THE physician's special knowledge becomes of value to the patient only as it is applied through the "physician-patient relationship." Similarly, medical social workers have specific information about the social implications of disease processes. To be useful to clients this information must be applied through an inter-personal "worker-client relationship." Both relationships involve a rapport between individuals based on an awareness of what the content of the interview means subjectively, as well as objectively, to the client or patient. The inter-personal relationship, it seems to me, is of the essence in all professional work. It involves the lawyer, minister and architect. At its best, it is based on a sound, studied knowledge of personality structure. Here and there throughout the land pioneering efforts are being made to include, as an integral part of professional training, courses whose purpose it is to teach beginning professional students about the structure of the personality and simultaneously, as part of this process, give them insight into their own personality traits. It is inevitable that through this increased insight the students themselves are helped to mature. In numerous medical schools psychiatry is being included in the freshman year's curriculum in an effort to accomplish the same function. I believe that a course dealing with "Growth and Change" would serve medical students even more adequately than an early introduction to psychiatry, helpful as that may be, because the individual's growth and change involves too many values which are not primarily psychiatric, and psychiatry too many concepts not relevant to an orientation course.

Against this background, with its emphasis on relationship between people, I should like to consider the pediatrician's role in the care of children and parents, and to do this with the medical social worker's role in mind.

Pediatrics today is concerned not just with illnesses of children but even more their health and its preservation; not just with bodies, or minds or the two combined, but just as truly with feelings and intra-familial relationships and ultimate social adequacy. The discerning pediatrician is by this definition vitally concerned with parent-child relationships. It follows that he needs insight into the family background of his patients. In private practice he remains among the practitioners who go into homes and have more or less intimate personal insight into the way of life of their families. In the large portion of his work within hospitals and in clinics in which he lacks this contact he should have the collaboration of trained medical social workers. Every children's hospital owes it to its patients to have a department of social service integrated into its working structure to help the medical staff gain needed vital information about the child's situation in his environment and, if need be, to consider changes in that environment.

In considering family environment the basic relationship is that existing between parents and children. It is the foundation upon which the child's security as a person rests.

Adapted from presentation at National Conference of Social Work, 1949, American Association of Medical Social Workers.
It is predicated upon three ever-present factors: the personalities of the parents, the character of the child, and the environment in which the relationship develops.

I believe that parents can be superficially classified as to aptitude for caring for their children as follows: A large group, to whom parental function comes naturally for any of a number of reasons, such as membership in a large family, warmth of personality, or a high degree of emotional maturity, need relatively little instruction. Another large group with less natural aptitude nevertheless finds that it can use written or oral information easily. It does not take these parents long to feel at home in their parental role. The third group is smaller and includes parents who, because of their own emotional constitutions, are blocked from applying sound knowledge. In this group are found mothers and fathers with neuroses of varying kinds and degrees.

It has been helpful to me to have this crude categoric scheme in mind in selecting my approach to patients. It has kept me from belittling a woman from group I, who already has a fine sense of proportion about children, by offering her information which she already has; it has encouraged me to be at pains to apply educational technics to those in group II; and it has made me realistic in my dealings with the emotionally limited people in group III, for example, by not asking from them what they could not give.

At this point I should like to consider what can be done by the pediatrician for those in groups I and II—first for the children and then for the parents.

A few years ago the term ‘anticipatory guidance’ came into prominence. For pediatricians the term means sharing of knowledge as to what is to be expected. Applied to the child, this includes such minor procedures as preparing him for an inoculation a moment before he receives it, by telling him that he is about to be given ‘a little pinch’ on the arm—or if he is older, a needle or ‘shot’—that it will hurt a little for a very little while and that he will probably find that it is not painful enough to cry about, but that it is all right for him to cry if he needs to. The term also covers approaches to more complicated situations, such as having to go to a hospital or having to undergo an operation. In the former situation the child who has been told honestly and in some detail about how he will be living for the next few days has at least been given some real concepts to cling to, and been spared the need to conjure out of his imagination a conglomeration of fear-laden ideas. I know from personal observations that the reasonably stable child over 3 years of age who has had outlined for him in simple terms each step of what he is about to experience accepts what happens with assurance rather than panic.

After the operation he adjusts realistically to postoperative discomforts and is quite free of panic states such as night-terrors which the child not so prepared often suffers.

Let us take, for example, preparation of a child for tonsillectomy. In a few minutes, I can tell him in terms of a story what he may expect to experience. I do this preferably a day or two before the operation, selecting this time because I believe that a longer interval would only give him more time to mull things over. After I have checked his physical condition, I tell him that he will be going to the hospital, up in an elevator to the laboratory, have his finger stuck so that a drop of blood may be drawn for examination, and then go up in another elevator to his room where he will be in a bed with sides and wheels on it. His mother will or will not be with him there, nurses will come in and out. Very likely while he is in his room, a nurse will bring him long white cloth boots and a white cap, and help him put these on. Finally, it will be time to go; he will be wheeled out in his bed, through the hall and onto an elevator which will take him down and then stop; its door will open and he, in his bed, will pass through the door into a
hallway. There he will see grown people dressed in white masks, caps, and gowns; some may stop to talk with him. After a bit, he will be wheeled into a room, helped from his bed onto a table and asked to lie on his back. A nurse or doctor will pour some medicine onto a cloth near his nose. The smell won't be too bad and all he needs to do is just what the anesthetist tells him to—blow the medicine away. Either before or after the anesthetist brings the cloth near his face, his eyes will be covered to protect them from the medicine. The medicine will make him sleepy and soon he will indeed be asleep. While he is sleeping, the doctor will be "fixing his throat." You will note that by not mentioning "cutting," "taking out," etc., which the patient does not actually experience, I have avoided an unnecessary reference to mutilating procedures. The story goes on thus. When he awakens he will be back in his room; his mother or a nurse will be there with him. He will feel bad, especially his throat where the doctor has been working. But everything is all done, and he will gradually feel better and better. It is all right to cry if he has to, but the quieter he is, the better he will feel. He will spend that night in the hospital and will be able to sleep a good deal. The next day he will go home and that night he will sleep just as always in his own bed. A few more days and he will be perfectly all right again.

Lest it seem inappropriate to have described the above procedure at such length, I hasten to point out that content of the discussion and attitude of the discussor are the essential factors. I believe that medical social worker who has the child's confidence can prepare him in his way just as well as the physician. A social worker in her contact with nurses and interns can easily teach such a technic. It is helpful if the parents are present when the child is being told about what is to happen. By being present they become sharers with the child in that part of the experience—a comfort both to the child and to them; their story will be consistent with reality and they may themselves see the whole procedure in a cooler light. Though it may seem a subtle point, the child's awareness that his own parents are there with him accepting the explanation lends legitimacy and acceptability not only to the story, but to the actual events which are to follow.

Similar forethought and purposeful sharing of information can help prevent chronicity and assure a return to health. The discharge of a patient when well should be as distinct a step in management of an illness as is recognition of the illness and beginning of treatment. It is not always easy to give up the secondary gains that sickness has brought and we can see this even in children. It happens much too often that a child goes home with explicit orders about medication to take and activities to avoid during convalescence, but no advice as to when these "standing orders" may be modified or dropped. As a result, parents continue to conceive of their child as abnormal and create an atmosphere consistent with illness rather than good health. Such an atmosphere makes it difficult for the child to consider himself truly well again, and thus makes for hypochondriasis. Anticipatory guidance can be of great help to the well-balanced parent, both through delineation of normal baby and child behavior, and through interpreting it in terms of maturation. Thus the mother who knows that it is normal for her baby to hiccup; to sneeze to clear its nose; to cough to clear its throat; and to breathe irregularly is spared doubts as to the normality and wellness of her child. It is part of the role, not only of the physician, but also of the social worker to prevent anxiety from lack of information.

As the child grows older the same approach serves very well. Just as the parent may be taught to understand the meaning of sneezing and coughing, that parent may learn to understand that the acquisition of sphincter control is the taking over by the child of a
complicated function at a time when he is ready to assume its control. It is not "training" in the sense that teaching a dog tricks is "training." Efforts of the parent who understands this will be considerate not only of the child's physical mastery of the nerves and muscles which control the processes, but of the child's attitude. The objective is to have the child accept responsibility for his own functions. In so doing he is taking a step toward maturity and autonomy.

Transferring of responsibility for his own functions to the child when he is ready for such control is fundamental to good parent-child relationship and may help to reduce the need for rebellion often seen in adolescents who have been held too tightly in leash by their elders.

By respecting the integrity of our children, being considerate, kind and fair, and I should add, honest with them, we do much more than "prevent behavior problems." We create positive values in the children. Our idiom of interpersonal relationship becomes their idiom, and they incorporate into their personalities whatever of graciousness they sense in us. I am convinced that this transmission of positive values is as real and even more important than the transmission of negative values, which because it is painful, we single out for special attention in our recognition that the child's behavior disturbance is in large measure the result of mistaken handling by his parents.

So much for the reasonably well-adjusted parents of groups I and II.

When we deal with the emotionally unstable parents of group III, we quickly sense or painfully learn that a simple common-sense approach is not enough. We cannot just tell such people what to do. Social workers are keenly aware of the need to take emotional limitation into consideration. This is evidenced by a basic axiom in casework: "meet the client where he is." "Meeting the client" means recognizing him for what he is and accepting him for what he is, rather than a mandate to make him over through psychotherapy. Psychotherapy concerns itself with intra-personal or intra-psychic dynamics, the specific realm of psychiatry. Social work focuses its attention on inter-personal relationships. Its skills are in dealing with the individual's current situation with respect to people, economics and, among other things, groups. In this sense social workers and pediatricians, with perhaps a few rare exceptions, are not psychotherapists. Emotionally maladjusted people, however, are part of our case loads and practices. While both social workers and pediatricians recognize and accept emotional limitations and refer these people to others for psychotherapy, adjustment to the emotional limitations, through skillful use of the role of doctor to the child and utilization of the skill of the social worker as a teammate, can be most helpful. Surely, a time is coming when not only the doctor working in a hospital or public health setting, but also the physician in private practice will have available to him and find himself utilizing medical social workers as a matter of course.

The social worker can round out the physician's conception of his patient in terms of his day-to-day living; his relationships to his family, to other children, to his teachers at school; in fact, to all people or groups or institutions which impinge upon his life. Since these relationships are just as vital a factor in the child's well-being as vitamins or operations, the pediatrician should seek out and learn to utilize information from the medical social worker and discover the ways in which she can integrate her efforts with his.

Children, well and sick, are first of all people, and physicians and social workers, in proper teamwork with parent and child, can help them to be healthy people, in every sense.

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