COMMENTARIES

History of Community Pediatrics

ABBREVIATIONS. AAP, American Academy of Pediatrics; CATCH, Community Access to Child Health.

The community is the setting where the many determinants of childhood health, which include biologic, physical, economic, and social factors, exert much of their impact.1 The American Academy of Pediatrics (AAP) has defined Community Pediatrics as a perspective that enlarges the pediatrician’s focus from one child to all in the community and includes advocacy, especially for those who face barriers to health care because of social or economic conditions.2 The pediatricians who established Pediatrics as a specialty in the late 19th century believed correctly that if they ignored the community, pediatricians ultimately would fall short in its efforts to improve child health.2

The history of Community Access to Child Health (CATCH) by Hutchins and colleagues3 in this supplement details the dramatic CATCH story and adds a chapter to the history of Community Pediatrics. Today, CATCH is well-established as part of the new AAP Department of Community Pediatrics.2

The CATCH evaluation contains two major findings that have their origin in Community Pediatrics. The first is the pivotal role of early educational experiences in preparing a pediatrician for his/her community-based activities. The second is that established practitioners as volunteers can impact on the important health problems of his or her community.

For more than 100 years, medical education consistently has sought ways of educating both medical students and residents in community settings.4 In the mid-19th century, community-based generalists provided medical care to their communities, and physicians were educated primarily through preceptorships and apprenticeships. With the introduction of the full-time university post-Flexner model (1910), education for practice shifted to the university and its teaching hospitals.5 Although Flexner emphasized the importance of social and preventive medicine, the Flexner Report established the full-time biomedical model of medical education based in academic medical centers and set the stage for the decline in the importance of community-based medical education.

A few educators recognized the risks in deemphasizing community care.4 To balance the move away from community education, programs were developed in the 1920s and 1930s that included home visits (Johns Hopkins, Tufts, Boston University) and social clinics (Boston City Hospital). For most of these programs, the community was the hospital outpatient department. In eastern Baltimore in the late 1930s, Robinson suggested a hospital might have a responsibility for a defined community. The Committee on Medical Costs in the 1930s included, among its remarkable recommendations, not only national health insurance, but also community health centers as community educational and service sites.6

Pediatrics played a significant role in many of these programs. Departments of Psychiatry and Preventive Medicine were active in developing educational programs that included the community. In the 1940s, medical student programs were developed in comprehensive medicine. Other programs placed medical students in the role of advisors. Pediatrics demonstrated a major leadership role in the 1950s in Family Care Programs, which were directed at both medical students and pediatric residents.

In the mid- to late 1960s, with the recognition of an overall shortage of physicians, especially generalists, residency programs were developed in family medicine, general medicine, and general pediatrics. Primary care became the 1970s term that described the work of generalists.4 Community-oriented primary care followed, representing a merger of personal and public health services.7,8

Whatever the term, ie, generalists, comprehensive care, family, primary care, community care, community-oriented primary care, the function described included care that was continuous, family-oriented, first contact, and longitudinal, delivered in the context of the family and community.4 In the 1990s, the AAP developed the idea of the medical home, which was seen as an achievable access goal for every American infant, child, and adolescent and was primarily community-based.9

The practice of medicine during the post-WWII period also was undergoing accelerated change. At first, change was driven by technology and science, but as medical care costs escalated and our country failed in almost every attempt to remove the financial barrier to health care (Medicare and the elderly were exceptions), economics took over. Change became rapid, tumultuous and, as we know today, not always for the better. More and more Americans were uninsured, and the uninsured and underinsured had limited access to health care and faced a
financial barrier accessing pediatric services, especially the medical home.

In the late 1980s, CATCH was developed as an AAP voluntary effort to overcome the access barriers, especially for uninsured and underinsured children, and volunteerism emerges as the second finding in the CATCH history. The 19th century general practitioner primarily cared for all who sought care. The surgeon in the early 20th century could charge a large fee to the few and justified the fee because the fee enabled him to give care to many. Physicians worried less about their own economics or the costs of medical practice, because the great depression of the 1930s impacted on physicians as much as the community in which they lived. Volunteerism thrived, continued through the WWII, and into the immediate postwar period.

As with other physicians, pediatricians donated their work, time, and effort in many community settings. Volunteerism intensified in the 1960s when this nation rediscovered poverty. Neighborhood health centers emerged in modern form, and pediatricians developed and worked in free clinics, school-based programs, mobile vans, and neighborhood health centers. CATCH mobilized pediatric community volunteer efforts. CATCH programs addressed a range of social and financial barriers children and their families faced. The AAP also developed the Pediatric Research in Office Settings project, in which greater than 1400 pediatricians currently are involved in research projects studying many of the clinical issues addressed by CATCH.

As Community Pediatrics enters the 21st century, we must build on history and work to see that education and volunteerism continue to make meaningful contributions, as was done in the 19th and 20th centuries. As history tells us, community pediatricians, however well-motivated, will not succeed in addressing many major child health problems until the financial barrier to needed medical care is removed and every child (and soon thereafter, every citizen) has quality health insurance. Only then will Community Pediatrics and pediatricians address fully the most important medical, social, and economic issues facing children and their families.

JOEL J. ALPERT, MD
Boston University Schools of Medicine and Public Health and Boston Medical Center
Boston, MA 02118

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Joel J. Alpert

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