

Editorial

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A Very General Overview of the Development Pediatric Emergency Medicine as a Specialty in the United States and Advocacy for Pediatric Healthcare; the Charge to Other Countries

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One of the first noted instances regarding awareness of pediatric specific illnesses in the United States came from the writings of Dr. Benjamin Rush during the late 1700's where he titled a section in his medical text "*Diseases Specific to Children*". Throughout the 1700's and 1800's and even early 1900's medicine was primarily a generalist profession where all ages were cared for by a personal family physician and there were virtually no subspecialties for adults or children. At that time in American history children were the great neglected segment of society in families, labor, and healthcare and were often treated more as property than valued life. There were a few pediatric advocates of note. Abraham Jacobi is considered the father of modern pediatrics and advocated for pediatrics being separated from the field of obstetrics. His actions were fundamental in the formation of the Section on Diseases of Children within the American Medical Association (AMA). In the 1930s there was a recognized need for separate pediatric specialty care advocacy organization and hence the development of the American Academy of Pediatrics (AAP) occurred. This was primarily born out of the lack of and need for federal funding to support pregnant women and children as well as the need for a foundational organization for the development of pediatrics as a specialty in the United States in the future. In the 1950's pediatric poisonings became commonplace due to chemicals available after the end of World War II. As a result, the first poison control center was formed in Chicago and a manual was published by the AAP on pediatric poisonings. Similarly, the first cardiac surgeries for congenital heart disease were occurring and the specialty of pediatric cardiology was arising. The rising nuclear threat in the 1950's and 1960's also raised concern for disaster planning meeting specific pediatric needs and led to further committees, interest groups and publications. In addition, as trauma specialties and general emergency medicine grew under the

auspices of the American College of Emergency Physicians (ACEP) and the American Heart Association (AHA) so did the need for sub-specialization for pediatric emergency medicine (PEM). In the early 1980s as an outgrowth of the ACEP and AAP, plans to cooperate and create the subspecialty of PEM began. The goal of the specialty was to train specialists, procure resources funding for research, and standardize training. The first subspecialty board for PEM was administered in 1992 and has continues to this date. Another outgrowth was federally funded agency called Emergency Medicine Services for Children (EMSC) whose goal was to find and fund resources, research, and training for PEM specialists, particularly prehospital providers. As late as 2001 the Institute of Medicine in their periodic report regarding United States healthcare noted that most emergency departments were still largely deficient regarding preparedness for pediatric emergencies. Since that time there has been intense emphasis on preparedness for pediatric emergencies and now the United States has innumerable academic and community hospitals with full pediatric preparedness. Similarly, with the modern explosion of medical information it is now virtually impossible for any physician to know all of one field. Most certainly no general emergency physician can possibly know everything regarding PEM thus obviating the need for PEM specialists to provide optimum care beyond the basics. Numerous studies in the United States have also demonstrated seriously ill or injured children care receive superior care with better outcomes when cared for in pediatric specific facilities. This does not imply that general emergency medicine and pediatric emergency medicine cannot co-exist and have economy of resources. It simply seems to be true that the best possible pediatric care is delivered by pediatric subspecialists with appropriate resources, funding, facilities and training.

As such it is now inconceivable that an appropriate healthcare system in the United States could exist without easily available pediatric specific resources such as PEM. Nonetheless, pediatrics continues to compete with adult specialties for resources as adults continue to have a conscious and unconscious bias toward them because of perceived greater adult patient productivity and contribution to society as a whole.

In conclusion, no matter what country, there will always be a need for committed individual and organizational advocates for the specific needs of children including the firm belief in pediatric subspecialties such as pediatric emergency medicine.

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