Community Pediatrics: The Rochester Story

Robert J. Haggerty, MD, and C. Andrew Aligne, MD, MPH

ABSTRACT. There are so many problems facing children today (eg, violence, poor nutrition, substance abuse, teen pregnancy) that conventional medical care can only address a small portion of these concerns. Thus, to be optimally effective, pediatrics needs to be linked to other disciplines and programs that address these issues by using different paradigms. Robert Haggerty, the originator of the term “community pediatrics,” reflects on how one can successfully practice community pediatrics in an academic setting and model it for young physicians while also improving the health of children at the community level. Here we tell the story of the years that Haggerty was chief of pediatrics at the University of Rochester and took on the challenge of fulfilling the department’s responsibility to all children in the county. Because of his pioneering work, his tenure was heralded as a critical period in the development of the field of community pediatrics. Pediatrics 2005;115:1136–1138; community pediatrics, Rochester, new morbidity.

Community pediatrics began well before I came to Rochester, New York, in 1964 and therefore cannot all be credited to me. When I was being recruited as chair, 2 community aspects attracted me. The first was that a practicing pediatrician was on the search committee, something none of the other departments I was looking at had, and the other was that the local health planning commission had appropriated $20,000 for the new chair to undertake a study of the hospital needs of children in the county. Thus, at least as far as hospital care, the department was thrust into the role of concern and responsibility for all children in the county. I was fortunate to recruit Joseph Stokes, MD, who had recently retired from the chair of pediatrics at the University of Pennsylvania, to be the consultant for this study. Together we ascertained that there were too many pediatric beds in the community and too many residency programs. With the help of Dr Stokes’ skillful negotiation powers, 2 of the hospitals agreed to close their pediatric beds. (As a carrot, they were allowed to build equivalent long-term care beds for adults.) The other 3 hospitals, including the university as the linchpin, were then linked into 1 system. After considerable negotiation between the university and the 2 community hospital boards of trustees, it was agreed that the chief of pediatrics as well as any other full-time faculty would be appointed jointly. A single residency program for the 3 hospitals was created. Thus, all pediatric inpatient services were linked with the university, and all hospital services for all children in the county were served by the same high-quality personnel. The first piece of the definition of community pediatrics, concern and responsibility for all children in a defined area, became the mission of the department of pediatrics.1,2

With support from the US Children’s Bureau and later the Office of Economic Opportunity and Center for Health Services Research, we were able to carry out community surveys to determine health needs and define areas that were underserved. On the surveys, we asked the parents about their major health concerns; they indicated that school programs, behavior, violence, and teen pregnancy were their main concerns.3,4 These were not the usual topics with which pediatricians were trained to deal. The only traditional medical condition that made the top 5 was allergies. Our experience with these surveys led us to use the term “new morbidity” to include the many biological and social problems that parents saw affecting their children’s health. This experience underscored the importance of assessing community needs and perceptions before beginning any interventions.

OVERCOMING BARRIERS TO CHANGE

Several of the community programs undertaken while I was chair were quite controversial. However, the resistance came not so much from community groups as from those in power. For instance, Evan Charney, MD, Kenneth Woodward, MD, and I ran into considerable opposition when we created an inner-city community health center, the Anthony Jordan Health Center. The president of the university did not think that we in the medical center should be doing this. Part of his worry was that the university would need to continue supporting the center if federal funding was withdrawn, which was, admittedly, a big risk. This is where allies came in. Mr Marion Folsom, former Secretary of Health, Education, and Welfare in the Eisenhower Administration and by then secretary of Eastman Kodak Company, was able to convince the president to accept the grant. We were able to demonstrate that the health center met a tremendous community need. One of the evaluations
of the center showed that children who used it had one-third fewer hospital days compared with a similar group that did not use the center.

Another clinic for the underserved started in that era was a migrant health program founded by John Radebaugh, MD, to the west of Rochester. This center has now become a year-round facility, the Oak Orchard Health Center. Controversies occurred here, as well. Farmers in the area who relied on the migrant farm labor to harvest their crops were not happy with what became an advocacy group supporting better environments for the laborers.

Change is not easy. Institutions are designed to maintain the status quo. Hence, there will always be resistance to major innovations even if they are of obvious benefit to children. However, what is now the institutionalized status quo seemed radical not long ago. Change is nonlinear. One has to be patient and persistent. Eventually, over the long term, if one is ready to take advantage of the opportunities that occur at certain critical junctures, it does become possible to push through important system changes whether at the local, state, or national level.

**IMPORTANCE OF INVOLVING DIFFERENT SPECIALTIES AND PROFESSIONS**

To address major health problems in the most effective manner possible, we need to use community-wide approaches involving cooperation at all government levels as well as with nongovernmental organizations. The primary care pediatrician’s office should be the medical home for the comprehensive care of children, and care should be coordinated to involve other disciplines such as health educators, child development specialists, and public-interest lawyers. Robert Hoekelman, MD, together with Harriet Kitzman, RN, PhD, headed the effort to develop the pediatric nurse practitioner program in Rochester. We were fortunate to have the School of Nursing here recruit as its new dean Lorretta Ford, MD, the originator of the nurse practitioner model in nursing here. We were fortunate to have the School of Nursing here recruit as its new dean Lorretta Ford, MD, the originator of the nurse practitioner model in nursing here. Klaus Roghmann, PhD, a sociologist, was the key to our community-pediatrics research. The description and evaluation of our programs were reported in a pediatric text that for the first time used the word “community” in the title. Dr Charney began the program of research in office practices with practicing pediatricians, which has now been taken up by the American Academy of Pediatrics as the Pediatric Research in Office Settings Network, with >1700 practicing pediatricians throughout the country doing research in their offices.

Some years ago, under a project sponsored by the Robert Wood Johnson Foundation, our local commissioner of health, pediatrician Andrew Doniger, MD, MPH, was able to coordinate 8 previously separate health agencies under the health department, providing uniform eligibility and intake procedures. However, he was unable to bring in any social agencies. That is a remaining challenge. I believe that we need to develop family resource centers, in which several disciplines can work together with families to provide more efficient and effective help. We have too many separate and insufficiently coordinated services for children. Linking private medical services with public health and social agencies to serve all children is the epitome of community pediatrics.

**SPREADING CHANGE**

One of the important aspects of practicing community pediatrics in an academic setting is the opportunity to change the behavior of the next generations of physicians by integrating community pediatrics into residency and fellowship training. Perhaps the most outstanding Rochester success story in this regard is that of David Satcher, MD. He came to us as a medical-pediatrics resident and swiftly made his presence known when he worked in our migrant and inner-city health centers and convinced us to initiate sickle cell screening of newborns. It was clear that he was a leader, because during residency, most people are happy to just survive. His commitment to the underserved and minority populations was evident then and has continued during his distinguished career as a department chair of family medicine, dean of a medical school, and as a most honored US Surgeon General. Among his many accomplishments as the top doctor for all Americans was his championing the need to diminish the disparities in health status between social classes. He also issued a ringing declaration of the need to do more for the mental health of all Americans.

The general pediatrics fellowship program produced a number of pediatricians who have become central to the world of community pediatrics today, including Phillip Nader, MD, Michael Klein, MD, Robert Chamberlin, MD, Jim Perrin, MD, and others.

I am pleased that my successors, Dr Hoekelman and Elizabeth McAnarney, MD, have continued the tradition of community-pediatrics training, and that there are now numerous other models to be found all across the country. The Pediatric Links with the Community rotation established by residents here in Rochester has been expanded with support from the Dyson Foundation into a Child Advocacy Resident Education program. Most of our pediatric residents now participate in this program, and they have gained numerous leadership skills while working on community projects. Making such programs available to all pediatric residency programs is a remaining challenge. If residents and fellows are able to experience community pediatrics during their training, we will see more practicing physicians engaged in such activities throughout their careers.

**THE FUTURE**

For those now getting ready to try to improve the health and well-being of children, I hope it has been instructive to look at how some positive changes were accomplished in the past. Although there are still many barriers confronting those who want to teach and practice community pediatrics, I am confident that, by working together with parents and professionals from many disciplines, pediatricians can overcome these obstacles. The need has never been greater. After all, our future is our children.
REFERENCES

Community Pediatrics: The Rochester Story
Robert J. Haggerty and C. Andrew Aligne

*Pediatrics* 2005;115;1136
DOI: 10.1542/peds.2004-2825F

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/115/Supplement_3/1136.full.html