A Pediatric Practice’s Journey to Provide Care to “Healthy Babies and Children”

Irwin Benuck, MD, PhD

Abstract

In 1923, Dr. Alfred Traisman literally hung out his shingle on the corner of Clark Street and Arthur Avenue in the East Rogers Park neighborhood of Chicago, IL, and thus began over 90 years of our practice—providing care to pediatric patients in the Chicagoland area. We have witnessed many changes since those early days but what has stayed consistent is the continuity of care, the focus on the patient, and our office as the medical home. The practice has 3 generations of Traisman pediatricians and some families can actually be traced back 5 generations. [Pediatr Ann. 2015;44(3):92-96.]

In 2013, after 40 years in our third location, we decided a move was necessary. We went through many boxes of stored equipment including an old microscope (Figure 1), glass reusable syringes and cartridges (Figure 2), and old medical instruments (Figure 3). We even found a pocket-book with street addresses and directions—the predecessor to the GPS (global positioning system)—which, at that time, was important for house calls (Figure 4). However, one old object caught my eye. It was an airway suctioning device (Figure 5). Why should a pediatrician in the 1920s need instruments for airway suctioning? What diseases did Dr. Alfred Traisman treat in the 1920s that would require suctioning? Investigating the diseases of that decade, it became apparent that diphtheria was a life-threatening communicable disease that required suctioning of the pseudomembrane of the posterior oral airway. There were no antibiotics and heroic attempts by infectious disease investigators were being made to provide some interventions, including an antitoxin and finally a toxoid, an inactivation of the diphtheria toxin that led to widespread immunization and practically the elimination of this deadly disease.

A LOOK BACK

The practice of pediatrics has evolved over the 90 years beginning with a specialty field to assist children through supportive care, later focusing on effective interventions, and now evidence-based prevention. Throughout the entire history, one aspect has always separated pediatrics from other medical fields and that is the strong advocacy to support our patients.

Hanging on one of the walls of the practice was a photo of Dr. Isaac Abt (Figure 6), who was a friend and colleague of Dr. Alfred Traisman. He was professor and department chair of pediatrics over a 30-year span at Northwestern University Medical School and Children’s Memorial Hospital. Seven years after our practice was founded, he became the first president of the newly formed American Academy of Pediatrics (AAP). What began with 35 members now has a membership base greater than 60,000.1 Dr. Abt and those founding members of the AAP knew that advocacy and leadership were essential for pediatric care. In his inaugural address, Dr. Abt states:

It is our desire to build an association so that every qualified pediatrician could seek membership. It will be necessary for the Academy to interest itself in undergraduate and postgraduate instruction and to exert a regulatory influence over hospitals. As an organization we should assist and lead in public health measures, in social reform, and in hospital and educational administration as they affect the welfare of children.1

Dr. Alfred Traisman not only practiced solo medicine but attended a new clinic he helped create at Children’s Memorial Hospital in allergy

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and joined the faculty of Northwestern University Medical School. In 1952 his son, Dr. Howard S. Traisman, completed his military obligation and residency training and joined his father in practice. The younger Traisman was armed with many new interventions that his father lacked when he began to practice. Newer antibiotics were produced to treat bacterial infections. The polio vaccine was developed and now countless children were being vaccinated effectively. The diphtheria toxoid was combined with pertussis and tetanus vaccines to give protection against these diseases. Children with cancer were being treated with anticancer therapies with greater success. It truly was the beginning of the “golden age” of medicine. Other specialties within pediatrics were making great progress including the surgical correction of babies born with congenital cyanotic heart disease.

Another photograph hanging on our walls was that of Dr. Willis J. Potts (Figure 7), who developed a procedure in the mid-1940s to provide palliation to babies born with tetralogy of Fallot by anastomosing the aorta to the pulmonary artery. Dr. Howard Traisman made a significant contribution in the field of juvenile diabetes. In addition to the busy general practice, he also ran the diabetes program at the hospital and wrote prolifically.
on the subject including the definitive text book on juvenile diabetes of its time. Like his father, he was active on the faculty of the medical school and had the reputation as a wonderful “no nonsense” medical educator and diagnostician.

LEGACY AND INTENTION

I joined the practice in 1982 and the third generation of Traismans, Dr. Edward S. Traisman, joined two years later. Dr. Howard Traisman was truly a mentor not only to me but also to all the other pediatric associates in the practice, as well as to his colleagues in the community, medical school faculty, students, and other mentees. On the first day in practice, I sat down with Howard and he asked me my plans. I replied that my intentions were to see patients. He nodded in agreement and told me that yes I was going to see lots of patients but that I needed to develop an interest. He did something quite remarkable that we encourage all our newer colleagues in the practice—offering “protected time” to develop a focus in pediatrics. Of course I enjoyed teaching, medical education, and advocacy but I also found myself gravitating to an undiscovered field and that was in preventive cardiology. Coronary artery disease begins in childhood but usually is not symptomatic until adulthood. What if we can effectively identify children at risk and develop strategies to reduce cardiovascular disease as they get older? Dr. Edward S. Traisman became interested in children with complex medical problems and has a joint appointment with rehabilitative medicine at the medical school. As newer pediatricians joined the practice, each was encouraged to develop a special interest. In future “Healthy Baby/Healthy Child” columns, you will read their articles.

The 1980s were a mixed time for those of us practicing in the trenches of pediatrics. A parent calling about a child with a fever in the middle of the night could be anything from a simple virus to bacterial meningitis. It was not unusual for a practice like ours to treat a half dozen of our patients yearly for Haemophilus influenzae B and Streptococcus pneumoniae meningitis. However, it was also a time when newer vaccines were being developed to help eliminate those diseases.

In addition, effective screening measures in the newborn nursery were being employed and expanded to identify children with treatable metabolic diseases. Neonatology was rapidly changing. Babies born weighing less than 1,000 g had a high incidence of morbidity and mortality when compared to today’s achievements. Antibiotic production was proliferating, which had diverse effects. In one instance, we were now able to treat more effectively children with bacterial infections, but on the other hand children in the community were receiving antibiotics for illnesses that were not indicated, resulting in the emergence of antibiotic-resistant strains. The focus during this era was primarily on intervention with the prevention of vaccine-related diseases.

The past 20 years has seen an additional shift of emphasis. Pediatrics has become more focused in preventive health care. Furthermore, advocacy for the children we care for was also becoming a priority to not only improve their health but also access to health care. However, as vaccine preventable diseases were fading, different diseases, not seen previously in the pediatric population, were emerging. The epidemic of obesity witnessed in the past decade is unprecedented, resulting in juvenile and adolescent hypertension, type 2 diabetes, fatty liver, and early risk for coronary artery disease. In addition, more children are being diagnosed with autism spectrum disorder. Attention-deficit disorder has become common. Various mental health issues, especially related to anxiety and depression, are frequently being diagnosed especially in our adolescent population.

TODAY’S PRACTICE

The pediatrician today spends a great deal of time screening for various medical problems. We have also become medical educators to improve health literacy for our patients and families. There is so much product competition that interferes with our patient’s health and well-being. Exaggeration and misinformation of the product’s usefulness has become more focused in preventive health care. Furthermore, advocacy has become more focused in preventive health care.

Drs. Howard Traisman and Edward Traisman were truly role models for those of us practicing in the trenches. They encouraged us all to develop a focus in pediatrics. Howard was active on the faculty of the medical school and had the reputation as a wonderful “no nonsense” medical educator and diagnostician. Edward became interested in children with complex medical problems and has a joint appointment with rehabilitative medicine at the medical school. As newer pediatricians joined the practice, each was encouraged to develop a special interest. In future “Healthy Baby/Healthy Child” columns, you will read their articles.

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the same time. In fact, when a trainee is not present, patients and parents will query where they are. Our trainees have a positive impact here and are well received by our patients and families. Our pediatricians and office staff enjoy contributing to the education of the next generation of physicians. It is an easy way to stay current and our trainees research anything we ask.

**Innovations and Challenges**

The emergence of the electronic medical record (EMR) for practices like ours has become a mixed blessing. On the one hand, communication with others in the system has made reviewing our patient’s records easy and is eliminating duplication of efforts. Prescribing electronically through the EMR ensures the prescription and dosing is correct and is available to our patients at the time of pickup. By electronically keeping a list of past and present prescriptions, mistakes are reduced and refills are made effortlessly. Notes are finally readable as many of us in medicine today failed the Palmer Method of Penmanship in grammar school, However, the cost of integrating the EMR has been considerable. Slowdown is an ongoing concern and when the system “crashes” patients cannot be seen. The fact that there is no common platform to review patient’s medical records from providers using other systems defeats some of the purpose of the EMR. Yet, even a 90-plus year old practice is adapting and when it works it is miraculous!

Managing a practice has become not only more complex but has increased the costs to pediatric practices that are already challenged with tight margins. For the first 70 years in our practice, fees were much lower and payment occurred at the time of service. In 1983, a complete health care visit was $23 and with added immunizations increased the cost to perhaps $40. Health insurance generally only paid for hospitalizations and medical or surgical procedures. Today charges may be 10-fold plus the added expenses of costly, but effective immunizations. Insurance now covers some of these expenses but requires additional office staff and billing software. Reimbursement is generally a fraction of these charges. Many private practices are joining together to form independent physician organizations to negotiate with payers and forming purchasing associations to buy medical supplies and immunizations in bulk. Still other practices are following the initiative of adult practices and selling to hospitals or other health care groups. In the past few decades, independent practices have dropped dramatically. How this decline translates to continuity of care, patient satisfaction, and quality will be determined in the future.

One of the growing challenges confronting the pediatric profession today is the misinformation that is accessed by our patients and their families. It is disappointing that the number of unimmunized or incompletely immunized children has grown, with the reintroduction of diseases that were practically eradicated now emerging in our communities. Furthermore, the unimmunized child not only presents a hazard to himself but to others around him. The once trusted physician is often viewed with skepticism. The already overextended pediatrician must spend additional time to provide counseling with evidence-based research that clearly demonstrates the benefits of immunizations with not always the expected results. Generally, there is no compensation for this service.

The practice and quality of care in pediatrics has also been challenged by others who are now advertising pediatric care. We have seen a large increase in retail health clinics (RHC) that continue to expand in number and services. Initially, only providing treatment for minor illnesses, these “clinics” now administer immunizations and perform school and sports physical examinations at low cost threatening the pediatric medical home. Furthermore, the supervision of these “providers” is superficial and usually off-site with only a review of a sampling of medical records. It is not an infrequent event for...
our office to receive a medical report about one of our patients who visited one of these facilities, resulting in poor care and recommended or prescribed medication that was not warranted. One such example was a patient who was thought to have exudative tonsillitis and large cervical nodes by the RHC provider. When the rapid throat culture was negative, blood was drawn to determine if this might be mononucleosis, and antibiotics were prescribed. When I reviewed the medical record from the RHC, I chuckled because I remembered that this patient had a tonsillectomy 3 years earlier. A phone call to the medical director who resided in a different state was cordial and apologetic with the promise that they will do better!

THE FUTURE OF PEDIATRIC PRACTICES

As we move forward, I question whether the independent pediatric practice will meet the same fate as the privately owned pharmacy? Is shift work replacing continuity of care? Will our patients have autonomy in choosing their physician or will they be assigned to a health care entity? Will there be a medical home for all children? Will the EMR depersonalize our relationships with our patients? Just as pediatricians in the early years were faced with challenges, we are faced with new ones. However, we have always been problem solvers and by putting our patients first, we will continue to be successful in the future.

REFERENCES