Pediat. Res. 6: 848–851 (1972)

Acceptance of the Howland Award

WALDO E. NELSON[2]

St. Christopher's Hospital for Children, Temple University School of Medicine, Medical College of Pennsylvania, Philadelphia, Pennsylvania, USA

Acceptance of this award carries several responsibilities. The recipient must make appropriate acknowledgment to the many to whom he is indebted. It has also become traditional that he comment on some interest or feature of concern to the society. Each of these responsibilities poses difficulties which most of you can appreciate.

Initially I must express my indebtedness to the membership for giving me the recognition implied in the granting of the Howland Award. I have always considered it one of the highest formal honors that could come to those of us in academic pediatrics. If one is at all objective, it is patently apparent that at most points in time no one stands out with clarity as the natural recipient of such designation. Without undue humility, I can recognize that such is the case today. There are a number of others who deserve this honor at this time more than I do. I trust that in this year, as in the oncoming ones when this award shall be assigned, the choice of a recipient is appreciated as being at best an arbitrary one and that the recognition is in large part to all those who have given the best of themselves to their roles in academic pediatrics. It is on this basis that I accept this honor.

Specific acknowledgments place one at great risk; one cannot give due credit to all who have contributed in one way or another, and one fears that his errors of omission may hurt unduly. No one of us grows or stands alone; my support and my indebtedness seem limitless, and my appreciation goes in full measure to the many I cannot mention personally here. Graeme Mitchell gave me my initial opportunities in academic medicine; his counsel and, above all, his confidence and friendship through those formative years have been a continual support. The decade of the thirties in Cincinnati provided a unique opportunity to be on the scene during the development of a full time teaching and research department—those years of association with Glen Cullen, George Guest, Bob Lyon, Frank Stevenson, Joe Warkany, and others left an indelible imprint resulting from the satisfactions and stimulation of working in a cohesive departmental group. Those were truly golden years and served me well in the opportunities which were to come at Temple and St. Christopher's Hospital for Children. I cannot mention my colleagues individually who shared in the development of our department nor those in my current haven at the Medical College of Pennsylvania. It is all still too close, and I trust a part of the present. Need I say more than that the honor accorded me today is "ours" collectively?

I must in all objectivity give recognition to two persons in my earlier life. It may well be that it was Charles Shatzer, biologist and Dean at Wittenberg, who unknowingly was largely responsible for steering my course from a business career to medicine. He had the intuitive sense of student personalization and a great capacity to make hours in the laboratory both pleasurable and profitable. I think I have never witnessed better demonstration of deductive reasoning as a teaching tool.

And then there was a grandmother—my maternal one. She lived with us throughout my precollege days. It is difficult to put this influence into perspective, because she was a part of the family from my earliest memories. It was she who was responsible for my somewhat unwieldy given names, from which I was fortunately partially separated in my preschool days. But otherwise, too, her influence was very real. Her formal education, limited to a country elementary school, did not limit her intellectual development; she was widely read and, in the strict sense, a scholar. I find myself with some frequency repeating aphorisms I first heard from her; as an example, "If you do not tell a lie, you need not remember what you have said." But most of all I remember sitting on the footstool before the old "coal burner" in her room, sometimes studying, but often just talking.

Finally, I must give credit to my immediate family.

Most know, I believe, the inside help I have had, especially with my medical writing activities. With the textbook, which fate and sentiment decreed should become our unsought and, I might add, undesired responsibility, I had home help of the first order. Many of you know from first-hand and/or from the prefaces of the several editions the roles which Mrs. Nelson and the children played. Some among our friends also know that the surest way I had to lose this home-based participation was to inscribe just one edition "to my dear wife." The risk was never taken.

Now to the subject of my remarks. (To what end(s)? By what means?) Few will challenge the assumption that the goal of pediatrics is to improve the lot of children—not only to cure disease, prevent illness, maintain a high state of physical health, guide parents and children alike in appropriate living habits, but also to encourage and support community activities concerned with the welfare of children. Put more succinctly, the aim of pediatrics is to assist each boy and girl to reach maturity equipped physically, mentally, and socially to function as responsible members of society within limits approaching his or her own potential and to have had the opportunities of thoroughly enjoying the years of getting there.

For obvious reasons, which include racial prejudice, overpopulation, overurbanization, and other displacements of people to areas and situations for which they are ill prepared, many children do not have the opportunities to which they are entitled. These inequities are not limited to health *per se*, though most if not all of them contribute directly or indirectly to health status. Few would disagree that the two most critical and most common pediatric problems of the moment are: (*1*) physical ones within the perinatal period which are largely centered among infants of low birth weight and (*2*) social or behavioral ones, the manifestations of which become most evident in late childhood and adolescence. Each of these is heavily dependent on socioeconomic factors. The percentage of infants of low birth weight among the poor in urban and rural areas in both so-called developed and developing countries is tremendously higher than among the higher economic classes living in more appropriate situations. The quantitative differences in the frequency of socially aberrant behavior may or may not be as great between these two social classes, but there do appear to be some qualitative differences. In overgeneralization, the social problems among the children of the middle and well-to-do classes seem to be related in good measure to overindulgence and overexpectation without the constant love, the understanding, and the setting of limits so essential to the child if he is to grow comfortably in our social complex. Among the poorer families, and especially in the ghettos, one finds more evidence of neglect and of the inculcation of bitterness and resentment.

If we can agree in general on our common goal, can we agree on the limits of pediatric responsibility? The pediatrician cannot be all things to all children. How clearly can we define the limits of what should be our direct responsibilities and what should be our indirect or supportive ones? These are basic questions of the moment, when there is so much ferment concerning child welfare. No attempt will be made to delineate them here. I shall only stress the importance of doing so. Only when the basic issues are clearly defined and the many problems related to them fully recognized can one hope to make significant progress. The ancient aphorism applies here: except as the problem can be clearly stated, it is not apt to be solved.

I shall add my firm conviction, however, that our primary responsibility as pediatricians is to function at the highest level possible as physicians, with emphasis on prevention of disease—on health maintenance—and on the pathophysiology of physical, mental, and psychologic diseases. These aspects must be uppermost in educational programs and in the interpretation of our roles to the lay public. Anything less could well delay continued and potential progress in child health for several decades.

It should not be considered that we are downgrading our role as physicians to children, if we acknowledge that the more important factors related to child welfare are social, economic, and educational. Rather, this recognition of nonmedical factors should contribute to a better understanding by the lay public of what they can and should expect from us. A clearer definition of our roles should also help to establish the base from which we can develop more effective services through continued experimentation in education and in training of student and physician, and in the delivery of health services. It is within these categories that we must direct our attention. Here I can only attempt to pose some of the important issues and questions. Answers must come from experience, hopefully based on well planned experiments, and not on some arbitrarily accepted universal scheme.

How many pediatric physicians are needed, in total, and in various categories? And what type or types of general pediatric physicians will be appropriate? Has the solo practice of pediatrics, currently available in large measure only to the middle and upper socioeconomic classes, had its day? If so, what should be the pattern or patterns of professional personnel to support or even to replace the general type of pediatrician? It has

become increasingly evident that many practicing pediatricians do not think that the demands made on them are commensurate with their training and many have left private practice for this reason. Much emphasis is being directed, however, to the need for primary care physicians. Could or should there be a special training plan for a primary care physician for children, or should the primary physician be the first contact for patients of all ages and in a broad sense be the generalist for the entire family?

If a role is developed for this so-called primary physician, what should be the extent of his education and training? For example, will it be for a shorter period of time than that of other physicians? And, if so, under what controls, including the possibility of special licensure, will he function? Will he practice independently, or will he work in conjunction with other physicians on a planned group basis? If the latter, what will be his relation to so-called paramedical personnel, *e.g.*, the pediatric nurse assistant or associate? And can the postschool training of these various personnel be synchronized in the same institution so that they have practiced their respective roles together? Further, should such training be in an institution in which more specialized training in general pediatrics and in the subspecialties of pediatrics is going on simultaneously? Here I shall have no hesitancy in voicing an opinion: I think every effort should be made to avoid any type of isolated or segregated training in patient care. If we expect several categories of professional personnel to work together effectively in community practice, they should develop their individual roles during their training periods in a unified care system.

Now that I have at least by suggestion created something of a straw man in the form of a so-called primary physician for children and possibly for their families, whose period of education and training would be something less than that of the average pediatrician of today, I find myself among those who think that his birth at this time would be premature. If we believe that we can extend the scope of service of the well trained pediatrician by preparing specially trained assistants for him, is not this enough of a venture for this decade?

There are many questions to be posed and answered in respect to the development of a pediatrician. What special and general qualities should he have? How can the medical school years be made more effective? There need be little concern about the unusually gifted student, with high motivation, and the capacity for well directed work toward a predetermined goal. The Darrows, the Gambles, the McQuarries will find their paths. It is for the average student of good motivation that we must be especially concerned. What can be done to be more effective in opening vistas for him, in providing stimulation and guidance during the time in which he must come to know that in the final analysis he is learning rather than being taught? This is your ecologic problem. What can you as teachers do to create a sympathetic and yet demanding and disciplined environment?

Most of us favor personalization of curricular activities within limits which are appropriate to a given student. Here again the exceptional student will make his way in spite of many difficulties. But it should be appreciated that for the average student the creation and administration of an elective program places greater demands on the time, interest, and intuitiveness of the teacher than does the prescheduled course. Unfortunately, even though this concept may be generally appreciated, it is too often neglected. Many elective periods find the average student dislocated and dangling and without a purposeful pattern to achieve a not too well defined goal. The only answer that I know to this situation is increased interest and involvement of the faculty. Perhaps in the selection of faculty more attention should be given to a *real* interest in teaching than to an *avowed* one. The idea should be more prevalent that charity (in this instance, teaching) should begin at home—and that the full time faculty member should be full time at home rather than full time away.

Elsewhere I have expressed my thoughts concerning the great need for objective regional planning for the delivery of health service [1]. In brief, I am in agreement with those who believe that we should be nearing the end of the solo practice of medicine, that physicians and their paramedical personnel should be grouped in neighborhood clinics and that for outpatient as well as inpatient services they and their patients should have ready access to the secondary or community hospitals and to the tertiary or medical center facilities in their area. Such a plan could be readily evolved in most, if not all, communities. The principal and only real stumbling blocks are people with vested interests, mainly physicians and members of hospital boards.

The opportunities for future developments in pediatrics and the responsibilities for them are great. Those of you in this room must assume major roles, if the currently available potentials are to be realized. I should not like to imply that either the American Pediatric Society or the Society for Pediatric Research should become primarily an action society. The need for the current pattern of an open forum for the presentation of experimental data is too great, and any feature which would risk lessening the effectiveness of this function should be avoided at all

costs. All of you, however, have opportunities to be involved in the issues mentioned here, namely, the determination of the pattern of medical care of children, preparation for it, and plans for its delivery. In other pediatric organizations there are ample opportunities for formulation of plans for medical care and for providing guidance and leadership for civic and governmental groups responsible for the development and maintenance of regional health facilities. This approach seems to me to be essential if we are to avoid a system developed primarily by politicians with promises beyond the range of reality, or one formulated principally by the American Medical Association, with interest centered too fearfully in the doctor's welfare and without the reality or courage to risk a system designed for the best interests of the community. As pediatricians we have tended to think of ourselves as being in the vanguard of medical growth and development. Perhaps we should reassess this concept and determine whether we have neglected some of the current problems. The two organizations best suited to provide leadership and to take effective action are the American Academy of Pediatrics and the Association of Medical School Pediatric Department Chairmen. The latter group in particular has the great responsibility to bring to city, state, and federal governments more definitive guidance for regional planning. In turn, each of us here should participate at our local level so that the chairmen of our respective departments can speak with confidence for their groups. At the moment we have confusion rather than coordination in health services which are supported by public funds. Need I but mention the overlapping and the lapses and other inefficiencies that result from the multiplicity of locally and federally supported programs, especially in the urban areas. Most of you will know these as well or better than I do. What I hope to convey is the idea that we should not cry because some financial support has been withdrawn by the government or be too ready or desperate to take money out of a different governmental pocket just because it happens to be available at the moment. It is our responsibility to guide governmental planning in our field.

Every well planned experiment requires a control, and appropriate ones should be constructed and utilized to test the various plans for the delivery of health care which will be evolved. In like manner, there should be clearly stated objectives: specific and general. I suggest that one important objective would be to determine the effects of planned health care on the attitudes of children and their parents toward such services, the manner in which they use them, and their sense of responsibility for their own health as well as that of the community.

It would be interesting if we could have a native population untouched by western civilization to serve as a control. Unfortunately, not many such populations exist any more, but a few may approach such a state. A short time ago Mrs. Nelson and I were privileged to be the only non-natives on a small island in the lagoon of the large island of Malaita in the Solomons. This small island was constructed by natives who had lived some centuries ago on the shore of the main island so that they might have protection from the more warlike natives from the highlands who periodically descended to carry away crops, pigs, and wives. This particular island is some 500 to 600 years of age, and though the natives are not without some contacts with the outside world, they have managed to continue a simple form of life which seemed on the surface at least to have fewer of man's troubles than is true in our setting. I think we have never spent a day with a seemingly happier or more content group of people. Perchance they have some attributes, especially in respect to child care and concern, which we could copy with profit.

And now in what may be termed by some the vernacular of our family, I must close by reemphasizing that while we are truly "for our birds," we are even more for our children.

Again my sincere appreciation for the honor you have accorded me.

Reference and Notes

1. Nelson, W. E.: Communication—Is this the art of medicine? Amer. J. Dis. Child, *111:* 545 (1969).
2. Requests for reprints should be addressed to: Waldo E. Nelson, M.D., Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pa. 19129 (USA).
3. Received for publication June 26, 1972.

Copyright © 1972 International Pediatric Research Foundation, Inc. *Printed in U.S.A.*