The previous message (Pediatrics, January, 1963) presented the role of the pediatrician as a clinical specialist; the other side of this professional coin is his role as family counselor. For the child is not complete without his family, and the family—man’s oldest institution—is unfilled without the child.

The background of this series was outlined in the first article as the concept of the author, enhanced by the shared thoughts and experiences of 20 pediatricians of his approximate vintage who practice in various parts of this country and in cities and towns of diverse size.

Some questions which have been posed or may arise should be answered. First, this series is a positive approach, and no attempt shall be made to catalog the disadvantages or occupational discomforts; they have been discussed by others. The challenge of pediatrics and the love of children make possible a full, satisfying life for the every-growing number of pediatricians.

Secondly, the emphasis herein on pediatric practice rather than total pediatrics reflects no lack of respect or affection for pediatric teachers, researchers, and other kinds of pediatricians. I have known many and worked with a number; they are imbued with the same ideals and purposes about which I write. A great strength of pediatrics and of the American Academy of Pediatrics is the cohesive force of service to children, which enables academicians and practitioners to work together exceptionally well. But I would feel awkward in attempting to describe those pediatric fields which are outside of my major experience; I must write of those things which I have known.

The second role of the pediatrician is that of family medical advisor and counselor, accompanying his service as the child’s personal physician. Herein is the fusion of the science and the art of pediatrics. He brings to this role the same background of training which prepared him to be a specialist for the ill child, with a knowledge of growth and development in many aspects. The permeation of pediatrics by the developmental concept is a hallmark of this specialty. Attention to details of growth and development received consideration early in American pediatrics. Many of us had the good fortune to be students of Scammon and his school of differential development, or of Blackfan, who was chairman of the 1930 White House Conference Committee on Growth and Development, which published the first extensive study of this subject. Since then it has pervaded pediatric thought and teaching, reflected recently in the Academy’s Section on Child Development and in the new National Institute of Child Health and Human Development established by Congress in October, 1962.

The pediatrician is therefore peculiarly alert to the needs of the growing child and is enabled to give the family continuing advice and direction during the long period of growth and development. He knows the special nutritional needs during periods of stress and rapid growth, in infancy and adolescence, and of the premature infant. Alert to abnormalities of growth, of the effects of illness or emotional disturbance, of qualitative dietary deficiency (since gross quantitative starvation is now rare on the American scene), he gives special nutritional guidance. Rapid advances in knowledge of endocrine or inherent metabolic defects enable him to treat these rarer disturbances...
or to refer the child for study and possible correction.

For those children who have serious congenital anomalies or crippling defects, physical or mental, the pediatrician frequently is—and more often should be—the center of teamwork skills. He must be aware of the many services which have developed rapidly during recent years, of the methods and abilities of medical and paramedical personnel who can help the handicapped child. The mentally retarded child, for example, does not require the special skill of a psychiatrist—whose knowledge and training are mental illness-centered—but does need special educators and the guiding care of a pediatrician; his family needs the pediatrician's sympathetic counsel and support.

The pediatrician has knowledge, too, of the process and problems of learning, of habit formation, of disciplinary guidance, and is in a position to give advice and reassurance to the parents. Attention to the minor behavioral disturbances of infancy and early childhood gives him an entree into the entire field of anticipatory guidance. His willingness to answer the young mother's questions about food, dress, room temperature, shoes, toys, and pets establishes him as an interested and knowledgeable person, specialist yet a most "favorite uncle." The confident relationship thus established with parents and grandparents (one pediatrician remarks that he "knows he has made the grade when he is accepted by the grandmother") pays off in great dividends when emergencies arise.

School problems come often to the pediatrician's office, from the family or the school. If he has had training in the techniques of interviewing and counselling, his skills and diplomacy develop rapidly. If not, experience soon teaches him to avoid taking sides with home or school, or between parents, also to avoid making major issues of minor problems. If outside help is needed, the pediatrician has knowledge of specialized services available; if troubles are minor, he can often advise parents or teacher. One of my correspondents remarked that he is often pressured to refer school children who have behavioral problems to the guidance clinic or to the psychiatrist. He says "I am now as conservative with this phase of medicine as I have always been in regard to tonsils." The alert pediatrician often helps to avoid school problems by supervising gradual separation of the child from too-close attachments to home and mother, by easing off undue pressures for perfectionistic performance, and by encouraging the recognition of achievement.

The pediatrician serves the family for prevention of illness and accidents. He has learned to use school and camp examinations as expert health summarizations, maintenance of inoculations, accident prevention instruction, and general health advice, instead of the mere process of filling out a necessary form. In my experience, only those children who are regularly supervised by pediatricians are likely to receive continuing and regular inoculations against contagious diseases. In fact, the pediatrician is often consulted by the adults in the family about their protection. In the community, he is considered the authority in this field, just as the Academy's Committee on Control of Infectious Diseases is on the national level. A parallel development, nationwide and local, is occurring in accident prevention and poison control.

Good family life revolves around the health and welfare of the family's children. The pediatrician is in an enviable position and deals with a favorable age to influence toward a happy family life and a good adjustment to life in general. After respect and trust develop, he may be presented with special family problems of husband and wife relationships, of grandparents and in-laws, of sibling rivalries and childhood fears, of finances, of special difficulties inherent in adopting parents (doubts of biological or parental adequacy, overproving) and adopted children, and many others. He may not be the most skilled family advisor available, although he is better than
he thinks, but he often is the person in whom confidence reposes. The unpopular but sometimes necessary home visit has the advantage of giving a knowledge of the family setting, the neighborhood, and sometimes a useful inkling of family life.

One of my panel related with great satisfaction the successful salvage of several families threatened with divorce, of being impartial but steadily helpful until family unity was achieved. I think of a business man and wife of this city, friends for many years, who have a daughter, two sons, and 14 grandchildren ranging from college age to near-infancy. I have been pediatrician for all of the grandchildren and one of the daughters-in-law, consultant when the daughter had poliomyelitis, and occasional advisor about other adult medical problems. The family and I have gone together through four episodes of poliomyelitis, one of meningitis, countless minor accidents, measles, mumps, chickenpox galore, one child with reading disability, and all of the pains of just growing up. There is an indescribable but very special relationship now between family and doctor; recently the grandfather remarked "Clarence, when anyone speaks of doctors or medicine, we measure what is said by what we know of you, because you are our children's family doctor."

The final phase of the pediatrician and the family comes as the children grow to adolescence and maturity. Every pediatrician, after a time, has teen-agers who come, no longer with mother, because they know and can confide in their pediatrician. Many of my panel spoke of graduating teen-agers, year after year, to college or sometimes to marriage. I remember the thrill of attending the first newborn infant whose father and mother had been my patients from birth to adolescence. One of my correspondents tells of a distraught 18-year-old who came to his home for help and advice because she was pregnant and couldn't bring herself to tell her parents, but she could confide in her former pediatrician. Within a half hour he was able to convince her and the boy friend, who had been waiting outside in the car, that secrecy and abortion were not the answers, but marriage was. A near tragedy was averted and three happy families resulted.

Instances could be multiplied of the role of the pediatrician as a family medical advisor, family counsellor, and "father confessor." Not the most financially remunerative aspect of pediatric practice, this can be the most rewarding in human values to the person who has a love of children and a desire to live a life of service.

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