There is no question that the world of children—and thus, that of Pediatrics—has changed in the 20 years since I graduated from medical school. Then, heading off to my internship and training in Pediatrics, medical (ie, scientific) issues still were paramount and costs were no object; we could admit a child for a fever of unknown origin and do a lengthy and thorough workup that provided an educational experience for the residents while also, hopefully, discerning the child’s illness and appropriate treatment. Since then, of course, two things have changed mightily: psychosocial and behavioral issues have become more significant factors in Pediatrics, the “new morbidity” so aptly coined by Robert Haggerty, MD; and financial constraints attendant to the perverseness of managed care have severely restricted the hospitalization and performance of elaborate testing on patients. Luckily for us and for our patients, we at the same time have mastered many common childhood illnesses, so that most patients can be treated safely on an outpatient basis. As I like to describe it, we have mastered the science of Pediatrics and now must focus on the art of our specialty, the fuzzy parts around the edges.

When I first learned of the Community Access to Child Health (CATCH) Program, I was working in a community health center in northern Illinois, doing outreach into the community and teaching medical students general pediatrics. Because of my other role, that of president of the Dyson Foundation (then a part-time job), I was asked to join the American Academy of Pediatrics (AAP)’s Partnership for Children. As so well described in the historical paper of this supplement, the concept of the Partnership was conceived of and developed the visiting professorships and the CATCH Program, I was working in a community health center in northern Illinois, doing outreach into the community and teaching medical students general pediatrics. Because of my other role, that of president of the Dyson Foundation (then a part-time job), I was asked to join the American Academy of Pediatrics (AAP)’s Partnership for Children. As so well described in the historical paper of this supplement, the concept of the Partnership was to bring together mostly laypeople who could assist the AAP in “furthering its goals and objectives.” We were asked to be advocates for and proponents of AAP initiatives; each of us was considered to have demonstrated an interest in children through our career activity. The vast majority of my fellow trustees of the Partnership are laypeople.

On first hearing of the CATCH Program of the AAP, I was somewhat skeptical. I had been trained that each and every one of us in Pediatrics must consider ourselves to be advocates for the children we treat, always remembering that the well-being of the child superseded all other concerns. In addition, I had been involved in rural outreach pediatrics at our health center, always trying to make the community and its systems more child-friendly and responsive. What, then, was this CATCH Program other than a name for what so many of us had already been doing? The answer was given to me in a clear, forceful, and persuasive manner by Dr Ed Rushton, then the project director of CATCH and a true proselytizer in the best meaning of the term.

In discussing CATCH with Ed, I experienced the proverbial “aha” phenomenon so well remembered from medical school neurology. As Hutchins and colleagues state, “CATCH is a philosophy, a process and a program, and is an evolving set of concepts based on program goals.” The point was not, then, that I had practiced in a quasi-CATCH manner; more importantly, the Academy—our Academy—was recognizing, perhaps at long last, that the health of all children in the community is all our collective responsibility. We could no longer be satisfied with delivering good care to those that found their way to us; rather, the message of Phil Porter, Ed Rushton and, now, Tom Tonniges is that we must, each of us, work within our community to improve the health of all the children. Those who had already practiced in such a responsible manner could and should feel validated and applauded by their AAP for their foresight and commitment. Additionally, the AAP confirmed, through its endorsement of and support for CATCH, that to fulfill its mission, the AAP had an obligation to focus energies on issues at the community advocacy level and could not be content to limit its attention to what was good for pediatricians in practice. To me, in my roles both as a funder and as a fellow of the AAP, this CATCH Program represented a bold, forward-thinking, creative effort by the AAP to address the most pressing health care issues facing children today. It would become, I quickly became convinced, the most important initiative the AAP had undertaken in many decades.

Indeed, the way I described it at the Partnership for Children meeting was that I felt CATCH would become the “tail that wags the dog” of the AAP. Hutchins and associates have described the support lent to CATCH by the Partnership through our ad hoc CATCH Advisory Group, which conceived of and developed the visiting professorships and the CATCH video, and raised funds from the Partners to support CATCH—in other words, we fostered edu-
cation, communication, and support of the Program at a crucial juncture in its development. The most important ingredient in those early deliberations of the CATCH Advisory Group, however, was the presence and participation of Dr Joel Alpert; he and I scribbled the concept for the visiting professors on a piece of paper passed between us. As you have read in this evaluation, it is the “CATCH visiting professors” that are identified as a viable concept worth continuing and expanding; the Dyson Foundation is gratified to have been the initial funding source of this program. When the Robert Wood Johnson Foundation decided to fund this evaluation of the CATCH program, I was pleased to be asked to join the advisory committee and thereby to work with my esteemed colleagues in an effort to analyze the CATCH Program. As I told Vince Hutchins at the time, trying to piece together the historical perspective would be a difficult task, but one that he has handled masterfully. Retrospective evaluations are always problematic, all the more so in this specific case because of the difficulty many colleagues have had in grasping the concept of CATCH. I believe now that most AAP members not only understand CATCH, many of us are supportive and even endeavoring to incorporate the concepts into our practice activities. Vital to pediatricians’ being able to do so, however, is a grounding in advocacy and community outreach, be it through medical school or residency training in such concepts. Going forward, the AAP will need to actively promote incorporation of training in community-based issues within residencies, thereby creating a cadre of pediatricians ready to tackle these difficult, somewhat elusive, problems of our country’s children.

Those of us on the funding “side of the table” are gratified when programs such as CATCH not only survive, but thrive, endure, and take hold. Just what ingredients ensure the viability of any given CATCH effort has been elucidated as much as possible in this evaluation. To a certain extent, that viability will always reside in the commitment of the individuals who are brought together in response to a particular problem or concern within a community. Armed with certain tools and encouraged by their colleagues, and recognizing “a responsibility toward all children within the community,” one pediatrician can—indeed, must—make a difference for America’s children. Issues of access to health insurance are gradually being addressed at the legislative level, but our responsibility as pediatricians to provide care and assist in improving the system of enrollment and access remains; programs such as CATCH can provide the tools needed to advocate effectively for the children in our communities.

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REFERENCES