can be said for our children's agencies on the positive side is that they are concerned not only with maintaining wholesome family life in which children can live, but they are concerned also with the positive construction, the building from anew, of families in individual instances. We have an opportunity here for really wholesome concentration on the building of strengths in family life. The very act of placing a child in a new family, for example, giving to orphaned children new parents, helping to "create" a family through adoption, giving birth in effect to a family situation—all this offers a rare opportunity for children's agencies to emphasize the strengths of family life and to demonstrate their concern with the total values of that family's existence.

I should like to point out in passing that I think the children's agency does, in a sense, represent one of the more wholesome trends in the development from the past to the present traditions of social work. If you will look back into the history of your early social welfare efforts, you will find what I call the period of institutionalization. At one time every social problem that required action because of the emergency of the situation—every social problem tended to be taken out of the home and placed in some kind of an institution. Your hospitals are an example of that, your mental hospitals, your jails; coming down to the more prosaic types of care, your orphanages, your old people's homes, your poorhouses. People were not treated in their homes; they were not treated as families. They were treated as individuals who had to be taken out of their family situation and given some sort of custodial care elsewhere, because they could not be given that kind of care in their own homes.

The history of social work in the last generation or so, and particularly in the child welfare field—and that is why I bring it in at this point—has been a history of deinstitutionalization, of taking children out of orphanages and developing foster home placement programs or developing adoption programs; of taking aged people, for example, out of homes for the aged and giving them the economic assistance that they require to maintain themselves in the ordinary community, and hopefully in their ordinary family circle. So that there are strengths to be found equally in the programs of these specialized child welfare and other agencies—strengths pointing in the direction of the maintenance of the family life approach. And yet it still remains true that almost by definition the specialized approach of the child welfare program, the specialized approach of the medical social work and psychiatric social work programs all point in the direction of that same kind of specialization with which you have had difficulty in the health field. Consequently, we too face the problem as to how, with a wide variety of specializations—each one concerned with a particular phase of

a problem—we can get an integrated family approach to a situation in which four or five separate specialized skills are all required in a given family situation.

I think it can be said of our field, as it was indicated of yours yesterday, that specialization leads to a fragmentation of our approach to the treatment of the family as a unit. It becomes almost inevitable that the specialist should concern himself with his problem, the problem on which he is a specialist, rather than the total setting in which his problem has to be treated; and where you get four or five specialists, each concentrating on one special phase of a total family situation, you have a fragmentation there that is very difficult to deal with.

I raise very briefly the question in your minds as to whether or not specialization is incompatible with the family unit approach that we have been discussing at this conference. I venture the opinion, without trying to argue at this point, because we have not got time, that specialization is not incompatible with the approach to the family unit; but in an age of specialization we must require, we must put emphasis on teamwork, coordination of effort, coordination of our approach to a total family situation, if we are to offset the ill-effects that otherwise will come from excessive specialization. I cannot subscribe, however, myself, to the point of view that we have to develop generalists who are completely competent in every field. I think it is asking too much of human beings as they are made today in view of the complicated areas of knowledge that we have to be proficient in. I think it is impossible to accept the proposition that we must have one person who is competent in all fields, who must deal with the total family situation in all its many ramifications. I think we have to accept the strengths of the specialists' approach to individual problems, and achieve our objective of a family unit approach to the problem by means which will involve the development of proper teamwork and proper coordination among the various specialists so that by an integrated approach, rather than by a single omniscient approach, we will be able to achieve that total integrated effort

vis-a-vis the family unit as a whole, which is the only successful hope of treatment on a family unit basis.

I should like to add finally, Mr. Chairman, a word or two about a special problem that I think we face in the welfare field today. So far as I can see, this is not as serious a problem in the health field. I think our social welfare legislation presents very special problems to us in the welfare field in terms of this approach to the family unit. Think of legislation in your own minds today, the kind of legislation that you yourselves know best: old-age assistance, aid to dependent children, aid to the blind. There again you have this fragmentation, this specialized approach to individual problems; and I think that one of the problems that we face in dealing with the family as a unit in so far as our welfare measures are concerned is the fact that our legislative structure in the field of public welfare measures tends rather to fragmentation than to the over-all family unit approach.

Of course, in its origins we did have the total family unit approach in the provision of economic maintenance in family homes. We had general relief, if you want to call it that, or general public assistance. It was because we found that we could not develop adequate levels of assistance on that generalized basis that we began, in the early years of this century, to develop a procedure in which we have deliberately chosen, out of the ruck of general assistance, certain categories of people. I am afraid we have deliberately chosen those people who raise the most sentimental responses in the public mind; and we have endeavored to raise the total level of our public assistance program by concentrating on special categories and making special provision for them. I will only recall to your mind that the first category of mothers' allowances—mothers' aid—was developed in the State of Illinois back in the middle of the First World War. That was the beginning of the development of our category program. That particular example is not one that worries me, because by definition the mothers' aid program did make provision for the mother who was left

as the head of the family and all of her children, and therefore we still had support to that family given by legislation on a total family basis.

But then we began to develop other types of assistance such as old-age assistance, concentrating on the problem of the aged person himself, not taking into account fully, at least certainly not in my country, and I don't think in yours, the fact that that aged person might have dependents. We decided we would pay him an old-age pension because he was over a certain age. But did we take into account that he might have an under-age wife, or that he might have dependent children, stepchildren or grandchildren? Did we make provision in our old-age assistance laws for the dependents? In other words, did we approach that problem as a family problem? I say for my country that we didn't and don't do it. There may be some brave souls who will suggest that in the United States or England they do approach it from a family point of view. I will be prepared to argue that also. I will be prepared to admit that both in England and in the United States you approach it to a greater extent from the family point of view, but I still say that the basic approach of all of our countries to these families in terms of our public assistance programs is a specialized, fragmentary approach. It may be that by piecing together these various fragments we get a total composite picture based on four or five pieces of legislation that does provide a living budget adequate to maintain a total family situation, but the very fact that we have had to piece together four or five individual component parts shows that we have conceived those individual component parts on a nonfamily unit basis.

I could give you illustrations of that and would be glad to, if any questions arise on that point in the discussion.

I say again that our legislation in the welfare field has been conceived, in my opinion, on a basis that tends to ignore the family unit as the unit with which we are dealing. By this device of categories, by this device of specialized approaches, by this device that we are now developing in the social insurance

field, trying to insure against certain risks like unemployment, industrial accidents, old age, and so on, we relate the benefits not to family need but to the wages that the individual earned while he was alive. By devices of that kind we are falling short, I think, of what we profess to be our objective, namely, the approach to the family unit as the basic unit of our society.

There are some reasons for this, some difficulties that we face in achieving this objective in its entirety. I have already mentioned the wage structure. Everybody knows that the wage structure in all of our countries is not based on the family unit approach; it is based on the productivity of the individual workman on the assembly line, in the factory, or in the office. None of us is paid in relation to our family responsibilities; we are paid in relation to our skills and their value to our employers. Therefore since our wage structure is not based upon the concept of the family unit but rather upon alleged individual worth, it follows that any insurance program, any program of social insurance, that we develop in relationship to wages—and it must be; otherwise you would be paying benefits during idleness higher than wages during activity—any insurance structure that is developed with relation to the wage structure must likewise, to a large extent, be based on a premise other than the family unit. Everybody knows that our social insurance programs almost in their entirety are based upon the premise that no benefit derived from a social insurance program shall exceed 80 or 90 per cent, whatever the maximum percentage, of wages earned during employment. By definition, your wage structure does not take into account your total family responsibilities; your social insurance program, which is a percentage of those wages at their highest point, likewise cannot take fully into account your entire family unit as the unit of responsibility.

There are other trends I should like to raise and ask questions about—matters about which I am far from certain in my own mind. How can we reconcile our talk today about the family as the unit of our approach, the unit of our concern, when

at the same time we are removing from the family unit certain of those responsibilities that traditionally have been part and parcel of our concept of the family? We have removed in large part in all of our countries the concept of responsibility of children for their aged parents. We have more and more taken on to the community's shoulders the responsibility for maintaining individual members of the family unit. That may be good. We have done it largely because we have recognized that the average family cannot afford to support them. We have not been able to develop a system that will provide families with enough to carry their own family responsibilities, such as those involved in caring for aged parents and other members on the fringe of the family unit. But if we are taking onto the shoulders of the community, because we think it is a good and proper thing to do, responsibilities that previously we accepted as part of the family's responsibility, then I think again we have to recognize that by that very act we may be weakening the family structure rather than acting in a manner that will hold it together.

I am not one of those old-fashioned people, I hope, who says that only by suffering and only by loading people with heavy responsibilities, are you going to maintain that sense of togetherness in the family; but I think that it is a contradictory force that we have accepted today. To the extent that we say the community as a whole must bear the responsibility for these aged people and for these individuals with special needs—to that extent, I believe, we are losing sight of the concept that we profess to hold to: the concept of the family as the integral unit of society. If we really believe that the family is the integral unit of society, we will try to maintain those bonds of responsibility and build our assistance programs more closely around the family unit, instead of which we are taking those responsibilities onto the shoulders of the community and treating the community, I believe, to that extent as a geographical area, a social area, in which a series of individuals rather than a series of families, live.

I think that is all I have to say, Mr. Chairman, with one exception, and that is that Miss Sheahan yesterday gave what was in my mind a very accurate and very graphic picture in respect to the nursing field of a situation which exists in exactly the same way in the social agency field. She outlined for us the difficulties of the specialized approach in the urban areas. She pointed to the difficulties of developing a family unit approach when you have a series of specialized nurses dealing with specialized phases of health in the urban community. We have exactly that same problem in our urban areas in so far as special case work and other programs of assistance go. We have, on the other hand, a picture very much the same as that which Miss Sheahan mentioned yesterday in respect to the rural areas; and here is one of the areas, at least, in which we can offset some of the difficulties that have arisen out of our fragmentized approach in legislation to family problems.

I should like to give you one illustration to indicate what I mean. In the Province of British Columbia, the westernmost province of Canada, they have, like most Canadian provinces, a wide variety of social programs: old-age assistance, mothers' allowances, child welfare legislation, etc. They have social problems arising out of their various institutions and various health programs, in which medical social workers and other social work strengths are required for auxiliary services; but all of those programs come to focus in the rural areas of British Columbia in the district social worker. British Columbia has developed a network of something like 175 district welfare workers, each one of them a generalized social worker stationed in a rural area, in a small town, with a population to serve within a radius of a relatively small area. All the social welfare problems that the British Columbia Government has coming to it, as well as certain ancillary problems that the federal government refers through the provincial welfare service—all those problems in so far as they affect that area come to focus on that individual social worker. So in those rural areas at least, it is possible for that one worker, perhaps serving as many as a

dozen different agencies of government—it is possible at least for her, if she is the right kind of person, to develop an over-all concept of the family need and the family problem.

To the extent that such a generalized approach is possible in the rural areas and, with modification, also in the urban areas, I think it is true to say that despite the fragmentized approach that is characteristic of our welfare legislation, we are still able to maintain some unity of approach to the integral family unit by the use of the generalized case worker.

DISCUSSION

BAILEY B. BURRITT: My experience in welfare work goes back to the first decade of the century. In New York City at that time there was little or no welfare work for families in their own homes at public tax-supported expense. There was no relief for families in their homes, except a trickle of relief afforded by voluntary agencies. There was no workmen's compensation to prevent the breakdown of family life through accidents. There was no unemployment insurance and no old age security through so-called insurance.

The outstanding fact was that families would break up. Children were herded into institutions for dependent children. The aged without means of support went to almshouses and the chronic sick to chronic hospitals. Most families in distress, economically through death, illness, accident, protracted unemployment, or other family economic distress, struggled along preferring to remain in distress even at the expense of increasing the number of deaths, the volume of illness, undernourishment, and gradual deterioration, rather than accept proffered assistance of breaking up the family through institionalizing all but the able-bodied members capable of self-support.

The results were disastrous. Confronted with this threat to the very foundations of family and social life, social morality and social conscience awakened and began to attack the problem. First came workmen's compensation. This was followed during the next two decades by legislation providing allowances for children in widows' families, by old age allowances, and the gradual extension of other forms of relief to the blind, the sick, etc.

Then came the depression of the third decade, with its resultant breaking down of the traditional restraints of the old poor law and

the opening of the gates to implementing modern concepts of relief.

It went further and moved toward the prevention of poverty through social security provisions for unemployment and old age. Meantime the social awakening was leading to more adequate compensation for work performed and the great improvement that this brought to family life through an improved standard of living.

All of this meant an extraordinary change in social life. No longer do we see family life in any significant amount broken up through the disaster of death, sickness, accident, unemployment, and other misfortunes to the economic stability of family life. A very considerable percentage of families have been removed completely from that marginal group which were plunged into poverty as soon as adverse social and economic circumstances overtook them. Social services in a more limited sense of the so-called public and voluntary welfare agencies are freed from giving attention to this large group of families. This has made possible a much more adequate service to the more limited number of families coming to them for care. Social security approaches to these problems, supplemented by the combination of voluntary and publicly supported social services, have not only made the break up of families unnecessary, but have in addition reduced the volume of deaths, sickness, and deterioration in the physical, mental, and moral life of families. Children in disadvantaged families are now better cared for, better fed, better educated, have less sickness, and fewer of them die.

We are now at the point where we are raising the question of where we should go from here. We are observing with much interest the experience of our neighbor, Canada, in granting allowances to children of specified ages irrespective of the economic status of the family, thus helping to tide over that most difficult period in the economics of family life when there are additional members in the family to be supported from the earnings of the breadwinner.

We are observing the interesting experiment in Manitoba and Saskatchewan, Canada, of extending home and hospital medical care to families through special and general revenues of the government without direct charges to them. We are students of the accumulating experience of Great Britain with their National Health Service Act which went into effect on July 5, 1948. We are fortunate in having this experience and that of other countries which have extended security and welfare provisions further than we have in New York to

draw upon before making further modifications in our own program.

It will be seen from this silhouette of trends in the last few decades that welfare measures have modified social life and the functions of welfare services enormously. Social welfare and public health have become politically important. All parties and all political candidates in their platforms and definite programs make reference to further improvements in welfare and health services. Good welfare and health programs have become good politics. And the impact of this upon family life has been enormous.

These significant developments leave us with the question of how far and how rapidly is it wise to go in extending present welfare services. This is now the subject of active debate. How far can the State go in extending welfare work and the so-called security to all families without weakening human efforts to better themselves? How far is it possible to go before diminishing returns appear in national productivity and national income and the leveling off or reduction of the average standard of living? These are some of the unanswered questions which confront us as we study next possible steps in the development of welfare work for families.

THE CHILD HEALTH INSTITUTE IN ROCHESTER, MINNESOTA[1]

BENJAMIN SPOCK, M.D.[2]

THE Rochester Child Health Institute, which from its start in 1944 until its incorporation this year was called the Rochester Child Health Project, has as its concern the physical and mental health of all the children of Rochester, Minnesota, a city of 33,000. It does not function as a self-contained institution, nor are its basic aims very original. Many of the services to which its staff contributes are not new to Rochester. There were well-baby and well-child clinics before; there was a nursery school before. Most of the services to which it contributes are actually under other auspices: the Rochester and Olmsted County Health Unit, the well-child conferences of the Mayo Clinic, the section on obstetrics and gynecology of the Mayo Clinic, and the public and parochial schools. Even its staff is largely borrowed from other institutions: pediatricians and psychiatrists from the staff of the Mayo Clinic, fellows in pediatrics and psychiatry from the Mayo Foundation, and public health nurses from the Rochester and Olmsted County Health Unit and the University of Minnesota.

What is it then? Basically it is a focal point which draws together agencies, individuals and points of view in the field of child health, and then tries to bring them to bear on the children through available activities. When staff and facilities are not available, or not sufficient elsewhere, the Institute may itself supply them. That is why it has three psychologists, one full-time and one half-time pediatrician, a nutritionist and a nursery school supervisor who are its very own, not loaned by anyone else. It also has some secretaries and statistical workers. It has some small offices of its own. In one respect its situation

[1] Published also in the *American Journal of Public Health*, 39, No. 7, July, 1949, pp. 854–857.

[2] Department of Neurology and Psychiatry, Mayo Clinic, and Psychiatrist, Rochester Child Health Institute, Rochester, Minnesota.

is unusual. There are only two private practitioners of medicine in Rochester who are not connected with the Mayo Clinic, and neither of them is a pediatrician. Therefore the Institute has the field of preventive pediatrics and psychiatry almost entirely to itself.

Dr. Henry Helmholz, for many years head of the section on pediatrics at the Mayo Clinic, conceived the idea, won the medical backing of the clinic and the financial backing of the Mayo Association, and persuaded Dr. C. A. Aldrich, who had pioneered in the fields of mental hygiene and child development within pediatrics, to become director. The Mayo Association provided the entire financial support until this year, when the Institute was incorporated in order to appeal for the additional funds necessary if it is to fulfill its broad aims.

I will describe briefly the main subdivisions of the Institute's work.

Prenatal care is carried out in two clinics: those of the sections on obstetrics and gynecology of the Mayo Clinic and the Rochester and Olmsted County Health Unit in the city hall. The latter is staffed by public health nurses, the Institute nutritionist and fellows in obstetrics from the Mayo Foundation, supervised by a Mayo Clinic staff consultant. Prenatal classes for expectant parents have been tried a few times in the past with only moderate success. We want to try again when we have more staff and more wisdom. A few obvious cases of emotional disturbance in pregnancy are referred to psychiatry in the Institute, but we do not yet have the staff which we want for the routine psychiatric evaluation of all our prenatal patients.

Practically all Rochester babies are born, at the rate of about 600 a year, in St. Marys Hospital, which is staffed medically by the Mayo Clinic and Foundation. A member of the section on pediatrics of the Mayo Clinic who is also on the staff of the Institute is in charge of the newborn nurseries, and he and a fellow in pediatrics make rounds to see all the mothers daily. This is the first contact between the mother and the Institute

staff proper. A family history is taken. The institute philosophy, with its emphasis on respect for the child's own developmental pattern, self-regulation of diet and schedule, and value of breast feeding, is gotten across through casual conversation on rounds, through the fellow's longer individual talks with each mother, and through printed leaflets, three of which are given during the eight-day lying-in period.

Within a couple of days of going home a public health nurse makes a home visit.

The babies return to the well-baby clinics at monthly intervals during the first year, five times the second year, and twice the third, fourth, and fifth years. There are two clinics, the largest run by the Rochester and Olmsted County Health Unit at the city hall six half days a week and staffed by an Institute pediatrician, Mayo Foundation fellows in pediatrics, and the public health nurses. A smaller clinic for private patients, which meets five afternoons a week at St. Marys Hospital, is similarly staffed except that the pediatrician is a member of the section on pediatrics of the Mayo Clinic.

Again, the emphasis, in the doctor-parent conference and in the leaflets, which are different for each age period, is on what to expect at each developmental stage and how to adjust to it. Dr. Leona Baumgartner of the New York City Health Department, who visited the Institute recently said jokingly that in the usual well-baby clinic you see the doctor talking and the mother nodding, but that in Rochester the mother is talking and the doctor nodding.

Medical examinations are given all children before they enter kindergarten or the first grade, and also during fifth grade, ninth grade, and twelfth grade. In addition, children in other grades are examined if they have had previous lesions or if examination is requested by the teacher, parent, or public health nurse. The examinations are unusually careful as school examinations go, being scheduled at the rate of one every twenty minutes. The parent is invited to be present (for children under high school age), the public health nurse is present

and the teacher is available. The referrals are pediatric, dental, and psychiatric.

The public health nurses are distributed predominantly on a geographic basis so that a family has the same familiar nurse whether at the well-baby clinic, a school health examination, or a sick call.

There is a wise nutritionist on the staff of the Institute who consults in the prenatal clinics and the well-baby clinics, works with the teachers in the schools and takes referrals generally from the public health nurses.

At present there are three nursery schools in Rochester for 115 three-year and four-year olds, organized by a citizens' committee and supervised by an expert from the Institute. Tuition is paid in full or part by parents but some scholarships are provided by service clubs. There is a total of five sessions a day, with two paid teachers for each session. Two of the nursery schools are located in public school buildings through the courtesy of the school board, but there is no other official connection with the public school system. There is also a nursery school run by the Catholic parochial school which the Institute nursery school supervisor advises.

The psychiatric staff of the Institute consists of a half-time pediatrician with psychiatric training, a part-time psychoanalytic psychiatrist who supervises the direct psychotherapy of children, and three Mayo Foundation fellows in pediatrics and psychiatry. There are referrals of early problems from the well-baby clinics, from the schools, from the public health nurses, from the psychologists of the Institute and from parents directly. Once a week there is psychiatric case conference in one of the schools, at which a problem child is discussed from the points of view of teacher, public health nurse, and pediatrician. The emphasis is as much on community management as on psychotherapy, as much on prophylaxis as on treatment.

Mental Health Act funds now are available to the Rochester and Olmsted County Health Unit for a small counselling clinic for adults and children. It will have a psychiatrist-adminis-

trator and a well-trained psychiatric social worker to start with. When it is actually set up the psychiatric staff of the Institute will function as part of its staff in respect to cases which require any appreciable length or intensity of psychotherapy. The simpler problems of the early childhood years which mainly require advice to parents will be handled in the pediatric setting in the well-baby clinics, whenever possible by the fellows in pediatrics, under psychiatric supervision.

The psychologic staff consists of three experienced people who at present are concentrating on a fairly thorough evaluation of all the children as they reach the age of 2½ years. There are three aspects to this evaluation: a Stanford-Binet test, a determination of the child's present adjustment in such areas as feeding, toilet training, sleeping, discipline, and sociability, and a discussion with the parent. In the latter, the child is not compared with other children but is interpreted in terms of his individual needs.

Plans are being made to repeat the psychologic evaluation as each child reaches the age of 5 years. These cross-sectional estimations at 2½ and 5 years are only a more thorough addition to the developmental and adjustment data that are secured at every pediatric visit. They have already shown, however, the inaccuracies and the omissions in the routine questioning of the less experienced fellows in pediatrics. They have shown also, even in a community where psychiatric and psychologic advice is freely available, that for every parent who has spontaneously sought help for a problem such as toilet-training resistance, there are several who have struggled along without mentioning it.

Another plan in the psychologic field is to ask each school teacher to evaluate each of her pupils each year on an adjustment questionnaire which we have prepared. This will help us to keep track of the children's development in the school years when the pediatric contacts are infrequent and will, incidentally, help the teachers form better estimates of their pupils.

The Rochester Child Health Institute has so far worked suc-

cessfully in a number of directions. The pediatric supervision of all the children of the city is good especially in the preschool years. The percentage of kept appointments for routine check-up is impressive. The philosophy of respect for the child's individual developmental pattern really seems to get across to the majority of parents. I think it shows, for instance, in the striking infrequency of feeding problems. As a newcomer in Rochester, one is impressed by the relaxed, friendly, accepting attitude of most mothers in the clinics. The value of healthy emotional development is recognized by staff, fellows in training, and parents. The desire for nursery school facilities keeps increasing. Some of the individual psychologic problems in children are being helped and the staff is learning how to detect them, how to prevent them, and how to treat them. All these gains will be applicable elsewhere. But we all feel that we have made only a beginning.

We are aware of the lack of continuity in guidance between pediatric visits, between psychiatric visits. The public health nurses in their present numbers are too few to follow-up all the problems between visits. The small departments of city and county welfare have their hands full with the more severe social problems.

There is much fundamental research to be done concerning normal development, both physical and emotional, and the interrelationships between the two. What part do inborn temperament, parental attitudes, and place in the family play in developmental patterns? Can inappropriate parental attitudes be changed before the child is born by methods that have a wide application? What part is to be played in the future by pediatrician, public health nurse, psychologist, social worker, nursery school and grade school teacher, and psychiatrist in guiding children's all-round development? We all know how individual children have been helped, but we certainly have not worked out yet a blueprint for using all the professional resources of the community for all the children. How far can pediatricians be helpful in preventive psychiatry? Should a

corps of guidance psychologists or psychiatric social workers be trained to take up where the pediatrician leaves off? Can the values of nursery school for children and their parents be spread thinner over more of the community?

We want to experiment with guidance nurseries for the flexible use of a large number of children and parents with no registration and no preconceived duration of attendance. We want to experiment with itinerant nursery school teachers who will move from neighborhood to neighborhood showing children how to have fun with each other and showing parents how to get along with their children right near home or in it. We have got to experiment for decades with different approaches to parent education, going back at least far enough to reach the future parents when they are in high school. We have hardly begun to make contact with all the other organizations from the city council and the Young Womens Christian Association to the Kiwanians and the real estate board who do not think of themselves as child-care agencies but are influencing children none the less.

I would like a chance to make another progress report to you in twenty-five years.

THE IMPORTANCE OF THE FAMILY IN THE PREVENTION OF MENTAL ILLNESS

KENT A. ZIMMERMAN, M.D.[1]

IN the discussion of this subject I feel I need to first develop briefly why it seems to many persons that the family as a unit may become the most important dynamic entity with which to deal and plan in relation to the prevention of mental illness. In order to think in this way it seems appropriate to consider the soundness of the idea that the family is the medium wherein is produced the basis of the personality structure, and given its potentialities of growth.

Historically this type of thinking about the family is relatively recent, and it comes to us from two sources: (1) the study of the individual within the family which got its impetus primarily from the psychoanalytical study of the individual, and which viewpoint was expounded in the now classic study in this field, that of Flügel (1), published in the 1920's. (2) About this same time sociologists and anthropologists, as represented by Margaret Mead and Ernest Burgess, made the second contribution to the concept of dynamics and its relationship to personality in the family growth when they introduced the idea of the family as a unit of interacting personalities (2) rather than as a unit influenced and molded merely by such external factors as economic change, migration, and social custom.

The combination of these two approaches, the analytical and anthropological, is now giving promise of continued major contributions in the study of personality as represented by the work of Abram Kardiner (3).

As a result of these studies, a practical working concept of the family useful for the sciences of psychiatry, sociology, anthropology then became the following: The family is a unit of interacting personalities, each with a history and function in

[1] Consultant for Mental Health of the State of California Department of Public Health.

a cultural milieu (4, 5). Psychiatry and psychoanalysis have contributed and continue to contribute with their findings to the first aspect of this definition. Sociology and anthropology have given us and will continue to give us contributions relative to the second aspect of this definition, the cultural milieu.

Biology has also exhibited much interest in the family from the heredity standpoint in that it sees the family as a transmitter of certain genic traits and their perpetuation (6). The reflection of this interest exists, of course, today in the persistent discussion in regard to eugenics and so-called selective breeding. To round out our definition, a restatement of the working concept of the family and its relation to personality development then becomes, as Meyer Nimkoff, for research purposes has so well put it (7), "The family is a mediator of genic factors on the one hand and cultural factors on the other, in the formation of the basic personality structure."

I have emphasized that each of these sciences will continue to give us contributions because I wish to emphasize that these concepts are dynamic in character. It is because they are dynamic, not static, that they are usable as a working definition in the field, adaptable to the infinite variety of personalities encountered, and capable of projective thinking into the future, which are the two necessities for "preventive" thinking and planning as to personality development.

Section II

THE INDIVIDUAL INTERREACTIONS WITHIN THE FAMILY

As a unit the family is conceived of in our culture as parents and one or more children. To the formation of the family each parent brings his own background and lifetime emotional experience which go to form the image each has of himself or herself in the role of husband or wife. These concepts are rarely expressed verbally by either of the parents, but each becomes aware of the other's concept of himself as a connubial figure over a period of time through the acting out by each parent of these roles. This process is often barely begun before children enter

the picture which again calls for the further reorientation on the part of each parent of themselves in relation to each other by way of the personality of the child.

In the growth of the children in the family, each parent, both consciously and unconsciously makes a contribution to the personality structure of their children, but at the same time the parents have reawakened in them certain problems related to their own growth and development. The dynamic force of these problems seems dependent upon the extent to which they themselves were able or unable to satisfactorily resolve them in their own growth. Also, many families have as part of their make-up one or more grandparents living intimately with them. This situation often complicates the process of parental maturity, since the presence of the grandparents reawakens or emphasizes certain disturbing child-parent problems, and this in turn causes reverberation upon the grandchildren and their developing personalities.

Psychiatry has elucidated for us to some extent that one of the main problems each individual has is the working through of his emotional dependency-independency relationship with his parents. This is made more or less difficult for each child depending upon the balance of each parent's dependency and independency needs and further complicated by the influence of such factors as sex of the child, position in the family, parental attitudes at the time of conception, chronic illness and other environmental factors or hereditary traits.

The major schools of dynamic psychological thought, the psychoanalytical and the gestalt schools, have postulated concepts of growth and development which in the main consist of factors primarily within the individual. For example, Freudian psychology conceives of the workings of the personality as resulting from the interaction of three components designated as id, superego, and ego, and that there is a common pattern of growth which can be separated into levels of experience characterized by certain predictable interactions of the id, superego, and ego. These have labeled oral, anal, and genital

periods—having for their orientation bodily areas of mucocutaneous junctions which are seemingly predominant in tension or sensation at certain periods of growth. Offshoots of the classic Freudian theory have emphasized other dynamic factors —such as the organ inferiority of Adler—or the libido and collective unconscious of Jung. In this latter concept, Jung was the first to emphasize the importance of the "race" or "archaic experience of mankind" as of primary importance in the internal dynamics of personality growth. This approach has been further modified by recent psychiatric thought which gives much weight to cultural factors in the understanding of personality formation and adaption. The psychobiological concepts of Adolph Meyer show this, and psychoanalysts are healthily beginning to question their own classic concepts. For example, Erickson recently elaborated upon a factor which he has named "group identity," and which he believes is as important as ego identity in the dynamics of personality growth (8).

Section III

THE CULTURAL CONSIDERATIONS

Certainly one consistent characteristic of the American family which even the most casual observer would grant is its diversity. This is not unexpected since our nation is composed of various cultural groups nationally, racially, and regionally. Another reason for the diversity is that all families seem to be in transition, or cultural change, toward a more or less common pattern as suggested by certain sociologists, yet out of all this diversity there still can be found certain characteristics which give us more or less generalized standards and a sense of orientation in the observation of families (9). Because the sociologists have identified these characteristics, we can have a sense of comparison of the stage of movement of one family toward the common pattern, and can therefore begin to perceive what the problems of a family are still going to be. This allows us to make possible predictions relative to the problems a family has to face in its growth as a unit. This, combined with some knowl-

edge of the individual personalities within the family, can give us impressions which will allow us to make scientific guesses as to the capacities of the individual and the family to meet the problems. Once we can do this, we have a tool which will enable us to think preventively.

Burgess has identified certain chief traits which apply to the American family:

1. Modifiability or adaptability
2. Urbanization
3. Secularization
4. Instability
5. Specialization
6. A trend to companionship

For purpose of our discussion I wish to amplify the concepts of companionship and adaptability. As to the companionship type of family the sociologists mean a family in which the cohesive unity in a family is found in the interpersonal relationships of its members as contrasted with the families which are labeled as institutional where families are held together predominantly by such forces as law, public opinion, custom, and duty. This does not mean that companionship between family members, affection, and happiness is necessarily absent in institutional families but rather it is that such is not the primary reason for formation of a family. Rather more important for institutional families are having children, social status, fulfilment of family social and economic functions in society (10).

The concept of adaptability of a family resides in the functioning personalities of the individual members. It seems to depend upon three factors: (1) psychological, or the degree of flexibility in emotional reaction to change or confronting a new situation; (2) the cultural or educational factor influencing the person to act in an appropriate way; and (3) the possession of knowledge and skills which aids in the making of an adjustment. Sociological research seems to show that the growing adaptability of the companionship type of marriage seems to

make for the greater stability for the family in the long run. In other words, family stability arises from the strength of the interpersonal relationships of its members, that is, affection, rapport, common interests and objectives, not the force of public opinion, customs, law, etc.

Another sociological contribution we have found of much importance in understanding family problems is the use of classification of families according to the locus of authority within the family. These are listed as:

1. Patriarchal (Amish of Pennsylvania)
2. Kinship control (certain Southern families, and Ozark mountaineers)
3. Semipatriarchal (Italian immigrant)
4. Emancipated (rooming house)
5. Patricentric (lower middle class)
6. Matricentric (suburban)
7. Equalitarian (apartment house)

Since internal migration of families is so prevalent in this country, the forces put into play when a family by reason of migration changes from one pattern of living to another, with consequent reorganization of its members to the locus of authority, will inevitably result in some increase in problems for the parents and their children in regard to each other's role and their emotional attitude to each other.

Section IV

The Application of the Above Principles in Practice

Since the family in its growth toward stability depends on interaction of personalities, we will expect: (1) personality clashes will from time to time exist between members of a family; (2) the children will be involved, since they are part of the family unit, with resulting influences on their own growth and development.

In order to gauge the family's behavior and the trend toward healthy stability of the family, we need to ask ourselves

wherein do workers who deal with families get the opportunity of learning about these family problems, and the family members' capacities to cope with them. Normally the opportunity comes when the family is confronted with new situations which increase the anxieties of its members and call for readjustments to each other. Such opportunities, for example, would be during the time of pregnancy of the mother where one gets a chance to learn of what her concept of the mother role is, her attitude toward the children, her pregnancy, and her husband. The well-baby clinics and doctors' offices wherein the problems of feeding, toilet training, and identification of children with parents give us inside attitudes of the parents about each other and their children and their attitude to the social group. Illness in the family of one or more members allows us to judge how well the family fares in its adaptability to crises and whether the dependency-independency relationship of the individual members is being handled satisfactorily.

There are other situations which force families to seek outside help such as economic crises, deaths, and the adjustments to war which gives the social workers, school teachers, ministers, physicians, nurses, and others an inkling of what the problems are in interpersonal relationships. To scientifically and skillfully help a family, a worker should listen and provide himself with a knowledge of the following: (1) Tentative evaluation of the personalities involved; and (2) a picture of the trend of the family in its adaptability pattern. We have found however, that most secure and competent family workers will spontaneously admit they are lacking in training and preparation for acquiring this basic information. At the same time, by studying their field functioning, we have also discovered what is needed by workers who attempt to help families with their problems (11). They need: (1) Knowledge and skill of what constitutes good interviewing and counseling, including a knowledge of the therapeutic relationship, appropriate to the professional functions of the workers; (2) a working knowledge of the growth and development of the individual; and (3) a

working knowledge of the cultural and social family problems in their communities.

Section V

ATTEMPT AT APPLICATION IN THE FIELD

As part of the exploration of the developing of a mental health program in health departments, we have been studying how to find ways in which to teach nurses on the job what they might do in working with their patients as part of their families in their adjustment. With the cooperation of the staff of a local health department, we have established what we call a family consultation clinic. This clinic meets once a week to which certain of the nurses refer a family which interests them and has given them problems in guidance, usually because of personal attitudes they are confronted with on the job. One or more members of such a family come to the clinic to have an hour's conversation with myself and the nurses about their problems. These are families which have been seen previously by the nurses in well-baby, tuberculosis, venereal disease clinics, or other services.

As part of the evaluation of a situation we must know the cultural background of the family, that is, of each parent, for example, whether the father came from an Italian semipatriarchal family or the mother came from a suburban matricentric family, the evaluation of the person as to his flexibility, and the nature of the personality defenses being used in the adjustment by himself as a person. A history of how the family met previous crises and what happened becomes important in judging the trends toward adaptation or defeat.

Next we draw our attention toward the children in the family, especially as to their growth needs. We are especially interested in: (1) attitudes of parents toward the child (a) at time of conception, and (b) in early infancy—feeding and toilet training; (2) the period of identification at the age of four or five in which the girl identifies with the mother in the family role, and the boy with the father's. We are concerned

especially when we find either one of the parents absent at this period or parents with ineffective personalities; (3) as to the school-age child we are especially interested in learning of the individual's behavior at the beginning independency period when he begins to be more critical of the parents and more accepting of group standards, and his success in establishing group relations between the ages of six and ten; (4) the early adolescent period where the growth forces again reactivates individual and family problems; and (5) the distribution and use of authority by the parents in the preschool, school, and adolescent periods we feel is of special importance for the growing individual who is to play his part in a democratic society.

We are finding that the concepts enumerated above are teachable, by means of a case discussion technique, to nurses in the field who have had relatively little or no exposure to individual casework practice as based on modern psychological and sociological ideas. Furthermore, it seems possible to do this with relative efficiency and as part of the daily work program of the typical small health department, provided there is good leadership present in the health officer and directress of nurses. We are thus encouraged that this may become one of the important methods of getting a practical and meaningful preventive mental health service to larger numbers of people.

References

1. Flügel, J. C.: Psychoanalytic Study of the Family. London, Wolff, 1926.

2. Levy, John: The Happy Family. New York, Alfred A. Knopf, 1945.

3. Kardiner, Abram: The Psychological Frontiers of Society. New York, Columbia University Press, 1945.

4. Nimkoff, M. F: Trends in Family Research. *American Journal of Sociology,* May, 1948, *53:* No. 6, p. 477.

5. Dollard, John: Needed Viewpoints in Family Research. *Social Forces,* October, 1935, *14:* p. 109.

6. Scheinfeld, Amram: You and Heredity. New York, Garden City Publishing Company, 1945.

7. Nimkoff, *Ibid,* p. 481.

8. Erikson, E. H.: Ego Development and Historical Change in THE PSYCHOANALYTIC STUDY OF THE CHILD. A. Freud and Hartmann, Kris (editors) New York, The International Press, 1947, Vol. II.

9. Burgess, Ernest W.: The Family and Sociological Research. *Social Forces,* October, 1947, *26:* p. 1.

10. Burgess, Ernest W.: The Family in a Changing Society. *American Journal of Sociology,* May, 1948, *53:* No. 6, p. 417.

11. Zimmerman, K. A.: The Beginnings of a Mental Health Program in a State and Local Health Department. *American Journal of Public Health,* June, 1948, *38:* p. 811.

DISCUSSION

DR. GEORGE S. STEVENSON: Dr. Davidson presented a problem that is, from the standpoint of progress in the field, very fundamental. He asks how we reconcile the continuous development and narrowing of specialization. He presented one suggested answer—teamwork. Teamwork in the psychiatric clinic has been a sine qua non of good treatment over the past twenty-five years. Treatment has routinely involved the psychiatrist, the psychologist, psychiatric social worker and occasionally the teacher, the public health nurse, and other professions in the study and treatment of the patient.

Dr. Zimmerman has indicated that every profession dealing with people in need potentially has before it cases which may on the surface seem to be peculiar to each profession, but which in their essence are very much the same. A common basic problem is family disorganization. This may bring one person to a pediatric clinic because of undernutrition, in another it may induce school truancy or school failure, it may bring another to the juvenile court or the child guidance clinic. Yet the effective handling of the problem is essentially the handling of the family and each must know about that. Specialization, then, depends upon the complexity of the underlying elements and the form of their expression rather than differences in the underlying elements themselves.

That means that both for economy and for the avoidance of confusion of the public all these agencies need to develop a common competence. This occurs in four areas. First, all of these professions have to talk with their clients, and talking needs to become just as seriously conceived and taught a technique as are the other techniques of medical practice. It is not so conceived at the present time except in the field of social work.

Second, Dr. Zimmerman speaks of a need to recognize anxiety, to know what it does, to know how it can be influenced and turned to a person's advantage. That is a common need of these professions.

Third, they all need to know the resources of the community, they need to know how they can be used properly. Again and again a clinic is set up in a community because some other agencies have failed to perform the functions that are appropriately within their scope. That is a poor solution. Each agency has to know how to effectively refer a patient to another service and to transfer to that other service all of the confidence and loyalty of the patient.

Fourth, each field needs to know the dynamics of the family and of the interrelationships of its members.

The points that Dr. Zimmerman has brought out for the most part pertain to the causative factors and thus to the prevention of neuroses. However, mental disorders do include in addition the more serious psychoses. But maybe it is all right to focus on the neuroses.

Now I should like to shift from preventive to positive mental health. It is not really a shift because effort for positive mental health has a preventive by-product if it is successful. It is rather a shift in orientation, for the preventive approach, as was pointed out yesterday, looks to the future. It is something that comes before; whereas the positive approach looks to here-and-now. The successful handling of the here-and-now is a step in the progressive development of the individual.

Not much has been written about positive mental health. The whole field of mental health is difficult to talk about, more difficult than other aspects of medicine, because it has developed its own strange scientific terminology. On the other hand, the lay public has its common terminology. It can see man as a whole, the subject of the psychiatrist in its every day experience; whereas it is not similarly familiar, let us say for example, with the subject of the cardiologist, the heart. We really have two languages, that of the layman and that of the scientist. The latter is not really one language either, because among the psychiatrists themselves there will be considerable difference in the use of terms. To avoid confusion, then, I am inclined to use the lay terminology even at the risk that it will sometimes seem to belong to the evangelist rather than the scientist.

What do we mean by positive mental health? Several things. For one, Dr. Zimmerman has pointed out that the nurse has a potentiality

for understanding the behavioral aspects of her work. In so far as she realizes that potentiality she is more at ease with herself and her community, and she gets satisfaction out of it. That is a sign of positive mental health. The first component of mental health is satisfaction. That is subjective. The second component is productivity. That is a thing that someone else can sense. Third, we have a mutually helpful relation between persons. This is both subjective and objective. These three are the characteristics to positive mental health—satisfaction, productivity, good social relations.

How are these characteristics brought about, how are they established? From the field of education we get our first principle: that these qualities—any talents for that matter—are developed through the process of using them, through their exercise. The exercise of a talent becomes both the process developing it and a source of satisfaction.

We don't need to identify and measure talents by psychological tests to induce their growth. If we give them the right cultural atmosphere and soil in which to grow, they will grow. If you have a psychological soil in which there is affection, friendliness, and respect, it may be expected that in that medium the individual will find the possibility of developing these three qualities—satisfaction, productivity, and good social relations.

When one lives in such a medium of affection, friendliness, and respect he is not preoccupied with a search for love. It is only when affection is in doubt that he is preoccupied with it. Unhampered by such doubt he is able to relate himself to the realities about him. He deals with them directly and so develops his potentialities for meeting the world face to face. On the other hand, if he is in doubt, if there is a denial of affection within the family or anywhere else, he becomes preoccupied with it, he constructs devious ways of securing love, and in that we find development of the neuroses.

On the other hand, this is a two-way process. The dilemma of being unloved and unrespected has its counterpart in the dilemma of the person who is unable to give affection. If the latter were able to accept his disability, there would be both a better prospect of his eventually developing affection and, on the other hand, avoiding the devious ways in which to compensate for that deficiency. It is those devious ways, even more than the lack of affection, which confuse and contribute to the development of that neurosis in others.

You may have noticed that I have avoided, or I tried to avoid—I did not succeed entirely—focusing entirely on the family, because affection, friendliness, and respect affect people whether they are within the family, within industry, or within the community. But we actually do focus especially on the family and on the child. The influences on mental health are more potent the younger the person and the greater his emotional ties to those about him. Within the family there is, therefore, the beginning opportunity to create for the individual the kind of a start that will establish in him a capacity for satisfaction, a capacity for productivity and for effective relationships with other persons—in short a positive mental health.

Dr. J. H. Sheldon: I have found the series of ten papers intensely interesting, because one has had the feeling all the time that one is taking part in a reorientation of medicine. Each one of us has brought here our own particular background of training and experience, and I speak only as a practising physician. I have been listening to all of the debate entirely from that standpoint. I want to thank Dr. Dublin and Dr. Meleney for the two papers they gave us. I found them quite seminal papers. Both of them emphasized that in the new form of health service to the family that they were trying to bring, some form of prepayment was necessary.

Now, I live in a country where there has been a social revolution and where prepayment occurs for every eventuality that may occur in one's slow passage from the womb to the tomb. Having listened to their two papers, I feel that it is urgent that we should, in our national health service at home, endeavor to incorporate as an experiment some of the types of family health centers that they have been describing and which have already been started in Great Britain in some centers. Why is that? It is because of the point that I memtioned last night: because I think that attack upon the family as the unit of health offers at the moment much the most hopeful way of attacking a large group of diseases which cause a great deal of sickness in the community and whose etiology at the moment is beyond our scope. I mean the psychosomatic diseases.

Let me give you an illustration of the sort of things I mean. In children you have got such things as nocturnal voiding; you have got asthma. I don't know what is happening here, but in Great Britain asthma in children seems to me to be becoming a distinct problem.

Cases are certainly far more numerous than when I first started practice nearly thirty years ago—and occur in all classes of society. It is a disease which is often wished onto the children by the anxiety of the mother. The parents usually have only one or two children, and it is in turn a family disease, which can only be attacked through the family.

If you go through adult life, you have a large group of diseases, such as peptic ulcers; duodenal ulcers; especially you have got the thyrotoxicosis cases; and you have got the enormous group of cases of asthma in children—surely those are matters of public health, and I think that the solution of the antithesis between preventative and curative medicine is going to lie in the attack by the public health person against those diseases.

But I do not think, having listened to the discussion, that the time is ripe yet. I think that there has got to be a great deal of private experimentation, mistakes made, and data discovered by a sort of experimental attack on this problem. One needs to know more about how best to approach the family, how many doctors are required, what type of doctor is required, and what training is required.

May I just give you one case report which illustrates the fact that family problems may result in physical disease. Before I left England, I was very concerned about a woman whom I was asked to see in consultation because she had severe rheumatism in the neck. I went to the house and found that she had what you might call a fibrositis. Once I was there, I was asked to see her daughter, who was in bed with what was clearly a hysterical paraplegia. There you have got a family illness, the solution of which came to me from the nurse, who told me what had really happend. They had been a perfectly happy family until some months before when the wife, who was sending a husband's clothes away to be cleaned, had gone through the pockets to see that there was nothing sent to the cleaner's, and she had found a letter in one of the pockets which the husband had very foolishly left there; she, equally foolishly, read the letter. Of course, it was the obvious letter—a letter from the other lady in another town, a letter written in terms of strong endearment. That had precipitated the trouble. That was the nexus in which the rheumatism in the lady's neck—she got a pain in the neck, you see, after that —that was the nexus in which rheumatism in the lady's neck and hysterical paraplegia in the daughter had arisen.

The patients were unwilling that I should enquire any further, and it had to be left at that—as, in other words—an inaccessible family problem which was producing physical illness in two people. It will only be after a lapse of time that the people will get used to the fact that phsyical illness in one individual may arise from emotional strains within the family. And when the populace as a whole has come to accept that, then those of you in public health will be able to go into the field.

Until then I think the experimenters have go two things to do. I think we have got to accustom the public to the idea that illness can arise as a result of emotional strain in the family, and I think we have got to do a lot of experimenting on different lines as to the best way of approaching that problem. But as to the general fact that the family is one of the essential units of medicine, having listened to this discussion, I have no doubt at all.

Dr. George F. Davidson: It seems to me we have a very interesting phenomenon here of an approach to health by two different sections of the medical profession, from two different points of view, gradually coming to the center and joining their forces together. The private practitioner has tended in the past to concentrate, I think it is fair to say until recent times, at least, on the illnesses of the individual; the public health officer, on the other hand, had to start initially as far away from the field of private practice as he could possibly get, in order to reassure the medical profession on some of their fears as to competition in the field, and therefore he started as a complete community person. One of the tenets of his profession was that he must almost never come in contact with what could be considered individual illness. He concerned himself with sanitation, sewage, water supply, things of that kind. Here we have the interesting phenomenon of all of us agreeing around this table on the necessity of each one of those groups narrowing the gap that has hitherto existed between them. We are urging that the private practitioner become more concerned with the practice of family medicine and with the development of the skills which hitherto we have associated with the field of the public health person. On the other hand, we find the public health man being urged to come more and more into intimate contact with the family.

It is inevitable that as this gap is narrowed, as the public health

person comes more and more into the field of individual illness and as the private medical practitioner extends his range more and more into the community field, there are going to be points of friction and confusion; and I think we had just better accept the fact that those points of friction and points of confusion are inevitable. They have got to be worked through. They are in themselves points at which we can take encouragement, because they are indications of the fact that at long last the fields of public health and private medicine are coming together in a joint collaborative effort which we are calling today public medicine or social medicine. And only as those conflicts are resolved, only as the confusion is ironed out, will we have any hope of joining the private medical practitioner and the public health worker together in a really integrated team that will work together not only for the health of the indivdual but also for the health of the family and for the health of the total community.

Dr. Cherkasky: This round table has had presented to it many interesting papers and opinions concerning the various problems applicable to the family. It seems to me that there has been a basic difference as to the interpretation of the word "family." Some of us view the family as a housing unit and relate it to the traditional services of sanitary engineering, water supply, etc.

Dr. Tom Dublin has presented a most provocative paper about the concept of the family as a biological unit of health. In our Home Care Program at Montefiore Hospital, we have by the force of circumstances been involved not only with the patient but with the family as a whole. We have found it quite impossible to do a job for the patient without taking into account the change in the emotional and social relationships with the other members of his family. Our doctors on the Home Care Program are not the kind that Dr. Davidson spoke about who use hocus-pocus and their black bags to make their fees seem more reasonable to the patient. Our doctor has extended his horizon, is recognizing that he is treating a patient, not a disease, and that he must be aware of problems which involve the entire family. Consequently, he utilizes the services of other specialized personnel. Our social workers, public health nurses, and doctors form a team which can approach the problems of the family as the unit of health.

It has been stated that when you take the vision of two eyes, you

do not get just an increased field of vision. You get something more than the mathematical addition of the sight of the two eyes: you get stereoscopic vision; you get depth. With this approach, we have a way of achieving positive health.

I hope that the result of this conference will be that all the various skills and all the various knowledges, that have been brought here, will join together just as the vision of two eyes, in an overlapping and a strengthening, so that we will have real depth of care for the people.

It has been stated here that we cannot embark on so visionary a program. Well, I guess what is vision today, was visionary yesterday. We have represented here all the essentials needed to make a family health program work.

CHAIRMAN BAEHR: The agencies concerned with welfare, health, and medical care are realizing increasingly that they have a common objective and must work in concert. Our impatience is due to the fact that they are not coming together rapidly enough. The reason they are not working together on these problems is because they find it difficult to carry their common ideas and the ideals into execution due to their different methods of work. The plea of Dr. Sheldon, Dr. Dublin, Dr. Meleney, and others for experimentation with new methods is, therefore, most important. The conflicts between the three different disciplines of welfare and health and medicine are still very great and they will not be resolved by preaching. They will only be solved by the development of a new experimental method of rendering the services, in which there is less opportunity for conflict.

For this reason I believe that the ideas expressed in the first papers of this symposium are extremely important, for they advocate a pattern of medical service in which there will be no room for conflict with welfare and public health work. Under this program the physician is interested in the family primarily, if only because of the manner in which he is employed. His relationship to the health services is most cordial, because he must bring them in and wants to do so. His relationship to the welfare services is equally cordial.

With that pattern of service, we may demonstrate how a health plan can be organized for a state or for the nation or for a local community in a manner which will overcome the resistances that have existed heretofore.

PARTICIPANTS AT THE ROUND TABLE ON THE FAMILY AS THE UNIT OF HEALTH

1948 CONFERENCE OF THE MILBANK MEMORIAL FUND

NOVEMBER 17–18, 1948

GEORGE BAEHR, M.D., Chairman

ATWATER, REGINALD M., M.D., *Executive Director, American Public Health Association*

BADGER, GEORGE F., M.D., *Department of Preventive Medicine, Western Reserve University School of Medicine*

BECKER, JOSEPH A., *Chief, International Commodities Branch Office of Foreign Agricultural Relations, U. S. Department of Agriculture*

BLUESTONE, E. M., M.D., *Director, Montefiore Hospital for Chronic Diseases*

BROWN, HAROLD W., M.D., *Acting Director, Columbia University School of Public Health*

BURNSTAN, ROWLAND, *Executive Director, State Charities Aid Association*

BURRITT, BAILEY B., *Executive Secretary, Health Maintenance Committee, Community Service Society of New York*

CHERKASKY, MARTIN, M.D., *Home Care Executive, Montefiore Hospital for Chronic Diseases*

CLARK, DEAN A., M.D., *Medical Director, Health Insurance Plan of Greater New York*

DAVIDSON, GEORGE F., *Deputy Minister of Welfare, Department of National Health and Welfare*

DAVIS, WILLIAM A., M.D., *Assistant Professor, Department of Preventive Medicine, New York University College of Medicine*

DINGLE, JOHN H., M.D., *Director, Department of Preventive Medicine, Western Reserve University School of Medicine*

DOWNES, JEAN, *Milbank Memorial Fund*

DUBLIN, THOMAS D., M.D., *Executive Director, National Health Council*

ELLICOTT, V. L., M.D., *County Health Officer, Montgomery County Health Department*

GODFREY, EDWARD S., JR., M.D., *Formerly Commissioner, New York State Department of Health*

HUBBARD, RUTH W., R.N., *General Director, The Visiting Nurse Society of Philadelphia*

JACKSON, F. W., M.D., *Director, Health Insurance Studies, Department of National Health and Welfare*

JOHNSON, MARIE L., R.N., *Assistant Director, Nursing Bureau, Metropolitan Life Insurance Company*

KRUSE, H. D., M.D., *Milbank Memorial Fund*

LEMBCKE, PAUL A., M.D., *Associate Director, Council of Rochester Regional Hospitals, Inc.*

MELENEY, HENRY E., M.D., *Professor of Preventive Medicine, New York University College of Medicine*

MUSTARD, HARRY S., M.D., *Commissioner, New York City Department of Health*

ROBINS, HUGH B., M.D., *Director, Calhoun County Health Department, Michigan*

RUTSTEIN, DAVID D., M.D., *Department of Preventive Medicine, Harvard University Medical School*

SHEAHAN, MARION W., R.N., *Visiting Professor in Public Health Administration, University of California School of Public Health, Berkeley, California*

SHELDON, J. H., M.D., *Director of Medicine, The Royal Hospital*

SIMMONS, JAMES S., M.D., *Dean, School of Public Health, Harvard University Medical School*

SPOCK, BENJAMIN, M.D., *Rochester Child Health Institute, Rochester, Minnesota*

STEVENSON, GEORGE S., M.D., *Medical Director, The National Committee for Mental Hygiene, Inc.*

VANVOLKENBURGH, V. A., M.D., *Assistant Commissioner, Local Health Services, New York State Department of Health*

WIEHL, DOROTHY G., *Milbank Memorial Fund*

WINSLOW, C.-E. A., *Professor Emeritus, Yale University*

YOUNG, DONALD, *General Director, Russell Sage Foundation*

ZIMMERMAN, KENT A., M.D., *Consultant for Mental Health, California State Department of Health*