Dr. Eichenwald: Pediatrics p 1

I'm Heinz Eichenwald, professor and chairman of the department of pediatrics.
? You're in xxxcharge of the intensive care unit for the newborn?
Well, I'm not really in charge of that, but it's a departmental function. We operate a , actually the only two intensive care units in the north Texas area. One of them deals primarily with newborns, one of them is a more general type of intensive care unit. One is at Parkland, the other is at chileren's medical center.
?Does your office here in Parkland reflect your position as chief of pediatrics for the hospital?
No, I feel very strongly that a pediatric department ~~xxxxx~~ doesn't segregate itself out of ~~a~~ the rest of the medical school. We depend for intellectual stimulation and support on other clinical and pre-clinical ~~xxxxxxx~~ departments. Obstetrics, certainly, internal medicine, surgery, and also all the pre-clinical departments. Even though headquarters are so to speak, is centered at Childrens' Medical center we house very, very few of our faculty over there, only those whose presence is immediately required because of their particular clinical responsibilities. In fact a lot of prople don't understand that Childrens' Medical Center and the Parkland Service are a single combined service. We have only one residency group, we have only one group of attendings. And of course they're physically connected.
?How does Pediatrics fit into the health center, ~~xxxxxxx~~ it's a fairly big component isn't it?
Yes, we're a very large component, partly because ~~xxxxxxx~~ we do more than just teach pediatrics.
?That's what I'm grasping for, what are all the aspects of this department?
Well, Pediatrics is perhaps somewhat in some ways different from some ~~xxxxxxx~~ of the other clinical fields. Of course I have a mission bias and I suppose I can only see it from my point of view. Health care for children involves many things which are not involved in other medical fields. Most medical fields take care of sick ~~xxxxx~~ people, the major mission of a pediatric department really is to keep children well, and to permit children to go to their maximum potential. So we deal very uniquely with the entire well being of the child. and really what ideally a department of pediatrics would do is to put itself out of business. Or at ~~x~~least to put the sick component out of business. Of course that's neither theoretically nor practically possible. So our department ~~x~~ operates not only medical care programs in terms of taking care of children who have problems, but we operate a very sizable number of activities and programs that are involved in trying to prevent children from getting sick in the first place.
?Could you name some of those?
~~X~~ The major effort along those lines is our West Dallas health project. Which is rather unique total ~~xxx~~ health program for children which incorporates ~~our xxxxxxxx~~ many of our ideas of preventive services. Which relate, you know , not only to the most obvious preventative services, immunization, well that of course is a very minor part of it, ~~we try to keep~~ the children ~~in~~ the West Dallas, who come from the most deprived socio-economic groups ~~and have the least~~ access to regular ~~xxxxxxx~~ health service we try to develop a total health care system for ~~them~~. Which keeps them healthy and permits them to achieve their maximum potential, maximum genetic potential which they might have,. That's one aspect. We are very much involved in school health programs which are a very similar manifestation. Schools are unique in that's the one place where you have a lot children together. And many health problems. Potential as well as actual become apparent in schools

And so we've been involved in school health programs and designing school health programs for other communities, such as Ft. Worth for example. And the director of school health in Dallas is a full time member of this department. We have something called the University Affiliated Center Program which is a very broad program which deals with children that have a variety of learning, intellectual, or communication problems, or which are identified as being potential candidates for these problems. This is then both a diagnostic and a remedial or a preventative activity, and again it is totally unique. There is nothing like it anywhere is the North Texas area. It's operated not in relation to the hospital but it's operated with the school district. Dallas Independent School District. As well as with three or four neighbouring universities who have graduate programs in this area. See all of these things are a little different from what you get normally with quote Doctors, M.D.'s But our concept is as I indicated very much broader than that. Not only, I'm repeating myself, I feel we should operate the best possible medical care program, but we would not be doing our job as pediatricians, as human beings, or as teachers if we limited our activities just to taking care of the sick.

?How would you catalog your activities as a teacher?

Well I think you teach by example. You can't teach someone pediatrics by spending all your time in a hospital taking care of sick children, I think you can teach pediatrics only by living an example. Sometimes I think perhaps we overdo it and perhaps the administration might think we are, we get involved, we ran for example for six years we ran a medical program in Vietnam. out of our department which is perhaps overreaching a little bit. But again this was social responsibility. Our activity there was related to trying to develop not only a medical care program, a health care program, for Vietnamese, which obviously has to be totally different from American health care programs, but also training the people who are going to operate it. And both I and our faculty co-operated, worked on this very hard for a goodly number of years, and in fact completed most of our goals. We have similar sorts of relationships, not as formally, with a number of central and south American countries and universities. Very informal, but we're doing substantially the same thing. Training some of their faculty here, we help them developing educational programs and this sort of business. All of this is a feeling that I think most of the faculty here has, that the view of medicine as just diagnosing illness and treating it is much too limited. I think a teacher must have a broader view, a practitioner generally is not able to. Although many of them do. Our pediatritians are known for their social involvement in many ways. I think this is simply an outgrowth of the way all of us were brought up. by teachers who also felt equally broadly.

? What are the formal aspects of teaching?

Well we teach basically by a clinical preceptor type. We give no lectures in pediatrics. We abolished lectures some ten years ago. And at that point our students suddenly began to do awfully well on their national boards. In fact they were first in the country on the national boards for nine years in a row. Now they no longer tell us how they stand but I presume they're going to continue this form of return. A teacher's role is not to simply cast pearls before swine, ~~which is what a lecture process does.~~ A teacher must sort of stand without his clothes on trying to solve a problem. And the problems cannot be artificial. ~~The way I teach and~~ the way most of the faculty teach is by presentation of patient problems. that we have never encountered before, ~~I made a rounds this~~ morning, the house staff delights in plucking two or three complex patients out and presenting them and then I have to think quickly on my feet. ~~And what I do and the way most of our faculty operates~~, wethink out loud. Medical students and house officers then learn through that process (of thinking out loud, how do you unravel a problem. It's not just having information, so how do you use it. The most difficult

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aspect of teaching medicine is not to teach people facts, anybody who has a basic IQ can learn facts, it's how to use them. How do you marshal all the information that's floating loosely around in your head onto a problem. How do you put all this together, how do you come up with a solution, a practical solution. How do you test that what you're postulating is in fact correct? Now obviously we also provide the students with a lot of facts. while we're doing that and this is part of the teaching process. But it's to me a much more realistic approach than getting up and giving a lecture on this problem. And that just doesn't work. I'm convinced this is a very bad way to teach clinical medicine. The department is unique in the fact that every one of us, even though nearly all of us are subspecialists, in addition to teaching their subspecialty, in pediatrics, such as nephrology, or endocronology, or what have you, teach general pediatrics. So the students actually see us as general pediatricians. They also see us as subspecialists. To me again this is image forming. We , you know the increasing subspecialization of medicine to people who are going to be practicing is a disaster. And of course medical school faculties tend to be very subspecialized. And what the student sees is not how does a general physiciah approach a problem, they see who does the physician refer the problem to, that's not an adequate way to teach. I realize of course I don't know all there is to know about Pediatrics by any means. But the students still see me and the rest of the faculty trying to struggle with a clinical problem.

?How does one measure what one knows about ones field?

Well, if somebody asks me aquestion and I don't know the answer, I don't know the answer. And that happens with some regularity. Pediatrics is a vast field, it encompasses nearly everything in internal medicine, plus many of its own problems. Even neonatology alone is almost as big as nearly any other medical field, and I'm not pretending that while we're teaching quote general pediatrics unquote that we're at the same time specialists in everything, we're not. Yet this is what the physician is going to face. We feel that the house officers here certainly ought to be able to handle ninety-eight or more percent of all the problems with children that they're going to encounter. Maybe two percent they would have to refer . But otherwise they just become drugstore clerks, they dispense pills and send patients who don't respond to the pill off to see somebody else. That's a very unhappy way of life. The medical students also I think ought to see what the primary physician can do. rather than just shrugging their shoulders and saying I'm a specialists, I'm a cardiologists I don't have to worry about the kid's feet. Which is unfortunately a very prevailing point of view. You know a mother comes to you and says my kid has flat feet and you say I'm sorry I don't know Im a kidney specialists.Why that's wrong. Lots of kids have flat feet and anybody who calls himself a pediatrician whether he's a kidney specialist or a, ought to know something about flat feet. Ought to be able to advise the motheraccordingly.

* — ?Specialization seems to be a very controvessial topic....?

Well I'm not saying you don't need specialists, obviously you do , but there's a difference between a teaching setting and the real world. I think we owe more to our students than having a bunch of subspecialists pop up likemarionettes and give their spiel on the limited area and disappear.

This is very artificial teaching. I think the students also ought to see me fall flat on my face. You know one of the worst problems that doctors have is their ego. They're the magician of our time, you know they wear a mystical atmosphere and very few doctors can ever admit to themselves or to anybody that they're worng. Well I've been wrong so many times, I still worry about it, it still bothers me, but I, you know , if I see a patient, since I'm not rehearsed, and I make a diagnosis and I'm wrong OK i"ve learned something.

study of newborns

NOT 14

Then the next thing you do is you go back with the students, with the house officers and analyze how you made that mistake. What could you have done to avoid it. That's the teaching process.
?Is this attitude unique here?
I don't know, I don't know.I think we're the only department where everyone teaches the whole subject. And uh, not the whole subject, but acts as a generalist in addition to being a specialist. Everyone makes general rounds. I think that's unique. The attitudnal things that we have about how to teach, whether that's unique or not I really can't tell you. I don't know. I do not know how other departments teach or what their basic philosophies are.
? What are the research aspects of pediatrics?
We have many different types of research carried out at many different levels. We have some rather strongly clinically related research, which has immediate applications. That's obviously a responsibility one has. We do a lot of pharmacological research . Since so much pharmacology really applies to the mature human being rather than the immature. and there are remarkably few data on that sort of thing .So there's a lot of that going on. We do some, a lot of very basic research. We have three or so PhD's MD's in the department whose interest is very basic and they may be dealing with membrane chemistry or tubular function in the kidney, or,microx puncture methods to treat renal disease . I'm sure have at some point a clinical application but not immediately. We do a lot of very basic fetal biochemistry of dealing with fetus. And fetal development type work. It's an enormously broad research program. But it's sort of interesting that some of our people who do work on development of the embryo , say cardiovascular function of the embryo, how it can be modified, also are operating, are involved in a mjor study of how one or the epidemeology of high blood pressure. in adolescnce and how one can treat it and whether treatment has any effect on long term outcome. and this sort of thing. I sort of like that. The fact that people try to work both in the immediate world and in the laboratory. and we have a number of very effective research groups And the department I think is well recognized in this. We have at least somebody on the editorial board of every major pediatric journal, plus some other journals. that don't deal with pediatrics.
?What are the main pediatric journals?
The journal of pediatrics, The american journal of diesases of children, pediatrics, where we have no member because you have to be amember of the academy and most of us are not. for a numbe number of reasons we are not members of the academy mostly political reasons. Some of the more specialized journals Journal of Infectuous diseases, journal of antimicrobial threapy, We write there are at lesst two or three members of the department in every textbook in pediatrics in the english language and some foreign countries too. So despite the youth of our faculty, I'm the second oldest person in the department and I'm fifty years old, they are, their influence extends farther than just in Dallas.

?Someone gave me some statistics on the number of Texas pediatricians who were trained here?
Well we're training close to half thepediatricians being trained in Texas. Now we consider ourselves a national program, we make no effort and no pretense that we're training people for Texas. I think we're out of that stage. People come here from all over, some of them stay, some of them leave. I think our function is more than just to say well, we're going to trainpeople for North Texas, that's but you know it's .
? It's still hard to visualize how to put all this in the film?
I can't tell you.
?Where is it all located, where does pediatrics take place?
Well it's located in Childrens' and at Parkland, and of course over here (medical school) Some of our activities go on completely at Childrems , those like cardiology.
?I've talked to Dr. Moore of the C&Y program in West Dallas?
The C&Y is the direct outgrowth of our involvement in the community. I personally feel very strongly that the Pediatric department that does not have a community involvement, and I don't mean running the clinic for the hospital, that's to me not a community involvement, I know I differ from Don Selden about that markedly, I think it's wrong to sit in a medical center and consider that your contribution to the community. It is a major contribution, and , but, for Pediatrics which must be involved at many different levels, that is not adequate. Also it doesn't permit the residents to have and adequate training program either. or the medical students for that matter. You may know the C&Y project the medical students say is the bestclinical experience that they have. And why because it's realistic. A hospital setup is never realistic.
?Some I talked to stressed the continuity of care?
Yes, well that's the basis of health care is continuity. Because out patients are continuously changing, they're continuously growing and adults just get older. I'm sure they grow too, but the emphasis on continuity of care whichmeans you can take care of the mother, well as when they are sick. The old Chinese concept is really a very good one, you pay a doctor only as long as you are well. As soon as you get sick you no longer pay him. I think that would be very good.
But you know I realize it's difficult to give athumbnail sketch of all the things we do. Because we're all over town, but that's what I think we ought to be doing. That's what we ought to be doing.
? I've talked to people who are committed to that sort of thing and others who seem more cautious.?
Well, but remember for the tradition of internal medicine say, and the tradition of surgery is not the tradition of pediatrics. What would be wrong is if I told the internists that they must have the same tradition that we have. We grew up differently, we were trained differently, we have a different philosophy from the very beginning. Pediatrics is not internal medicine applied to children. And internal medicine is not pediatrics applied to adults. These are different concepts of medicine And I think this is where the problem comes in. Alot of people donot understand that. That the reason we do these things is not that we are do-gooders or this sort of thing, the reason we do them is that this is basically part of the basic philosophy of Pediatrics.

And we feel since we had the responsibility of teaching students and teaching residents , we cannot teach them by talking about something. We can only teach them by demonstration. So it would be wrong for us to talk about the public health tradition of pediatrics, the community involvement of pediatrics, and sit is an ivory tower. You see those two things are not compatible. ?I haven't heard any one speak as strongly of the traditions of their field?
The tradition of pediatrics is total health care for the child. Some people would add the family to this also. Of course the family cannot exist,I mean the child cannot exist ina vacuum. The child consists, is a member of the family. And the child's well being , which includes his mental, emotional, physical health , you know involves the community, the school, the family, and himself. Thus pediatrics must involve itself with all these things. It cannotinvolve itself with illness alone, it must involve itself with well being., it must involve itself with things which are traditionally not considered illness.For example school problems. The children who can't read. Whose problem is,it? Well the treatment of it is an educational problem, that's not the physicians responsibility Thediagnosis, why can't the kid read?, that may not be and educational problem. The kid may not be able to read because he's stupid, or he may not be able to read because he's got a bad teacher he may not be able to read because he has a true CNS problem which is called rather loosely dislexia, so thediagnosis of it becomes a medical thing. Now you' can't divorce yourself from it saying that's not the function of a doctor. You see what I'm saying? Any thing that pertains to the child, to the child's general well-being becomes a function of pediatrics. Now we've perhaps expanded it more thanmost people have, because we've been in a position through the administration here and through the heavy support we have enjoyed. from them for these particular concepts. we've been able to expand this more You know we say well the children of Vietnam are our responsiblity too. Well you can say they're really not, they're somebody elses, that's true, they are somebody elses On the other hand we have an ability to deliver certain things and we have an interest in it. And if everybody else washes their hands of it, nothing ever gets done. So it's a humanistic philosophy, let's put it that way. Now, you know it's sort of funny that I;m talking that way cause I made my reputation in laboratory research. But this is not uncommon in pediatrics. I don't know if you heard Carlton _____ the Nobel Prize winner this year who dielvered our Azle lecture. It was probably the finest lecture ever given in this medical shcool at least the finest I've heard in twelve years. This was a brilliant esposition of , this man who got his Nobel Prize for really very basic virology, he's a trained pediatrician, has his pedictric boards and all that sort of business, he has never forgotten that he's a pediatrician. He made rounds with me for two days and you know it's pretty unusual for a Nobel Prize winner He didn't try to snow the audience like a lot of them do , like with a lot of superscientific stuff, he talked about in a one and a half hour lecture he talked about molecular biology, virology, immunology, neuropathology, neurophysiology, epidemeology linguistics, social anthropology, child development anda few other things

And to me this was an ideal performance, which I don't think the audience recognized. Ideally that's what a pediatrician ought to be. Because he talked about people. In addition to talking about the molecules. And that's, you know in many ways he a uniqee human being, it was tremendously impressive. And I think a lot of people missed the message. Well he wasn't trying to give a message. You know it's very interesting. It's very interesting and the other Nobel Prize winner we had from pediatrics, was a professor of pediatrics for many years. You know he taught general pediatrics. Now he's a dean, but he's still involved in things which are removed to some degree from what he got his Nobel Prize for.

?Tell me a little about your laboratory research?

Well, my subspecialty, if you want to call it that, is infectuous diseases. And I worked on a variety of things in infectuous disease, I became very interested in some of the problems of infants. Because we, this was a sort of never-never land since people were applying the same criteria, I suppose one might say to infants as they were to older children and adults. And of course infants are totally different. They get totally different diseases, they handle them differently, so my work was related to that. The responses of children, their immunologic responses. And then we became very much involved in some very practical considerations, staphylococcal epidemics and that sort of business., there are some epidemeologic and theoretical concepts. It's a....

I probably within the field of infectuous disease worked on about thirty different aspects of that. Which includes.. goes from immunology to virology with bacteriology inbetween Again I think it's an example of the fact that pediatrics tends to be fairly broad. even within a subspecialty. I don't do much any more I'm sort of, I guess more of a philosopher. with some of the people in the department. Right now we're, because of the fact that the department is so large. While I discuss research, I make suggestions and that sort of thing, and since the Vietman project which was terminated about a year ago, oh I spent four or five months a year I just haven't had the time. I presume sometime in the near future I will prpbably go back to it.

?Do you miss it or do you enjoy the sort of relationship you have to it now.?

I enjoy everything I do, If I missed it I'd go back to it. But right at this moment there are other goals I consider more important for me. and for the department. and so we're working on that.

?What are those? Have you covered them?

Yeah, pretty much. All these activities that I've described of course involve an enormous amount of time. Once you get away from the medical center you're no longer in the emotionally comfortable surroundings, you know, you have to deal with the school district, very nice people, very lovely people, but they think differently, and when you get involved with a neighboring university it involves a good deal of discussion (laughs) it takes a lot of time. And I'm on the board of two, three schools here in town. That takes time, but tha's again I think is a function that I have. And you know it's education, again it's a part of pediatrics.

?Do you interview the applicants for residencies here?

Yes. Which is a major chore.

?How do you screen them for these types of interests?

I don't screen by interview. I've never found this to be an effective technique. I'm very easily fooled. by psychopaths. And you know a good looking blond could get by me anytime. And I don't, we don't use that here. Two of us talk to the residents but we

only form a very, very general impression. You know, whether they can speak English in a coherent sort of a way, and express themselves, but in terms of selection we use our own methods which consists of a lot of telephone calls and writing friends, because Pediatrics is quite small, who know these people and asking them specific questions and seeing you know what sort of responses we get on that. basis. That involves a lot of time. Just this year we're going to have more that two hundred and fifty American born, American trained applicants for the fifteen or so positions that we've got. The problem is that there are not that many good pediatric residency programs around. There are a lot of pediatric residency programs but ....

Earlier you spoke of the Academy, none of you belong to it, why?

The American Academy of Pediatrics, it's the practitioners union so to speak. And I've never joined, I've never taken my boards in pediatrics, I 've got my own personal view of boards, I can't understand something that tests you when you come out of your residency and then certifies you for life. When we know that in five years everything will have changed completely, but we don't retest the person. to see whether he's changed. and to me a concept that rests on a single certifying examination is a farce, a pretense, it's it's a sham, it's putting something over on the consumer and I never took my boards for that reason. And I've argued that point with the boards now for twenty years. The boards are finally turning around . But they are turning around at pressure from the Feds., not because they want to.

?These are all the boards?

I can only speak for pediatrics. The other boards as far as I know don't recertify either. They're beginning to move into that, but it voluntary and that sort of thing.

?Does your program have some obligation to continuing education then?

Oh yeah, You know again, Obviously since we're the only show in town, we're the only pediatric service in North Texas, and since we have a massive educational establishment, so to speak, one of our responsibilities is the ongoing education of pediatricians, and family practitioneds, not just pediatricians. Anyone who takes care of children medically should be able to join into this and they do. Our grand rounds are very well attended, people come from Sherman and Waxahatchie and places like that. So we're obviously providing something plus the fact that we have shorter seminars, one and a ½ , two days on subjects for the practicing physician and we tailor make postgraduate activities for someone who wishes to say, have a, to increase their knowledge in a particular area. So we work out with them a one-two-three week curriculum utilizing the things which are normally going on in the department . We do that all the time.

?What marks the change from pediatric care to adult care? Why is there not so much emphasis on comprehensiveness in adult care?

I cant tell you that. See I've never lived in both worlds. I've only lived in one. I can understand.. there are personality differences (?between people who become pediatricians and others?) Yes. We become pediatricians because I think we subscribe to a certain point of view. And that of course would tend to relate to how you practice subsequently. It's difficult for children to switch from a pediatrician to an intern. I've got three children, one is twenty one and one is eighteen, they , their peidatrician really doesn't want to take care of them anymore, because he thinks they're. ... but they don't want to leave him. Not only because they've had a long term association, a sort of member of the family, which a good pediatrician ought to be. But because they both have beeb to internest and they say the internast is so damn cold. Now that may be because they really didn"t know that person and therefore the person retreated, but pediatricians usually don't sit behind a desk, for example when they're talking to someone, they're sitting in this sort of relationship. This is why I'm sitting here. It's a matter of the way you do it, you don't hide because you can't do that with a child. And you see there are certain things,

due to the fact that we deal more with children than with adults, we develop certain not only patterns of thought but patterns of behoviour. Because the kid is veryhonest , a lot of people don't realize how honest children are. Now if a kid don't like you , he'll tell you.

?Whose portraits are those on your wall?

The top one is John Enders, who "s a virologist, who won the Nobel Prize. Albert Sabin, who you know. Jabin Maxime(?)

And the chap underneath is Sam Levine who was my chief on my residency. I was in that department till he retired.

?Have you been associated with ...?

All three of them yes. Informally with the top two. We've been good friends. That's one of my heroes, let's put it that way. John Enders, he's a Phd, he 's not an MD. Albert Sabin is a pediatrician. , who went into virology. Sam Levine was a pediatrician. whose specialty was infants, actually prematures. , but was a superb general peidatrician.

?What about John Enders?

He, received the Nobel Prize for the cultivation of polio virus in tissue culture. Actually for developing much of the modern technology fo virology. Wonderful man. And of course Albert Sabin has done a lot more than just the polio vaccine. Most people that's the only thing they think of. He's one of the giants of infectuous disease.

?You said that pediatrics was a small field...?

Yeah, we know just about everybody in academic pediatrics, there're just not that many people in academic pediatrics. And the American Pediatric Society, which is the honor society of pediatrics, has maybe two hundred, two hundred and fifty members. I don't know how many, but there' are not that many members. So you know all the members. Cause they tend to be the most senior people in general.

?Help me make a list of department activities that I might observe?

Grand rounds, wednesday mornings at 8:15 in Childerns' Medical Center Auditorium There are several types of rounds. The specialty rounds, the general rounds. and there are my rounds. which tend to be a little bit of a circus. I make rounds every day on a different part of our service. So I have only the people on that particular service so it stays quite small. and the attending on that service , that is a full-time faculty member. makes rounds two-three days a week in adition.

Yours is the Chairman's rounds?

No we don't call it Chairmans rounds, because Chairman's rounds generally means everybody sits around and looks very formal. No I take each service in rotation. It takes me a week to get around. I make rounds at night too which upsets people. Not formally, I just wander around and talk to people. You know. House staff's gotten used to that but in the old days they , probably thought I was spying on them. Which in fact I am. But I wouldn't put it quite that bluntly.

?What else?

Well I think the University Affiliated Center, The learning disability program you ought to look at. I'll take you to Vietnam with me, if you like. (?Why not?) (We have to have this finished by March) Oh, no I won't be there, probably not by then.

?Not taking that lightly, is theresome documentation of that that we might use, pictures film, reports, etc.?

We didn't write on it because we did not wish to identify ourselves too strongly for obvious reasons. That was dangerous, we were in an area which was heavilly VC controlled and so we kept a very low profile. The VC knew we were there. This is VC (desk name plate) the VC gave that to me. That little piece of metal is from an American plane they shot down. So we had very through contacts, because otherwise we wouldn't have survived it.11