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American Pediatric Society Presidential Address 1989

Pediatrics in the Next Decade

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Members of the American Pediatric Society, honored guests, ladies and gentlemen. It is my distinct pleasure to convene the 100th scientific meeting of the American Pediatric Society. Before any of you begin to wonder what is happening here, let me assure you this is not, in the words of Mr. Yogi Berra, "déjà vu all over again." The organizational meeting of the American Pediatric Society was held in 1888. So last year we celebrated its centennial. That meeting will be forever memorable primarily because of the extraordinary symposia which were organized by Paul Quie but, because we are social beings, memorable as well for the exquisite gala arranged by Audrey Brown. There is no intention to repeat those events this year. Indeed, such repetitions should occur infrequently, possibly once a century. Nonetheless, this year marks the 100th anniversary of our society's first *scientific* meeting. On September 20, 1889, the first scientific meeting took place in the Office of the Surgeon General in Washington, DC. That meeting was adjourned so that the members could meet the next day at the Johns Hopkins Hospital. This year, by happy circumstance, the Hopkins, or as it is more fondly called, The John, is also celebrating its centennial. Shortly after my remarks, we will hear a review of 100 years of pediatrics at Johns Hopkins.

It is not surprising that I take this occasion to project my views of the future of pediatrics and of the American Pediatric Society. My two immediate predecessors, Drs. Sam Katz and Paul Quie, have done likewise. The titles of their presidential presentations were: "The Completion of a Century" and "Advent of the Second Century of Pediatrics," respectively. Frankly, those were intimidating titles with which I had trouble. For a brief period I considered "Well, now we're in it." But that was just a hackneyed title, not what I wish to convey. Because I don't have a distinguished record as a futurologist, I decided I should address my thoughts to the short term, the next decade. Our presidential messages have been broadly similar, but each has been different. I have chosen to focus on two issues that I believe are crucial for the continued growth and success of our society and our specialty. These are teaching and the role of women in pediatrics.

First, pediatric education. A number of organizations, such as the National Residency Matching Program, have declared that pediatrics is a declining specialty choice. That is simply not the case although it is true for internal medicine and family practice. Each year the American Board of Pediatrics conducts an In-training Examination to which more than 95% of all pediatric programs subscribe. When the results of that examination are distributed, an accompanying request is sent, both to the subscribing programs and to the few nonsubscribing programs, to provide lists of residents at each of the three levels of core pediatric education. These data clearly indicate that for the last several years the number of pediatric residents is constant or rising slightly. Because these data conflict with information gathered by the Association of American Medical Colleges or the NRMP, one must ask who to believe? The answer is clear: the American Board of Pediatrics. Not just because I work there now, but because of a much more fundamental reason; pediatric chairmen and program directors pay a fee for each person who takes the examination and I can assure you, both from personal experience and my knowledge of program directors, none would pay for phantoms. Thus, in contrast to the significant decline of enrollees in the other primary care specialties, enrollment in pediatrics is stable. Nonetheless, we must not become complacent. Debt burdens of graduating medical students are increasingly staggering. Perhaps surprisingly they are neither greater nor lesser for graduates choosing pediatrics than for those choosing any other specialty. But there is a very real concern that the specialties with the potential for a higher income or a more attractive lifestyle may influence career decisions and impact on pediatrics as a career choice in the future.

Thus, it seems clear that we, the members of the American Pediatric Society, the principal teachers of pediatrics in our nation's medical schools, have a singular responsibility to encourage students to enter our field. Our major obligation as teachers of medical students is to introduce them to the joy of pediatrics. I strongly support the Association of American Medical Colleges' report of the panel on the General Professional Education of the Physician (the GPEP report) and urge that our faculties study, debate, and implement its many recommendations. In every medical school, one or more pediatricians should be identified by the department to be responsible for developing curricula and teaching programs to better educate medical students broadly and, in the process, to encourage students to choose pediatrics as a career. These individuals should be paid by the dean and must derive recognition in the form of salary benefits and promotion for fulfilling these responsibilities. The *only* function that is unique about medical schools is the education of medical students. Every other activity of a medical school can be conducted elsewhere: research, graduate medical education, and patient care. These activities should remain a major part of our medical schools, but not at the price of neglecting medical student education. Clearly that is what is happening today. None of the medical schools with which I have been or am currently associated consider medical student education to be their highest priority. Some portion of tuition should, and must be, directed to the support of a cadre of physicians dedicated to the education of medical students. This group cannot teach all of what needs to be taught but, surely, they can set the curriculum. In commenting on the GPEP report, Joe St. Geme said it all. "The most compelling consequence of these deliberations will be the restoration of the sense of joy and enthusiasm of our medical students for the excitement, wonder and future of biomedical sciences in human medicine and an inclination to devote one's professional life to the intrigue of investigative medicine."

Let me now turn to another area of great import to the future

of pediatrics, and academic pediatrics, in particular. I'll begin with another quote. "It is useless manufacturing articles for which there is no market and in Canada the people have not yet reached the condition in which the lady doctor finds a suitable environment; in fact, Quebec and Montreal have none and in smaller towns and villages of this country, she would starve." These remarks were made by Sir William Osler in his Presidential address to the Canadian Medical Association in 1885. Times change. The proportion of women entering medical schools has increased strikingly in the last two decades, from 10% in 1967 to 37% 20 years later. In 1987, the last year for which data have been reported, 52% of all pediatric residents on duty in accredited programs in the United States and Canada were women. For both internal medicine and family practice, the proportion of women residents was approximately 28%. That same figure was the mean for all residents in 1987. Forty-five percent of residents in ob/gyn were women, 20% in anesthesiology, 13% in surgery, and 1% in urology. In 1988, the percentage of women first-time takers for the written examination of the American Board of Pediatrics was 56% compared to 50% just the year before. During my last 10 years at the University of Pittsburgh, we had uniformly more women than men in our entering residency class. Although this could have been attributed to my sex appeal, the facts are that we matched more women than men because they were better and we ranked them higher.

It is imperative that the members of our society give recognition to the multiple and more complex roles of women pediatricians as compared to male pediatricians, as homemakers, spouses, mothers/child rearers, and not least, victims of their husbands' desires for careers. There are incontrovertible data that women pediatricians' career choices and geographic locations are more heavily influenced by their husbands' than male pediatricians are by their wives' career decisions. Additional data gathered by the American Board of Pediatrics indicate that women pediatricians are more likely to choose careers in general practice and, incidentally, in HMOs. Consequently, women are less likely than men to choose careers in subspecialties. For reasons that have not been critically analyzed, women who choose careers in academic pediatrics are less likely to apply for and much less likely to be successful in obtaining RO1 and other peer-reviewed grants than are male pediatricians. Janet Bickel, who heads the program of Women in Medicine at the AAMC, has shown that in pediatrics, as in all of the other specialties, women are underrepresented by promotion to tenure ranks, as division heads, chairmen of departments, or deans of our medical schools. This must change. But not by changing standards, but by changing requirements. Because of the infinitely more complex demands on women physicians, women should be allowed more time to reach tenure status and more time to complete research projects. We must develop social systems in our universities such as child care programs and the provision of adequate time off for pregnancy and child care.

Let me now turn to the role of the pediatric subspecialist. As a consequence of thoughtful deliberations by several organizations, a concept has emerged, with which I am in complete agreement, that the pediatric subspecialists of the future should not only be better trained, but also should focus their professional lives in an academic health center. By academic health center, I mean an environment usually, but not necessarily, associated with a medical school where the pediatrician can devote essentially all professional activity to the subspecialty. Here his or her clinical skills would focus on the performance of the technical and procedural skills inherent to the subspecialty (such as endoscopy or vascular access or intubation), he/she would be a consultant to the general pediatrician on secondary problems and would provide the hands-on management for patients who require tertiary care. In addition, the subspecialist would be responsible for teaching the subspecialty to students and residents and would advance knowledge in the field. Relatively few individuals will be able to accomplish all these tasks. Some will function primarily as clinicians/teachers and others primarily as investigators. Both groups are needed; both deserve to be rewarded equally both financially and promotionally. I am steadfastly opposed to the concept of providing subspecialty clinical training so that the general pediatrician can have a hobby. The current special requirements for programs in general pediatrics require educational experiences so that fully 80% of all subspecialty problems can and should be in the domain of the general practicing pediatrician.

A blatant example of where our current training of subspecialists has gone wrong is neonatology. As a pioneer neonatologist, whose certificate number is 4, I share the blame for the multitudes of neonatologists whom we have trained and certified. There are more certified neonatologists than all other subspecialists combined. And what has been the consequence? In short, it has unraveled one of the most exciting developments of the last quarter century—the regionalization of neonatal care. Neonatologists have infested nearly all of our hospitals, thereby displacing general pediatricians from caring for normal newborns as well as those with secondary level problems for which they have been trained and for which they are fully competent to provide. My fervent hope for the future is that with enlightened social programs that assure prenatal care for *every* woman, coupled with research that leads to an understanding of the causes and control of labor, prematurity will be reduced to a very low level before the turn of the century. As a consequence, neonatal intensive care units, particularly in community hospitals, will become like the tuberculosis sanitoria of the 1950s . . . empty. Regionalization of neonatal intensive care can again be the mode.

The development of the Pediatric Scientist Training Program, made possible in large part by the leadership of Fred Battaglia, and the decision of the American Board of Pediatrics to require three years of training in all subspecialties with the requirement that graduates who wish to be certified demonstrate both clinical and research competence are directions that are right for pediatrics and right for our nation's children.

Earlier this year the Association of Medical School Pediatric Department Chairmen (AMSPDC) initiated a program called Frontiers in Science, whose purpose was to instill a sense of excitement of academic pediatrics to a group of residents selected by a subset of its membership. For the first time our society has also initiated a program to invite residents to attend this meeting. These residents were selected from 30 programs in the United States and Canada, who were not represented at the AMSPDC meeting, and who are represented by a larger constituency—all the pediatric programs. There are about 244 accredited programs in pediatrics of which about one-half are members of AMSPDC. I happily acknowledge the substantial contribution of Mead Johnson Nutritionals in supporting this effort. At both this meeting and the AMSPDC meeting, women residents have been well represented.

In the critically important quest to attract men and women into careers in academic pediatrics, I would like to resurface an idea I proposed several years ago when I was the chairman of the Assembly of the Association of American Medical Colleges. It is the concept of loan forgiveness. The idea was not pursued by the AAMC administration after I left office. That is the natural history of a dead duck. Today, as a lame, if not dead, duck I propose that we resurrect this model, but just for pediatrics because our specialty has spoken so strongly in favor of research. The program would work like this. First, a subspecialty resident would be required to complete at least 3 years of training and demonstrate a level of provisional research competence, e.g., as first author of a research publication in a peer-reviewed journal. Second, he or she would have to be recruited as a *full-time* faculty member with at least 50% of time protected for research. Having cleared these two hurdles, 20% of government loans would be forgiven for each year the candidate remained in this role. Thus, total loan forgiveness could be accomplished in 5 years. This

would be an especially attractive inducement for candidates applying to the Pediatric Scientist Training Program. But it would be a forceful inducement to others dedicated to a career in academic pediatrics as well. Assuming 100 candidates, each with a debt of $50,000, the yearly cost would be 1 million dollars. Chicken feed. If our pediatric societies agree with this proposal we should ask the Public Policy Council and the Academy of Pediatrics' Council on Governmental Affairs to assume leadership in following through with discussions both with the public and private sectors to fund this program.

Inasmuch as I have emphasized the special role women will play in pediatrics for the foreseeable future, I am especially pleased that at our business meeting later this morning it will be announced that the President-Elect of our Society will be Mary Ellen Avery and our Secretary-Treasurer will be Catherine DeAngelis. I would like to conclude my remarks by identifying three women who have been particularly important to me in my pediatric career. Audrey Brown has served as the Secretary-Treasurer of our organization for the past 6 years and has been especially helpful this year during my presidency. Barbara Korsch who, by woundrous chance has been Chairman of the Council this year, has been a splendid friend for many years. It would be ungallant to say how long. However, the relationship began when she was one of my teachers during my residency. She has continued to teach me many things but especially about caring for others. And finally, I wish to thank Dr. Lois Pounds, a superb pediatrician and my closest friend. Thank you very much.