was outlined and suggest its adoption in a complete or modified form.

My recommendations concerning the psychological handling of the cardiac child during the pre-operative years are directed to the general practitioners, the paediatricians and the cardiologists. The aim which I have in mind is the prevention of the development of abnormal emotional reactions, disturbed behaviour, and defective personality integration, which I have shown can arise in association with this condition. I believe that there is a tremendous amount that can be done for these children in this respect. They require constant encouragement and reassurance. I want to stress that the question of whether a cardiac child will make a satisfactory emotional adjustment rests essentially in the hands of the parents. For this reason, it is towards the parents that psychological assistance should be principally directed. It is most important that recognition should be given to the value of devoting time and attention to these parents. If this is not done, it is quite impossible to treat the total problem entailed in any case of congenital heart disease.

The family

Once the diagnosis has been established, an attempt should be made to make a simple assessment of the family unit. In order to do this, a single short interview with each sibling would be required. Depending on circumstances, it may be necessary to interview the father on more than one occasion. The mother will require the most time and attention, the extent of which will depend on her specific needs for psychological assistance. This assessment of the family unit could be carried out in the space of very little time, and it would prove invaluable in gaining an insight into the problems not only of the patient but also of the parents.

I am convinced that thorough attention to the mother's difficulties would be richly rewarded. A few remarks on the aetiology of her child's condition, together with a little patience in answering her questions on that score, could do a tremendous amount towards dispelling unnecessary feelings of anxiety, rejection and guilt. Misconceptions should be eradicated from the start. The mother should know that congenital heart disease is not uncommon, that medical science has made tremendous advances in this field, and that the treatment of this condition is often entirely successful. This preparatory reassurance would be most important during the initial distress from which the parents suffer.

The nature of the various emotional reactions and behaviour patterns that might arise in her child, and reasons for them, must be given adequate explanation. She must be advised how best to handle these disturbances. The problems of sibling rivalry must be explained and the dangers of over-anxiety and over-protection carefully elucidated. The mother should be encouraged to attend for periodic discussions of her problems to ensure an adequate control over the patient's emotional development.

The amount of psychological assistance which a mother may require will naturally vary with individual demands. If evidence of marked emotional disturbance in the parents is forthcoming, regular psychotherapeutic sessions will become necessary. The presence of grossly neurotic reactions would call for psychiatric aid.

Conclusion

I have no hesitation in expressing the view that a cardiac clinic is falling short in its responsibilities if it fails to give consideration to the psychological problems which I have outlined.

There remains one further point to be clarified. This discussion has been confined to psychological aspects of congenital heart disease, but it may be considered that a good deal of what has been said could be equally well applied to other conditions. This is in fact the case. The example of congenital heart disease has been used to draw attention to the possible importance of psychological aspects of organic disorders and to emphasize what I like to refer to as a total approach to medical problems. I hope I have at least succeeded in stimulating an interest in an approach which I believe in all sincerity to be a correct one.

Favourite Desserts

(*Continued from page 33*)

beat well. Sift together **1½ cups flour, 3 teas. baking powder (2 on the high veld), a pinch of salt,** and add to egg-fat mixture with **two-thirds cup water.** Fold in **stiffly beaten egg whites.**

Bake in moderate oven about 30 mins. Serve with custard.

SURPRISE APPLE CAKE

Make a crumb crust using **2 cups biscuit crumbs** Marie biscuits (crackers, crushed corn flakes, etc., may be used) together with **½ teas. cinnamon** and **2 tbs. melted butter.** Spread this crumb mixture on the bottom of a deep 10" cake pan, or spring mould, or a pyrex dish from which you will serve the cake, reserving some of it.

Beat **3 egg yolks** well, add **1 tin (1⅓ cups) sweetened condensed milk, 2 tbs. lemon juice, grated rind of 1 lemon, 2 cups sieved apple sauce** (which is simply stewed apples, only they should not be sweetened, because the tinned milk will make them sweet.) Fold in **3 stiffly-beaten egg whites.** Pour into cake pan and cover with remaining crumbs. Bake in moderate oven (about 350) for about 50 mins. Serve hot or cold. If serving cold, let cake cool in oven.

ALMOND APPLES

A rather nice version of baked apples. Boil **1⅓ cups water with 1 cup sugar** for 5 mins. Peel and core (leaving them whole) **4 large, tart apples.** Cook them gently in the syrup until tender. Lift out carefully, place in a baking dish. Add to the syrup **⅛ teas. cloves, ¼ teas. cinnamon and 2 teas. butter,** and cook the syrup until it is thick. Fill the apple centres with this syrup, stud the apples with **blanched slivered almonds (about third cup)** and bake in moderate oven until almonds are slightly browned. Chill and serve with cream.

A "TO-DAY'S HEALTH" ARTICLE

The Difficult Years

The physical and emotional changes of puberty often put a strain on the whole family. But there's much you can do to ease your youngsters' growing pains.

By ELIZABETH B. HURLOCK, Ph.D.

A TIME comes in every child's life when he "grows up" — when nature transforms his body into that of an adult. This transformation process, known as puberty, begins around the tenth year for girls and a year or two later for boys. It lasts about four years, but this, as well as the age when puberty begins, varies greatly from child to child.

During this period, the whole body is changed. The child reaches his adult height, weight, and body proportions; sex organs grow in size and begin to function. The physical features that distinguish men and women — hair on the body, change in tone of voice, and development of hips and breasts — gradually appear, and many changes take place in the functioning of the internal organs.

These changes affect the child's health, emotional states, interests, and behaviour. During the period of most rapid growth, just before the girl's first menstruation and the boy's first nocturnal emission or "wet dream," most youngsters are listless. They frequently suffer from digestive disorders, headaches, sleeplessness, finicky appetite, and general achiness.

Behaviour is also affected. They are moody and grumpy, speaking only when spoken to and then often in as few words as possible. They have a constant chip on their shoulders, often misinterpreting anything said or done as a personal insult. They pick quarrels without any apparent reason and have outbursts of uncontrolled temper and crying. They go around looking as if they had lost their last friend.

It's common for them to be clumsy and awkward, tripping over their own feet, dropping things, or knocking into furniture and people as they walk across the room. Even more exasperating to parents is their tendency to let their home duties slide or do them so badly that someone else must do them over.

The same is true of their school work. Good students seem to drop to the bottom of the class almost overnight. Even the most patient attempts to explain the seriousness of this are likely to be interpreted as "nagging" or to be shrugged off with the comment, "So what?"

This is hard on parents, but even harder on the child. He is worried about whether he is normal if his pattern of development differs in even the slightest way from that of his classmates. He wonders if he is getting stupid when he sees his grades slipping and is afraid his whole future is in jeopardy. He feels his parents and teachers don't understand him and are constantly picking on him, that his friends are mean to him, and that the world is against him.

This strain on parent-child relationships often grows increasingly serious with time. If the situation isn't properly handled, a youngster in puberty can develop unhealthy attitudes toward himself as a person and toward people which can seriously affect the whole course of of his life.

When a child's physical growing pains are eased, his psychological growing pains will be less severe and his chances of emerging with little or no psychological damage will be greatly increased. Here are some of the things you can do to help your child through this difficult period:

1. Find out just what happens during puberty, when, why, and how it happens. Knowing what is normal will help ease your worries about the child's development.

2. Have your child checked by a doctor as soon as he starts to grow rapidly, and again every three or four months until this transformation period ends. Your doctor will quickly clear up your worries and help both you and your child.

3. If his school work begins to slip, discuss the problem with your youngster's principal or teacher.

4. Tempting meals and between-meal snacks of wholesome food will ward off the fatigue that accompanies rapid growth. Keeping physical fatigue to a minimum will reduce the storm and stress of puberty which sap everyone's energy and patience.

5. Accept his bad humour, occasional temper outbursts, and even rude remarks as you do from anyone who is not feeling well. He is probably ashamed of himself and will tell you so later if you don't erect a barrier by punishing him.

6. Be ready to discuss sympathetically your youngster's problems, but don't pry into his affairs. Get him to open up by discussing in an impersonal way something you have read or heard that fits into what you **think** is bothering him, such as acne, being tired, or poor school work.

7. Be cheerful and keep the home atmosphere cheerful. This serves two purposes. First, it will discourage the child's desire to go off by himself, which often leads to daydreaming, usually with a martyr theme, thus increasing the already-existing belief that the world doesn't treat him fairly. Secondly, a cheerful atmosphere helps minimize physical discomforts, the major source of the psychological growing pains that lead to the psychological scars of growing-up.

More Questions and Answers

(See also page 32)

Friendly firmness

COPING with a one-year-old can sometimes be very tricky. Here is Mrs. J.E.R's problem. How much discipline should I give to my son Robert? He appears to be very independent and self-willed, and we find it hard to know where to draw the line. He does understand the meaning of the word "No", and will sometimes obey. So far we have restricted its use as much as we can. Just what obedience can we expect? For instance, when he scratches the wallpaper we ignore it. Should we do anything about it? He will not allow anyone to feed him. He dives into the food with his hands, screams with irritation at the slightest effort we make to help, and is generally very noisy at the table. He also screams with temper when being dressed.

Our psychologist, who specialises in the difficulties of small children, says that even in the best-regulated families things will go wrong sometimes. The trouble with your little boy is one of relationships. It is hard to say why he should be up against his world, so angry with those around him. Possibly his early feeding included painful experiences. Colic or other tummy troubles can seem to a baby like an attack upon his body. As if Mummy, the all-powerful, is hurting him. Not unnaturally, he reacts with anger and hostility.

You, who know all about Robert, will know whether he did suffer when on the breast or with the bottle. If so, you will have to be very gentle and patient about his present feeding habits. It is not a bad thing that he wishes to feed himself. You would be wise to encourage this, messy business as it is, for in this way he will learn all the sooner to acquire skill in eating. Let him have a spoon every time. Probably he won't be able to use it yet, but one day he will, in imitation of the grown-ups. This would be a good social way of asserting his growing independence.

You may think of other ways in which the first year of life was seriously disturbed, and act accordingly. There may have been illness, or separation, either of which would shake faith in the parent-child relationship.

About discipline — this is rather a big term to apply to a one-year-old. Friendly firmness can be a real help to a small child, though. This makes for a feeling of security. Mummy knows her own mind and is not frightened to express it. If a child senses that Mummy is scared of doing the wrong thing, his anxiety is bound to be increased. So it is better not to ignore destructiveness, as with the wallpaper. Be firm about it, but at the same time provide play material that can be safely attacked. Old cotton reels, tins, a toy hammerboard, are all good for letting off steam. It is fine to have a little chap with so much energy, if you can get him to divert this in the right direction.

FORMULA 21 DIET

Q. What is your opinion of the Formula Diet 21 for slimming? Please advise me about this.

A. The Formula 21 diet is probably the most honest and sensible proprietary slimming preparation that there is on the market, and here's why.

The basis of slimming is a proper diet. A manufacturer who makes this quite clear, who tells you what a proper slimming diet is, and who sells you a preparation which makes no claim except that it will help you to keep to this diet, is a very rare and admirable bird. And this is just what the Formula 21 people do. Their slimming diet incidentally is a low carbohydrate diet, so it works on the same principles as that in the **Family Doctor** booklet **Slim Safely.** The main ingredient of Formula 21 is methyl cellulose, which helps to fill your tummy and so stops you being hungry. So there's no reason why you shouldn't try it.

Puppets in Czechoslovakia

(*Continued from page* 16)

Many leading glove puppet and marionette companies are not bogged down by technical gadgets and electrical buttons, and the essence of their artistry emerges from their complete captivation of an audience within the severe limitations imposed.

In Czechoslovakia, provision is made for the systematic training of puppet artists. Courses in puppetry are organised at district, regional and national levels, with state subsidies. Special classes at art schools give instruction in the designing and making of puppets, stage properties and sets. At the Academy of Dramatic Arts, at which foreign students are also enrolled, an all-round training in puppetry is given.

How much enriched South African theatre could be if such facilities were made available here. It is certainly a worthy goal for the future.

Help for Troubled Children and Parents

The article following is actually taken from a report by the Society for the Protection of Child Life, Cape Town, given at the annual meeting of the South African National Council for Child Welfare. We have shortened the report, which we thought would be of general interest to our readers.

During 1957 the Society for the Protection of Child Life became very concerned about the incidence of juvenile misbehaviour — and often of delinquency — reported in the press or brought to their notice by parents and guardians unable to cope with the situation. Social workers felt that specialised attention should be given to these cases, many of which were due to broken parent/child relationships or to broken home life. The Society set up a service for Parent Guidance and Consultation with an experienced social worker in charge, assisted by panels or advisers from different fields — education, health, psychology, psychiatry, legislation, social work, etc.

The term "Parent Guidance" has shown itself to apply very aptly. In general case work with and for children the focus is on the child, but emphasis in this section has on the whole been on work with parents, for three reasons. It was found that insecurity in the relationship to a parent or acting parent in the home was basic to most adolescent difficulties. Adolescent children normally have middle-aged parents who are themselves, at the stage of life, often going through a period of per-

sonal difficulty, re-evaluation and readjustment. Help for the difficult child comes best through his parents.

Usually the parent or the adolescent approached the social worker with either specific symptoms (for instance, truancy) or with a more general feeling of dissatisfaction (such as child difficult at home or adolescent wanting to leave home). Occasionally reassurance on the normality of such symptoms or advice on how to tackle them was enough and the matter could be cleared up further by the persons concerned. Usually, however, the problem was already of long standing and really serious, so that a thorough investigation was essential, with parents, the child, visits to the home and contact with other professional people such as teachers and doctors all involved.

It is as yet impossible to assess the effectiveness of the methods used. It soon became clear, however, that there was a fundamental need for someone to co-ordinate the efforts of all those related to the child, such as schools, hospitals, doctors, lawyers, the courts, employers and other welfare organisations.

General family conditions

There is no clear indication that the families we are dealing with are of a special type, except, perhaps, in their *composition*. We found a large number of complicated families, and that it was the child outside the normal family relationship who was likely to present the problem.

Of every ten families, 7 had a married man as the head of the family, the other three being a widowed or divorced woman, or a separated or unmarried woman. Five of the households had a monthly income of under £60, five to six of over £60. Of every 10 mothers, between 5 and 6 were housewives, three were working full time, and one was working part-time. Of the mothers who worked three-quarters were married, of whom about one-third would have to work (apart from other reasons) to fulfill their children's basic needs, while one-third could meet their children's needs on their husband's incomes and presumably worked for other reasons. The remaining third worked for a combination of reasons including personal reasons and social pressures.

In each 10 families, six were "abnormal"; two were simple "broken" families; three were complicated (two parents and at least one child not directly related to both parents); one was a complicated broken family (one parent with at least one child not directly related to that parent).

The main factors found to be important in the problems presented were these:

Parents

In 21 cases, financial complications; 24, lack of interest and control; 17, separation; 14, excessive concentration on or ambition for child; 13, mental abnormality or deficiency; 13, excessive absence from home; 13, incompatibility; 13, separation; 12, prolonged ill-health.

Children

These were the important factors: broken home, 27; broken home background, 29; foster care and adoption, 19; past institutional care, 17; mental abnormality or deficiency, 12; external social circumstances, 7; physical abnormality or prolonged ill-health, 4.

In each case it was obvious that there were several factors involved, combining to place stress on the whole family. In such a family the child who was different, physcially, mentally or socially, became the focus for the stress. This often initiated a vicious circle of misunderstanding, blame and difficult behaviour in the child, further stress on the family, increasingly difficult behaviour, and so on.

We found that there were basically two ways of breaking this vicious circle:

(a) Counselling with parents and child, with the object of relieving some of the stresses on the family, explaining the "abnormal" child and bringing this child into proper focus; and

(b) Working through the environment, for instance by arranging for better housing, employment, schoolings, etc., or, if necessary, temporary removal of the child away from home, while continuing to work with both parent and child.

Although these children were in no sense uneducated, yet their educational needs were often not fully met in the sense of education up to their ability. In this same way, housing might provide shelter but not living space; clothing might meet daily needs but not the special needs of adolescence; medically and mentally the children might meet minimum standards but not function effectively; occupation might provide for material needs but not for the deeper need for recognition and stimulating new experiences; spare time was available but seldom constructively used in recreational or cultural activities; in personal relationships, while this group usually had the love and affection of at least one parent, seldom did such relationships provide either the attention these youngsters so badly needed or the consistent security of a stable home. *In short, the child appeared often to be in the home but not part of it.*

In our study of the types of families we worked with, we have had to discard some popularly held notions on the "causation" of adolescent difficulties. This study has also pointed to lines of investigation which would be fruitful in understanding and helping our cases further.

We have been deeply impressed by the desire of many parents to help their children, and also with the generosity of many adolescents in understanding family pressures.

As the problems were presented to us, the influence of home life on the child appeared to outweigh by far outside influences. We must, however, keep in mind that nowadays parents themselves are handicapped by the fact that in practice society does little to back up their values; and furthermore that it is extremely difficult to assess the effect of outside influences on the child's mind.

THE GERM THAT LIKES HOSPITALS

(Cont. from page 8)

antibiotic was used most heavily in that hospital over a given period. But it is a phenomenon that involves other types of organisms besides the staphylococcus."

Spread in several ways

Whether staphylococci or other types of organisms, hospitals have a real battle because the bacteria-caused infections originate in the hospitals and spread in a number of ways. Mary K. is an example.

Mary left the hospital with her infant a few days after its birth. About three weeks later the infant broke out with ugly skin sores, excreting pus. Mary developed an abscess on her right breast. The infant's father, who was helping care for Mary and the baby, came down with painful boils. Mary's mother—nursing a bad cold—contracted staphylococcal pneumonia and died.

Members of an entire family have been known to fall victim in one way or another to the staph bug once it germinates inside the family circle. Doctors have reported large, angry boils surrounded by a cluster of smaller boils — called "satellites" — on the body. Single abscesses on the breasts of nursing mothers have been known to drain for over a year. A mother has been known to contract a staph infection while in the hospital with her newborn infant and return with the same germ a year later when giving birth to another child.

Visitors also responsible

The staphylococci may be passed from infant to infant when too closely grouped in maternity sections of hospitals. The germ also may travel air-borne from one environment to another in hospitals. It may be spread by chronic carriers among hospital personnel or by occasional visitors.

In one eastern hospital an epidemic began spreading in the maternity ward. There followed period of high and low incidence of staph infections. Aseptic techniques were tightened, hospital personnel was cultured, and every means was taken to stamp out the disease. The situation continued for nearly six months, then one of the surgeons recalled a nurse's aide who worked at the hospital one day a week. A nasal and throat culture disclosed her as the carrier and the staph infections were stamped out.

Several other staph infection epidemics have been eliminated by detecting and treating carriers. A strain that prevailed in one nursery for a month finally was traced to an anesthetist in the delivery room and the strain disappeared from the nursery when she was transferred from the obstetrical service.

Some studies claim the transmission of the organism from infant to infant is of greater importance than personnel carriers. One staph epidemic implicated the infant's umbilicus, or navel, in the spread of the disease. It was observed a lower colonization existed in the nursery when an antiseptic solution was used in the care of the umbilicus stump, which is likened to an infected wound.

Bathing infants daily with hexachlorophene soap apparently reduces the spread of staph infection, presumably by preventing colonization on the skin and by reducing the frequency of transmission by the hands and air.

Rubber gloves no help

The hands of nursery personnel have been considered a likely carrier although the use of sterile rubber gloves has not had any effect on the course of an epidemic. It has been found, too, that staph epidemic strains may be isolated from persons in the general community, that a mother may infect her newborn, and that an epidemic can be started in the nursery by one infected infant. It also is known that the same staph strains can be isolated from patients in all parts of the hospital and that nursery personnel frequently are exposed to such patients or the staff caring for them.

Staphylococcal diseases originating in hospitals are not new. In 1879 it was demonstrated that diseases caused by micrococci usually originated in hospitals. Then, as now, hospitals were the dominant source of fatal infections, most of which probably were caused by staphylococci. The adoption of Lister's principles and improved techniques by others diminished the mortality from surgical wound infections.

Scattered reports during the 20th century showed that surgical wound infections had not ceased as a dominant killer. In 1925 records of postoperative wound infections in a New York hospital showed the infection rate to be 15 percent for clean wounds, seven and a half times greater than had been estimated by the chief of one of the surgical services.

In 1938, a survey showed that about five percent of clean operative wounds in New Haven, Connecticut, developed signs of infection and that well over 50 percent of such infections were caused by staphylococci.

Wound infections increase

In 1954, seven and two-tenths percent of clean surgical cases in Boston Hospital developed postoperative infections and since then the infection rate has increased one-half to one percent.

PERSON-TO-PERSON INFECTIONS

Disease-producing organisms may pass from person to person by four routes :

1. *Upper respiratory (e.g., pneumonia, diphtheria, and measles).*
2. *Gastro-intestinal (e.g., typhoid fever and the dysenteries).*
3. *Skin (e.g., syphilis and impetigo).*
4. *Parenteral (e.g., transfusion hepatitis and encephalitis).*

Most known communicable diseases fit into one or more of the above groups. Hospitals readily care for persons with these diseases without widespread cross infections.

It appears, from such reports, that infection of surgical wounds in hospitals, especially with staphylococci, remains a considerable cause of death.

A gradual increase in staphylococcal disease among newborn infants in American and British hospitals during 1917 to 1935 is substantiated by documented surveys. In Chicago very few nurseries were exempt and in one hospital five epidemics, each of two months' duration, occurred between 1917 and 1928.

Fortunately, the road ahead has a silver lining when viewed in the light of what has transpired in the past. The major enteric (intestinal) diseases have yielded largely to improved community sanitation. Immunization has virtually conquered diphtheria, smallpox, and tetanus. Streptococcal disease has been much subdued by antibiotics. What remains now is staphylococcal disease, probably the foremost parasitic cause of death in many of the nation's modern communities.

Hail new antibiotics

One of the most encouraging developments in the battle against staphylococci-resistant strains is a new antibiotic called Kanamycin. It was discovered in 1955 by Dr. Hamao Umezawa, a Japanese medical scientist, and has been hailed as an effective drug against staph-resistant strains.

Another antibiotic — ristocetin — has given indications clinically of effectiveness against infections caused by staphylococci and gram-positive organisms. Ristocetin not only arrests the growth of infectious organisms, it kills them. This particular bactericidal characteristic is believed the reason for its clinical efficacy. Ristocetin must be used with extreme caution because of ill side effects on patients with kidney impairments.

Few doubt but that the staph germs — regardless of how tough — will eventually fall before the onslaught of the antibiotic age. Until then hospitals have an obligation to their patients and communities to keep tight controls on their aseptic procedures, since they are the reservoir of most antibiotic-resistant strains of staphylococci. Many hospitals already have snapped into action by organizing vigilance committees to investigate every case of surgical or medical infection.

Visiting privileges cut

Many hospitals have closed their nurseries during the initial outbreak of staph infections, sterilized the nurseries and everything in them, checked personnel for carriers, and isolated patients with staph infections. Visiting privileges have been sharply curtailed or eliminated and separate bags and cans set up for handling laundry from contaminated areas.

Operating room personnel have been requested to scrub up more thoroughly, change masks during operations more frequently, and hold fast to "no admittance" regulations in the operating rooms. Patients have had their stays in the hospitals shortened so they would avoid the risk of becoming staph infected.

Working closely with the hospitals in the battle against staph infections are bacteriologists, public health experts, and hospital executives. Dr. Stuart Mudd, professor of microbiology in the School of Medicine, University of Pennsylvania, and chairman of the American Medical Association's research committee, convened a meeting of representatives of health organizations to discuss the staphylococcal disease problem.

A committee on infections established by the American Hospital Association is headed by Dr. Dean Clark, director of Boston's Massachusetts General Hospital.

A.H.A. issues warnings

The Association's recommendations to hospitals include warnings against routine indiscriminate use of antibiotics; long hospital stays; contact with infected hospital patients, staff members and personnel; crowding and inadequacy of facilities; prolonged operative procedures, and extended use of continuous intravenous therapy by venipuncture or indwelling plastic tubing.

Equally important, says the Association, are contaminated equipment, supplies, dressings, air, dust, wall and floor surfaces, linens, laundry chutes, and filters in ventilating and air conditicning systems. Frequent changing of filters and cleansing of the systems are recommended because staphylococci have been found lurking in such places.

A humidifying device, typical of the apparatus generally used in oxygen therapy, has been found to contain contaminating organisms in hospitals. The extent of contamination was greater than anticipated and some of the bacteria were extremely dangerous.

Following this discovery, a systematic procedure for the care of humidifying units in oxygen therapy has been adopted. The water to be used in the humidifier must be sterile, and when the level in the reservoir falls, the residue must be discarded and replaced, not merely replenished. After each period of use the glass reservoir must be cleaned and inspected before the unit is again used.

Recommended by the A.H.A., too, is wet mopping of floor surfaces and minimum vacuuming so as not to raise dust particles containing staph-resistant strains. Some hospitals are using plastic mattress coverings which can be easily cleansed with disinfectant.

Staph germs everywhere

There is no substitute for sanitation. Necessary is strict cleanliness for all areas of the hospital, not merely the operating and delivery rooms and nurseries. This also applies to communities, for all of us have staphylococci within us or on our bodies waiting for a chance to attack newborn infants, wounds, surgical openings, and persons in run-down condition.

The goal is to block or destroy the staphylococci before they find favourable habitat in susceptible hosts. Competent authorities stress that the prevalent cause for infection epidemics is bacteria resistant to antibiotics. They explain that indiscriminate use of the antimicrobial drugs for minor illnesses places a person in real jeopardy by aiding germs to build up resistance to drugs to which they once were sensitive. When a serious infection strikes and calls for antibiotic therapy, the indiscriminate user of the drugs may learn too late that he has sounded his own death knell.

But there is a brighter side, too. Some antibiotics still are effective against the staph resistant strains. And new, effective antimicrobial drugs, like Kanamycin, are proving their worth.

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