SPECIAL REPORT

The trouble with pediatricians

Robert R Tanz

Rarely, as far as I can discern, do the pediatric departments of the six medical schools in Chicago come together to address an issue in health care. There are certainly many issues available: pediatric AIDS, infant mortality, prematurity, access to care, health care finances, funding pediatric education, and probably others. But the Chicago area pediatric department chairmen have come together to deal with violence. In announcing their alliance against violence the chairmen have firmly established their desire to make the children of Chicago safe in their environments. Development of this alliance, its goals, and its eventual products, are relevant to injury prevention advocates, practitioners, and researchers everywhere.

Why violence? When I began to work in the area of injury prevention, the hot topics were motor vehicle and other unintentional injuries. We fought the child safety seat and seat belt battles. We reported on product injuries, falls from windows, tricycles, bicycles and child seats on bicycles, pedestrians, tap water burns, and much more. Relatively little attention was paid to intentional injury or violence except for child abuse. Since the mid-1980s violent injuries have garnered more attention, I think not because unintentional injuries have become less important—they remain a major cause of morbidity and mortality—but because we have come to recognize that violent injury is also a major cause of death and disability in childhood. We are surrounded by images of violence, both real and fictional. Violent injury is expensive in both monetary and social terms, and it is seemingly so preventable.

Why is this alliance coming together in Chicago? Violent injury is not unique to Chicago, or even to the United States. But Chicago is near the heartland geographically, socially, and politically. There are six medical schools in Chicago and there are even more hospitals with pediatric programs. If you want to start an alliance you need more than one; Chicago has a critical mass if ever there were one. Other American metropolitan areas have several medical schools with pediatric programs, but it is in Chicago that the academic pediatric community has committed itself to counter violence.

Chicago has historically been a nidus of medical education and medical innovation—blood banking, infant incubators, and heart surgery for blue babies were pioneered in Chicago. T Duckett Jones first described his

criteria for the diagnosis of acute rheumatic fever at a meeting at the Palmer House on 16 June 1944. Subsequently, the nation's, maybe even the world's, largest registry of rheumatic fever patients was established in Chicago.

There is a child welfare tradition in Chicago from Jane Addams and Hull House to the founding of the nation's first juvenile justice system in 1899—recognition that children need special consideration. In addition, many people at Chicago universities, medical schools, and hospitals have developed expertise in violence related fields. I see an alliance to stop violence against children as yet another example of the vitality of the medical community of Chicago.

But Chicago suffers from an epidemic of violence and violent injury, making this alliance vitally important. Here are a few examples of our problems and a small subset of the questions in need of answers.

Violent crime

Violent crime decreased in 1997 in the Chicago area (and throughout Illinois)—the sixth consecutive yearly decline.¹ Murder, criminal sexual assault, robbery, aggravated battery, and arson were all lower in 1997 than in 1996. Even youth homicide declined. Unfortunately, we don't know why violent crime is down. We can speculate, but we don't know if we are doing something right or this is just another downswing to be followed by an equally unexplainable upswing. Sadly, the most common cause of death for a 15–19 year old in Chicago is still a gunshot wound.

Questions: *Can we develop ways to better evaluate our prevention and treatment programs? Can we develop a city-wide violent injury surveillance system? Do we know what works or doesn't work to reduce violence? What can we do to keep the guns away from the kids?*

Domestic abuse

At least one member of the world renowned Chicago Bulls basketball team has been accused of domestic abuse. He has also been arrested for illegally carrying a handgun in his car even though two of his team mates lost their fathers to gunfire and both parents of a former member of the team were killed with a gun. The Chicago White Sox baseball team employs an admitted and convicted wife beater. One

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might wonder if this is the kind of hitter the White Sox need.

Questions: *What is the effect on our children when individuals prominent in our culture engage in antisocial or violent acts? What is the effect on children when they witness violence, especially in their own homes? Does experiencing corporal punishment predispose a child to violence when older? Can we develop curricula to effectively educate young physicians to recognize and appropriately treat and refer victims of domestic violence? How can we protect both women and children from abuse?*

Firearms and suicide

In April 1998, two teenaged boys in Mokena, Illinois committed suicide together. They used two handguns that belonged to one of their fathers. Illinois law does not require that firearms be stored safely.

Questions: *Can we improve the impact of our advocacy efforts, changing both public and legislative perceptions of firearms? Should firearms be designed with technology that prevents children or unauthorized people from using them? Do we understand teen suicide? Can we prevent it?*

Racism and peer violence

In 1997 three white youths brutally beat a black teenager who was traveling through their neighborhood.

Question: *What are the relationships between racism and poverty and youth violence?*

Gangs

The United States Supreme Court announced that it will rule on the constitutionality of a Chicago ordinance that allows police to disperse a group if they believe one of the group is a gang member. Failure to disperse places everyone in the group at risk for arrest. A total of 43 000 people were arrested for violating this ordinance in less than four years.

Questions: *What is the role of gangs in Chicago's epidemic of violent injury? Why has gang violence seemingly escalated in frequency and severity? Does frequent or repeated police activity diminish gang activity or alter gang membership? Will violence decrease if gang membership decreases? Can we deter inner city youth from joining gangs?*

Child abuse

A man stood trial in Chicago in April 1998 for the death of the 5 year old son of his girlfriend. The boy died of peritonitis in November 1996. An older sibling had previously been treated for a suspicious injury.

Questions: *How can we improve the child welfare system to protect children, to recognize that the child, more than the parents, needs the protection of society? How do we balance the rights of children with the rights of adult defendants? Can child abuse be prevented? To what degree is experiencing child abuse a factor in perpetuation of violent behavior?*

Distrust of authority

Gang members boarded a bus that was transporting children to an activity and terrorized the children. A police car drove by without stopping to help.

Questions: *How do we change the perception of many of these children (and many adults) that no one can protect them? How can we make our children safe in all of their environments?*

Prevention versus punishment

A teenage honor student died from a gunshot wound outside a community hospital emergency department. The hospital had a policy forbidding employees from leaving its emergency department to assist an injured or ill person. In response to this event the hospital was threatened with removal from the federal Medicare program, the source of much of its reimbursement for medical care. The hospital was scrutinized by the press and various health care agencies but there was no discussion of public policies and attitudes that fail to prevent firearm injuries.

Question: *How can we convince government agencies, policymakers, and legislators that prevention of injuries is more effective than treatment? Why do we avoid harsh responses to gun policies that seem to accept death and disability as the necessary consequence of private ownership of firearms?*

There are many more examples and many more questions. They come from schools in Jonesboro, Arkansas and Springfield, Oregon, as well as in Chicago. And from other countries where massacres have included children: Australia, Ireland, and Scotland, for example. This alliance of pediatric department chairmen must address the various syndromes of violence: child abuse, domestic violence, peer violence, assault and homicide, and suicide. A conceptual framework relevant to pediatrics may be useful for the alliance and for everyone interested in preventing violent injury, perhaps one based on development. We should consider the predisposing factors, the correlates, and the effects of violence from infancy through maturity, on the child and on the family. We need to address clinical care from prevention through physical and psychological rehabilitation. We need to find and fill the gaps in our clinical programs, our educational efforts, our research, our community relationships, and our advocacy. It seems to me the purpose of this new alliance is to use *collective* resources to effect measurable improvements in the lives of the children of Chicago. Can it succeed?

Fortunately, the work of this alliance need not start from scratch. There are dozens of programs currently in existence in Chicago addressing juvenile justice, child abuse, epidemiology, prevention, peer relations, clinical care, rehabilitation, costs, and more. Not all are housed in departments of pediatrics or even in medical schools.

Any alliance draws its strength from its individual members, but in a mature alliance the whole is greater than the sum of its parts. Most of us know little about what everyone else is

doing, so the formation of this alliance has initiated a learning process that has no end in sight. Putting aside our institutional differences and our sometimes selfish needs we can build upon expertise developed at all of the Chicago area medical schools, our departments of pediatrics, our hospitals, and a variety of non-medical programs. How to accomplish this goal is still not clear, but collaboration on research, program development and evaluation, fundraising, and advocacy seems to be a natural place for academically oriented medical leaders and institutions to start.

I believe there is one thing that sets pediatricians and pediatrics apart from the rest of medicine. Back in the early 1980s I went with several other pediatricians to the offices of the Illinois State Medical Society. The state medical society was then, and still is, the most influential political lobby in Illinois—and we had a meeting with their chief lobbyist. We wanted him to push for a law to require that young children be placed in child safety seats when riding in a car. His response was an eloquent statement of what sets pediatricians apart, and why six medical school departments of pedi-

rics in Chicago have formed an alliance to prevent violence. As he turned us down he said, “The trouble with you pediatricians is that you only care about the kids”.

While the dual tasks of working together and preventing violence may be daunting, if we maintain our focus on the welfare of children we can succeed. In Chicago, pediatricians have taken the lead. Elsewhere it may be general physicians or other child advocates who join forces. In time, perhaps the Chicago pediatric alliance will be the model by which universities, hospitals, and academic and health care institutions in other cities and countries collaborate to the benefit of everyone in their communities.

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The Chicago alliance of pediatric department chairmen, now called the Alliance Against Childhood Violence, came into being as a result of the commitment of Martin G Myers, MD, former chairman of the Department of Pediatrics, Northwestern University Medical School and Children's Memorial Hospital, to the shared vision of the medical school pediatric department chairmen.

¹ Major crimes drop for the 6th straight year, police report. *Chicago Tribune* 19 January 1998.

Cool cash

Congratulations to Leonie Forsyth, Kidsafe officer in the Hunter region of New South Wales. She has negotiated an injury prevention message that stretches boundaries. The local building society, the Newcastle Permanent, is running the message “Hot water burns like fire—limit your hot water to 50 degrees” on the screen of the automatic teller machines as you wait for them to dispense your money.

“Injury is the leading cause of death for persons aged 1–44 years. It accounted for 47% of all deaths in this age group in 1996. The impact of injury at young ages is reflected in the average of 32 years of potential life lost (YPLL) before 75 years due to each injury or poisoning death compared with nine YPLL for cancer and five YPLL for ischaemic heart disease” (*Australian Injury Prevention Bulletin*, Issue 19, August 1998). Available on NISU's web site, www.nisu.flinders.edu.au.

A 4 year old girl, who was left unattended with two siblings in a motor vehicle with its engine running, died after being trapped in the automatic window mechanism. The combination of poor design, that is the inability to reverse the closing mechanism in response to resistance, and parent behaviour in leaving the children in the vehicle with the engine running, contributed to this tragedy (*Pediatric Emergency Care* 1997;13:345–6).

Plastic hairbeads would seem to be innocuous enough, but three children are reported to have sustained skull fractures after falling while wearing plastic hair fasteners which embedded into their skulls. Flat fasteners might be a safer design option (*Pediatric Radiology* 1997;27:790–3).