Reinventing a Specialty: How Pediatrics Survived Its Own Success

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The first issue of Pediatrics appeared in 1948, a moment of history at which the prospects for pediatric science had rarely seemed brighter. The greatest accomplishments in child health of the early twentieth century had been for the most part preventive. Infant mortality had declined substantially thanks to maternal education campaigns, widespread pasteurization, and overall improved living standards. Now scientific pediatrics appeared ready to launch its own revolution. Penicillin and the antibiotics, hormonal therapies, oxygen for premature infants—all exemplified a newfound power of the pediatrician to treat, and even cure, disease. The message was not lost on the public. Some of the most powerful images of the United States during the 1950s were the pictures of the “polio pioneers,” the long lines of American schoolchildren waiting voluntarily for a chance to receive the Salk vaccine. Pediatric leaders may have winced at Jonas Salk’s use of television and radio to announce the vaccine’s success, but could not have helped but take satisfaction from the response of a grateful public.

Yet there was another side to this story. The commentaries and letters to the editor that appeared in Pediatrics during the same years reveal a profession torn over its future. There was widespread concern that pediatrics could not last for long as a primary care specialty. The purpose of this article will be to examine editorials and commentaries to both illuminate this paradox and then trace how its resolution led to a redefinition of what it meant to be a pediatrician. My focus is on the years between 1955 and 1975, the critical years of the transformation.

MEDICINE’S MOST FRUSTRATING SPECIALTY

Letters to the editor of Pediatrics during the 1950s do indeed reveal a picture of boredom, exhaustion, and discontent. “Many pediatricians are running themselves ragged by routine work,” asserted one Michigan practitioner, “neglecting their own wives and children, and gradually abandoning the inquisitive and intellectual part of pediatrics.” The same writer added that some offices deliberately removed chairs from the examining rooms to eliminate the long sit-down conversations that might ensue.

Why had mid-century pediatrics, seemingly on the verge of its greatest scientific promise, become (in the words of Medical Economics) “medicine’s most frustrating specialty”? Put simply, pediatricians found themselves unable to apply their sophisticated hospital-based training in practice. A survey of almost 2000 pediatricians in 1958 found that only a minority reported “no significant difference” between their expectations of practice and its reality. The remainder, who included almost all younger pediatricians, cited a litany of complaints including long working hours, unnecessary phone calls, and an unexpectedly high proportion of well-child care and behavior problems. One disgruntled Illinois pediatrician lamented a specialty in which “a man spends 2 years devoted to acquiring a highly-specialized skill and then enters a practice which 90% of the time does not require this skill.” Another put it more succinctly: “Anxious mothers and running noses are not what I was trained for.”

Yet such gloomy prognostications did not tell the whole story. The postwar period witnessed not only the apogee of pediatric science but the birth and popularization of infant psychiatry. The prophet of the movement was Dr Benjamin Spock, whose Common Sense Book of Baby and Child Care (first published in 1946) reassured millions of baby-boom mothers that “you know more than you think you do.” Perhaps, but who better to guide those instincts than the reassuring figure of the family pediatrician? A growing number of pediatricians, particularly leaders in academic outpatient departments, argued for a “New Pediatrics” reflecting a shift from a curative to a preventive and psychosocial orientation.

The great debate over the relevance of pediatric residency education to practice thus began. In 1959 Pediatrics editor Charles May openly questioned the future of the general pediatrician in his provocative editorial, “Can the New Pediatrics Be Practiced?”

Could it be that the skills of pediatricians have reached a degree of excellence which cannot be put into practice simply because the public is not prepared to pay the price? Can “comprehensive care,” including mental hygiene, be dispensed hurriedly in visits kept brief by economic necessity?

May’s editorial launched a series of letters and commentaries that collectively added up to a virtual mid-life crisis of the pediatric profession. They are fascinating as reminders that our present structure of pediatrics (as primarily an office-based primary care profession with a second tier of subspecialists based in academic centers) was far from inevitable.

It is interesting that few responses called for the British model of the hospital-based general pediatric consultant. May took for granted that there would “never be enough LeonarDos to form an Academy of...
genuine ‘consultant’ physicians.” He and his correspondents generally assumed the trend within medical centers toward subspecialization to be both beneficial and inevitable.¹⁰

But what of the office-based pediatrician? Some writers were more than willing to relegate what they called routine “shot and formula” or “sick call” pediatrics to general practitioners. Pediatricians could most profitably use their skills by forming group practices combining individuals from various subspecialties. Such a model, in the words of a California practitioner, could conceivably “provide the family unit with an overall private physician, very much as a football team is made up of eleven specialists, each with his own particular skills.”¹¹

Most writers, however, argued that office pediatrics provided its own set of challenges requiring pediatric expertise, an expertise that could not be gained solely in the hospital. Academic generalists in particular championed this model. The children’s outpatient director at Ohio State University asserted that “it is no more challenging to treat a case of meningitis or handle a patient with hyperelectrolytemia than it is to manage that 4-year-old who began having encopresis last week.”¹² The point might have been pushed a bit far, but represented a kind of argument that has become familiar ever since.

May’s critique nonetheless deserved consideration. In 1959 (as today) the really difficult part of comprehensive pediatrics was to make it work in a busy practice. One examines in vain the extensive list of “anticipatory guidance” teaching goals laid out for every visit by the recent “Bright Futures” guidelines for suggestions on how to cover them in the 10- to 20-minute office visit.¹³ Many of the early advocates of comprehensive pediatrics were remarkably creative in this respect. A practitioner in Tucson wrote of how his practice switched to a prepaid payment system allowing more emphasis on preventive care. His practice’s program offered parent classes, discussion sessions for older children and their parents, group psychotherapy sessions, and teenage youth forums.¹⁴

Having opened the controversy, May himself vacillated over its resolution. Rejecting the oft-made assertion that the nature of pediatric practice itself made the pediatrician a competent counselor, he argued in a 1959 Pediatrics editorial that “More than a condescending gesture must be made toward teaching of mental hygiene; it deserves proportionate emphasis in the training of pediatricians.”¹⁵ But just a year later May offered a very different proposal in the American Journal of the Diseases of Children, presumably to emphasize his independence from the Academy. Here he explicitly advocated a vision of a future of fewer pediatricians limited to the roles of teachers, specialists, and investigators:

The cultivation of the mental health and social welfare of children will not be left entirely to pediatricians, and they should not delude themselves by supposing they can become a priestly class of counselors on all things . . . Unless limits are set, the primary tasks of physical care will be diluted and dislocated beyond recognition and the pediatrician may no longer be considered a physician.¹⁶

May’s proposal was quickly denounced by the president of the Academy in 1961.⁹ The debate over whether office-based pediatricians ought to turn over well-child care and minor illness to others, or to expand the concept of well-child care, has continued to rise at various junctures ever since, though rarely so clearly as in the aftermath of May’s editorial. Particularly notable was Henry Silver’s development of the University of Colorado’s child health associate program in the late 1960s as a strategy to develop a “well-child care specialist” to allow the pediatrician more time for complex illness.¹⁷ Nonetheless, the issue was not to be settled by editors or academicians. Powerful forces, both external and internal, were shaping the profession. This became especially clear as pediatricians confronted the 1960s.

THE NEW MORBIDITY

The rediscovery of poverty during the 1960s set off a parallel process in pediatrics. The civil rights movement awakened many Americans to the fact that the country’s overall rising standard of living had left many of its citizens behind. As Michael Harrington pointed out in his influential analysis, The Other America: Poverty in the United States, growing affluence had benefited the mathematical average while accentuating the gap between the privileged and poor. There was a real sense of shock among many Americans to find that hunger and poverty still existed amidst the unparalleled prosperity after World War II.¹⁸

Pediatricians during these years rediscovered their own “new morbidity” of childhood. The exposure of the “battered child syndrome,” which struck the editorial pages of Pediatrics in 1963, provided an example of a “hidden” pediatric morbidity that had evaded 1950s complacency.¹⁹ Other examples came to include the consequences of modern technology (accidents and poisoning) and social disruption (the problems accompanying divorce and adolescent pregnancy).

The role of pediatricians on the public stage during the 1960s was quite prominent. Julius Richmond, a prominent early advocate of the New Pediatrics, became director of Project Head Start. At its inception the underlying philosophy of Head Start acknowledged the early years of childhood to be the most critical in breaking the poverty cycle. The program was intended to assist disadvantaged children through activities addressing health, education, and social services. On the medical side, Head Start promoted community health screenings for children, an example that would be followed for adolescents with the rise of the Youth Corps Program.

Yet were practicing pediatricians prepared to address the “new morbidity” of poverty? Richmond received many letters from practitioners complaining of inadequate consultation; one suspects that the “community empowerment” philosophy underlying Head Start did not always mesh with professional expectations.²⁰ The problems of arranging systematic
follow-up for problems identified by screenings were significant. As Alfred Yankauer editorialized in 1966, arranging to pay for such care was the simplest problem to solve:

How many offices are geographically accessible to the ghettos of our large cities and the abandoned belts of our rural poverty? How many, even with the motivation to do so, are equipped to deal with a racially mixed clientele, with disorganized family units, unaccustomed to appointment systems, frightened of strange well fitted surroundings, unable to communicate their concerns, and culturally conditioned to a hostile world? There is already a full and privately well paid demand for comprehensive pediatric care which these same offices struggle to fulfill and which in itself often limits the intake of new cases.21

The 1960s did bring about programs to address these concerns, particularly the community health center movement in which many pediatricians participated. Still, the obstacles listed by Yankauer have been difficult to overcome. Although legislation gave rise to many new services for impoverished children, these programs—including health care—have often been fragmented and without coordination. There resulted a natural tendency of the New Pediatrics in private practice to focus less on the new morbidity of poverty than the psychosocial morbidity of the middle classes.

Advocacy for children led to controversy in other arenas as well. Editorials in Pediatrics went beyond the scientific realm to address such issues as the population explosion and the use of napalm on children in wartime.22,23 Benjamin Spock himself became a prominent antiwar activist and even third-party candidate for President, becoming a lightening rod for the charge that the new “permissive” style of child-rearing had produced the anti-authoritarian baby-boom generation.24

One interesting editorial in 1972 is worth reading as a defense of Spock’s child-rearing philosophy set in this context:

To consider permissiveness as a determinant for the turmoil in our rapidly changing society is a gross oversimplification... What will best prepare us to face problems—a method of unquestioning upbringing or one that adopts an experimental attitude toward the self and the world? We need more seekers and questioners! Permissiveness in child-rearing should be fostered, not feared, since it is essential for the development of open and inquiring minds.25

The intergenerational battles of the 1960s have echoed in other pediatric commentaries addressing adolescent use of marijuana, birth control, and (most recently) the parental right to spank.26–28 Pediatricians have found themselves repeatedly negotiating a difficult line between advocating for children and becoming identified by parents as one of the outside forces threatening their families.

REDESIGNING PEDIATRICS

In some ways, however, pediatric education changed less than might be expected during the 1960s and early 1970s. One could argue, in fact, that the gap between hospital training and private practice became wider than ever. This was not so much by design; indeed, continuity clinics and better ambulatory experiences both made progress during the period. These developments were nonetheless countered by the service requirements placed on residents by the newly-emerging pediatric and neonatal intensive care units.

Debate over pediatric education became more stringent during the 1970s. David Nathan, division chief of pediatric hematology-oncology at Boston Children’s Hospital, learned this the hard way after writing a controversial editorial in 1973, “Primary Care and Medical Research Training.” The main thrust of Nathan’s commentary was a savage blast against the status quo of medical education:

Our laissez-faire training system, fueled by federal grants, has in fact developed an unparalleled degree of expertise in the medical sciences, rightfully the envy of the entire world. But during this same period we have failed rather miserably to supply primary care deliverers not only for deprived areas of the country, but in middle-class communities as well... Imbued with the concept of freedom of choice and opportunity, we have encouraged the cream to rise to the top, the top defined as specialty and research medicine.29

These were hardly words calculated to please establishment academicians. But Nathan’s commentary provoked an angry series of letters from an entirely different direction. Most overlooked his central point (attacking the tendency to see research as more valuable than clinical medicine) and instead criticized his proposed solution of retraining senior academicians in pediatric preventive science. Nathan’s comment that retraining laboratory-based researchers in the field of public health might bring the discipline a new measure of rigor struck many readers as elitist (to use a favorite charge of the era). Inverting Nathan’s own metaphor, one reader wrote that “I for one, would feel much more comfortable seeing a man who is capable of understanding the problems of the delivery of health care in New York City, studying the rate at which potassium enters the red cell, rather than the reverse.”29 The brief controversy was not so much important in itself than for the way in which it captured how the tense political climate of the 1960s and 1970s entrapped more than one would-be reformer.

Still, academicians and clinicians who were able to step above their apparent boundaries were critical to propelling pediatric education forward. One example was provided by Abraham Bergman in his 1975 essay, “Pediatric Education—for What?” Bergman was especially prescient in realizing that pediatric general practice is not simply an extrapolation (much less simplification) of hospital practice. Drawing from his own experience of “trading places” for a summer with a local practitioner, he observed the essentially different emphases of residency education and primary care. “In teaching hospitals,” he noted, “the CPC is the World Series; the “rare bird” diagnoses, a grand slam homerun. Management skills are relegated to the minor leagues.” Bergman suggested that this orientation failed to do justice to the skills of the embattled practitioner having to make weighty management decisions with limited time and resources. “Diagnosis is really not the tough part of medicine,” he concluded: “management is.”30
The debate over the structure of pediatric residency, of course, has continued to the present day. Disagreement persists over whether the best foundation for a career in general pediatrics is laid by training emphasizing the sickest patients and most unusual conditions, versus those seen most commonly in practice. Its resolution is further complicated by the conflict faced by program directors between education and service needs. Still, undeniably there has been progress in working out a more even balance between the two philosophies of training.

One last development deserving notice during the 1970s regarding the “New Pediatrics” was the rise of research to document its effectiveness. Such research goes to the heart of Charles May’s concerns in 1959 that pediatricians not push the limits of their expertise without forethought. Here again Alfred Yankauer of the Harvard School of Public Health helped spark debate through his 1973 editorial, “Child Health Supervision—Is It Worth It?” Yankauer had noticed that much of the timing and structure of well-child supervision had evolved more or less as an accident of history, guided by little rigorous research. Recognizing that “To question such methods thus appears to threaten the professional rank and file as well as to conflict with the pursuit of its leaders,” he called not for an automatic restructuring of practice but for careful research examining current and new models. The expansion of such research in the past decade has in fact been encouraging.

What will Pediatrics witness during the next 50 years of its existence? Disturbing clouds certainly lie over the profession. Public support for social and medical programs is far from assured, pediatric chairmen face tighter budgets than ever in recent memory, and managed care threatens physician autonomy. Behind all these threats lurks the seemingly inexorable expansion of the morality of the marketplace in health care.

Yet, despite the temptation to present these trends in apocalyptic terms, it is worth affirming that pediatrics as a profession has weathered substantial crises in the past. The 1950s may be remembered nostalgically as a golden age before managed care, but the pages of Pediatrics reveal that they were hardly a golden age for many general pediatricians. The future of the profession is no more inevitable today than it was then, assuming pediatricians continue to be distinguished as advocates for children rather than for themselves.

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