COMMENTARY


Comments by Iris F. Litt, MD

The purview of pediatrics includes the growth, development, and health of the child and therefore begins in the period before birth when conception is apparent. It continues through childhood and adolescence when the growth and developmental processes are generally completed. The responsibility of pediatrics therefore may begin during pregnancy and usually terminates by 21 years of age.1

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Short and concise, yet this Statement developed by the Council on Child Health of the American Academy of Pediatrics (AAP) and published in 1972 had a monumental impact on the health of teenagers, as well as on the practice of pediatrics.

An earlier position of the AAP (1938) had defined the upper limits of pediatric practice to extend “well into adolescence.”2 Although some pediatricians at the time were seeing early adolescents, many chose to discontinue care for patients who were approximately 12 years of age. The age cutoff for admission to hospital pediatric services was 14 years. It is noteworthy that in 1969, the Council on Child Health had been charged with updating this position. What transpired in the 3 years that intervened reflects perceptions about the respective practice domains of the other specialties, as well as changing views about the health of adolescents.

According to those close to the debates that took place, the Statement went forth only after reassurance from the leaders of those other fields that such an extension of the age limits of pediatrics would not be opposed. That views about adolescent health changed over a 30-year period reflects the results of research, as well as the realization that the developmental perspective of the pediatrician would best serve teenagers.

In relationship to this critical Statement, let us consider the five stages of evolution of the field of adolescent medicine over its 40-year history (dating from the time of the establishment of the first training program at the Children’s Hospital in Boston, MA, by Dr J. Roswell Gallagher):

1. recognition of the biologic uniqueness of adolescents;
2. recognition of systematic differences among groups of adolescents (based on pubertal stage and timing, gender, ethnicity, chronic illness, etc);
3. recognition of the interaction of psychosocial and biologic factors in determining health of teenagers;
4. recognition that physicians require special skills and orientation to best care for adolescents; and
5. advocacy for special health care needs of adolescents.

Research by pediatricians, as well as our colleagues from other disciplines including psychiatry, psychology, and education, has been primarily responsible for the first three of these stages in evolution of the field. Many publications in Pediatrics over the years have advanced our knowledge of these special developmental aspects of teenagers. Among the earliest of these are reports establishing age-appropriate reference standards for growth3–6; and consideration of gender-based health problems more common in adolescents than in either children or adults.7

Attention of pediatricians to the psychosocial needs of this age group is to be found in publications in Pediatrics in the late 1950s. McClendon,8 Deisher and O’Leary,9 Milman,10 and Salber,11 for example, focused on delinquency, school phobia, and smoking, respectively.

It appears that the fourth of these stages—recognition of the special skills needed for care of teenagers—coincides with the time of publication of this Statement by the AAP. It legitimized care of adolescents by pediatricians, and to some, had the force of a mandate to pediatricians to do so. Not all pediatricians, however (especially those trained in more traditional programs focusing on infant care and infectious diseases), felt comfortable and knowledgeable in the care of teenagers. In response to the sense among many pediatricians that they were ill-equipped to meet the special needs of teenagers, the AAP undertook a major effort to provide continuing medical education to provide the needed skills. The resultant increase in interest and expertise in the care of adolescents by pediatricians is, perhaps, the most important legacy of this publication.

In recent discussions with some of my colleagues who were already working with teenagers, including Drs Deisher and Rauh, we recall that at the time we...
fled that this publication legitimized what we had been doing. Of great importance, it also led to increased resources and space within academic pediatric departments. This occurred at a time when federal monies available for hospital construction supported the building of inpatient units for adolescent patients.

The most valuable result of this redefinition of the age limits of pediatrics was, undoubtedly, the opportunity to teach a growing number of trainees interested in adolescents. The creation of the Section on Adolescence by the AAP also was an outgrowth of the recognition of the need for continuing medical education of pediatricians in practice. Because the Society for Adolescent Medicine had been formed in 1968, primarily by pediatricians and a few internists, and held its early national scientific meetings in concert with those of the AAP, there was synergy in the training effort.

The impact of publication of this Statement also can be felt in the increasing requirements by the Residency Review Committee for inclusion of formalized training in adolescent medicine in pediatric programs.

Most recently, the force of this statement was felt in the documentation for the need for subspecialty certification in adolescent medicine by the American Board of Pediatrics. The establishment of subspecialty certification ensures that there will be academicians capable of training generalist pediatricians to provide primary care to teenagers. It also is significant that this was a conjoint SubBoard with the American Board of Internal Medicine, paving the way for eventual improvement in management of the transition of health care from adolescent to adult settings as they mature.

The issue of interface with internal medicine was critical in the deliberations that led to the setting of the upper age limit of adolescence at 21 years. According to Sherrel Hammar, MD (personal communication), this reflected acknowledgment of the difficulty faced by teenagers with chronic illnesses in finding appropriate care providers when they reached adulthood. The improved longevity of many of these patients is, happily, leading to efforts to train internists and family practitioners in their care.

Despite the importance of this definitional Statement to the care of teenagers by pediatricians, it is sobering to find that only 7% of office visits to all physicians are by adolescents, despite the fact that they constitute almost 20% of the population. Moreover, more family practitioners than pediatricians are providing the care. The sad reality is that 25 years after this Statement was published, most teenagers still are not getting any care, let alone the care they deserve.

REFERENCES
5. Reed RB. Patterns of growth in height and weight from birth to eighteen years of age. Pediatrics. 1959;24:904–921

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Comments by Mary Ellen Avery, MD

ABSTRACT OF ORIGINAL ARTICLE. A controlled trial of betamethasone therapy was carried out in 282 mothers in whom premature delivery threatened or was planned before 37 weeks’ gestation, in the hope of reducing the incidence of neonatal respiratory distress syndrome by accelerating functional maturation of the fetal lung. A total of 213 mothers were in spontaneous premature labor. When necessary, ethanol or salbutamol infusions were used to delay delivery while steroid or placebo therapy was given. Delay for at least 24 hours was achieved in 77% of the mothers. In these unplanned deliveries, early neonatal mortality was 3.2% in the treated group and 15.0% in the control subjects. There
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