

Industrial Nursing Section

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WEDNESDAY AFTERNOON SESSION

October 4, 1944

Presiding: PAULINE KUEHLER, R.N., Standard Oil Co. of Indiana, Whiting, Ind.**Teamwork of Industrial Physician and Nurse Gets Results****W. G. HAZARD**

Acting Chief, Bureau of Industrial Health, New Jersey Department of Health

Teamwork in the plant medical department—as in all other activities of industry—is essential to success. Once teamwork prevails, *results* are bound to follow. We have been enabled for several years to watch *good* teamwork and *bad* teamwork in a variety of industrial concerns. Repeatedly we have been impressed how lack of teamwork leads to far more than professional inefficiency. It leads to misunderstandings among the workers, waste to the management, and even personal loss to the individual. For the company, poor teamwork is just *bad business*.

Medical policies of a plant depend on the type of medical supervision: whether there is a physician full-time, part-time or on call. The full-time plant physician gives written and verbal instructions and assistance to the nurse much the same as in hospital or private-duty nursing. It is by far the most desirable form of medical supervision. Our remarks here are directed mostly towards the plants that have part-time or on-call physicians. These plants make up the bulk of industry.

A part-time physician is one who is paid a regular retainer fee month in and month out, in return for which he visits the plant periodically to supervise, diagnose, treat and examine. An on-call physician is one whose fee depends on the number of cases treated, on the number of physical examinations given, and on the number of other special services performed. Unfortunately, he may not even know the occupational hazards of the plant with which he is associated, and it is often surprising how many on-call physicians there are who never visit the plant. For the nurse and for the corporation this is the least desirable form of physician arrangement, because it affords the least medical supervision.

In industry, as in the military forces, organization is basic. For the plant nurse,

lack of a clean-cut organization line often obstructs her best efforts, without her realizing it. A nurse is accustomed by her professional training to report to a physician or to a supervisor of nursing. When she gets in a plant, she may find a confusing picture. A recent bulletin found this about supervision of industrial nurses in some 868 establishments: When the physician was part-time, nurses reported to him in one out of every three (34%) establishments, but when he was on call, nurses reported to him in only one out of every 25 (4%) establishments. In the other establishments with on-call doctors, two out of five (39%) had their nurses report to the personnel manager; and the remainder of the establishments, more than half (57%), had their nurses reporting to the superintendent or to some other plant official. "A number of nurses interviewed," the bulletin stated, "were not certain to whom they were responsible." Teamwork in those plants where the nurse is responsible to a minor department head, or where she actually does not know to whom she reports, must certainly be difficult.

The greatest need today perhaps in industrial medical departments is for closer medical supervision—and the nurse should constantly try to "sell" her management on this. For example, she should have frequent conferences with her supervisor, pointing out new services her department can render, emphasizing her own limitations in giving any medical care but first-aid, explaining how a good medical department can cut operating costs even in a small plant, and educating him gently but persistently in industrial health. She should route magazine articles to him that support her current projects. She should not only send him statistical reports at least monthly on her work, but she should interpret these in a sentence or two, using the records as indicators of needed improvements in her de-

partment. She should prepare an annual report on the health of the plant, just as the treasurer prepares a careful report on the finances of the corporation. Her report, however, should not be merely a maze of figures, but a guide to a better health program for the next year.

Should Know Plant

Next to knowing her boss, an industrial nurse should know the plant and the industry to which it belongs. Whatever the method used—the important result is to have the nurse regularly visit the workrooms, familiarize herself with the operations, and get to know—and be known by—the employees.

Just as a nurse should send marked copies of medical journals to her supervisor, she should get on the routing list for trade journals which today devote more and more space to plant health activities.

In addition to the mechanical side of her plant, a nurse who is not under full-time medical supervision must help her part-time or on-call consultant in dealing with other departments in the plant. She should know all department heads. She should know the business procedures of the plant that affect her work; how to requisition supplies, how big a budget the medical department has; how work orders are processed to the maintenance department. Above all, she should know and consult frequently with those persons handling safety and workmen's compensation. She should, in short, know "her way around" the plant and know how to get things done.

Professional Do's and Don'ts

The above suggestions are made to help the new nurse feel more at home in the industrial atmosphere. In the daily handling of her cases, there are many ways of a professional nature by which she can build teamwork between the physician and herself.

The nurse should always regard the person she is treating as a patient. She is not there to determine liability for the injury or illness. That is the job of someone else in the plant. She must never get into an argument with the worker as to whether she is permitted to treat a case or not.

Her job, in addition to first-aid treatment, is to take a complete history of what the symptoms are and how the ailment

arose. She should visualize what happened in the plant—for example, how heavy the article was that the man lifted, whether he was accustomed to lift that weight, whether it was a part of his job, whether there was mechanical handling equipment available, and many other important though small phrases that make up the complete story. To construct such a history, which subsequently may be worth thousands of dollars to the company, she must know well—as already mentioned—the plant lay-out and operations. The write-up of all cases should be complete—but especially so in those involving a worker's back, or in cases where there are symptoms of rheumatism, lumbago, arthritis, or neuritis.

In giving any treatment the nurse should work under written procedures, when she has a full-time physician in charge, or under written standing orders when she has a part-time or on-call physician. If there are nonprofessional workers at the plant, they also should have written standing orders. Standing orders protect the nurse, the worker, and the management. The nurse is responsible for procuring them.

In handling non-industrial cases, the nurse should be provided with a definite policy to follow in deciding when anything more than simple first-aid—which is always permissible—should be given.

Maintain Standard

When a plant has no full-time medical service, the nurse is usually in charge of the rooms that make up the medical department. She can promote good relationships with the part-time or on-call doctor by maintaining a standard of environmental and personal cleanliness that would be demanded in a good hospital.

Most nurses are affiliated with the American Nurses Association, but probably more should take advantage of the State and local sections of their industrial nursing organizations and public health nursing organizations. To keep current on industrial health news, many nurses regularly read such magazines as the *National Safety News*, *Industrial Hygiene Foundation publications*, and *Industrial Medicine*.

"Selling" the Plant Health Program

The industrial nurse is in a better position to get her plant adequate medical service than anyone else. From her intimate

knowledge of the workers, and of the occupational hazards to which they are exposed, she can aid the part-time or on-call physician immeasurably. From her experience and study of industrial nursing she can recommend improvements to her management.

According to the survey of industrial nursing already mentioned, there are eight recognized activities of nurses. All the plants surveyed that had nurses were found to practice two of them: (1) maintenance of plant dispensary (supplies, records, reports), and (2) care of occupational ailments and emergency care of non-occupational ailments. Generally less than half of the plants surveyed, however, had their nurses engaged in the other six activities. These are:

	<i>Per cent of plants</i>
(3) Participation in physical examination program	50%

(4) Participation in health education program	15
(5) Assistance in safety education and accident control.....	42
(6) Assistance with environmental sanitation....	39
(7) Participation in plant welfare program	75
(8) Home nursing service.....	25

It is safe to say that scarcely a plant exists in the part-time or on-call medical service group that cannot expand its medical and nursing programs to the advantage of the worker, the management and the community. These plants look to their nurse as their resident "health expert," and she is thus well situated to feed ideas to management for plant health improvement, for more nearly adequate medical service, and for the safer handling of employee disabilities.

Nursing Ethics in Industry

By CATHERINE R. DEMPSEY, R.N.

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We expect the graduate nurse to understand the results of each step in an intricate medical treatment; to expedite these procedures with expert manual and mental skill and fortitude; and to straighten out her patient's emotional reactions. Instead, we often find this graduate bewildered, struggling to combine with her highly professional duties those of the house-keeper, personal maid, interior decorator, personnel director; safety engineer, clerical worker. Perhaps some of this so-called bewilderment regarding professional duties may be the reason we hear so much discussion today about a code of *nursing ethics in industry*.

What do we mean by nursing ethics in industry? Webster gives one definition of ethics as "broadly, the science of ideal human character." Charlotte Aikens in *Ethics for Nurses* states, "as relating to nursing, ethics has to do with the ideals, customs and habits which the members of the profession are, by degrees, accumulating around the name and general characteristics of the woman known as the trained or professional nurse."

In discussing nursing ethics in industry, what is the first and most important point for us to consider? Does management

clearly understand nursing ethics in industry? Does the physician clearly understand nursing ethics in industry? What about the labor organizations? How many workers have any appreciation of the subject? Last but not least, does the industrial nurse herself fully realize the importance of a code of ethics?

From the staff nurses of one nation-wide company we received the following: "World War II has again brought to the foreground the importance of industrial nursing in helping to maintain in industry all workers physically and mentally fit, in order to speed production. As she has a specialized piece of work to do, *ethics* require trust in the industrial nurse. To bring about this trust, she must have, among other qualifications, tact, adaptability, order, promptness and memory. She must also be an adviser in essentials of good health and hygiene, and to be able to see the viewpoints of others and be a real friend to the employee without being intimate."

Ethics Always Count

The same rules of ethics taught us in our training are just as applicable in industrial nursing as they are in institutional

nursing. However, in industrial nursing more responsibility is relegated to the nurse so she must be ever mindful of these rules and regulations. Usually her immediate supervisors and associates are doctors and nurses, and her behavior as concerns them should be respectful and above censure. Between the industrial physician and the industrial nurse lies a profound understanding of the nurse's capability and limitations. From this profound understanding has arisen a marked degree of confidence bestowed by the physician in the industrial nurse and an awareness on his part of her true value in the profession. However, the management of the plant and the patient often are not aware that such ethics do exist and at times will expect the industrial nurse to overstep her bounds. Especially is this true in the small plant where only a part time physician or no physician at all is employed. With tact, the nurse must explain to the managing personnel or to the patient that she is limited in what she can and cannot do. Once her limitations are understood by all, she experiences great satisfaction in her work as nurse, counselor and confidant.

It is invaluable for industrial nurses wherever possible to maintain an active part in their alumnae, state, and national nursing associations. In this way contact is maintained with ethical problems of other nurses.

Nurses in the office of the medical director of an entirely different company say: "It has been the custom for some nurses in industry to follow a hospital code of ethics for reference in the industrial clinic. This did not work as well as they expected; so from there they went to the old school of trial and error, which is a help only when it is too late.

"There is a basic code for all nurses, embracing personality, professional manner, loyalty, executive ability, appearance, but the nurse in industry may be judged in three other ways:

"(1) *The nurse who is too severe.* This nurse is never very popular. She is called snooty, cold, uninterested, mercenary and a host of other names. She may cooperate with management and personnel in an approved manner, but her lack of sympathy with the worker, whom she was employed to benefit, will jeopardize her popularity.

"(2) *The nurse who is too familiar.* This

nurse shows favoritism and talks about a worker to anyone who has time to listen. She shatters the confidence of all workers, without which her chances in industry are limited. Counselling can only be done by gaining the worker's confidence.

"(3) *The nurse who has reached the happy medium.* This nurse is admired for her fairness and her loyalty to management and worker. She respects authority, observes rules, is progressive, mixes well with all workers, takes an interest in all plant activities. She is the nurse who knows that workers are not machines, and a monthly servicing will not make them run smoother."

From another section of the country we receive this quotation: "The successful industrial nurse must be first, a good nurse; second, she must like people; and third, she must have a strong sense of Ethics.

"One of the most important qualities for a nurse in industry to have (or develop) is the ability to see the entire industry objectively and understand clearly the relationship of her department to the whole. Even though she is expected to be a tower of strength and a fount of wisdom, she is wise not to expect or accept special privileges or consideration. She will do a better job by being a good company employee.

"The nurse in industry is in a position of guiding and teaching all workers. Her own mental control and emotional stability are her first concern. Without them, she can do only a routine job. With an understanding heart and a level head, the nurse in industry can do an inspired job. Her opportunities for educational health work are unlimited, as are the ramifications of her job and her usefulness to her company.

"A doctor once described an industrial nurse as a 'diplomat at large.' Her patients are her fellow employees. A patient is usually only such for a few moments at a time. This creates a different relationship from that existing in any other type of nursing. She must be in the position of respecting the confidence of the patient, yet not keeping from management or safety any information vital to the well-being of this individual or other employee.

"We all know how a department head will sometimes ask, 'What's the matter with him?' when told that one of his workers is ill and should go home. It is a natural and, in most cases, genuinely interested

question. However, it is one that the nurse must answer most carefully. The boss is not a member of the patient's family.

"It is not ethical for any nurse in any position to assume responsibility which is not rightfully a nurse's work. If we have less supervision, then our responsibility to our own nursing profession, the medical profession, and to our management—not to overstep the bounds—is greater than in other lines of nursing.

Must Know Hazards

"It is, of course, necessary for a nurse to be intelligent about general conditions in her plant, to know the hazards, to serve on committees, to advise about conditions of cleanliness, etc. A nurse can understand a surgical operation so well that she knows each move that is to be made and each instrument to be used. However, this does not qualify her to perform the operation, but makes her an able assistant. The same rule applies to her cooperation with the Safety Engineer. She must understand how to do so intelligently. Suggestions and recommendations can be made and conditions reported."

The following opinion comes to us from the supervising nurse of another nationwide corporation:

"Because of the wide range of industrial jobs, skilled and unskilled, employees are attracted to industry from all sections of the United States. As a consequence, great numbers of people are grouped together whose modes of living, attitudes and reactions are vastly different. A nurse, in order to benefit these employees as well as management, must have the qualities of a teacher and a broad understanding of human nature. The average employee who is antagonistic to routine medical procedures, who disregards safety rules, and jeopardizes his health, does so in most instances through lack of understanding, rather than a desire to hinder the nurse in the performance of her duties. Nurses should be carefully selected for industrial positions. Supervisory personnel should select nurses who have a basic academic background: psychology, sociology, social case work, and Principles of Public Health and Industrial Nursing. Three years' training in an accredited school does not necessarily qualify the nurse for industrial work.

"Time should be spent during the first

interview to determine the applicant's emotional stability; whether or not she is quick tempered; is she congenial; can she take orders; does noise affect her; does she favor some patients and not others; does she sincerely like nursing and why has she applied for the position. The answers greatly determine the adjustability of a nurse to industrial work.

"If a nurse is emotionally unstable, she cannot be depended upon to teach a convincing health program. Quick tempers can and will destroy a feeling of confidence between lay and medical personnel. A nurse who cannot harmoniously work with other nurses is demonstrating her incapacity to make adjustments which are frequently required in emergency work. Inability to take orders creates a friction between the supervisory and staff of both factory and medical personnel. Favoritism among patients divides employees into two camps: those who like the nurse and those who do not, sometimes to the extent of passing up necessary treatment.

"A nurse's reason for entering the industrial field must be based on a sincere desire to promote health education. She must believe in her work in order to convince the employees of the importance of building up and maintaining the maximum of health."

In July, 1943, the Royal College of Nursing in England issued a pamphlet on a "Code of Ethics Governing the Professional Conduct and Procedures of the Industrial Nurse." Following are a few of these rules as quoted from this pamphlet:

"The following rules have been drawn up as a guide to nurses in the industrial field of public health nursing, and have been endorsed by the Association of Industrial Medical Officers.

"They are intended to govern the professional relationship between the industrial nurse and:

- a) industrial medical officers and other medical men;
- b) other members of the nursing profession;
- c) management;
- d) employees;
- e) other professional workers.

"The nurse employed in industry shall conform to the accepted professional principles and instruct auxiliary nursing personnel accordingly.

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"1. The nurse shall hold in confidence all personal matters imparted to her and all family affairs coming to her knowledge.

"2. Anything relating to the health of the employee, of which the nurse gains knowledge in her professional capacity, shall be treated as confidential, unless the law requires otherwise, and disclosed only to the industrial medical officers, her nurse colleagues, or the employee's own medical attendant.

"3. The nurse shall not influence the religious or political opinions of employees or members of their families.

"4. The industrial nurse shall not influence the employee in the choice of any particular doctor.

"5. The nurse shall maintain a strict neutrality in any political issue involving differences between management and employees. She shall not allow herself to be involved, by statement of opinion or other-

wise, in differences between the management and employees.

"6. Medical records concerning the employees kept by the industrial medical officer are confidential documents. As these may be placed in the custody of the nurse during the doctor's absence, she shall not allow any other person to have access to them except with the approval of the responsible medical officer."

The basic ethics of the nursing profession as outlined in the Florence Nightingale Pledge, which was formulated by a committee in the year 1893, are just as applicable to nurses in industry as they are to nurses in any other branch of the profession.

The nurse in industry must often assume or carry more responsibility than the nurse in other fields, especially if she has only a part time physician or no physician at all. Therefore, she must be ever alert to maintain these basic ethics in order to uphold the highest traditions of the profession.

THURSDAY AFTERNOON SESSION

October 5, 1944

Presiding: PAULINE KUEHLER, R.N., Standard Oil Co. of Indiana, Whiting, Ind.

Industrial Nurse's Application of Psychiatry

LYDIA G. GIBERSON, M.D.

Industrial Psychiatrist, Metropolitan Life Insurance Company, New York

You nurses are among the true pioneers of industrial medicine. You blazed the trail (as far back as 1895 when workers were just something you hired), did the initial job we are all talking about today.

You retain within yourselves the greatest contact with the workers of whom you are one. It is through your sympathy and understanding of all phases of the industrial medical problem, that the proper understanding can reach those empowered to deal with the worker. In that sense your field is almost limitless. It reaches into every facet of the worker's life. His life on the job, off the job, physical and mental. And it is about the mental side I would like to speak today. Upon your accurate report and understanding, must rest, in large degree, the benefits which industrial medicine can furnish.

Workers will talk to you in the course of your duties. Don't be bored just because you are busy. What they have to tell you can have a definite psychiatric benefit and bearing. Make mental or even written notes, and transmit them to your medical department. They may be of immense benefit to the patient under a proper medical setup.

You have all heard, I am sure, the many adjurations concerning accidents, and safety in general. No one knows more poignantly than you the results of industrial carelessness. Your job to preach that gospel is pretty plain.

Describes Emotional Stress

But there rides beside every man at the bench, the intangible ghost, which no amount of training can remove—his other life—his emotional life—his life in the process of

living. And that takes in his twenty-four hours a day living. His financial worries, his family cares. In fact, the sum total of his emotional life.

It is beside him every waking hour. At the bench, at home and, if you believe the Freudians, in his sleep. You have a twenty-four hour man to deal with. His troubles should not be a bore. They are important. They bear directly on his work and therefore on your job of keeping him healthy.

I don't mean to suggest by this, that all he's got to tell you is pertinent. There are some chronic bellyachers, a few malingerers, and a few who are just there for the paycheck. But there are others, and many of them, who have various physical and truly mental burdens, and these should be carefully listened to and helped.

Yours is not the job of sorting out the sheep from the goats, but a medical observation post from which can flow a current of immensely valuable data, whereby your medical organization, and, in turn, your personnel management, can function to infinitely greater advantage.

Let me illustrate: Mary X reaches you. She can't concentrate. She's jittery. She's making many mistakes. This is unusual for Mary. There is apparently nothing organically wrong. You find out she has a flyer brother. He's been reported missing. With great effort she has controlled herself and carried on. Suddenly in her Section, there is much talk about the war. Her mind wanders. Errors creep in. Production goes down. At home Mary has had to present a brave front. A sick mother cannot be unduly upset. Mary pours out her story to you. She gets relief. She can steady herself now. You can also help with some wise suggestions to the Section Head. Thoughtless remarks and unnecessary gruesome tales of war and war prisoners can well be dispensed with on the job.

There's probably no one who looms as large on our national or industrial scene as G.I. Joe, who's coming back to us some time, and the sooner the better, say we. Undoubtedly, you've read a great deal about this gent. About what he'll think, about

the way he'll act, about the way we should act, etc.

I personally resent the idea, that when he comes back, he's going to be some sort of stranger we can't talk to or deal with as we've always dealt with him.

Loves G.I. Joe

He's the man we've always known and loved. He's G.I. Joe—American, who has been away from us for a time, doing a dirty job he won't talk about if you don't first.

He's coming back to the one country he knows and loves. He wants only to resume the life and work he's left—to work, hold his head up, support his family and find out how the Dodgers are doing. That's why we like him.

So it seems only a matter of common gratitude and humanity to smooth his path, to act as though he were only one more applicant for a job (let personnel policy take any further steps necessary).

There will, of course, be many, seeking jobs, physically or mentally disabled. But again their American pride has earned its right to be recognized. Help 'em, but above all, don't pity 'em.

There will be certain medical regulations laid down for you, in the course of time, dealing with these men. As your duties demand it, you will have to administer them. But—as many of you must have some G.I. in mind, don't pity him and don't ask him unnecessary questions.

He has been confronted with questions probably for years and the greatest kindness you can do him is to keep your official contact with him to a minimum. Try to acquaint yourselves, as closely as you can, with the conditions of his reemployment and assist him within these limits to meet a situation, which, at best, will be complicated. His medical history in the army should be a matter for your careful scrutiny.

No matter what steps are taken by personnel or management for meeting this situation, yours is one of the most important liaison jobs that can be done for the returning Service man. He needs your understanding but *not* your sympathy.

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New Trends in Treatment of Industrial Injuries

By DR. EDWARD C. HOLMBLAD, M.D.

Managing Director of American Association of Industrial Physicians and Surgeons,
Chicago, Ill.

There has been during the past few years the greatest advancement in the primary treatment of injuries. Prompt, efficient and intelligent treatment of minor and serious injuries has now been supplemented by the use of sulfonamide therapy directly into the original wounds. Dirty wounds of the hands or feet come into our clinics with lacerations and bleeding, sometimes injuries to bone, nerves, tendons and muscles. The serious injuries you refer to the hospital for cleansing, local sulfonamide therapy, suture or other indicated treatment. In many flap lacerations of the scalp, face and hands, the bleeding is controlled, flaps lifted back with forceps and sterile sulphanilamid dusted and sprinkled directly into the wound. This sulphanilamid or other sulfonamide should be sterile. It can be placed in liberal quantities without hazard, but should not interfere with the closure of the wound. Be careful not to get it in the eyes, as it is painful and may set up a conjunctivitis. A much higher percentage of primary wounds so treated within the first hour or two after injury go on to primary healing. A very much smaller percentage than formerly become infected. We can now immobilize with bandages and even plaster paris splintage, and close wounds by suture that formerly we dared not close. Wounds that had to be under constant observation for infection that might be developing are now observed for localized swelling or temperature changes without removal of dressings.

Many surgeons are taking advantage of the preventive value of sulfonamides in cases of injuries. In the army and navy wounded men are instructed to take sulphanilamid or other sulfa drugs internally immediately after injury. In industry, then, when we have injuries of a severe enough magnitude, most of which are hospitalized, it is good treatment to prevent infection by giving the sulfa drugs internally for the first five or ten days, thereafter in gradually decreasing doses.

When the patient does not come to us until he already has an infection, we can

again take full advantage of preventing spread of the infection. Cellulitis, following injury, yields well to massive internal sulfonamide therapy, although the local application of sulfa drugs or sulfa ointments is of almost negligible value after the infection has started. In addition, we use all the well recognized principles of treatment of infection: rest, localization of infection by hot packs, incision and drainage of abscesses, etc. Most infections localize much faster and in some instances abscess formation is prevented by internal sulfa therapy. I prefer sulfadiazine internally, giving with it an equal amount of soda bicarb to eliminate gastric irritation.

Ninety per cent of the spontaneous cases of osteomyelitis occur as complications from superficial skin infections such as boils; therefore, boils and skin infections must be cleaned up and healed as quickly as possible. In some cases of repeated staphylococcal infections such as boils, styes, axillary abscesses, nose infections, I have had satisfactory benefits from a course of staphylococcus toxoid (digest-modified) injection therapy.

Penicillin treatment, still a hospital procedure, has saved many lives and reduced the complications and severity of many infections. Its value is mainly in streptococcal, staphylococcal, meningococcal, gonococcal and similar infections. It is life saving to those patients who cannot take the sulfa drugs internally without severe reactions.

More X-Rays Used

In the treatment of fractures and dislocations, there is a trend to much earlier and more frequent x-rays of injured hands, feet, elbows, knees, shoulders, etc., especially when there is an adequate history of sufficient trauma. We are well satisfied if 50 per cent of the cases we x-ray have fractures. It is much better to take a few more x-rays than to pass up one or two fractures. Nothing brings more discredit on a plant medical department than to have the family physician pick up a fractured

foot, toe, hand or finger that was missed at the plant simply because an x-ray was not taken. Another reason for early x-ray of more cases, and one of the most valuable, is to establish medico-legally the presence or absence of fracture and the presence of old fractures and old pathology that can definitely be established if x-rays are taken in the first two or three weeks. Let the case go six months or a year and then it is not so easy to prove that the old pathology antedated the injury. One other important fact is that by taking the x-ray early, after adequate trauma, you gain the confidence of the patient. You can tell him positively that there is no bone injury nor fracture, and he usually appreciates your thoughtfulness and interest in his injury.

In cases of dislocations it is imperative that x-rays be made before the dislocation is reduced. X-rays rule out complicating bone fractures and establish by the best evidence the existence of an actual dislocation. The scarcity of x-ray films showing dislocated fingers is usually due to the fact that most of these dislocated fingers are reduced before the x-ray is taken, many times by the patient or one of his friends pulling on the finger. Many an interne or young doctor's diagnosis of dislocation has been doubted simply because he did not have an x-ray of the condition before he reduced it.

Why do we splint and immobilize fractures without much displacement? That means that the bone fragments have not moved out of their normal place, or even that in some cases there has been very little displacement. If the original injury was not sufficient to cause the bones to move out of place, certainly your subsequent treatment and the patient's conduct are not going to displace the fragments. There are some exceptions. Fractures of both bones of the forearm or weight bearing on the bones of the legs or metatarsals of the foot are such examples. We immobilize or support such fractures by splints only long enough to relieve pain. I have seen many fractured fingers and toes that were relieved of great pain by simply removing tongue depressor, adhesive tape or even plaster paris splints. In most instances these patients are much more comfortable with a simple gauze or sheet wadding dressing.

The patient should use the injured part

to the maximum extent of his comfort. We get better preservation of muscle, joint, nerve and even bone function and tone if we start easy and early movements of these muscles and joints, passively at first, later actively. The blood and lymphatic circulation is always much better in cases of early mobilization and usage of the injured part. One very striking observation of this point occurs when we compare the edema, swelling and disability of a fractured ankle treated by the old method of immobilization in a cast without weight bearing and using crutches for months, with an ankle fracture treated by weight bearing and a cast with a walking iron or walking heel support. The former has a lot of edema after removal of the cast, the ankle is stiff and painful, and many weeks are required to bring about weight bearing. In the case with the walking iron, there is very little edema and swelling after removal of the cast. The patient puts on his shoe and starts right out to walk, sometimes even without a cane. From many such observations I believe that in cases of fractures without displacement or with very little displacement early movement and early usage within the patient's comfortable tolerance are most effective in reducing disability periods and permanent disability end results.

Metatarsal bars properly placed on the underside of the instep of a shoe have been most helpful in permitting patients with fractured metatarsals or toes to walk around early.

The use of long Kirschner wires to immobilize fractures of long bones, such as the radius, ulna, humerus, tibia, femur and even metacarpal, metatarsal and phalange, is meeting with excellent success.

Many problem cases several months old came to me for evaluation of their injuries and suggestions for further treatment. In taking the history, too often I found that the doctor saw the patient the first time and started a heat lamp treatment of 20 to 30 minutes' duration, but that the nurse or some other office attendant gave him the treatment subsequently. In one case recently the patient went into the room, turned on the lamp, took his treatment, turned off the lamp and went about his way with only a fleeting glance from the nurse attendant. In several other instances,

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I have known of patients with plaster paris body spica casts being placed under heat lamp treatments, with the casts on, for 30 or 40 minutes. Wasn't the cast enough without adding the discomfort of an ineffective heat lamp treatment? These procedures do not deserve in the least part the name of physical therapy.

Each case turned over to receive physical therapy should first have a thorough examination by a physician or surgeon, who should be responsible for improvement and treatment. He should examine the patient at least once a week or better twice weekly. A weekly or periodic conference between the physio-therapist and the attending surgeon can be made most valuable to the patient. A trained physio-therapist knows by experience what results are to be expected from each type of physical therapy treatment. When such improvement does not occur, she then looks for conditions or factors that might be modifying or delaying recovery. In this connection we have learned that abscessed teeth are associated with about 50 per cent of the subdeltoid bursitis shoulders, and even these shoulders with demonstrable calcification in the subdeltoid bursa. Recently we have confirmed Dr. William R. Cubbin's observation that many calcified subdeltoid bursitis cases have a high uric acid blood chemistry, establishing a common relationship to gout.

Some cases not responding to physical therapy treatment are those unfortunate individuals who suffer from a genuine Sudek's atrophy or painful bone atrophy. It is better not to expect too rapid improvement in that type of case and to keep the employer posted on a guarded prognosis.

Malingers Are Spotted

Properly administered physical therapy gives information about patients with doubtful complaints, when the physical findings are not consistent with the complaints. After a ten day or two week therapeutic test treatment period, the surgeon and his physiotherapist can convince themselves that the patient is a malingerer or a gross exaggerator. Recently one such shoulder case was found never to keep afternoon appointments for treatments. In ten days we had the information that he was running a racing book at the track and of course couldn't come in for afternoon

treatments. He was sent back to his job and told if he wanted to continue running a racing book in the afternoon he had better get a night job. It is surprising how often these patients reveal themselves and their motives for continuing disability. One employee earning \$50.00 a week brought in enough insurance benefit papers to pay him \$100.00 a week. Who couldn't afford to remain disabled under such conditions?

All back sprains are by no means protruded intervertebral disc cases. Remember that the disc case usually comes on from a lifting effort, has some disability immediately, and usually greater disability within 24 to 48 hours. There are almost always loss of Achille's tendon reflex and an area of anesthesia. More detailed differential diagnosis is left to the neurological and orthopedic surgeons.

Some traumatic surgeons advise absolute bed rest immediately for the injured or sprained back. This hospital treatment is excellent and to be recommended where feasible. Jolting and jarring a sprained back is poor treatment; but, in many instances, bed rest, ambulatory activity such as being up for meals or going to the toilet, do not appear to retard the patient's recovery. We determine at the time the patient is seen whether he should be treated in the hospital as a bed case or at home as a semi-ambulatory patient. Give him reasonable treatment, bed rest, support to the back, rigid bed if necessary, analgesic and sedative medication and palliative relief measures such as an electric pad, hot water bottle, hot tub baths, and massage in moderation. If after three to five weeks your back case is not making satisfactory progress toward recovery, then it will be advisable to make a complete and accurate diagnosis: x-rays of his spine and x-rays of teeth and sinuses to rule out focal infection, prostatic examination, blood count, blood chemistry, basal metabolic test, special tests for typhoid, undulant fever, etc., special x-rays for intervertebral disc with contrast media, spinal puncture, neurological and orthopedic examinations and consultations and any further measures that may aid.

Almost 50 per cent of our hernia cases have pain referred to the upper sacral and lumbo sacral region of the back, much the same area to which prostatic pathology refers its pain. So constant a finding is this

that we believe the converse statement to be true: many cases of back pain are due to inguinal hernias of which the patient is unaware. For this reason every hernia case is asked if he has back pain, and likewise every case of back pain is examined very carefully to rule out inguinal hernia.

First Impressions Count

The first impression that a patient gets of the plant physician, nurse and medical department is sometimes very important. Therefore, modern equipment, clean surroundings, pleasant, kind, understanding personnel pay excellent dividends in obtaining the patient's confidence. Show a genuine interest in the patient's injury problem. To him it is most important and he may have an anxiety problem even if you can't see objective evidence of traumatic injury. An error of tact is committed when a doctor or a nurse tries to minimize the extent of a patient's injury. It is also unwise to make comparisons between this patient and someone else more seriously injured. It is much better, if there is a simple injury, to make the necessary examination, explain tactfully in a sincere way that it does not appear to be serious, and that you have every reason to believe the injury will make a complete recovery in a reasonable time. Then proceed to render the necessary treatment carefully.

There are always instances of a hypercritical, antagonistic type of employee that will try the patience of everyone in the medical department. Your first reaction is to argue with such an employee to prove that his criticisms are untrue, incorrect or not founded on fact. This simply makes matters worse. You are playing right into his hands, and he makes a mountainous issue out of a trivial one. It would seem to me to be a much shrewder procedure to be overly-nice and if necessary over-treat such a patient. I know that in many instances I have won the patient's confidence and helped him get well, by simply giving him a chance to get it off his chest.

There is a tactful way to send an injured person back to work. In minor injuries it works well to say, "You probably want to keep working?" or "Do you think you can keep at work?" or "Would you like to try to continue working?" You give the patient an opportunity to decide that he wants to keep working; and you

have avoided that unfortunate situation where the patient feels you have ordered him back to work even though he was injured and felt he should go home. I know of many patients with simple fractures of the toes or removal of toe nails who have preferred to go back to work. I frequently help a patient make the decision by saying, "You don't have to go back to work; you can go home. But the nature of this injury is such that it is perfectly safe for you to go back to work if you want to. We'll let you, if you think you'd like to keep going." Then on the release we write for the patient's benefit, "Allowed to continue work." How much better that is than to take a dominant attitude or on his release to say, "Ordered back to work."

The term "light work" has become a bug-bear to foremen and supervisors. They always suspect the employees of "soldiering" on the job or using their injuries to get soft jobs. So when we are ready to send a man back to light work we tell him to talk to his boss and see if there is some modified work for him. Then when the man or his boss tells us the kind of work he can do, we release him to resume modified work. The boss is satisfied, the patient happy, and so am I. The term "modified work" seems to be a much better phrase than "light work."

Tact is required also when treatment is to be terminated and the patient wonders what you are going to do with him if he has a permanent injury with specific loss or disfigurement. Treatment should not be terminated exactly at the same time you send him back to work. We prefer to carry over the treatment period a week or two until the patient has proved to himself his ability to renew work. If dressings are necessary we have the opportunity of seeing the patient after he goes back to work. In cases of serious injuries or disfigurement, we tell the patient when he resumes work that we know there is going to be some permanent injury and we also know there is going to be further improvement. So we call him back sometime between six months to a year after his injury, and then give him an appraisal examination and report his permanent disability. Some patients try to hurry their disability settlements. If one can reasonably expect any further improvement, then the permanent disability evaluation should be deferred:

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