Rethinking Well-Child Care: Lack of Standardization at the Beginning
Henry M. Seidel
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**TABLE 1.** Pediatric Practices and Data Collected at the First Visit

<table>
<thead>
<tr>
<th>Practice No.</th>
<th>Practice Description</th>
<th>Data Points Routinely Collected at the First Clinic Visit After Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical center with pediatric residency</td>
<td>Weight, temperature</td>
</tr>
<tr>
<td>2</td>
<td>Medical center with pediatric residency</td>
<td>Weight, temperature, heart rate, respiratory rate</td>
</tr>
<tr>
<td>3</td>
<td>Medical center with pediatric residency</td>
<td>Weight, length, head circumference</td>
</tr>
<tr>
<td>4</td>
<td>Medical center with pediatric residency</td>
<td>Weight, head circumference</td>
</tr>
<tr>
<td>5</td>
<td>Community hospital with family medicine residency</td>
<td>Weight, length, head circumference</td>
</tr>
<tr>
<td>6</td>
<td>Community hospital with family medicine residency</td>
<td>Weight, heart rate, respiratory rate</td>
</tr>
<tr>
<td>7</td>
<td>Community hospital</td>
<td>Weight, temperature, heart rate, respiratory rate</td>
</tr>
</tbody>
</table>

Rethinking Well-Child Care: Lack of Standardization at the Beginning

To the Editor.—

I applaud Dr Schor’s article “Rethinking Well-Child Care.”1 He rightly draws attention to the unreasonable expectations and anachronisms of routine well-child care. Recently, I came across some unexpected practice differences that highlight the challenges of rethinking well-child care.

By happenstance, I had learned that another general pediatric practice had a different routine than ours concerning something I had thought was rather basic. Specifically, our 2 practices differed on the data points routinely collected at the infant’s first clinic visit after birth. A literature search failed to unearth any recommended guidelines. Intending to discover the “community standard,” I contacted 7 other general pediatric practices, only to discover 5 different routines (Table 1).

The only item on which every practice agreed was routinely measuring the infant’s weight. None obtained blood pressure, and none checked pulse oximetry. The rest seemed up for grabs. Each practice had a rationale for its approach. For example, those practices that routinely took temperatures did not want to risk missing a fever or hypothermia. Those practices that did not routinely take temperatures felt that the frequency of false-positives (fever or low temperature) in the otherwise healthy infant was too high to justify routine temps. None of the practices referred to any studies in support of their routines.

If something so simple and basic shows such variability, it is no wonder that standardization of more elaborate issues is so difficult. I support Dr Schor’s call for “a single authoritative source of standards for well-child care”(p214) and agree that a good first step would be a thorough revision of the *Recommendations for Preventive Pediatric Health Care*.

MIKE DUBIK, MD
Pediatics
Naval Medical Center
San Diego, CA

REFERENCES


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To the Editor.—

July 1, 1953, marks the first time I began to think in earnest about the role of the pediatrician. Before that, through 5 years and 3 months as a pediatric house officer and 2 years in the United States Army, I had simply taken for granted what my training had implied and what the Army had demanded of me. That July day, however, was my first day in solo private practice. It was a busy day, because I was covering for a man on vacation.

A woman called with a simple question: “Is it alright for our 3-year-old daughter to see me and my husband naked around the house?” I remember the question, but I cannot remember how I answered. I hope humbly. I also remember thinking that I had not been trained for this. In fact, in today’s terminology, I had probably been better trained to be a “hospitalist” than anything else. I could do a cut-down or a tracheotomy, and I could insert a 25-gauge needle into a 26-gauge vein.

It was a matter, then, of flying by the seat of my pants, seeing patients, reading, learning, working very hard, and arriving (in time) at some sense of what my patients wanted of me, by their definition (the community’s definition of what my role was to be). And in the last 50 years that definition has been further honed by patient expectation and the mandates imposed by new awareness and the realization that something was missing in our education and training.

The effort has been made to modify the pediatric residency experience with greater attention to what some call the “new morbidity” and what I call “recently realized morbidities,” and to the context and content of what we now call “primary care.” There have been helpful changes, particularly with mandated experience in outpatient service. This falls short, however, because the residency must continue to serve the needs of sick children in hospitals as in the past and because our increased understanding of disease and our expanding technologic expertise have made the learning experience even more demanding (witness the time devoted to neonatal intensive care units). Our young men and women are graduating from the residency years still better prepared to be “hospitalists.”

Decades after that July 1, I had been detailed to mind our grandson as he attempted to surf at a Cape Cod beach. I took with me a copy of “Pediatrics.” Reading it stirred slumbering thoughts. Seven articles carried the message that “the pediatrician should” give attention to a number of issues ranging from guns to cigarette use in the limited time with each patient at a so-called “well-child visit.” I would have felt intimidated were I still in practice. How could I do it all? I thought back to a >30-year-old study reported by Fred Anderson in New Haven suggesting that the laying on of hands at infant check-up visits was not particularly productive in terms of benefit to the infant. The idea that these unnecessary efforts for which we were reimbursed be eliminated was not well received. There was no particular reimbursement for advice given, just for the examination and for the immunizations.

Hospital demands on residents and the still-dominant economic base of pediatric practice remain as barriers to the preparation of persons who might be better able to satisfy the needs of children as defined by the community and the burgeoning realization of recently and, really, not-so-recently recognized morbidities. Advice, counseling, and a profound understanding of both physical and behavioral growth and development and the relationship of the child to family and community should be at the heart of the skills of the persons who might take the place of the pediatrician who is still not ideally prepared and who is certainly economically constrained.

We might need a new name for such a person. The suffix “-pod” comes from the Greek and refers to “foot.” A “pediapod” might be literally thought of as “child-footed,” but I do not think it is too much of a stretch to think of the term as “child-based.” Regardless of name, we need a person at least somewhat different from the presently trained pediatrician to fill the role suggested by society, by our newer understanding of the needs of the young and the morbidities that are increasingly commanding our attention.

The questions that arise suggest a sea change in our present approaches, and if we are to improve the lot of the child, we must keep our minds open and unfettered by the obvious difficulty inherent in change.
guidance principally by the needs of children and their parents titled "Pediatrics for the 21st Century." However, real reform of pediatrics has long claimed the mantle of children's health and development, but pediatric education and training well met. Pediatrics has long claimed the mantle of children's health and development, and I now turn to the question: (1) To what extent is pediatrics about children and promoting preventive care? One might also add that finding ways to move toward a practice that is more efficient and effective approaches to care and aligning incentives; (eg, reimbursement) with quality also would be helpful advances.

Dr Seidel raises at least 2 difficult and fundamental questions that arise from his perception of the needs of children and families: (1) To what extent is pediatrics about children and promoting their health and development, and to what extent is it about children's diseases? (2) How do we address the mismatch between pediatric training and the role of pediatrics? These are not new questions, but the field of pediatrics and its leaders have judiciously avoided confronting them. Consequently, many of the needs of children are not being well met. Pediatrics has long claimed the mantle of children's health and development, but pediatrics and training and education and training have failed to adequately support that claim. Although there have been some modest efforts to revise the content of pediatric training, these have been, in Dr Seidel's words, a "Band-Aid approach" and have not fundamentally reassessed the field of what pediatrics and its approaches to care for children. Dr Errol Alden, Executive Director of the American Academy of Pediatrics, has tried to promote the discussion by convening a series of forums titled "Pediatrics for the 21st Century." However, real reform of pediatric education will take not only broad discussion among pediatricians of all sorts but also a structured strategic process guided principally by the needs of children and their parents rather than by the needs or desires of the profession or of academic medical centers.

**REFERENCES**


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Rethinking Well-Child Care

**To the Editor.—**

Dr Schor's article in *Pediatrics* called attention to the fact that many of this nation's children fail to receive periodic preventive health care as set forth by the American Academy of Pediatrics in its *Recommendations for Preventive Pediatric Health Care*. He cites data showing that not only is the quality uneven but many children do not even receive the services when they are of no cost to the family. To ameliorate these problems, he offers a number of suggestions including changing the periodicity schedule; naming each well-child visit to call attention to its primary focus; eliminating inefficiencies such as physical examinations; using acute illness visits to administer some preventive services; reinforcing parental guidance; and a few others. Perhaps Denver's Partners in Health Care (PHC) can add a few more considerations to making preventive child health care available to all children.

PHC

In the early 1990s, my co-workers and I addressed the problem of the failure of all children receiving the preventive health services recommended by the American Academy of Pediatrics. The underlying premise of our approach to the problem was that to achieve full compliance requires the active collaboration of parents and physicians, with supplementary support by a variety of community groups. The program consisted of a passport (parent-held health record that also served as a provider's medical record), the health providers, and a tracking system staffed by a community coordinator. The passport included 3 major sections: the first section consisted of health summary charts, health problem lists, family medical histories, and consent forms; the second section contained the records of individual well-child visits; and the third section had health suggestions for parents to remove from the passport and display at home to serve as daily reminders. The first 2 sections were printed in triplicate using carbonless pages. One copy was for the health provider’s child health record; the second copy was for the parent and remained in the passport; and the third copy was sent to the community coordinator. He/she in turn scanned each evaluation into the computer, which printed out services provided and thereby enabled the coordinator to notify the provider of services omitted, enabling the provider to notify parents of services inadvertently omitted.

**RESULTS**

The program was implemented with >3000 newborns in 6 separate sites: Denver’s Community Health Program (which serves the indigent), private pediatric practices in Denver, and public health clinics and private practices in Colorado Springs, Colorado’s Fremont and Chaffee Counties, and Quincy, Illinois. A randomized, clinical trial in Denver’s Community Health Program involving 360 of 776 newborns receiving the passport showed the program’s strengths (S. J. Cohen, EdD, B. A. Gitterman, MD, A. L. Baron, PhD, K. L. Reiner, MPH, K. A. Lynch, BA, and W. K. Frankenburg, MD, MSPH. “Improving Adherence With Preven-