only copy

also published vol II

THE DEPARTMENT OF PEDIATRICS OF CHILDRENS HOSPITAL.

In 1875 when the Dispensary for Women and Children opened in San Francisco, under the supervision of two physicians, Charlotte B. Brown and Martha E. Bucknell, most physicians were General Practioners, specialization had not reached its present peak. Pediatrics as a specialty was not recognized by the American Medical Association until 1880 and the American Pediatric Society was not organized until 1887.

Jacobi. Mary Putnam Jacobi

The two physicians soon added a third and a group of consultants with special interests in certain diseases, although they did not necessarily limit their practice to that specialty. At this period, therefore, we cannot think of pediatrics as a separate department. The sick child was treated by the physician best prepared to meet his special needs. Women and children generally were grouped together.

In 1885 Harry M. Sherman, who was particularly concerned with the crippling diseases of childhood, was appointed to the staff. He was to continue on the staff for 35 years. George McChesney, who succeeded him, described Dr. Sherman to the nurses in 1925 as " The first specialist on the West Coast for deformities of children". The number of patients seeking his services increased rapidly and it became necessary to find or build larger quarters for his clientele. A drive was put on in the name of " Little Jim" a crippled child who was in need of a hospital bed. The first Little Jim ward was built in 1895. It was at that time the only special facility for crippled children in the city. Later the two medical schools had accomodations and still later the Shriners Hospital shared in the work.

The contagious diseases, before the introduction of immunization and antibiotics, posed an equally grave problem to the Hospital. To prevent cross-infection, a special pavilion was put up on the Hospital grounds for easier isolation of these patients from the rest of the children. William B. Lewitt was placed in charge of the contagious diseases in 1903. (The further growth and development of this service will be told by Dr. Edward B. Shaw.) See other paper

The obstetrician, in general, took care of both the mother and infant.

In 1885, ten years after the opening of the Dispensary, Emma Sutro Merrit was placed in charge of the Medical and Surgical Diseases of Children, a post which she held for the next 20 years. She was joined later by Dr. Francis Sprague. At this time two outside Clinics were started, one at the Chinese Methodist Mission at 952 Washington Street and the other at the Boys and Girls Aid Society on Clement Street. New staff members had been added and these two clinics were conducted at various times by the following doctors,- E.R. Field, E.J. Fifield, Isabel Lowry, Elizabeth Lowry and later by many others. An Eye, Ear, Nose and Throat Clinic was started by Dr. Elizabeth Sargent, who was assisted by Dr. George Powers of the Consulting Staff.

Many famous San Francisco names appeared on the consulting staff through the years. Among them were Drs. Henry Gibbons Sr., John Morse, J.D.B. Stillman, J.H. Wythe, C.E. Blake, D.W. Montgomery and William Watt Kerr. Later the terminology, apparently, was changed and instead of a consulting staff, the positions were designated as Visiting, Assistant Visiting and Dispensary Clinicians. At all times there were both men and women on the staff. By 1890 the major departments had been established; these included Medicine, Surgery, Pediatrics, Obstetrics, Communicable Diseases, EENT, Pathology and Dentistry.

In 1887 the Hospital was opened on its present site on California Street. This was a long distance from its previous location and must have caused some difficulties in transportation of the sick and handicapped children. There is no mention of this in the reports.

It is interesting to note the Agencies that referred children to the Hospital. These included:- Society for Prevention of Cruelty to Children.
Sisters of the Holy Family.
Associated Charities.
Pacific Rescue Home.
Boys and Girls Aid Society.
California Foundling Home.
Methodist Chinese Mission.
St. Marys Hospital.
Graeco-Russian Church Seminary.
German Benevolent Society.
French Ladies Benevolent Society.
Sheltering Arms San Jose.
Good Templars Home for Orphans.
Bishop Armetage Orphanage, San Mateo.

The report of 1900 lists the diseases treated. This forms an excellent basis for comparison with the diseases of children at later dates. The Orthopedic service saw and treated 96 children with tuberculosis of the skeletal system,- the spine, bones and joints. The other conditions mentioned were fractures, dislocated hips, spastics, club feet, etc, totaling 43 in addition to the tubercular problems.

There were 77 surgical admissions which included many of the same problems seen at present. The striking difference, however, was in the number and types of cases requiring surgical drainage of abscesses. There were 26 admissions for such treatment and these included Cervical Glands, Osteomyelitis, Empyema, mastoiditis and boils. One year listed 5 mastoidectomies and the next twelve.

The Pediatric admissions were numerous and varied, including, naturally,

many diseases still common among children. Significant is 46 cases of malnutrition. The major problems, then as now, were the respiratory diseases. The complications of these, however, were far more serious then and complications were also more numerous. Tonsilitis, frequently, was followed by swollen cervical glands which might last for weeks or months and often ended by abscess formation requiring drainage by surgery. Otitis Media often progressed to mastoiditis and surgery; Bronchitis frequently resulted in pneumonia and this might progress to pleurisy or empyema. Lobar pneumonia caused by the pneumococcus was alarming; the child might run a very high fever for seven to nine days and then drop by crisis. Death was not rare. The Dysenteries were very serious and very debilitating, especially in infants. Other late results of Streptococcic infections, such as rheumatic fever and nephritis, were not recognized as sequelae until much later. Rickets, scurvy and congenital syphilis were not uncommon.

Probably the worst recorded statistics, although not the year of the most admissions, were in 1906 when 703 children were admitted and 96 deaths occurred. The population in the early nineteen hundreds in San Francisco was not as great as at present. In 1870 - the population was 149,473 in 1880 - " " 233,959

The first years of the twentieth Century finds more familiar names on the staff. Dr. Emma K. Willets, after 3 years as resident physician, was highly praised by the Board and was made chief of the surgical services. This probably was the first true separation of the children into surgical and medical divisions. Dr. Merritt had been in charge of both. Dr. Mary Botsford became chief of Anaesthesia in 1908 after a year of internship at the Hospital. By 1910 the visiting staff had increased to 27. Some of the old remaining ones were Drs. Wanzer, Sherman, Von Hoffman, Lewitt and Watt Kerr. New names appearing were Adelaide Brown, daughter of Charlotte Blake Brown,

Wallace Terry, Langley Porter, Anna Flynn, Elizabeth Keys, Rachel Ash, George Ebright, and Anna Rude. The specialties were still not clearly defined, especially Pediatrics. Thus Rachel Ash had substituted in Pediatrics at the University of California Medical School for Dr. William Palmer Lucas when he accompanied Herbert Hoover to Holland after WWI. Later Dr. Ash became Chief of Medicine at Childrens Hospital.

After the first White House Conference on Children and Youth in 1910, there was ~~marked~~ increased interest in the health of children at local levels. Dr. Adelaide Brown was concerned about the quality of milk reaching the City and was instrumental in the formation of a Milk Commission to study both the milk and the sanitary status of the dairy farms and their workers. The result was certified milk. It remained in vogue until pasteurization became routine. Two other doctors greatly concerned about the childhood infections were Karl F. Meyer then in charge of the Hooper Foundation at the Medical School and E. Charles Fleischner who was later to be Chief of the Communicable Disease Department at Childrens Hospital. Dr. Fleischner died in 1926 at the age of 44.

The decline of many diseases of childhood before the advent of immunization and antibiotic therapy was due to public health measures taken to assure pure water, clean milk, better nutrition and improved living conditions.

In 1913 Dr. Julian Wolfson was appointed neurologist for the hospital, Dr. James Watkins was added to the orthopedic staff and Walter Alvarez was the first X-Ray Radiographer,- the same Alvarez who later was to win fame at the Mayo Clinic, and whose son was to win the Nobel Prize.

The name of Florence Holsclaw first appears on the records in 1915. Associated with her later were Drs. Jewel Booth, Jessie Bierman and Charlotte Boehme. Drs. Myrl Morris, Rena Piper and Clain F. Gelston were at various times with Dr. Langley Porter. Dr. Fleischners name does not appear in reports until 1917

although he came to the city in 1910 and worked with Dr. Brown on the Milk Commission and in the Well Baby Clinics as noted earlier. Pediatricians associated with Dr. Fleischner were Drs. E.B. Shaw and H.E. Thelander. He had others with him for short periods of time among them was Dr. Lloyd Hardgrave. Apparently even some psychiatry was practiced at this early date since the name of Olga Bridgeman appears in the records of both UCSF and Childrens Hospital.

In 1924, when I came to Childrens Hospital as an intern, Florence Holsclaw was Chief of Pediatrics. She also supervised the infants of " Babys Aid" an organization that provided homes for abandoned and orphaned infants. The mortality in this group was high. Many of them were admitted to the hospital for treatment of dysentery or respiratory infections. Pediatrics was located in one of the early round buildings facing Sacramento street. This was a three story building and the so called clean cases were kept on the first floor, the mildly infectious ones on the second and the orthopedic problems on the third floor or "Jim Ward" as it was known. Surgical Pediatrics was on the third floor of the main building. Maternity and the newborns were in a small building, since removed. Dr. Fleischner was Chief of the Communicable diseases, Dr. McChesney of Orthopedics, Dr. Keys of Obstetrics, Dr. Willets of Surgery and Dr. Flynn of EENT.

The Hospital had twelve interns and two residents, all women. One resident supervised the surgical services and the other the medical ones. The house staff had quarters on the top floor of the Nurses Home. They were on call day and night with no specified time off but, with permission and a willing relief, were permitted to take an afternoon or an occasional week-end off. Board and room were provided and they received a stipend of $15.00 a month.

In general the University Hospitals did not pay their interns, and for this reason some felt that to receive pay was an indication that the internship was inferior to that of the Univesities. The stipend was seldom mentioned! It was a very interesting group of interns in 1924; one was from Scotland, one from England, one from Canada and the rest from all parts of United States. Dr. Bronson who was in charge of the Cardiac Clinic, had studied in England and was responsible for the British physicians coming all the way to California. Edith Bronson drowned in Yosemite when vacationing there with her British friends. This was a tragic event for her friends and for the Hospital. One interne, Virginia Milner, contracted a strep infection from a surgical patient and died of sepsis and meningitis.

Dr. Holsclaw died in 1929. Members of the pediatric staff at that time included Drs. Myrl Morris, Clain Gelston, Rena Piper, Jessie Bierman, Charlotte Boehme, Hildegarde Henderson and Hulda Thelander. Clain Gelston was elected chief of the Department in 1932 and served until 1951. In addition, he was Hospital Administrator from 1933 to 1942. Dr. Gelston asked Drs. Bierman and Thelander to assist him on the Pediatric service. The service was already well developed. The Out-patient Department had special clinics for well babies and pre-school children; specialty clinics in Allergy, Cardiology, Neurology, Chest, Eye, and by now, Ear, Nose and Throat had its own clinic. There were also specialty clinics in other Departments serving children. These included, Dermatology, Orthopedics, Genito-urinary diseases and surgery. Dr. Morris retired from practice very early, she said she retired at the insistence of her brother, also a physician. She later stated that it was a grave mistake to retire early and warned the younger women entering medicine to stay on the job. Dr. Morris died in 1973. Dr. Piper died in 1954. Dr. Hildegarde Henderson, although never very active in private practice did introduce Hematology as a field of special interest to the hospital.

Jessie Bierman elected to go into Public Health and has served well in that field at local, State and National levels. She also participated in the World Health Organization and did an in-depth study of children in Hawaii.

The years of depression in the ninteen thirties were tragic for many patients and also for several young doctors who got their first practice experience by working in poverty programs. Several older ones ready to retire or already there, lost so much in the crash of 1929 that they returned to work. These years were followed by World War II, a time when the population of San Francisco increased rapidly, and its profile changed due to the influx of workers to the Ship yards and the Military Headquarters located in and near the City.

After the war, The American Academy of Pediatrics, (founded in 1933) , appointed a Committee to study pediatric services and Education in USA. This was a very intensive study extending down to city and urban levels in all the states. Dr. Warren Sisson was Chairman of the Committee and Dr. John Hubbard was Director of the project. The results were published in 1949 by the Academy in a book entitled, "Child Health Service and Pediatric Education".

However, it was not the war, nor pediatric education, but laboratory discoveries that changed and revolutionized pediatrics. The possibility of immunizing against certain diseases and the discovery of antibiotics that would kill the infecting organism without injury to the host is undoubtedly the greatest contribution to health of the twentieth century. Smallpox vaccination goes way back; it was followed many years later by Toxin-antitoxin against Diphtheria; Then by Toxoid, a safer agent against Diphtheria, and to it was added immunization against tetanus and then whooping cough (pertussis) now known as DPT. Since then vaccines have been developed against measles, mumps, and best of all, against Polio the dread disease for so many years. Although immunization

against tuberculosis was practiced extensively in Europe, most Americans chose to use testing for the disease with "TBC", isolating the patients, often in Sanatoria and treat ~~them~~. This method has proven satisfactory.

It is well to review the type of treatment utilized by physicians before the ~~advent of~~ the antibiotics were discovered. Steam was administered for cough either by a bedside kettle or directed into a tent over the child. Mustard plasters were used extensively for chest infections, more by some doctors than others. The discontinuance of mustard plasters probably pleased the nurses more than any other change. Dr. Von Pirquet of Vienna was an ardent advocate of sunlight as therapy. As a substitute in this country, sun lamps were often used during the recovery period. These prolonged illness of childhood were very debilitating and many children were sent to convalescent homes for several weeks or months. These institutions were located out of town to increase the childs exposure to warmth and sunlight. The best known locally were Stanford Convalescent home in Palo Alto and the Bothin Convalescent Home in MArin. There were also Sanatoria for Tuberculosis.

Infection was such a hazard that very strict rules of isolation of new patients were in vogue; throat cultures were routine, as were tbc tests, Schick tests, and blood counts, urinalysis and sedimentation rates. Visiting hours were very limited, usually two afternoons a week and for parents only. These routine practises were difficult to change, but, stimulated by the pediatric studies and the excellent results from the use of antibiotics and immunization, changes gradually took place.

In the early days of the Hospital, the physician who delivered the baby usually also took care of the mother and child. By 1950 the newborn nurseries were under pediatric care.

The Hematology Laboratory was opened in 1949 by Drs. Aggeler and Wallerstein.

Dr. Sylvia Hoag joined them later. The Cardiac work was continued by Dr. Ann Purdy. Her assistant for many years was Mrs. Lucile Boole, not a physician but a dedicated person who worked not only at Childrens but also at the University heart Clinic where she assisted Dr. Edith Irvine-Jones, a Scotch girl who had interned at Childrens Hospital. The physicians who worked with Lucile Boole said she could diagnose a heart condition as readily as the doctors. It was Dr. Purdy who first associated sore throats and Streptococcic infections as causes of Rheumatic fever and nephritis of childhood. Others were reluctant to accept this concept for many years, but it is now an established fact.

In 1951 Dr. Gelston died and Dr. Thelander was made Chief of the Department. The work progressed without interruption. The reports of 1950-51 note that all the internship and residencies were filled. Additions to the staff ~~the~~ were chiefly residents as they completed their services and went into practice. Names on the roster were Drs. Dorothy Orr, Martha James, John Miller, Alice Potter, Louise Yeasell, Margaret Reese, George Sherman and Louis Ogara. Also temporarily on the staff were doctors from Marin County, these later developed pediatric services at the local hospitals. Some of these physicians were,- Drs. Grace Goebel, Robert Dermot, William Kerr Jr., Dorothy English, and Degenhart. Dr. John Piel from the office of Shaw and Thelander ~~was also a member~~ joined Westaff.

Dr. Pieter DeVries was our first pediatric surgeon. He was responsible for the successful separation of our first Siamese twins, two thriving young ladies now. Dr. DeVries has left for another post and Dr. George Hyde is now the pediatric surgeon.

Dr. Piel organized the youth clinic thus relieving the teenagers of the embarresment of classification with children at a sensitive period. Adolescents were also given a special area in the Hospital for in-patient treatment. Later Dr. Richard Brown joined the Clinic and finally took complete charge. A teenage maternity service was provided under the supervision of Drs. Brown and Webb.

In 1952 the Child Development Center was opened financed in part by the Cerebral Palsy organization. When Polio was conquered, birth defects were added ~~to the~~ financed

in part by the March of Dimes and Crippled Childrens Services.

Childrens Tumor Board was started by Dr. Joseph Kushner. One year 18 tumor cases were discussed by the Board. When the Adult Tumor Board was organized, it seemed wiser to combine the two into one Board. The Cardiac Clinic continued under Dr. Purdy.

The treatment Room for emergency care was implemented and considerable study made of acute poisoning in children in order to try to prevent unnecassary fatalities.

A weekly seminar called " Childhood Ecology" was a joint venture of Pediatrics and Child Guidance to explore all factors affecting children. It started in July with a discussion of pregnancy and the intra-uterine period, and grew up, as it were, with the child through the year, ending the next June with a discussion of adolescents. Outside participants were invited, including educators, social workers, psychologists and even judges from the juvenile court. At times parents participated. The group also made visits to institutions serving children such as Sonoma, Napa and convalescent homes then in existence. Most of the old institutions such as orphanages , sanatoria and convalescent homes were no longer necessary. Many had been taken over by other agencies and were serving other needs such as Day Care Centers and Nursery Schools.

The Out-patient Clinics were supervised by pediatricians as follows:

General pediatrics.....	Cabos, Degenhart, Leininger, Macaulay, Baumann,
Allergy.....	Louise Yeasell and Wm. Kerr.
Cardiac.....	Ann Purdy, John Piel, and Grace Goebel.
Neurology.....	Elizabeth Rees and Elsa Cabos.
Well Baby Clinics...	Reese, Sherman, Cabos, Plate and Orr.
Dermatology.....	Francis Torrey.
Otology.....	Ki Martin, Castro and Dorothy DAnno.
Urology.....	Oca Goodwin and Olson.

Surgery..... Mary Mathis.

Orthopedics... Abbott and Bost

Treatment room and Poisoning ,.... John Piel and Susan Atwell.

Childrens work in Pathology and Biochemistry was greatly enhanced in 1956 when Dr. Sam Nerenberg joined the staff and became Chief of the Laboratories. Dr. Evelin Sires, was a great help in childhood radiology. Other pediatricians and co-workers with the department were Drs. Leonards, Lester Luz, Edward Smith, Alice Potter, Dorothy English and in childrens orthopedics, Drs. Larson, Ashley and Callender; in Child Guidance were Drs. Kaplan and Ryan.

Junior members and new arrivals joining later were,- George Sorokowski, Louise Taichert, Robert Dermot, Margaret Cariss, George Bates and Bradford Cohn. Rex Whitworth M.D. started a branch of the Collaborative Study, a national attempt to study children from conception on and factors interfering with normal development or causing anomalies or early death. After a trial period the National Group decided that the funds would go to University Hospitals and Medical Schools and the study was discontinued. Much of it, however, was pursued in the Child Development Center.

Started also at this time was an Alumni Association, designed primarily to bring former house staff back to the Hospital for an all day Seminar on some pertinent medical problem. These continued for a number of years and then the Medical School instituted Continuing Education in Medicine under the leadership of Dr. Roger Wilson and Dr. Seymour Farber. They suggested, and it was accepted, that all these programs be centered at the University for organization, preperation, mailing of brochures and other assistance even though the meetings be held at Childrens Hospital. Many of the former residents and internes participated in these Seminars. Mentioned among these are Marcia Levin, Ruth and Henry Kempe, Marvin Naman, Sarah Malin, Bill and Pat Clarke

Hildegarde Waasa and even two of the internes of 1925 attended when visiting here,- Dr. Madge Onhauser from Canada and Dr. Hilda Davis from England.

Students from the University Medical School had come to Childrens Hospital for some of their pediatrics and particularly for communicable disease teaching ever since 1922. Originally this was arrangement through an agrement that required the teaching to be done by faculty members from UCSF. In 1950 this was changed and all the teaching was carried on by the Staff at Childrens, most of whom were also on the clinical staff at the Univesity Medical School.

In 1954 when the new building replaced the Little Jim Building and the WW round building, diseases of childhood had changed so markedly that orthopedic cases were combined with clean surgical cases thereby eliminating a special ward for orthopedics. This meant ,of course, that tuberculosis was no longer a major orthopedic problem and draining osteomyelitis cases had yielded to antibiotic therapy.

By 1957 the communicable diseases most feared were under control,- there was no more diphtheria, pertussis, measles, mumps, scarlet fever or poliomyelitis; the other infectious diseases could be handled either in the intensive care unit or isolated in rooms on the pediatric floor. This meant the closing of the building that had housed the contagious diseases since 1912. What tragedies and triumphs its walls could record!. Dr. Shaw left Childrens Hospital as Chief of CDD in 1958 to become Chief of the Department of Pediatrics at UCSF his alma mater. There have been few Educators with as varied experience in all phases of pediatrics as Dr. Shaw brought to the Medical School. The Univesity has awarded him with an Honorary LLD and made him the recipient of the Gold Cane. He was also awarded the Abraham Jacobi award in 1973 by the American Medical Association Division of Pediatrics. Dr. Richard Leonards was made director of

contagious diseases and has continued to watch over the epidemiology of the Hospital and teach the house staff in this dicipline s.

In 1961 Dr. Thelander retired from the active pediatric staff but continued to head the Child Development Center until 1967 when when Dr. Jerome Mednick took over. John Piel was made Chief of the Department of Pediatrics. Dr. Gray Patton assisted him.

As the work increased, it was decided to pay a fulltime pediatrician to take over all the responsibilities of the Department. Dr. Ira Brandt was selected for this position in 1968 . He was replaced by Dr. Samuel Giammona in 1971. Dr. Lillian Blochman was full-time director of the newborn nurseries and the intensive care for prematures and sick infants. When she moved elsewhere, Dr. Jane Brady replaced her in that service. Dr. Paul Wilson was consultant to the Ambulatory pediatric patients with William Kiyasu as assistant.

The pulmonary Laboratory was opened by Dr. Giammona. For the first time the various hospitals of the City with pediatric services are co-operating in the teaching program. The house officers are rotated and the medical rounds are held in the different hospitals.

The Department is now divided into five sections as follows:- In-patient, Ambulatory, Newborn Nurseries, Youth service and Child Development. The full time physicians are,- Drs. Giammona, Richard Brown, June Brady and Hilty, & Jerome Mednick

The Ambulatory services are divided as follows:-

Well Baby
Allergy
Cardiology
Metabolism and Genetics
Hematology and Oncology
Surgery
Pulmonary diseases
Neurology
Psychiatry
Infectious diseases
Pathology

H.E. Thelander, M.D.
11/7/74

Ward Cahill was the only son of Ed & Vera Cahill. Vera & Mame Fleischacker were sisters. Ward was a flyer in WW II & killed over the English Channel

67 West Clay Pk.
San Francisco
March 17, 1930

Dear Aunt Mame

I hope you are having a nice time on the steamer. I hope you don't make the stewart work and "feed the fishes."
Will you bring some stamps from Europe. Grandpa gave me a cross between a ~~graph~~ grapefruit and a lemon and it looks like a little dinky grapefruit. I hope you have a ~~trip~~ big Klosepin when you go to the hilltowns.

Love,
Ward

C
O
P
Y

382 Fighter Sqd.,
Army Airdrome,
Santa Rosa,
California.

Dear Mother and Dad:

Time out for a letter. Not much but something to let you know that Elaine and I are still alive and kicking.

It isn't so bad up here. We have taken a five room house about a mile from the field and about six miles from Santa Rosa. It is furnished and everything is included except the electricity. Price -- $60.00. Elaine drives me to work every morning and calls for me in the evenings. I get every fifth day off which isn't so bad.

In addition, your son is now a full fledged flight leader. Quite a job. If I hold it it will mean quite a lot in the future when we go overseas. For one thing a flight leader never takes the job of tail-end Charlie and it is the tail-end Charlie's that always get shot to pieces. This unit will go over seas as a unit. Everything will go at the same time except the airplanes. We will get brand new airplanes at our destinations. By everything I mean that the crew chiefs, armorers, intelligence officers, everything will go together. This is a plenty good deal because we will know each other and each others capabilities.

We got in a brand new P-39 (Q-10) today. It is by far an improvement on the other model P-39s. For one thing we will no longer have to worry about propellor settings. This is automatically taken care of by the manifold pressure. This airplane is reserved for flight leaders only. That means that Tommy Thompson, the fellow whose job I took at Mills Field, and I are the only flyers for the ship. I hope that neither of us scuttle it.

Well, this is quite a job I got myself all of a sudden so I have to go back to work.

Incidentally, Chunky and I are now growing a victory garden in the landlady's apple orchard.

Love to all. Write to the above address for the two of us.

(Sgd) WARD.

May 28, 1944.
England.

COPY

Dear Mr. Cahill:

I received your letter of May 15th to realize what I should have known; the Army would give you no information on Ward. I know you are wondering why I haven't written before. I assure you it was not because I didn't want to, but because they won't allow us to write to any of the relatives for a certain length of time.

In hopes that this will reach you first, and knowing that you want the facts, I shall not hold back anything. According to the clippings Margaret sent me, they left me with the same impression that you must feel -- that maybe someday Ward would come back. At first I thought it would be better to let you keep on having hope, but then I stopped to think how my folks would feel in the same situation, and I know they would like to know the truth. So realizing that this will hurt you more at first, but hoping it will be for the best I'm writing this letter to you knowing you will not show any more of it to Elaine and Ward's Mother than you know that they should read.

The weather was very bad on the morning of April 15th and the overcast was low and thick. Ward, Sgt. Hare and Lt. Webster were flying with the Group Leader. After climbing through the overcast for a long time, and getting extremely tired from the mental and physical strain, the leader got his air speed too low, lost control of his ship, and went into a spin. Ward was flying formation on his wing and, naturally, went into a spin too. The leader and his wing man recovered. Apparently Ward and his wingman, Sgt. Hare, ran together for they didn't recover in time. They apparently didn't bail out because Lt. Webster flew over the whole area in an attempt to find a little rubber boat they give us, to no avail.

He wasn't very far out in the North Sea and patrol boats would have picked him up if he had made it O.K. At least 60% of the men we have lost in combat to date have been due to bad weather conditions.

Ward was an excellent pilot and I know that if he had had a chance he would have made it alright.

I can not put into words my feelings and I hope that I have done the right thing in being so frank.

Certainly Ward was among the fellows I have met in the Army that I can be proud to say I have known and flown with. He did a great deal to make my life a little brighter and fuller. I shall never forget him for it.

I know Ward was, as the rest of us are, more than willing to give his life for the preservation of the type of life we enjoy back home and for the wonderful parents like you and your wife and my mother and father, and greatest of all wives and sweethearts like Elaine and Margaret.

Although I know you are grieved deeply at his loss, feel proud, as the men who knew and flew with him feel proud: that you had the honor of knowing and having a son like Ward.

There is no one who regrets the loss of these brave and great pilots more than those of us that are left behind to realize that it should have been one of us who had not so much to live for than he who had so much.

With sincere regrets and the greatest of sympathy.

(Sgd.) Tommy

P.S: Please do not find it necessary to answer this letter. I hope some day to again have the opportunity of enjoying your company.

Part of a book this should be published by ...

MAINTAINING GOOD HEALTH

Huldah E. Thelander, M.D. and Robert G. Patton, M.D.

The dictionary defines health as being the "state of being sound in body, mind, or soul," and it is important that we recognize that it's meaning is such a broad one. Maintaining good health encompasses a good deal more than just keeping our skin clean and brushing our teeth.

Since the beginning of civilization, men have been concerned with keeping themselves well. In ancient, primitive days it was believed that sickness and physical defects were punishments inflicted on men by gods or demons. The "medicine men" of primitive societies tried to remove the "spell" of illness by performing magical rituals. The Greco-Roman god of health was Aesculapius. He had two daughters, Hygeia and Panacea. Although illness was still held to be a supernatural visitation, men, by Greek and Roman times, had some knowledge of anatomy, performed surgery, and used medicines, usually derived from roots and herbs. Throughout the middle ages, medical practice remained based on the principles of Greek science, and there were few new contributions. With the renaissance, came the beginnings of modern medical science, and such men as Vesalius, Paracelsus, and Ambrose Pare. William Harvey, in the early 17th century, accurately described the anatomy and functioning of the heart and circulation. The development of knowledge in bacteriology, physiology and chemistry, which have led to our present knowledge of health, have all come in the "scientific age" of the past century.

There are several ways in which we maintain good health among people. First, there are the personal or individual ways in which we, or our doctors, keep our bodies well. Then there are the things that we do together with other people to protect our health. This is often called "public health". For instance, our town or city government makes certain that our water supply is free of desease-producing germs, and that our sewage is disposed of properly. Our state

governments also make laws and provide services which protect the health of the people of the state as a whole, such a s providing laws to insure the proper handling of food in restaurants and stores, and keeping statewide health records so that the development of epidemics can be spotted. The national government, too, has important health duties in protecting the nation as a whole. The enforcement of quarantine laws prevents the entry into the country of people who have such very serious and contagious illnesses as smallpox. The Pure Food and Drug Administration takes care that foods and medicines are safe and uncontaminated. There are also many cooperative international health organizations, such as the World Health Organization, and the International Red Cross.

Immunity is an important part of our resistance against infections. In the case of some illnesses, such as chickenpox, we can get immunity only by having the disease. With other more serious diseases, such as smallpox, tetanus, diphtheria, and poliomyelitis, we now have ways of making ourselves immune without actually having these very dangerous infections. It is important that all of us receive the vaccines for these four diseases, and that we make sure that we keep up-to-date with our immunizations. Many of these have to be repeated every few years. Your doctor may want to give others, such as the measles vaccine, and if you are fortunate enough to travel abroad, some special immunizations may be necessary.

The foods and fluids which we eat and drink (see NUTRITION) provide the materials for the daily operation of the body machinery, and for growth. We need a certain amount of water each day (about one ounce for each pound of body weight). More than the usual amount of water is needed when the weather is very hot or when we are doing a lot of vigorous exercise. We need proteins (meat, milk, etc.) to repair and build new muscle and bone. Carbohydrates (bread, cereal, sugar) and fats (butter, mayonnaise) provide the fuel which our body converts into energy. A well balanced diet contains all of these in proper amount, and is

divided into three meals a day. Each of these meals is important; one should not make a practice of doing without breakfast, for instance. Between-meal snacks should be small (unless one is engaged in very vigorous work or exercise), and should consist of milk or fresh fruit rather than candy, soft drinks or milk shakes. It is not good for health to be overweight. Being too heavy results from eating more than the body needs for growth and for work, so that the excess food is converted into fat and stored as such by the body. Maintaining correct and healthy body weight depends on two principles. First, one should get as much exercise as possible, in order to "burn up" the extra food energy. Second, one should be careful about the "fuel foods" (fats, starches, and sweets), and should eat no more of these than is necessary to provide energy for the work of the body. When weight loss is desirable, the diet should consist mainly of lean meats, fish, or fowl, skimmed milk, vegetables and fruits. Before embarking on a diet, however, your doctor's advice should be obtained. Fad diets and dietary foods, especially, should not be used without consultation.

Vitamins are substances which are necessary in regulating the chemical reactions of the body's metabolism. They are needed in very small amounts, and an ordinary diet, containing all of the basic items mentioned in the preceding paragraph, contains all of the vitamins needed by most people. In certain cases, your doctor may decide that additional vitamins are necessary, but be sure to consult him before buying and taking vitamin pills. Millions of dollars worth of unnecessary vitamins are bought each year.

Exercise is an important part of the daily care of the body. Not only does physical exercise help keep weight under control, but it keeps muscles healthy and in good tone, and is good for the heart and blood vessels. One should have a planned program of daily exercise. This might include vigorous walking, running, bicycling, calisthenics, swimming, or active games such as basketball or tennis

Of just as much importance to health, is recognition of the need for

adequate sleep. It is part of nature's design that our bodies need a daily period of total rest during which the "batteries," which provide the energy for life processes, can be "recharged." The need for sleep varies with age, but no one of high-school age or less should have less than ten hours of sleep daily.

The outermost and one of the most important organs of the body is the skin. The skin is not just an inert sack which holds our bones, muscles, and organs, but is, instead, an active tissue, important in regulating the body temperature, the body fluid, and in protecting the body against infection. The skin contains many little oil glands which enable it to keep its smoothness and pliability. The most important part of good skin care is cleanliness, which can be maintained by the frequent use of soap and water. Occasionally, bacteria may gain entry into the skin glands or hair follicles, and produce the local infection which we call a "boil." At other times, the skin may become irritated by chemical substances, and a blistery, itching rash may develop. The most common cause of this reaction is contact with the sap from the poison ivy, oak, or sumac plant, but other things, such as paints or cosmetics may cause this. The skin may be easily injured by the sun, and care should always be taken to protect against sunburn through the use of a protective cream, and through sensible limitation of exposure.

In the early 'teen years, there is a natural tendency for the oil (sebaceous) glands of the face and adjoining areas, to become swollen and inflamed, and to produce a rash called acne. This occurs to a certain extent in all teenagers. For reasons unknown, it tends to be more severe in some than in others. It is nothing to be ashamed of, and will clear up in time. The most important thing to do about acne is to keep the skin clean with soap and water. Sometimes, special soaps and medications are helpful, but these should be used only under the direction of a doctor.

The care of the eyes should include a test of the vision once every year

or so, as well as prompt attention to any discomfort, irritation, or injury of the eye. Styes are infections in the lash follicles or in the lubricating glands of the lids, and may need medical attention. "Eye washes," drops, and ointments should not be used unless prescribed by a doctor. One should avoid staring directly at sources of ultra-violet light, such as the sun, sunlamps, or acetylene torches.

The ears should be washed frequently, but nothing should be placed into the ear canal itself. Ear wax (cerumen) in normal amounts is a useful substance which protects the ear canal and ear drum from external matter. It may occasionally accumulate sufficiently to block the ear canal, in which case the ears should be cleaned by a doctor. Earaches, or difficulty in hearing, also call for a medical examination.

Irritation, stuffiness, or itching of the nose may be caused by infection with viruses or bacteria (the cold), or by allergy to dust, plant pollens, or animals (hay fever). Nose drops, sprays, and inhalers may themselves b irritating if used too much. Nose-bleeds, when they do not occur often and are not difficult to stop, are not a matter of concern, but if frequent or prolonged should have medical attention. Sore throats, or hoarseness are usually due to infection with bacteria or viruses, and when severe, or when there is also fever, may require special medication.

Care of the teeth is aimed toward prevention of cavities in the teeth themselves, and in keeping the gums around them healthy. It is advisable to brush the teeth thoroughly after meals (three times a day if possible), and to massage the gums as directed by the dentist. Between-meal sweets and soft drinks should be avoided. A visit to the dentist every six months is essential. The addition of fluoride to the water supply of your city is also of great help in preventing cavities.

Taking good care of your lungs requires little more than getting plenty of exercise and fresh air, and having coughs attended to by your doctor. One more thing requires serious mention, however. You may begin to think, during the next few years to come, about the problem of smoking. In the past few years, we have begun to see that smoking, which was once considered a fairly harmless habit, is really quite harmful to the lungs, as well as to other organs of the body. You are urged strongly not to begin this habit. As with many other habits, it is much easier not to begin, than to stop once you have started.

In recent years, tuberculosis, which was once a grave and prolonged disease, has become quite curable with drugs when discovered and treated early. For this reason, everyone, particularly everyone under the age of 21, should have a tuberculin test once every year.

The health of your digestive system (stomach, intestines, and related organs such as liver or pancreas) can be best guarded by eating a well balanced diet, and by avoiding an excess of heavily seasoned foods or foods that are rich with fat or sweetening.

The portion of food which is not digested and absorbed into the body, is eliminated by the large intestine. Most people have a bowel movement daily, but this can be more often or less often, and still be perfectly normal. Unfortunately, many people worry too much about the regularity of this process. When true constipation is present, your doctor can give helpful advice about a change in diet or a medication. It is not a good thing to use laxatives frequently without medical advice.

The muscular and skeletal system provides your body with its supporting framework, and with its ability to move. Muscles function best and remain in good tone when you exercise them regularly, and "educate" them by participating in skilled games, gymnastics, or dancing. Good, straight, posture is important, not only for one's appearance, but also in keeping the back strong and supple. For

proper care of the feet, one should wear shoes which are well fitted, give good support, and are comfortable. Cracks, redness, and itching of the skin between and around the toes may mean that there is a fungus infection. This should be examined and treated by your doctor. Blisters, and hard rough spots on the skin of the feet, called calluses, mean that there is abnormal wear and friction from shoes which are not properly fitting. "Flat" feet actually cause no trouble in most cases, but may occasionally require special shoes or arch supports.

In the early 'teens most children begin a period of their growth called puberty. During this period, a sudden spurt of rapid growth occurs, and boys and girls become physically more like adult men and women. The important thing to know is that puberty, or adolescent development, happens much earlier in some than in others--as early as 10 or 11, or as late as 16 or 17--and that those who have their adolescent development later are just as normal and healthy as those who have it early. The boy, who at fifteen, has not yet had his spurt in growth and who has not had his "voice change" or begun to shave, may notice that many of his classmates are quite mature, and may therefore think that he, himself, is abnormal. This is not so. This boy will, within a year or so, go through the changes of puberty, and will be just as normal and healthy an adult as will his classmates. The same may be said for the girl, who at fourteen, has not yet started her menstrual periods and who has not developed a mature figure, at a time when many of her classmates have. She too, is, in all probability, perfectly normal and healthy. Whenever there is any doubt or worry about these changes of adolescence, it is always good to see your doctor for a reassuring examination and discussion.

A brief mention should be made of emotional health (see MENTAL HEALTH). In recent decades, it has become known that a person's emotions or feelings are just as much a part of his total health as are the condition of his stomach or his chest. We know that the state of one's feelings and emotions can effect his digestion, his energy, his resistance to infection, and his ability to think and

learn well. When we feel afraid, worried, sad or angry, to the extent that these feelings keep us from having a happy life, then we should talk to someone about them. Often, the doctor is the person best equipped to discuss such things with us. It never helps to keep these feelings "bottled up." Almost always, just talking about them will bring much relief.

Accidents are really the greatest of all threats to the health of people in their school years. You are urged strongly to learn to swim, to observe traffic rules and signs whether walking or bicycling, to observe all safety rules when operating machinery, and to handle inflammable things in a safe way.

Finally, serious mention should be made of the problem of drugs and medicines. There are countless pills and tonics available without a prescription--vitamins, cold medicines, pain relievers, "stay-awake" pills, weight-reducers, and many others. Many households also have an assortment of bottles in the medicine cabinet, prescribed by doctors for past illnesses. Many of these medicines may be quite harmful when taken without the direct instruction of a doctor, and it is urged that you do not make a practice of treating yourself and of taking medications. There is an old saying that "the person who treats himself has a fool for a patient."

PEDIATRIC EDUCATION AND PRACTICES: SOME QUESTIONS.

H.E. Thelander, M.D.

Ped. Educ. Practices

1972

A pediatrician recently was asked what deficiency he had found in his training for practice. His prompt reply was that the three major professionals who deal with children, e.g., pediatricians, educators and psychiatrists, have no common language--each speaks his own jargon and does not understand the other. An experienced nursery school teacher, when asked about the qualifications of pediatricians and psychiatrists in child behavioral development, replied, "They know as little about it as a mother with her first baby."

The Academy of Pediatrics was founded not for the benefit of pediatricians but for "The Welfare of Children". In 1935, Dr. Henry Deitrich[1] in his presidential address expressed concern for recent graduates entering the field of pediatric practice because of the decline in infant and childhood morbidity, the extension and improvement in public health, the dissemination of knowledge concerning mental hygiene and the overproduction of pediatricians. In 1970, the Carnegie Report[2] calls for a 50 per cent increase in medical students, more opportunities for women and minorities, development of nine new medical schools, establishment of a National Health Manpower Commission to review the total spectrum of health care personnel, creation of a voluntary National Health Service

Corps to bring improved health to minorities and more equitable distribution of the financial burden.

What happened in pediatrics in the intervening 35 years? In the post-War study of Child Health Services[3] by the Academy of Pediatrics, a great variation was found in the Pediatric Departments across the country. Some had budgets as high as $100,000, others only $5,000 a year. Also, there was marked inequality in the distribution of health services; in some areas of the country there was one pediatrician to 5,000 children, in others one to 35,000. The recommendations of the Study called for improvement both in medical education and in health services to all children.

Pediatric education changed ~~also~~. The time allotted to medical school postgraduate years has been extended from two to three years. Its scope now comprises rotation through various pediatric services such as ward work, newborn nurseries, ambulatory care, specialty clinics, emergency services, etc. Other innovations in the last decade include child development centers, youth clinics and even teen-age pregnancy services. Pediatricians have succeeded also in adding new courses to the core curriculum, recognizing the importance to all physicians of basic knowledge of human development, the hazards to which the embryo and fetus may be exposed, the role of genetics,

and the significance of these factors as antecedents to subsequent disease.

There is justification, therefore, for pride in the accomplishments of the past 30 years: in prevention and cure of many killing diseases, as well as advances in general understanding of children. On the other hand, this country as well as other nations is experiencing a marked increase in violence, delinquency, emotional disturbances, rebellion of youth, drug abuse, teenage pregnancies, etc. Must we, as pediatricians assume some liability for this sickness among the young? Have we a responsibility to examine our practices, to seek understanding and, perhaps, to provide some effective measures for prevention? Do we understand the origins of destructive behavioral patterns? Have we utilized fully the knowledge of other professionals?

It seems evident that "human development" must be studied in much greater depth and breadth than that provided by growth charts and such parameters as age of walking, talking, and toilet training. It will be necessary to study the development of behavior and not place reliance merely on retrograde analysis of neuroses and psychoses. For such studies, other laboratories than outpatient departments, well baby clinics, sick wards, and child development centers are essential. Women as well as men are needed to interpret

infants and children, their motivations, their creativity, their learning processes. Are there laboratories for such studies? There are.

The past decade has seen a rapid development of nursery schools and day care centers for preschool children. The observation of teachers[4] who live with children for 6 to 8 hours a day are of immeasurable value in interpreting behavior. A nursery school on the hospital grounds, for children of the working personnel, could be used for such observations. If this is not available, institutions in the community would certainly welcome such participation (there is always a dearth of male figures on the premises). Casual observations are not enough. There should be actual participation over a long enough period of time to learn the subject. It should be part of the pediatric rotation in a well-developed training program.

The second recommendation of the Study of Child Health Services, e.g., "Improvement of Child Health Care" was never successfully implemented. Concern for the delivery of health services consequently has surfaced again. Would we be farther ahead now if we had pursued the course then recommended? How can we catch up?

Pediatrics, although a late-comer, is one of the major departments in a medical school. It has tended to imitate the other departments in teaching, research and service. Health services to children, however, differ from those to adults. The hospitalized child represents only the apex of a vast pyramid of health problems of children. It is in this other area where both education and delivery is deficient. Pediatric residencies do not give adequate training or prepare the aspirant for the problems he encounters. He imitates what he has learned for an office to which his patients will come for services, with services available in an approved pediatric department in the hospital of his choice where he can place those of his patients that need diagnostic studies or therapy best administered in that setting. He will want residents and interns in his department. These demands result in a few large pediatric hospitals--a few because there are not enough sick patients in the pediatric bracket to supply many hospitals with enough patients to meet accreditation requirements. Let us, then, turn our thoughts to the problem of the consumer.

Are mothers content to travel across the city and then wait long periods in overcrowded corridors before receiving any attention? Is there a basis for criticism

of these services? A high percentage of mothers work either to augment a meager income or because they are the sole support of their children. In one day care center, 80 per cent of the children were from one-parent families. Medical facilities are open for a limited number of hours during a 5-day week for the convenience of the institution. How does a working mother get care for a sick child when she comes home from work or has only week ends? Well baby clinics and emergency hospitals have been strategically located in communities in order to facilitate services. Why should not clinics for other medical services, both minor ones and illneses, not necessitating prolonged hospitalization be similarly located in community hospitals? Should there not be evening clinics as well as day time services, and emergency care?

In order to accomplish this type of change perhaps the attitude of medical schools must change. Could not part of the intern's and/or resident's time be spent in these centers, with credit given for it on the same basis as ward work? It is of equal importance in quality and vastly more so in quantity. In developing countries this pattern of service is the rule. In remote areas there are clinics for routine care of children. Those patients who have been screened and require more extensive study and therapy are sent to the next largest facility for short-period hospitalization; only the complicated problems are sent to the

completely equipped medical center. The prestige of all services should be equal, as ~~well as~~ should promotions in academic rank for all who work therein

The greatest challenge to modern pediatrics is the fulfillment of the motto "For the Welfare of Children". New discoveries are important but, while devoting time to these, should we leave the rest of the work undone?

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1946-48

SOME OBSERVATIONS ON THE PRACTICE OF MEDICINE.

H. E. Thelander, M. D.

After the International Pediatric Congress in New York, a European colleague said that the Europeans envied us our research laboratories but in hospitals and equipment they already had obtained much of what United States was still contemplating for the future.

This statement confirmed my impression during a recent visit to the northern European countries. The buildings and equipment were exceedingly well provided for, sometimes to the point of extravagance, especially when compared with the austerity under which the people lived, with heat, food and clothing severely rationed. In a new hospital in Stockholm, for example, the ground floor had an immense entrance hall which, like a hotel lobby had a news-stand, a flower shop, a snack bar, a coffee shop, and, unlike a hotel, two day nurseries, one for the children of employees and one for the children of ambulatory patients. A Finnish doctor described a new pediatric hospital in Helsingfors modern to the degree that it had the wards equipped with radio ~~nurses~~. Most of the general hospitals visited had departments of radiology with separate equipment for chest, urology, gastro-enterology and often an entire floor for X-ray therapy, 90% of which I was told was for arthritis. (There had been no heat in homes since February.)

In socialized medicine interest is focused at a different level than in private practice; in the former interest is in the group; in the latter it is in the individual and the handling of his special problem. It is an accepted maxim that humanitarianism operates in inverse ratio to the distance separating the donor from the benefactor. It is therefore not surprising to find that in a state or socialized system the major interest is directed toward buildings, equipment, personnel and statistics and that this interest may predominate even though the individuals at the local level are in need of food, shelter, clothing and warmth; nor is it surprising to find that many patients are hospitalized for

"social reasons" and for long periods of time, the hospital becoming a domiciliary from the rigors of the home. The inherent weakness of the socialized system is its failure to deal with individual needs at a local level; it is impersonalized. It has been paraphrased in one of our own large clinics as follows: "The doctors talk only to doctors and the patients talk only to God."

In private practice where the relationship on the other hand is entirely personal and on a doctor-family basis, the inherent danger is the opposite, namely that, overburdened with the duties and cares of a personal nature, the physician fails to see the overall picture or fails to participate in the planning for the general health problems of the community, state or nation.

Actually a dual system such as we have in United States with a well developed private practice and an efficient public health service should effectively overcome the inherent weaknesses within each system. The fact that we have the two systems may account at least in part for the phenomenal progress Medicine has made in our country. It is a two party system that not only mutually supplements the weaknesses inherent in each, but the critical scrutiny that each keeps on the other is wholly healthy. History has proven repeatedly that any organization, even the most idealistic such as religion, if unopposed, succumbs to totalitarian practices.

In United States, public health started as an outgrowth of private practice, being created when those duties of the practicing physician which were of public concern were delegated to full time personnel. There has been no fear therefore that organized private medicine would seek to eliminate public health. Public health on the other hand has shown such aggressive tendencies that there is ample reason for suspecting that its ultimate aim may be the elimination of private practice.

The practicing physician, traditionally an individualist and reluctant to join any group, is accused of monopolistic sins on one hand and union tactics on the other. The layman is against doctors collectively although strongly for his personal physician. The high cost of medical care is attributed solely to the physician although it is primarily due to the high cost of hospitalization and laboratory expenditure. The doctor's income, however, is dependent on payment for services and any defense he makes of private practice boomerangs on him in the most sensitive area, that of economics, for it is interpreted as a fight for his right to capitalize on the unfortunate sick. The fact that the average income of physicians is very modest and fluctuates precariously with other economics, or that he annually contributes a great deal of time to care of the sick without remuneration, counts for naught in this emotional battle. The other aspects, those of personalized care and personalized responsibility, the real trigger mechanism of progress, as well as the obvious economy of paying directly for services received without any middle men and especially without an entire system between patient and doctor, are lost sight of. However if these aspects were replaced the change would be most acutely felt in this country and might very well initiate a retrogressive period that would mark the present era as the golden age of Medicine.

If the aim is not elimination of private practice, then public health should define clearly its purpose and ultimate aims so that private and public health together might reach agreement on their respective spheres of influence. Where these spheres overlap, standing committees at local, state and national levels could be maintained to review the problems and make decisions when indicated. Only then will the perennial struggle against dangerous legislation cease so that we might get on with our business of establishing a health system for our nation second to none.

of 1963

REDEVELOPMENT IN PEDIATRICS

H. E. Thelander, M.D.*

As a part of the discussion on the panel on handicapped and retarded children, I was asked to present the point of view of the practicing pediatrician. This was done in a series of slides. In order to keep the continuity of thought in the written summary the Tables and Drawings are labeled here as "Slides".

SLIDE I. SAN FRANCISCO STATISTICS

Population	750,000
Children under 20 years	199,000
Children on ANC**	12-15,000
Severely Handicapped	2,000
Those in special classes for blind, deaf, halt, retarded.	
Fringe Cases	12 - 20% of all children

Those:
- Emotionally disturbed
- Deprived
- Neurologically handicapped
- Learning problems
- Anomalies and other defects
- Borderline IQs

Comment: Statistics of this nature may be obtained from such sources as the Census Bureau, Public Health Department, School Department and Public Welfare. This fringe group is the reservoir for many of the community problems, the drop-outs, delinquents, neurotics and the plain inadequate citizens. An expensive survey is not necessary and often serves merely to kick the problem upstairs instead of sweeping it under the rug.

SLIDE II. CHILD DEVELOPMENT CENTER

(For diagnosis, total assessment, therapy, follow-through and counseling)

Staffs: Medical: Pediatricians for evaluation and consultants as indicated

* Director Child Development Center, Children's Hospital, San Francisco.

** Aid to Needy Children

Non-Medical: Psychologist
Social Worker
Educator
Speech-Audiologist
Reading Therapist
Physiotherapist
Occupational Therapist

Secretarial

Volunteers

Comment: Children with severe handicaps as well as those on the fringe need a careful medical examination in order to make a basic diagnosis. In addition they need an assessment as to their abilities and disabilities in functioning. The family and environment of a handicapped child needs to be assessed as to its strengths and weaknesses in order to help the child attain his maximum potential. The child, even when handicapped, is a growing organism and his development in all areas needs to be re-assessed at intervals. In infancy and early childhood, these reviews are done fairly frequently in much the same manner as well baby visits have been established. As the child grows older, fewer assessments are necessary. The crucial periods are: at two to three years when the child is acquiring his independent skills, namely walking, talking and toilet training; at six to seven years when he is at the age when the three R's are mastered; at adolescence when he is faced with adult independence and the interference of his handicap with this accomplishment; and finally as an adult desiring to marry, raise a family and hold a job.

In the process of helping these children and their families it became apparent that the needs of the children and the established community agencies did not dove-tail. This will be noted below.

SLIDE III. Insert picture.

Comment: A child with defects whether inherited or acquired has more than one problem. Interference in early foetal life may affect one organ more than another but, to some degree, the whole organism is altered. The community agencies and facilities on the other hand have been developed around categories. This makes it impossible to either finance the evaluations properly or to place the children in an optimum learning situation. As examples: Public Health through its Crippled Children's Services will pay for diagnosis and hospital treatment for certain disease categories. This, however, does not help a host of other children with equally great need, nor does it follow through with the necessary counseling, placement or frequent re-assessments; similarly, the School for the Deaf will not take a deaf child with cerebral palsy and the School for Cerebral Palsy will not take a child who also is deaf. The

Mental Hygiene Division has clinics for Child Guidance but it will not furnish a Center with personnel for evaluations or consultations (both much needed). Psycho-therapy as administered in the Child Guidance Clinics is seldom needed. The private agencies have become so enamored with Research, National and International Medical meetings and "Public Relations" (whatever that is) that there is very little money left for service.

Faced with this situation, there seemed only one recourse. The children are indivisible and will continue to come as bundles of multiple problems. The agencies, however, can change. For this change the term "Redevelopment" has been used. It is a term that has been used for modernizing the physical aspects of communities by both mending and by razing and rebuilding.

The rest of the Slides pertain to this need.

REDEVELOPMENT

SLIDE IV. There should be no indigent children.
There should be no discrimination against children because parents cannot pay.
Federal, State and Local Public Health Agencies should contract for care at private or University Hospitals.

Comment: This should be self-evident.

SLIDE V. A diagnostic, assessment and therapy unit as described under "Child Development Center" should be as essential a part of a Pediatric Service as are the Clinical Laboratories with a Pathologist in charge of a paramedical staff.

Comment: These Centers should be associated with Hospitals and Pediatric Centers. They should not be in Schools, in Mental Hygiene or in Public Health Departments. The Medical diagnosis is basic. One is reminded of a parallel situation in the case of pneumonia before antibiotics were available. With no therapy other than mustard plasters and steam, the etiological organism was of academic interest only. The acquisition of specific therapies, however, requires greater attention to specific diagnosis. In the field of retardation and handicaps the stage has been reached where specific diagnosis is equally essential. No longer should children with imperfections and impaired abilities be dumped into one classification, "retarded", not even into three, "idiots, imbeciles and morons".

SLIDE VI. The number and types of problems associated with our aging population as well as the changing pattern of

illnesses in children calls for more hospitals exclusively for adults. Programming for handicapped children should be developed in Pediatric Centers.

Comment: This concept will take redeveloping since Hospital Boards, Administrators, Staffs and Accreditation Boards have been habituated to think in terms of four Clinical Departments in all Hospitals with the result that services for children are severely fragmented. There may be a cardiac program in one hospital, a plastic surgical program in another, congenital deafness as a small part of an adult program for the deaf, and so on ad infinitum. In this situation not only does service to children suffer but teaching and research likewise. If all of these services were forced into Pediatric Centers by promoting hospitals exclusively for adults, the habilitation of handicapped children would be enhanced.

SLIDE VII. Diagnosis is not enough. Pediatricians must follow a child's functioning into the home and community and help to rectify the present outmoded and expensive as well as totally inadequate super-structure.

Comment: A diagnostic facility as a part of a Pediatric Hospital Center to which problems of development can be referred with as great ease as they are to a clinical laboratory and without loss of the patient has been a welcome addition to the physicians of the community.

SLIDE VIII. It is essential that we get off the treadmill of:

Surveys
Demonstrations
Pilot Studies
Projects
Grants

and do some constructive, long-term, properly financed community planning for handicapped children.

SLIDE IX. Insert picture.

Comment: In Space science, the astronauts and the nuclear physicists are working as colleagues to solve the problems in this new field; in the health sciences the money for research is entirely out of proportion to the money for services. A lesson from Space Science would accelerate the resolution of some of the health problems.

SLIDE X. Insert picture.

Comment: As Medical Science has evolved there has been a tendency to combine three functions, teaching, research and service, in one individual. Obviously, at present "the dish has run away with the spoon"; Research is prospering at the expense of service and teaching. This picture could be altered rather quickly as follows:

Service programs should be set up in Hospital Centers to meet all the health needs of all the children in a community. Removing children from indigent lists would make this possible. Careful records and observations can furnish many new ideas as well as an abundant amount of material for laboratory research. This could be supplied to a research colleague who could see the number and kind of patients called for by the study and only for the length of time required; Service to the patient would be uninterrupted. Education could be conducted in a similar manner with a teacher accompanying the students to the center. This is now being done by nurses and several other disciplines. In a seminar after the patients have been seen, the clinician supplements the teacher's session and is available to answer questions.

Pediatrics has the potential to take the lead in developing a whole new concept of health care, education and exploration.

November 1963

1946-48

MEDICAL TRENDS

Certain trends in postwar American medicine are worthy of note. Probably the most significant one is the fairly recent emphasis on general practice. Both in the medical journals and at medical meetings papers dealing with the problems of the general practitioner have appeared more and more frequently. These discussions are devoted not only to the training of the general practitioner by longer rotating internships, refresher or continuation courses and short term residencies but also to the qualifications, duties, responsibilities and limitations of his work. The trend is a healthy one for many reasons. In a vast country like ours with many large areas sparsely populated the well trained general practitioner should be the key person to a good health program. Specialization and even widely scattered groups of specialists can never meet the real grass root needs. There is no better solution to the needs of our rural areas and small towns than well trained men and women in medicine who at the end point can treat 85% or more of all the problems encountered and properly direct the rest to the centers where specialists can serve them.

The work of the general practitioner in the outlying districts will be greatly enhanced by the accomplishment of the second obvious trend, that of implementation of the doctors with hospitals, equipment and ancillary services. The work of the Hospital Commission should be of invaluable help in accomplishing this objective.

A third trend noted is the appearance in our journals and at our medical meetings of papers dealing with the doctor's responsibility toward all health matters in the community. With specialization there has developed among doctors an attitude almost approaching scorn for participation in

community welfare work. The ancillary services have been compelled to fend for themselves even though they have sorely needed and desired medical guidance. It is becoming apparent now that nursing, social service, occupational therapy and other allied work need medical guidance. Even other agencies of the community need medical advice on the health problems arising in the field of recreation, schools, rehabilitation of the handicapped, custodial care, and similar agencies. To all of these the doctor is the proper consultant.

The fourth trend noted in medical literature is discussion relating to decentralization of medical education. By decentralization is meant primarily the elevation of the smaller satellite hospitals to approved status for interneships and residencies and the affiliation of these with medical education centers for clinical and pathological conferences, medical rounds, refresher courses and similar functions. This accomplishment will serve three main purposes, namely education in part of the recent graduates by the medical men in small communities and the acquaintance of the young medical men with problems in the rural and suburban areas, a training which has been almost completely lost to the young doctors taking post-graduate work in large medical centers. Secondly, decentralization will bring continuation studies to the practitioner in his own area in a much more effective manner than he can get such training by returning to the medical center. Finally, the care of the indigent and low income people of rural and suburban places can be patterned after the university clinic service on a free or part pay basis, eliminating the necessity for the encroachment of government medicine with its incomplete services, such as maternal and well baby clinics, into these areas.

The fifth trend is the emphasis on the rural health problems. The work of the Committee on Rural Health reveals one interesting feature particularly, namely the participation of lay groups and non-professional individuals into discussion and planning of the programs. The consumer should be heard in medicine. Often he has not been permitted to be heard in the discussion of the distribution of health.

It is possible, therefore, to visualize American medicine developing along a pattern in which physicians will be trained in these large groups: Medical educators, research workers, public health officers, government medical officers (Army, Navy, Veterans), specialists and general practitioners. These groups, it is hoped, will cooperate completely defining their spheres clearly and clarifying areas of disagreement by properly constituted committees. There should be no "caste" system, no fear, no aggression of one group into the field of another. Health facilities should be distributed according to population needs. Medical education should flow freely and naturally to all members of the medical fraternith and medical problems in reverse flow should come back to the personnel and centers especially equipped to handle the obscure and difficult cases. At present, for the first time in many years, it looks hopeful that American medicine may continue to develop in its traditional free enterprise fashion not only advancing as it has in the past in research but also distributing its accomplishments to the entire population and thereby in reality creating a health service secondary to none in the world.

H. E. Thelander, M.D.

1949

REPORT ON THE 18TH ANNUAL MEETING OF THE AMERICAN ACADEMY OF PEDIATRICS.

The American Academy of Pediatrics met for its 18th annual meeting in San Francisco November 14 to 17, 1949. Preceding the meeting on November 11 and 12 seminars were held on Allergy, Dyscrasias of the Blood Marked by Bleeding, Emotional Problems of Infancy and Childhood, Care and Problems of Newborn, Endocrine Disorders of Childhood and Adolescents, and Virus Infections. The seminars have become very popular with the members of the Academy of Pediatrics. The number attending is limited and the sign-up is so rapid that the announcements go out by mail in such a manner that all parts of the country receive the announcement at the same time and acceptance is often by telegraph. The round-tables are also exceedingly popular and are limited in the number who may attend. Sign-up for these is therefore handled ~~often~~ in the same manner. A suggestion was made by one of the members this year that might help to solve the question of overflow in attendance, namely that the room be divided into two sections and that the participants in the round-table or seminar be in the front part of the room and they alone be permitted to take part in discussion; that the others remain as a silent audience in the back part of the room. It is possible that they might even be in another room with a radio broadcast to ~~a second overflow room.~~ this room. Someone even suggested a one way screen in order not to interfere with the round-table and yet participate ~~in the round-table~~.

The seminars and round tables are educational primarily. They offer a chance to clarify and exchange new knowledge and experiences. Some subjects are popular every year and repeated twice at each session. Others are given only several years apart. This year there was a repeat on Problems of the Newborn, Heart Disease, Emotional Problems, Allergies and Immunology.

A new one on foot problems was added ~~this year~~. There were ~~two~~ 3 major symposiums, one on Congenital anomalies & a third on Congenital anomalies one on Cancer in Childhood, ~~and another one~~ on Poliomyelitis. This latter took the polio patient from the acute stage with all the many manifestations, requiring the respirator, catheterization, and tracheotomy, through the subacute period when heat and physiotherapy are instituted, ~~and~~ into the ~~beta~~ rehabilitation stage, and finally through the surgical procedures which may eventually also add ~~to~~ to function. Dr. Shaw emphasized and the rest of the speakers concurred that teamwork was of extreme importance in restoring the patients to useful lives. It was the work of physicians, pediatricians, general medical personnel, nurses, physiotherapists, occupational therapists, psychiatrists and engineers.

That the Academy's interest is not limited to the interesting case was shown by devoting one session to the studies that have been made and are still in process on the Improvement of Child Health and the Study of Child Health Services. The survey has been completed and the results are now published in two volumes, one is entitled "The Study of Child Health Services and Pediatric Education" and the second is the statistical supplement. A third report is in the making. It is to be an interpretation of the Study and was presented in its preliminary form at this session. After review and criticism it will be made available ~~for~~ from publication.

The medical exhibits, as usual, were very enlightening. Of especial interest should be mentioned the exhibits on "Angiocardiography" by Los Angeles Children's Hospital, "The Congenital Heart in Pediatrics" based on a study of 400 cases, with exceedingly valuable models, and the "Control of Bone Growth by Epiphyseal Stapling". Of interest was a non-medical subject entitled "Legible Lantern Slides" from the Mayo Clinic at Rochester, Minnesota, showing again that other fields than medicine can contribute to our medical education and knowledge. Other exhibits that gathered the crowds were "Revascularization of the Brain in Retarded, Convulsive and Spastic Children" from Cleveland, Ohio, "Retrolental Fibroplasia in Premature Infants" from Johns Hopkins, and "The Child Development Center" by Dr. Ann Martin from Children's Hospital of the East Bay in Oakland, Calif.

I asked several people to write their impression of the biggest scientific thing gained at the meeting and the replies to some of these were very interesting. One of the doctors says that this was her first Academy meeting and she was really thrilled with all of it. She was most impressed by the stress on genetic and prenatal environmental factors of mental hygiene and children's behavior.

Another reply said that the entire conference was excellent, that it was exceedingly gratifying to see the vital activities going on in all phases of pediatric work, and she was especially impressed by Dr. Joseph Johnson's exhibit on "Protein, Nitrogen and Calcium Retention in Adolescence."

Several people, not only medical but newspapers likewise were impressed by Dr. Louis Diamond's report that the Rh negative blood from female donors showed a mortality rate surprisingly low as compared with blood from male donors in cases of erythroblastosis. The new drug Gemonal in the control of both petit mal and grand mal seizures came in for comment. One of the visiting doctors from Sweden was impressed by the symposium on cancer and the lecture on potasium balance by Dr. Danowsky.

The Academy of Pediatrics has gotten so large that the membership is contemplating a reorganization in order to facilitate the work that must be done. A preliminary plan was presented to the membership and this will be studied and acted upon at a later date. The next annual meeting will be at the Palmer House in Chicago.

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A REPORT ON HEALTH EDUCATION IN THE PUBLIC SCHOOLS OF SAN FRANCISCO

On Thursday and Friday, March 8 and 9, 1951 a health education workshop was held at the City College of San Francisco. The group was divided into two sections, one representing the elementary grades conducted by Miss Ethel Mealy and the other the secondary grades conducted by Miss Margaret Leonard. Mr. Watt Long lead the orientation session and presided at the final meeting when reports were presented. This workshop concerned itself primarily with health education and not with health services in the schools. However it is impossible to completely separate health education and health services and there are many ways in which the practicing physicians should enter into the picture and whenever possible the educators in those areas where the doctor's experience and knowledge is much wanted and needed.

It is now generally conceded that you cannot compartmentalize a child and give him health exclusively by the doctor, education exclusively by the school, religion exclusively by the church, and so on. Life is a whole and the various disciplines should work in cooperation toward transmitting their services to the child as a total symphonic experience instead of a series of jargons.

After exploration of the total field the workshop settled down to discuss certain areas which were most pertinent and offered the best chance of accomplishing something definitive. These areas were grouped around questions like these:

What are the health needs of pupils and teachers?

How can an awareness of health needs be developed in pupils, teachers, parents, and others?

What personnel in contact with pupils are qualified to help teach health education?

How can the skills of the personnel in school, in the health department and in the community be utilized?

How can a system of inter-communication be developed between such personnel?

What type of plan might be developed in the schools?

There then followed in as far as time permitted discussions around such questions as:

Are children interested in health?

What methods can be used to stimulate interest?

What materials are there to work with, and should there be any goals set?

Some answers were found and many questions were left for further study and exploration. 1) It was agreed, for instance, that education can be given to a child on such subjects as nutrition, rest, recreation, cleanliness, courtesy, human relations and preventive measures that are available. 2) Literature, films and other teaching aids can be evaluated and utilized. 3) An inventory of the faculty to determine the teachers who are interested and have had training or experience should be made and such personnel enlisted in any health program. 4) In-service training of teachers in health matters can be expanded. Teachers and principals should be able to recognize problems and be oriented to their significance so that needy pupils may be properly directed for help. Cited as examples were the persistent nail biter, over-aggression in a child, excessive daydreaming, sudden poor scholarship, and the like.

There was discussion also on what might be developed at each school to utilize the interested and experienced teachers, the nurse, the dentist or dental hygienist, the school physician, the community physician, and other community resources as well as the parent groups in developing a plan. The question was raised, should each school have a health council?

There are certain aspects of the above work to which the practicing physician might easily lend a hand.

1) If individual schools throughout the city will promote health councils to advise the faculty on the subject of school health and health education, why should a physician in the school district who has a child or children in the school not be on that health council?

2) The in-service training of teachers in health matters has already been done in part by the Health Education Committee of the San Francisco County Medical Society. The Society has had some experience, not all of it successful but enough success so that it need not be discouraged. This is a pioneer piece of work and may eventually be developed to a useful service. Maybe if health councils are formed with physicians on these, more general education to a larger number of teachers can be promoted. The content of these courses needs careful study and evaluation.

3) One of the voiced difficulties was the long delay, sometimes six months, in getting appointments for urgent mental or physical problems. Again, a health council by studying the community resources could probably remedy this situation.

4) The medical profession must somehow promote health educators. These are highly trained people who have studied the techniques of organizing schools and communities to promote and integrate health programs. A city the size of San Francisco should have at least eleven health educators, one to supervise

the citywide plan and ten to be apportioned to the different geographical areas of the city. San Francisco has at times had one and sometimes two. Most of the time it has had no health educators. The doctors will find no better assistant in promoting good public relations on health matters in the community than the health educator.

It is hoped that physicians, especially those who are parents, will be alert to the health needs in their own districts, thus distributing the work among many physicians and at the same time making the problem a more personal one.

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