from summary progress report 1982-84 Training in the Behavioral Aspect of Pediatric Care to Maternal and Child Health - Nat. Office January 1984

FINAL NOTE FROM HELEN GOFMAN, M.D.

From my experience being part of the Child Study Unit since it's inception as the Pediatric Mental Health Unit 36 years ago, and my 20 years of efforts in writing grant applications and summary progress reports, it seems appropriate to include this note with my last report.

I have seen a tremendous change in the teaching and acceptance of bio-psychosocial issues as part of pediatric practice. When I started as the first fellow in the Pediatric Mental Health Unit, the only teaching I had received in my residency was a rotation in Langley Porter Neuropsychiatric Institute Childrens' Service in a program designed for child psychiatrists. In the field of behavioral pediatrics, there were no textbooks, manuals, or syllabi available; in fact, the term behavioral pediatrics was, as yet, unknown. And yet, I think many pediatric housestaff were hungry for training in this area. From it's inception as a teaching program, the residents rotating through our Unit were enthusiastic learners and supporters of our efforts. It has been their enthusiasm and support that has enabled us to continue despite the mushrooming of other areas in pediatrics that are concerned with more glamorous, high powered medical technology.

Looking at the contributions of the CSU to pediatric training and to health care of children and families, the following seem most important. The CSU has developed a model for behavioral pediatric training that enables pediatrics really to treat the whole child (to consider his physical, intellectual, language, temperament and coping skills, his family's system, and his community) rather than caring for an organ system. I think our teaching has been unique in that it has emphasized using the family's, child's and physician's strengths instead of concentrating on pathology. And that we have emphasized learning by doing - learning interviewing and assessment skills by really doing supervised interviews and evaluations. Our unique contributions I see as:

1. Understanding biopsychosocial needs in chronic illness - our early studies of the emotional aspects of dwarfing, cystic fibrosis, chronic eczema, and asthma were all presented, but sadly never published.

2. Learning disorders, their evaluation and management as a way to teach biopsychosocial pediatrics (including a multidiscipline approach). Ours was the first multidiscipline teaching team in our Department, or possibly in the entire Medical Center. From this teaching we evolved the Pediatric Reading and Language Development Clinic - again, a "first" as part of the Pediatric Department service and teaching programs. More recently, we have enlarged this to include classes for preschool children with delayed language development. A new exciting study skills program for gifted and able young adolescents is already being applied in the San Francisco Districts Middle Schools.

3. Family approach to pediatric care - since the middle sixties, we have emphasized the family system approach and family interviewing as an important skill. Our book, The Family is the Patient, has been well received by pediatricians, but is already going out of print (publishing is a "tough" business for us!).

4. Housestaff support groups - now discussed as part of pediatric training, was unheard of when we started. Our experience and studies of the results were presented at an Academy meeting, but after several "non-acceptances" for publication, the authors gave up in discouragement (it was a good paper).

5. Continuing education - we have pioneered in continuing education in the area of pediatrics from George Schade's Ross Conference in 1954, our hundreds of conferences on learning disabilities and language disorders, our two large national conferences on Adolescence, and our seminars on family interviewing. We now, with younger minds and energy, hope to improve the area of continuing education in behavioral pediatrics with a new pilot program of learning by doing for the practicing physician.

6. Our follow-up studies of children with delayed language ~~- this was~~ development another "first" in showing the serious effects on academic achievement, social interactions, parent-child relationships, and self esteem. This study was presented at an annual meeting of the Western Society for Pediatric Research, but, again, alas never published.

7. Combined fellowship with subspecialties - this program should be most exciting. It may lead back to "the good old days" when we were smaller and I had almost daily contact with the staffs and trainees in certain subspecialty programs such as endocrine, allergy, cystic fibrosis, seizures; ~~and~~ when trainees from subspecialties worked with CSU staff on their patient care; and when we even shared in research studies!

Behavioral Pediatrics, I think, is at last being accepted as part of pediatrics. It is unfortunate that lack of funds in medical schools, state and federal budgets threaten to stunt it's growth at this time. I see this as a critical time for behavioral pediatrics and for pediatrics itself. Without attention to behavioral (biopsychosocial) issues, pediatric care may be conducted by physicians in family practice and pediatricians may become caretakers of organ systems.

Despite changes in staff and severe stresses from budget cuts, the CSU has been able to maintain it's teaching programs and even add exciting new programs. This can only happen because of ~~it's~~ its dedicated, hard working staff and the availability of superb teachers and clinicians - many of whom received training from this project. I pray it can continue.

Mary McAllister
Management Service Officer
Department of Pediatrics

1984

From: Helen Gofman, M.D.

Dear Mary,

I calculate that I am owed 39 days of vacation (see the chart). In addition, in the last three years I lost 19 days because I exceeded my 48 days maximum vacation savings. I, therefore, do not feel I can give up all my vacation time to the University as I first stated. I will take one month (20 days vacation pay) and donate 19 days of official time, and 19 days of non-official time to the University. I feel this is generous.

Retirement

My office is being moved to the Reading Clinic where I will be carrying on my research. I will ~~share this office~~ with Mrs. Whitsell. There is no furniture for this office. As emeritus, I request that I be allowed to move a file cabinet, a desk and chair, ~~and one~~ bookcase to this office. These are not required by the Child Study Unit at this time.

Sincerely,

Helen

Helen Gofman, M.D.

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