May 30, 1968

Dr. Theodore D. Scurletis
Director, Personal Health Division
North Carolina State Board of Health
Box 2091
Raleigh, North Carolina 27602

Dear Ted:

I do not believe that your article on "Care for Children and Youth: Today and in the Seventies" is the least bit provocative. Your comments are timely and need to be made over and over again.

I am enclosing a proposal that I made to Dr. Harvey Estes regarding Physicians Assistants which I believe is more practical than the more sophisticated programs (Silver, Kelsey, Duke) now advocated. Moreover this could utilize many older and experienced women (30 - 45 years) who have had all the children they are going to have and who would, in contrast to the young, unmarried nurse, remain in the health field.

Congratulations on this splendid paper. I am keeping the draft for my files.

My warm regards and best wishes.

Sincerely,

Jay M. Arena, M.D.
Professor of Pediatrics

JMA/erf

JACOB KOOMEN, M.D., M.P.H.
STATE HEALTH DIRECTOR
AND SECRETARY-TREASURER
W. BURNS JONES, JR., M.D., M.P.H.
ASSISTANT STATE HEALTH DIRECTOR

NORTH CAROLINA
STATE BOARD OF HEALTH
P. O. BOX 2091
RALEIGH, NORTH CAROLINA 27602

May 27, 1968

Dr. Jay M. Arena
1410 Duke University Road
Durham, North Carolina

Dear Jay:

I am writing this paper for presentation on June 6 and would appreciate any criticism you might have. Please note that I Have been asked to present a provocative paper in order to encourage discussion and I don't necessarily believe everything I have written here.

I would be anxious for your reaction and would appreciate it if you could give it to me no later than Monday, June 3.

Sincerely,

Theodore D. Scurletis

Theodore D. Scurletis, M. D.
Director
Personal Health Division

TDS:ce

Enclosure

Arena

DRAFT

CARE FOR CHILDREN AND YOUTH: TODAY AND IN THE SEVENTIES

In the United States today there are approximately 17,000 pediatricians who, with the ever decreasing number of family physicians, are providing the health care for approximately 75 million juveniles in the United States. Some estimates indicate that this approximates 50% of the pediatricians that are needed to meet the total child health needs of this country. These numbers would obviously indicate that it is impossible to expect that the training of additional pediatricians will solve this problem.

The content of pediatric practice has also changed. The emphasis is now on the tremendous expansion in preventative pediatrics with its increasingly time-consuming segment of guidance and the management of behavioral and emotional disorders. The treatment of acute illness is probably the major function of the practicing pediatrician today, and, unfortunately, this also indicates that it is the only care received by too many children.

The pediatrician of today is faced with the problem of seeing too many patients in too few hours. As a result, he is faced with the unfortunate problem of either compromising standards of care or seeing additional patients because of demands being placed on him. He finds himself primarily spending the greatest proportion of his time dealing with minutia, problems which do not tax his imagination nor are they the problems that he, himself, is trained to do. This may be phrased in another manner, saying that he is dealing with problems with which people less skillful than he could easily deal, and that many of the talents that were developed in his training are not being utilized. He is also faced

WITH THE FACT THAT IN DEALING WITH THE COMPLICATED PROBLEMS OF THE MULTI-HANDICAPPED CHILD AND THE GROWTH OF SUBSPECIALTIES IN PEDIATRICS HE HAS BEEN REDUCED TO A GENERALIST IN THE FIELD OF PEDIATRICS. HE IS ALSO HINDERED WHEN HE IS SITUATED IN A SMALL COMMUNITY AND PRACTICING IN THE ENVIRONMENT OF A SMALL HOSPITAL WHICH DOES NOT HAVE THE LABORATORY, THE CONSULTANTS, THE SKILLED NURSING SERVICES AND THE OTHER ANCILLARY SERVICES HE NEEDS TO ADEQUATELY DEAL WITH THE COMPLEX PROBLEMS OF THE ACUTELY ILL CHILD WHICH REQUIRES HOSPITALIZATION.

AT PRESENT THE TREND IN PEDIATRICS HAS BEEN IN THE DEVELOPMENT OF GROUP PRACTICES, HOPING THAT THIS OFFSETS THE PROBLEMS OF THE SOLO PRACTITIONER. THIS, OF COURSE, HAS MANY ADVANTAGES THAT ARE OBVIOUS; HOWEVER, DOES NOT RESOLVE THE PROBLEM OF THE LIMITED NUMBER OF PEDIATRICIANS, BUT IN A SENSE PRODUCES ANOTHER COMPLEXITY TO THE SITUATION IN THAT HE FACES THE SIMILAR PROBLEMS OF A SOLO PRACTICE, BUT IS NOW REASSURED BY SHARING HIS FRUSTRATIONS WITH THE MEMBERS OF THE GROUP.

BERGMAN REPORTED A STUDY WHICH CONFIRMS THE PREVIOUS OBSERVATIONS.[1] HIS STUDY REVEALED THAT PEDIATRICIANS SPENT NO MORE THAN HALF OF THEIR TIME WITH PATIENTS AND, OF THAT, AT LEAST 50% OF PATIENT TIME WAS SPENT IN WELL CHILD SUPERVISION. HE DESCRIBED THE WRITINGS OF DR. C. A. ALDRIDGE, WHO HAD KEPT METICULOUS RECORDS IN HIS PRIVATE PRACTICE, DATING BACK TO 1934 THAT SHOWED NO GROSS CHANGE FROM THE PRESENT STUDY. HIS STUDIES WERE STRIKINGLY SIMILAR TO THOSE OF DEISHER'S REPORTED RECENTLY.[2]

ALONG WITH THE FRUSTRATIONS OF HIS PRACTICE, THE PEDIATRICIAN IS FACED WITH THE EVER INCREASING COMPLEX OF GOVERNMENT SPONSORED PROGRAMS, WHICH ARE ATTEMPTING TO CARE FOR THE SOCIETY'S LESS FORTUNATE CHILDREN. HE HAS PARTICIPATED WELL IN THE TRADITIONAL WELL BABY PROGRAMS, SPONSORED UNDER PUBLIC HEALTH AUSPICES, ONLY TO FIND HIMSELF DOING MORE OF THE SAME IN AN INEFFECTUAL MANNER.

He is being asked by OEO programs to render intensive care to the deprived child to the extent that it is impossible for him to meet the demand. Coupled with this, he is being asked to participate in programs under sponsorship of the Elementary and Secondary Education Act, which are designed to correct problems which should have been corrected in the earliest ages of life and have the accumulated complexities of 6-7 years without medical care. He is being asked to participate in complex programs, such as Maternity and Infant Care and Children and Youth projects under the sponsorship of the Children's Bureau and to give guidance to the development of community programs in the implementation of Title XIX. Add this to his historic role in the development of crippled children's programs and infant care programs of his local community, and the specialized programs and involvement of the voluntary organizations of the community in which he resides.

To make matters even more frustrating, he involves himself in the spirit of community activity only to find himself serving the same children in different ways. Moreover, they impose on him requests for information on forms with which he is not familiar. He is frequently asked to participate in programs in which he is not involved in planning or in implementation, and in which he can frequently not see any demonstrable results.

Dr. John McQueen in a survey of the Maternal and Child Health and Crippled Children's Directors of the various states reported many conflicting opinions about the effects of Title XIX on total pediatric care.[3] Within this report, however, there are several common sentiments which should be brought to your attention. There seemed to be a fear that Title XIX projects would lower the quality of care being rendered under present crippled children's programs, and, secondly, that most of the Title XIX programs had been in operation for such a short time that it was difficult to assess the real impact on total pediatric care.

I CAN SEE NO POINT IN BELABORING THIS SUBJECT FURTHER. WE ALL RECOGNIZE THAT PEDIATRIC PRACTICE HAS CHANGED DRAMATICALLY IN THE PAST 20 YEARS AND IS DUE TO CHANGE DRAMATICALLY AGAIN. MANPOWER PROBLEMS IN THE HEALTH PROFESSIONS DEMAND THAT SKILLED PERSONNEL MUST BE UTILIZED MORE EFFICIENTLY IN A MANNER MORE ACCEPTABLE TO THEM. THIS TASK WILL NOT BE ACCOMPLISHED WITHOUT FRUSTRATIONS AND MANY CONFLICTING VIEWPOINTS BEING EXPOUNDED. ALREADY WE HAVE SEEN SOME CHANGES THAT HAVE BEEN WELL RECEIVED AND HAVE DEMONSTRATED THEIR EFFECTIVENESS.

IN 1962, THE MATERNAL AND CHILD HEALTH SECTION OF THE N. C. STATE BOARD OF HEALTH DECIDED TO INSTITUTE A PROGRAM OF WELL CHILD SUPERVISION BY REPLACING THE CLINICIAN IN THE WELL CHILD CLINIC WITH A NURSE TRAINED TO DO SCREENING. AT FIRST THIS PROGRAM MET WITH RESISTANCE; HOWEVER, WHEN INSTITUTED IN A COUNTY HEALTH DEPARTMENT WHICH HAD AN INTERESTED NURSE AND AN INTERESTED PRACTITIONER OF PEDIATRICS IT DEMONSTRATED ITS VALUE WITHIN A YEAR. IT HAS RAPIDLY SPREAD IN CONCEPT SO THAT IT IS NOW PRESENT IN APPROXIMATELY 50% OF THE COUNTIES OF THE STATE OF NORTH CAROLINA, SERVING APPROXIMATELY 50-60% OF THE CHILDREN. IT HAS BEEN HINDERED BY LACK OF FUNDING AND LACK OF CONSULTANT PERSONNEL AT THE STATE LEVEL FOR MORE COMPLETE IMPLEMENTATION. IT IS OUR FEELING, HOWEVER, THAT THIS PROGRAM HAS DEMONSTRATED THE EFFECTIVENESS OF NURSE SCREENING WHEN ASSOCIATED WITH PEDIATRIC SUPERVISION, A SUBJECT ON WHICH I WILL SAY MORE LATER. A SIMILAR PROGRAM[4] HAS BEEN INSTITUTED IN A PROJECT IN BALTIMORE UNDER THE AUSPICES OF THE CHILDREN'S BUREAU SPECIAL PROJECT FOR CHILDREN AND YOUTH AND IS DEMONSTRATING MUCH THE SAME TYPE OF EXPERIENCE THAT WE HAVE DEMONSTRATED IN NORTH CAROLINA. IN CHICAGO, THERE ARE INTERESTING EXPERIMENTS BEING CONDUCTED IN DETECTION OF ABNORMALITIES OF VISUAL, MOTOR AND AUDITORY DEFECTS IN CHILDREN AS YOUNG AS 8-10 MONTHS OF AGE UNDER A SPECIAL PROJECT STUDY. AUSTIN REPORTS A VERY SUCCESSFUL EXPERIMENT WITH THE USE OF THE PEDIATRIC SYSTEM IN A PRIVATE PRACTICE WITH EXCELLENT RECEPTION BY THE PARENTS.[5]

THE COMPREHENSIVE PROJECTS FOR CARE OF CHILDREN AND YOUTH UNDER SPONSORSHIP OF THE CHILDREN'S BUREAU HAVE BEEN WIDELY HAILED AS THE ULTIMATE IN PEDIATRIC CARE. AS HAS BEEN NOTED PREVIOUSLY, THERE WERE SEVERAL INTERESTING ASPECTS TO THE VARIOUS PROJECTS THAT COULD BE COMMENTED ON. HOWEVER, IT IS OBVIOUS THAT THESE PROJECTS ARE OF SUCH COST THAT IT SEEMS IMPRACTICAL TO THINK THAT THEY COULD EVER BE APPLIED GEOGRAPHICALLY TO COVER THE TOTAL CHILDHOOD POPULATION. IT SEEMS THAT THE PROJECTS CALL FOR A HIGHLY SKILLED "CORE STAFF" TO SERVE THE PROJECT AND YET SUCH HIGHLY TECHNICAL "CORE STAFF" COULD EASILY SERVE TO SUPERVISE A TOTAL STATEWIDE PROJECT. AS YET SEEN IN NORTH CAROLINA, ONE CANNOT REALLY FEEL THAT MUCH MORE IS BEING ACCOMPLISHED THAN BUYING TREMENDOUS AMOUNTS OF CARE WITHOUT REALLY INSTITUTING AND DEVELOPING NEWER MECHANISMS OF PROVIDING TOTAL CARE. IT IS HOPED, HOWEVER, THAT THESE PROJECTS WILL DEVELOP NEWER MECHANISMS WHICH, AT A LATER DATE, MIGHT BE APPLIED TO TOTAL PROGRAMS FOR CHILDREN. IT WOULD BE HOPED THAT THEY WOULD SERVE AS PILOT PROGRAMS FOR THE TESTING OF DIFFERENT AND NEWER MECHANISMS FOR THE PROVISION OF CARE. ON THE PLUS SIDE, ONE MIGHT SAY THAT THESE PROJECTS DEMONSTRATE FOR THE FIRST TIME A TOTAL COMPREHENSIVE APPROACH TO CHILDREN AND THEIR PROBLEMS AND COULD SERVE AS MODELS FOR THE FUTURE.

UNDER THE DIRECTION OF DR. SILVER,[6] A PEDIATRIC NURSE PRACTITIONER TRAINING PROGRAM WAS BEGUN SEVERAL YEARS AGO. HE SAID, "THE PEDIATRIC NURSE PRACTITIONER PROGRAMS PREPARES NURSES TO ASSUME AN EXPANDED ROLE IN PROVIDING TOTAL HEALTH CARE TO CHILDREN IN THE OFFICE OF PRIVATE PEDIATRICIANS AND IN AREAS WITH INADEQUATE HEALTH SERVICES. NURSES PROVIDE COMPREHENSIVE WELL CHILD CARE TO WELL CHILDREN AND IDENTIFY, APPRAISE AND TEMPORARILY MANAGE CERTAIN ACUTE AND CHRONIC CONDITIONS OF THE SICK CHILD. THEIR PROGRAM HAS RESULTED IN A REALIGNMENT OF FUNCTIONS PERFORMED BY PHYSICIANS AND NURSES SO THAT EACH OF THEM CAN ASSUME RESPONSIBILITY FOR THOSE ASPECTS OF THE PATIENT'S NEED THAT THEY CAN PERFORM MOST EFFECTIVELY.

AS ASSOCIATES OF PEDIATRICIANS IN PRIVATE PRACTICE, PEDIATRIC NURSE PRACTITIONERS FUNCTION SKILLFULLY AND COMPETENTLY IN PROVIDING PROFESSIONAL SERVICE WHICH RESULTS IN IMPROVED PATIENT CARE AND A MORE EFFICIENT AND EFFECTIVE USE OF THE SKILLS AND TIME OF BOTH THE PHYSICIAN AND THE NURSE." THE DEPARTMENT OF PEDIATRICS[7] OF BOWMAN GRAY SCHOOL OF MEDICINE IS DEVELOPING A PROGRAM OF TRAINING PEDIATRIC ASSISTANTS. THEIR PROGRAM IS ONE OF TRYING TO ANALYZE THE PROFESSIONAL ROLE OF THE PRACTICING PEDIATRICIAN AND TO REDEFINE THE ROLE IN WHICH THE NON-PROFESSIONAL CAN BE UTILIZED. THEY ARE APPROACHING THIS FROM THE STANDPOINT THAT THOSE THINGS WHICH REQUIRE SIMPLE PROCEDURE, BASIC INTELLIGENT OBSERVATION, ABILITY AND APPLICATION OF EASILY ACQUIRED KNOWLEDGE WILL BE CLASSIFIED AS SUBPROFESSIONAL AND THOSE THINGS WHICH REQUIRE EVALUATION, PROFESSIONAL JUDGMENT OR ADVANCED SKILLS WILL BE CLASSIFIED AS PROFESSIONAL. THE LATTER TASK WILL BE THAT OF THERAPEUTICS AND WILL BE THE SOLE PROVINCE OF THE PROFESSIONAL TRAINED PEDIATRICIAN. THE OTHER TASK WILL BE CLASSIFIED AS SUBPROFESSIONAL AND WILL BE DEALT WITH BY LESSER TRAINED INDIVIDUALS. THIS PROPOSAL IS ONE WHICH WILL BE AT THE ASSOCIATE DEGREE LEVEL AND IT IS ESTIMATED THAT IT COULD CARRY APPROXIMATELY 50% OF THE PROBLEMS AND WORK VOLUME OF THE AVERAGE PRACTICING PEDIATRICIAN, UNDER PEDIATRIC SUPERVISION.

THIS MATTER WAS DISCUSSED WITH THE CONSULTANT NURSING STAFF[8] OF THE N. C. STATE BOARD OF HEALTH, MATERNAL AND CHILD HEALTH SECTION, AND SEVERAL INTERESTING IDEAS WERE PROPOSED. FIRST, IT WOULD BE EASIER TO UTILIZE NURSES AS PEDIATRIC ASSISTANTS SINCE THEY WOULD REQUIRE LESS TRAINING AND THEY ARE PART OF THE TRADITIONAL MEDICAL TEAM. SECONDLY, MANY OF THE SERVICES NOW PERFORMED BY NURSES WOULD HAVE TO BE DELEGATED TO LICENSED PRACTICAL NURSES AND NURSES AIDES IN ORDER TO FREE THEM FOR THIS EXPANDING ROLE. THIRDLY, AN EXPANDED ROLE FOR NURSING MAY ACTUALLY ENHANCE RECRUITMENT OF PEOPLE INTO THE PROFESSION.

FOURTHLY, THIS SUBJECT IS IN NEED OF INTENSIVE EVALUATION TO IDENTIFY THE PROPER ADDITIONAL TRAINING THAT WOULD BE NECESSARY IN ORDER TO FULLY IMPLEMENT SUCH PROGRAMMING. AND, FINALLY, AND A MOST INTERESTING COMMENT FROM ONE OF THE STAFF, "THIS ADDITIONAL CHALLENGE AND RESPONSIBILITY FOR NURSES WOULD NOT NECESSARILY REDUCE THE RANKS OF NURSING SINCE THE UNCHALLENGED ARE LEAVING NOW. THIS TYPE OF UTILIZATION OF NURSES WOULD INCREASE RECRUITMENT. THE RANKS OF BACCALAUREATE GRADUATES COULD BE FILLED BY ASSOCIATE DEGREE GRADUATES; THE NUMBER OF THESE PROGRAMS BEING INCREASED. AIDES AND CLERKS CAN ASSUME MANY OF THE TASKS NOW BEING DONE BY THE NURSING STAFF."

RECENTLY IN AN ARTICLE IN U. S. MEDICINE, DATED MAY 15, 1968[9], DR. DWIGHT L. WILBUR, PRESIDENT-ELECT OF THE AMERICAN MEDICAL ASSOCIATION, STATED, "NURSES WILL ASSUME INCREASING RESPONSIBILITY FOR THE CARE OF THE PATIENT UNDER THE SUPERVISION OF THE PHYSICIAN." HE SUPPORTED THIS ON THE BASIS THAT THE NURSE WAS THE IDEAL INDIVIDUAL TO BE DELEGATED THE RESPONSIBILITY OF THE PHYSICIAN ASSISTANT SINCE THIS WAS THE TRADITION OF MEDICINE.

THIS DISCUSSION IS NOT ONE IN WHICH ONE SHOULD ARGUE THE MERIT OF EITHER OF THESE PROPOSALS, BUT RECOGNIZE THAT THESE ARE THE DIRECTIONS IN WHICH WE CAN RESOLVE THE PROBLEMS OF MEETING THE NEEDS OF CHILDREN IN A MANNER WHICH CAN BE ACCEPTABLE. ONE MIGHT REFER TO AN ARTICLE BY ENGLES[10] WHICH DISCUSSES THE PROS AND CONS OF A PROGRAM AT DUKE UNIVERSITY, DURHAM, NORTH CAROLINA, IN TRAINING THE PHYSICIAN'S ASSISTANT. THIS PROGRAM IS VERY COMPARABLE TO THE ONE AT BOWMAN GRAY SCHOOL OF MEDICINE, WITH ONE EXCEPTION, AND THAT IS PRIMARILY THAT THIS PROGRAM IS ONE TO DEVELOP AN ASSISTANT FOR THE GENERAL PRACTITIONER'S OFFICE IN CONTRAST TO THE ONE AT BOWMAN GRAY, WHICH IS SPECIFICALLY DESIGNED TO DEVELOP A PEDIATRIC ASSISTANT. ONE MUST RECOGNIZE, OF COURSE, THAT THERE ARE MANY PROBLEMS TO BE ENCOUNTERED IN THE DEVELOPMENT OF THESE PROGRAMS, AND I BELIEVE THAT THEY WILL

BE DEALT WITH IN THEIR PROPER TIME AND PLACE. IF WE CAN ONCE FORGET OUR DISCIPLINE ORIENTATION AND RECOGNIZE THAT WE HAVE INTERDISCIPLINARY PROBLEMS TO BE FACED IN THE DEVELOPMENT OF PROGRAMS, I AM SURE THAT THEY CAN BE FOCUSED IN SUCH A MANNER THAT THEY CAN BE MADE ACCEPTABLE TO ALL. TO WHAT THEN, MIGHT THIS LEAD US?

I PROPOSE THAT THE PEDIATRIC PRACTICE OF THE FUTURE WILL BE A COMBINATION OF THE PEDIATRIC ASSISTANT, WHETHER IT BE THE NURSE PRACTITIONER OR THE PEDIATRIC ASSISTANT AS BEING DEVELOPED AT BOWMAN GRAY, ASSISTING THE PEDIATRICIAN IN PROVIDING WHAT I MIGHT DESCRIBE AS A TOTAL CONTINUUM OF CHILD CARE. FOR THE SAKE OF SIMPLICITY, IT MIGHT BE WELL TO LOOK AT THESE FACETS FROM THE STANDPOINT OF CONTINUUM OF WELL CHILD CARE SUPERVISION AND IDENTIFICATION OF THE CHRONIC DEVELOPMENTAL PROBLEM AND ITS PROPER DIAGNOSIS AND REFERRAL; AND THEN SECONDLY, THE PROBLEM OF CARE OF CHILDREN IN HOSPITALS.

IF APPROPRIATE, I BELIEVE THAT WE MIGHT EASILY DISMISS THE CARING FOR CHILDREN IN THE HOSPITAL BY SAYING THAT, FIRST, REGIONALIZATION OF INPATIENT HOSPITAL CARE INCLUDING INTENSIVE CARE OF NEWBORNS AND HOSPITAL CARE OF THE COMPLICATED PEDIATRIC PROBLEM SHOULD BE ENVISIONED. REGIONALIZATION OF ALL MEDICAL CARE WOULD RESULT IN LARGER HOSPITALS, WHICH WILL BE MORE EFFICIENT IN OPERATION AND WOULD HAVE AVAILABLE, BECAUSE OF SIZE, AN ADEQUATE DIAGNOSTIC LABORATORY, X-RAY FACILITY, AND THE COMPLIMENTARY FACILITIES OF SURGERY, ANESTHESIA, BLOOD BANKS AS WELL AS THE OTHER MULTIFACETED CONSULTATIVE RESOURCES A PEDIATRICIAN WOULD NEED IN DEALING WITH AN ACUTELY ILL CHILD. ITS SIZE WOULD BE SUCH THAT IT WOULD JUSTIFY THE MAINTENANCE OF 10-20 BED INTENSIVE NEWBORN CARE UNITS BY COLLECTING ALL THE PROBLEMS OF NEWBORN CARE FROM THE GEOGRAPHICAL AREA WHICH THE HOSPITAL SERVES. THIS WOULD ALLOW FOR THE MAINTENANCE OF SKILLED NURSING PERSONNEL AND ADEQUATE HIGHLY TRAINED PEDIATRIC NURSING SUPERVISORS. THEY

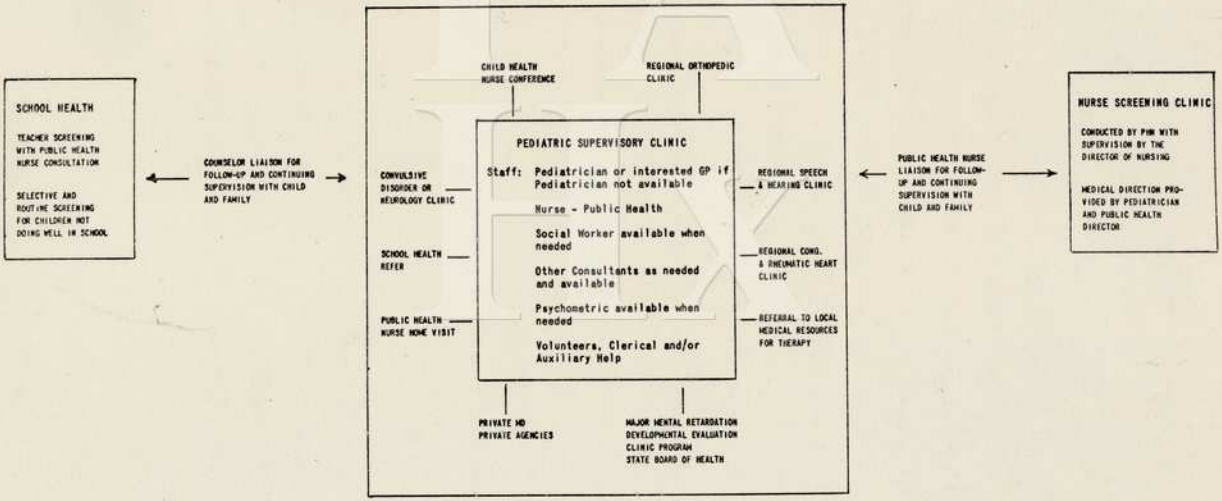
WOULD HAVE AVAILABLE MICROCHEMICAL TECHNIQUES AND THE ANCILLARY FACETS OF SERVICE NEEDED IN CARING FOR THE PROBLEMS OF THE NEWBORN. THE SAME THING WOULD APPLY TO THE PEDIATRIC DEPARTMENT, WHICH WOULD BE LARGE ENOUGH TO MAINTAIN A SKILLED NURSING STAFF, BOTH FOR THE ACTUELY ILL CHILD AND FOR THE CHILD REQUIRING SURGERY. THE PEDIATRICIAN WOULD THEN SERVE THE ROLE OF BOTH CONSULTANT AND SUPERVISOR AND THE TASK OF KEEPING PARENTS INFORMED OF PROGRESS AND EDUCATED TO ROUTINE CHILD CARE WOULD BE LEFT WITH THE HIGH SKILLED NURSE SUPERVISORS. THIS LENDS ITSELF TO THE PROGRAM BEING ADVOCATED BY THE OBSTETRICAL GROUP, WHICH BELIEVES THAT THE ONLY WAY THAT WE CAN PROVIDE QUALITY NATAL CARE IN HOSPITALS IS BY REGIONALIZATION OF SERVICES IN REGIONAL HOSPITALS AND CONCENTRATION OF PERSONNEL IN THOSE HOSPITALS TO DEAL WITH THE COMPLEX PROBLEMS OF THE COMPLICATED OBSTETRICAL CASE, WHICH REQUIRES ANCILLARY FEATURES OF A GOOD LABORATORY, NURSING PERSONNEL, ETC. REQUIRED FOR INTENSIVE CARE OF THE NEWBORN.

THESE HOSPITALS WOULD ALSO HAVE ALL OF THE OUTPATIENT FACILITIES REQUIRED TO DEAL WITH THE MULTIFACETED PROBLEMS OF THE MULTIHANDICAPPED CHILD AND TO HAVE THE ANCILLARY INTERDISCIPLINARY EFFECT OF NURSING, SOCIAL SERVICES, PSYCHOLOGICAL SERVICES, ETC. IN DEALING WITH THESE PROBLEMS. MANY OF THE CHRONIC ILLNESSES AND HANDICAPPING CONDITIONS NOW REQUIRE METICULOUS MULTIFACETED SUPERVISION AND THE EMPLOYMENT OF TEAMS OF MEDICAL AND NON-MEDICAL PERSONNEL TO ADEQUATELY HANDLE THEM. THIS HAS BEEN BEAUTIFULLY DEMONSTRATED IN THE SERVICES FOR EVALUATION OF THE DEVELOPMENTALLY RETARDED, THE CHILDREN PRESENTING WITH MINIMAL BRAIN DYSFUNCTION AND THE CHILD WHO PRESENTS WITH THE COMPLICATED CONGENITAL ANOMALIES THAT ARE FREQUENTLY SEEN.

OF COURSE EACH OF THE REGIONAL HOSPITALS WOULD BE RELATED TO A UNIVERSITY MEDICAL CENTER WHERE THE MORE COMPLEX PROBLEMS CAN BE REFERRED AND CONSULTATION WOULD BE AVAILABLE TO THE REGIONAL HOSPITALS FOR SERVICE. THIS WOULD ASSIST THE CLINICIAN IN MAINTAINING HIS SKILLS BY FREQUENT CONSULTATION AND EXPOSURE TO THE SCIENTIFIC AND RESEARCH ASPECTS OF THE MEDICAL CENTER AND AT THE SAME TIME SERVE THE DEVELOPMENT OF THE PEDIATRIC SERVICES IN THE REGIONAL HOSPITAL.

LET US NOW TURN OUR ATTENTION TO WHAT I WOULD SAY IS THE FUTURE OF CONTINUUM OF CHILD CARE. (REFER TO SCHEMATIC DIAGRAM) FIRST, I SEE THE UTILIZATION OF WHAT WE MIGHT REFER TO AS THE NURSE SCREENER IN PROVIDING ALL THE DETAILS OF NORMAL WELL CHILD SUPERVISION. THIS WOULD INCLUDE INSTRUCTION TO MOTHERS ON CARE OF FEEDING, BATHING, TOILET TRAINING AND THE OTHER ROUTINE PROBLEMS OF GUIDANCE THAT SO BADLY PLAGUE THE PEDIATRICIAN BY TELEPHONE. SHE WOULD CARRY OUT, UNDER PEDIATRIC DIRECTION, IMMUNIZATIONS ON A PRESCRIBED SCHEDULE. SHE CAN TAKE HISTORIES WITH GREAT EMPHASIS ON THOSE ASPECTS OF HISTORY WHICH HAVE RELATIONSHIP TO DEVELOPMENTAL ABNORMALITIES AND ACUTE ILLNESSES. SHE CAN BE TAUGHT TO PALPATE THE ABDOMEN AND LOOK FOR SIGNS OF NORMAL AND ABNORMAL NEUROLOGIC DEVELOPMENT. SHE COULD BE TRAINED TO AUSCULTATE THE HEART AND LUNGS AND TO ASSESS HEIGHT, WEIGHT AND HEAD CIRCUMFERENCE BY USE OF GROWTH AND DEVELOPMENT CHARTS AND DETERMINE, WITH THE USE OF SOME DEFINITE CRITERIA, WHETHER REFERRAL IS INDICATED. SHE WOULD BE ASSISTED BY CLERICAL PERSONNEL WHO WOULD INSURE, BY GOOD RECORD SYSTEMS, THAT CHILDREN ARE SEEN AT PROPER INTERVALS AND SOME FORT OF OUTREACH PERSON COULD BE UTILIZED TO SEARCH OUT THE PATIENT WHO IS DELINQUENT IN MEETING APPOINTMENTS. INCLUDED IN THESE OBSERVATIONS WOULD BE PROPERLY TIMED OTOLOGIC OR AUDITORY TESTING AS WELL AS VISUAL TESTING AND AS FOLLOW UP ON THE ABNORMAL CHILD. THE NURSE WOULD SEE THE CHILD ON ROUTINE FOLLOW UP VISITS OF SUCH CONDITIONS AS CHRONIC NEPHRITIS AND RHEUMATIC FEVER, UNDER SUPERVISION OF COURSE. NATURALLY SHE WOULD REFER ANY CHILD WHO SHOWED

PLAN FOR TOTAL CONTINUUM OF CHILD CARE



SIGNS OF DEVELOPMENTAL LAG OR ABNORMALITY TO WHAT WE MIGHT REFER TO AS THE PEDIATRIC SUPERVISOR (THE PEDIATRICIAN). HE WILL THEN REVIEW THE CHILD AND THE HISTORY AND RECORDS TO DETERMINE THE TRUE EXTENT OF ABNORMALITY AND DEVISE A PLAN OF ACTION TO BE CARRIED OUT. HE WOULD BE ASSISTED, OF COURSE, BY PEDIATRIC PSYCHOLOGISTS AND OTHER CONSULTANTS AS NEEDED IN FIXING THE TRUE PATH OF THE TOTAL CARE THAT THIS CHILD SHOULD BE EXPOSED TO, FULLY UTILIZING ALL COMMUNITY SERVICES, ALL GOVERNMENT SPONSORED SERVICES, AS WELL AS HIS OWN SKILLS AND REFER THE CHILD TO THE REGIONAL HOSPITAL, IF HOSPITAL CARE IS NEEDED, OR TO THE MEDICAL CENTER FOR SPECIALIZED SERVICES THAT CANNOT BE PROVIDED IN THE REGIONAL HOSPITAL. IF THE CONDITION IS SUCH THAT IT NEEDS OBSERVATION AND FOLLOW UP, IT COULD BE CARRIED OUT BY RETURNING THE CHILD TO THE SUPERVISION OF THE NURSE SCREENER FOR SUCH CARE. THIS PROGRAM AND PATTERN WILL BE CONTINUED UNTIL THE CHILD ENTERS SCHOOL, AT WHICH TIME THE CHILD WILL BE EXPOSED TO A MEDICAL, PSYCHOLOGICAL AND SOCIAL EVALUATION FOR SCHOOL READINESS AND ANY ABNORMALITIES OR LACK OF MATURITY THAT MIGHT BE DEMONSTRATED AT THIS TIME COULD THEN BE EVALUATED IN A MANNER IN WHICH THE SCHOOL WOULD BE ASSISTED IN PLANNING A PROGRAM OF EDUCATION FOR THE CHILD. FOLLOWING HIS ENTRANCE TO SCHOOL, A WELL DEVELOPED SCHOOL PROGRAM OF ROUTINE HIGH INDEXED SCREENING WOULD BE DEVELOPED WITH DIAGNOSTIC SCREENING AVAILABLE FOR THOSE CHILDREN WHO PRESENT PROBLEMS IN THE SCHOOL SETTING. THE PHYSICIAN AGAIN WOULD SERVE AS A DIAGNOSTICIAN IN DECIDING THE PATTERN OF CARE TO BE FOLLOWED WHEN SUCH PROBLEMS ARE DEMONSTRATED. THIS CARE WOULD BE CARRIED THROUGH WITH THE ASSISTANCE OF THE WELL DEVELOPED HEALTH EDUCATION PROGRAM AND GRADUAL TRANSFERENCE OF RESPONSIBILITY FOR THE CHILD'S HEALTH FROM THE PARENT TO THE CHILD AS HE APPROACHES TEENAGEHOOD.

Discussing in a sense what we might describe as the ideal total pediatric care of the entire child population, one must recognize the need for proper coordination all government and community sponsored programs in a manner as to reduce complexity and eliminate duplication and bring about efficient coordination and administration. One might suggest that this might be accomplished through the Office of Comprehensive Health Planning, under the auspices of the Partnership for Health Act, which would require that each state develop a total comprehensive program and that all such programs' aims for care of children and youth be coordinated under central administrative direction at the federal as well as the state level.

The Child Health Act of 1967 and the proposed Child Health Act of 1968 demand that the programs under Children's Bureau sponsorship and Title XIX must be closely coordinated. The Acts also require that there be total coordination of maternal and child health and crippled children's programs and that they be expanded to all geographic areas of the United States by 1975. The Act of 1967 sets a deadline for special projects to expire in 1972 and that all the money in special projects would be converted to formula monies to the State. The Child Health Act proposal for 1968 extends this to 1974. At that time the states will be obligated to include in their plans at least demonstrations of comprehensive programs for children and youth and maternity and infant care. One further and most important requirement is that there be a definition and mechanism for quality control developed. At a recent meeting in Washington in which the 50 states were represented a great question arose, "Just how can this be done?". There was no one present who, in light of the experience of Utilization Review under Title XVIII of the Social Security Act, felt that this was a realistic possibility.

THE SECRETARY OF THE DEPARTMENT OF HEW RECENTLY STATED THAT THE RE-ORGANIZATION OF THE DEPARTMENT WAS AIMED AT BRINGING ALL HEALTH SERVICES UNDER COMPREHENSIVE HEALTH DIRECTION. IN LINE WITH THIS, HE ANNOUNCED HIS PLAN TO TRANSFER THE MEDICAL ASPECTS OF CHILDREN'S BUREAU TO THE NEW DEPARTMENT OF MEDICAL SERVICES UNDER THE NEW ASSISTANT SECRETARY, AND THAT THE MEDICAL ASPECTS OF THE OFFICE OF ECONOMIC OPPORTUNITY WOULD BE TRANSFERRED SHORTLY AND THAT EVENTUALLY TITLE XIX WOULD ALSO BE TRANSFERRED. WITH THIS ANNOUNCEMENT, IT SEEMS THAT ONE CAN LOOK TOWARD THE GRADUAL COORDINATION OF ALL HEALTH PROGRAMS IN THE NOT TOO DISTANT FUTURE. WHAT THEN IS THE ROLE OF PUBLIC HEALTH IN THE FUTURE OF TOTAL MEDICAL CARE OF CHILDREN? I WOULD SAY THAT IT IS PRIMARILY ONE OF ASSISTING THE COMMUNITY AND ITS PRACTITIONERS OF MEDICINE IN DEVELOPING TOTAL PROGRAMS FOR CHILDREN, THAT THE MASS CARE FOR PREVENTATIVE SERVICES WILL BE ACCOMPLISHED THROUGH CLINICS SUCH AS THE NURSE SCREENING CLINIC AND THE MEDICAL CARE BE RENDERED THROUGH THE PRACTITIONERS OF THE COMMUNITY. SPECIAL SERVICES THAT CANNOT BE DEVELOPED IN THE COMMUNITY WILL BE DEVELOPED IN THE REGIONAL HOSPITALS, HOPE-FULLY WITH THE COOPERATION OF PUBLIC HEALTH PROGRAMMING. THE PUBLIC HEALTH PERSONNEL SHOULD BE READY AND CAPABLE OF RENDERING COMMUNITIES AND GEOGRAPHIC AREAS WITH CONSULTATION OF A CALIBER THAT WOULD ENABLE THE DEVELOPMENT OF A TOTAL PROGRAM ON A PRACTICAL BASIS. IT IS TO BE HOPED THAT ALL FUNDING OF MEDICAL CARE FOR INDIGENT CHILDREN WOULD BE EVENTUALLY ACCOMPLISHED THROUGH A SINGLE MECHANISM SUCH AS TITLE XIX; HOWEVER, WITH DEFINITE SAFEGUARDS TO INSURE THAT THE QUALITY OF CARE UNDER THE CRIPPLED CHILDREN'S PROGRAM WILL BE MAINTAINED. THE PRESENT CRIPPLED CHILDREN'S PROGRAMS COULD EASILY BECOME THE FOCUS AROUND WHICH TITLE XIX PROGRAMS COULD BE DEVELOPED AND THE PRESENT CRIPPLED CHILDREN'S STAFFS COULD BE UTILIZED AS THE MEDICAL CONSULTANTS FOR THE DEVELOPMENT OF THE PEDIATRIC SERVICE PROGRAMS. THE PRIMARY ROLE OF MATERNAL AND CHILD HEALTH

PROGRAMS WILL BE THOSE OF PROVIDING WELL CHILD SUPERVISION, WITH HEAVY EMPHASIS ON EARLY CASEFINDING AND PREVENTATIVE SERVICES. IT WILL BE ENCUMBENT UPON MCH PROGRAMS TO EXTEND THEIR ARMS INTO THE DAY CARE PROGRAMS, WHICH SHOULD BECOME INCREASINGLY AVAILABLE SO THAT THEY MIGHT USE THESE SERVICES TO PROVIDE COMPREHENSIVE WELL CHILD SUPERVISION FOR THIS GROUP OF CHILDREN WHICH HAVE BEEN DIFFICULT TO REACH IN THE PAST.

AT A RECENT MEETING I HEARD THE DEAN OF NEW YORK UNIVERSITY MAKE THE STATEMENT, "NOW MEDICARE WILL PROVIDE MORE MEDIOCRE CARE FOR THOSE WHO ARE NOT PRIVILEGED TO HAVE RECEIVED MEDIOCRE MEDICAL CARE AS IT EXISTS TODAY." SHALL THE SAME BE SAID FOR THE CARE OF CHILDREN? THE SOLUTION, IT SEEMS, RESTS PRIMARILY WITH BETTER ORGANIZATION OF CHILD CARE PROGRAMS WITH BETTER UTILIZATION OF EXISTING PERSONNEL, WITH SPECIAL EMPHASIS ON THE DEVELOPMENT OF NEW TYPES OF PERSONNEL.

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Physicians (Pediatric) Assistants

(Dr. Jay Arena - 4/68)

(1) Aides (1 yr)

6 months of practical nursing
2 months of laboratory training
2 months of clinic training (assigned to house officer)
2 months in physician's office

Duties:
(1) Fill out history forms, check list of medical data, etc.
(2) Weigh, take temperature and BP
(3) Do simple laboratory tests and collect specimens
(4) Assist physician with examination
(5) Minor duties

(2) Assistants (2 yr)

9 months of practical nursing
3 months of laboratory training
9 months of clinic and ward training (assigned to house officer)
3 months in physician's office

Duties:
(1) As above except more sophisticated such as conduct follow-ups, screen phone calls, etc.

(3) Associates (3 yr)

Present 2 year course plus 9 months clinic and ward training (assigned to house officer), 3 months in physician's office.

Duties:

Will vary depending on specific training and assignment such as: Pediatrics, Surgery, Cardiology, Anesthesiology, etc. Will have considerable responsibility in doing parts of the examination and in the management and follow up of the patient.

NOTE:

In 1900 there was one supportive person for each physician, today the ratio is 13 to 1. By 1975 it's expected that the ratio will be 20 to 25 to 1.* It is going to take some imaginative new ideas to obtain and train these individuals. Certainly all programs developed should enable people in one medical field with talents and interest to progress to a more stimulating and higher, better paying specialty. ("Career Ladder")

*Dr. Darrel J. Mase, Jr., Medical Tribune, Monday, April 1, 1968.