Approaches to Preventing Child Abuse

The Health Visitors Concept

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A better title for this lecture would be "A Vindication of the Rights of Children," after the classic essay, "A Vindication of the Rights of Woman," written in 1792 by Mary Wollstonecraft, which set forth the plight of women in those days.

Children in the Western world (though not yet in the southern hemisphere) have made striking progress in the past 200 years. Seen against a background of virtually being nonpersons, they are slowly emerging as citizens with rights of their own. In 1763, the poor-law governors (that is, the welfare department) of the parishes of St Andrew's and St George's in London were entrusted with 59 infants: of these, all but two had died two years later. But not only the poor died. Between 1767 and 1769 in London, in the absence of epidemic disease, there were 16,000 baptisms and 8,000 infant burials reported—half the children died. Because of this appalling mortality in the first years of life, George Armstrong opened his clinic for poor children in 1769, focusing on the period from birth to age 4. He quickly achieved success in lowering the mortality of his patients, though it was at great personal and financial sacrifice. He was what in this day would be called a "bleeding heart," but he did not just show constant pity for the needy young; he also possessed three other qualities: he was a hard worker, he was an activist, and he was a visionary. He worked very hard, making his rounds on his paying patients in Hampstead in the morning and then, generally, walking five miles to his clinic downtown. He saw over 4,000 patients each year, spending about 2½ hours in his clinic each day. He was greatly concerned with the importance of ensuring easy access to care. He was an activist in instituting the first infant clinic anywhere. Early on, when he sought support from patrons, each paid one guinea per child per year to sponsor a child and then two guineas for the second child per sponsored year. In time, the overworked clinic helpers tried to limit his patients to those with sponsorships in hand, excluding those without—in other words, those patients who didn't have their clinic card. Let me quote Armstrong: "This hindered their coming more than can well be imagined. The circumstance, by the by, may afford a useful hint: to be very cautious of any obstacle that is thrown in the way, if we mean to render charity generously useful." He was primarily concerned with "a good start," the time from birth to age 4 years. And he was a visionary: preventive medicine was his long suit—good hygiene, feeding, health care of the youngest.

A hundred years later, in 1874, Mary Ellen, a child living with stepparents in New York, was cruelly treated, and it required the Society for the Prevention of Cruelty to Animals (there was no Society for Prevention of Cruelty to Children) to intervene on her behalf as a member of the animal kingdom. She was removed to safer quarters. Soon came child labor laws and universal, free education. In the last 50 years increasing attention is being paid to the health of young children and we are now, in 1975, addressing the civil rights of children.

Prenatal, Perinatal, and Postnatal Observations

Throughout the Western world it has become almost routine for children to have periodic health assessments. As part of this assessment, we

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do a standard history and physical examination, the technique of which is pretty well accepted all over the world. I propose that these be supplemented by standardized observations in the prenatal, perinatal, and postnatal care of families. Table 1 lists ten warning areas in prenatal care indicative of need for extra services.

You will note that none of these observations, nor those made during and after delivery, has anything to do with social class, education, or financial status. They deal with attitudes and feelings.

If prenatal observations are not possible, then much of this information can be obtained, along with delivery room observations, on the first postpartum day.

During delivery, mother, doctor, and nurses are very busy. But they are busy with the perineal end of the mother, and birth is often a struggle between the obstetrician and the uterus from which he skillfully extracts the child. The mother's head is three miles upstream.

I and my colleagues encourage fathers to be present in the delivery room, and more than 90% come. We ask our nurses to look at the mother (and the father, if he is present) and answer just three questions: How does she look? What does she say? What does she do? The parents' reactions to their newly born child are carefully observed. Are the parents passive, showing no active interest in the baby, not holding it? Are they disappointed in its sex? Are their reactions hostile or their comments inappropriate? Is there eye contact?

Observation of reactions after the baby goes home is also important. Significant warning signals are listed in Table 2. Positive factors, which may partially offset these, are listed in Table 3.

My colleagues and I have tried to determine whether our child abuse and "failure to thrive" patients came from the group we thought to be in need of extra services. We studied 300 consecutive births and concluded that 20% of them seemed to be in need of extra services. We divided these families into two groups by random numbers: The control risk group received the best care that is routinely provided, including a single visit by a visiting nurse, regular well-baby appointments and, also, a telephone call to the physician caring for the family, in which we voiced our concern about the parent's attitude toward the baby. The second risk group received active intervention through the extra services shown in Table 4. Detailed results of this study will be reported separately, but we found no instance of child abuse by the 240 mothers about whom we had no concern, and that the modest intervention given to half of our risk families significantly reduced the incidence of many problems including abuse and "failure to thrive."

Similar efforts are in progress in California, New York, Colorado, North Carolina, the District of Columbia, and elsewhere, using mostly visiting nurses, although a number of these programs have begun to utilize lay health visitors. The intervention we propose can be carried out simply. It is available to each of us in our current pediatric settings. However, since a large percentage of children who need help are not brought to us for "checkups" and do not have meaningful contact with any type of health personnel on a regular and ongoing

Table 1.—Observations of Parents-to-be in Physician's Office or Prenatal Clinic

1. Are the parents overconcerned with the baby's sex?
2. Are they overconcerned with the baby's performance? Do they worry that he will not meet the standard?
3. Is there an attempt to deny that there is a pregnancy (mother not willing to gain weight, no plans whatsoever, refusal to talk about the situation)?
4. Is this child going to be one child too many? Could he be the "last straw"?
5. Is there great depression over this pregnancy?
6. Is the mother alone and frightened, especially by the physical changes caused by the pregnancy? Do careful explanations fail to dissipate these fears?
7. Is support lacking from husband and/or family?
8. Where is the family living? Do they have a listed telephone number? Are there relatives and friends nearby?
9. Did the mother and/or father formerly want an abortion but not go through with it or waited until it was too late?
10. Have the parents considered relinquishment of their child? Why did they change their minds?

Table 2.—Observations to be Made at Postpartum Checkups and Pediatric Checkups

1. Does the mother have fun with the baby?
2. Does the mother establish eye contact (direct in face position) with the baby?
3. How does the mother talk to her baby? Is everything she expresses a demand?
4. Are most of her verbalizations about the child negative?
5. Does she remain disappointed over the child's sex?
6. What is the child's name? Where did it come from? When did they name the child?
7. Are the mother's expectations for the child's development far beyond the child's capabilities?
8. Is the mother very bothered by the baby's crying? How does she feel about the crying?
9. Does the mother see the baby as too demanding during feedings? Is she repulsed by the messiness? Does she ignore the baby's demands to be fed?
10. What is the mother's reaction to the task of changing diapers?
11. When the baby cries, does she or can she comfort him?
12. What was/is the husband's and/or family's reaction to the baby?
13. What kind of support is the mother receiving?
14. Are there sibling rivalry problems?
15. Is the husband jealous of the baby's drain on the mother's time and affection?
16. When the mother brings the child to the physician's office, does she get involved and take control over the baby's needs and what's going to happen (during the examination and while in the waiting room) or does she relinquish control to the physician or nurse (undressing the child, holding him, allowing him to express his fears, etc)?
17. Can attention be focused on the child in the mother's presence? Can the mother see something positive for her in that?
18. Does the mother make nonexistent complaints about the baby? Does she describe to you a child that you don't see there at all? Does she call with strange stories that the child has, for example, stopped breathing, turned color, or is doing something "on purpose" to aggravate the parent?
19. Does the mother make emergency calls for very small things, not major things?

Table 3.—Positive Family Circumstances

1. The parents see likeable attributes in the baby and perceive him as an individual.
2. The baby is healthy and not too disruptive to the parents' life-style.
3. Either parent can rescue the child or relieve one another in a crisis.
4. The parents' marriage is stable.
5. The parents have a good friend or relative to turn to, a sound "need-meeting" system.
6. The parents exhibit coping abilities, ie, the capacity to plan, and understand the need for adjustments because of the new baby.
7. The mother is intelligent and her health is good.
8. The parents had helpful role models when they grew up.
9. The parents can have fun together and with their personal interests and hobbies.
10. The parents practice birth control; the baby was planned or wanted.
11. The father has a steady job. The family has its own home, and living conditions are stable.
12. The father is supportive of the mother and involved in the care of the baby.

Table 4.—Special Well-Child Care for High-Risk Families

1. Promote maternal attachment to the newborn.
2. Phone the mother during the first two days at home.
3. Provide more frequent office visits.
4. Give more attention to the mother.
5. Emphasize nutrition.
6. Counsel discipline only for accident prevention.
7. Emphasize accident prevention.
8. Use compliments rather than criticism.
9. Accept phone calls at home.
10. Arrange for regular home visits by a public health nurse or a lay health visitor.

basis, it is clear that something else is needed.

The Health Visitors System

I propose that we in the United States develop a system of lay health visitors, although nurses can be used when available, and that these health visitors work with traditional health professionals in assuring that the basic health needs of every child are met, especially during the first four years of life.

This program for utilization of health visitors should be a national one, but any state, or any one of our 3,362 counties, could start right now. Any county could—but no county yet has. In most places the health visitor will not be a nurse. Instead, the ideal candidate will be a successful mother who is able and interested in sharing her experience and goodwill with less experienced young families. She could well be chosen by her neighbors as one of their trusted own. The health visitor will form a bridge between these families and the health care system.

It is true that virtually all European child health visitors are trained nurses and that they do very much good, but it must also be said, in all candor, that their orientation is largely toward mother-crafting skills. They tend to shy away from matters of feelings, and they are relatively passive in dealing with the families who don't want their services. Recently, one experienced European health visitor told me, "If they won't let me in, I don't do a thing. It's their kid, after all, and I have no right to interfere." She said that this was the general feeling of the nurses in her local district. This attitude is also often found in Scandinavian countries where I visited: all have good health visitor systems; nobody wants to violate the rights of parents.

So the system itself is not enough. One has to have meaningful access. Lay health visitors can be trained in a period of a few days, because they will be learning just a few facts to be grafted on the important foundation that they already have, namely, their success as mothers and their intimate knowledge of the community that they serve.

Our first concern has to do with the parent-child relationship. We know that difficulties are often encountered when there is a prolonged separation such as in prematurity or early illness in infancy, when there are obstetrical complications such as cesarean section or maternal illness—all these interfere with bonding in some families. I was taught that some mothers couldn't love their newborn babies because they suffered from postpartum depression. I now know that as many postpartum depressions are caused by the mother's finding that she doesn't love her baby. The health visitors will also be involved in helping to fulfill the health needs of siblings, fathers, grandparents, and others.

Ideally, the health visitor should get to know the family during the pregnancy period. She should have knowledge of what happened at delivery and during the first few postpartum days so that she may be more able to assist effectively when she makes postnatal visits. The physician may want to notify the health visitor very early in the pregnancy so that she can be of support to the mother-to-be. She can provide advice on how to prepare for the child's arrival, types of supplies that will be needed, and she may even provide some supplies. Many of our mothers have greatly benefited by gifts of disposable diapers and infant formula so they could have one hour of rest each day. To be more specific, we should subsidize young mothers. We are the only Western nation that does not do so.

If the health visitor's first contact with mother and father is in the hospital, she can gain critical information at that time. On the first or second day after the arrival of the family at home, she will visit, leave her telephone number, and encourage calls. This will be the essential lifeline between the family and herself. It is nonthreatening and therefore useful.

If the need is there, visits will be frequent. Doctors will have an invaluable resource in the health visitor when they are troubled about the progress of a young infant, and they will be able to gain great insight into the possibility of a postpartum depression, serious marital problems, financial crises, or existing attachment difficulties. Such problems are more likely to come to the attention of the trusted lay health visitor as she visits in the home than in the brief, well-child visit in a busy office or clinic.

I propose that health visitors be utilized regularly, not only in the first months of life, but at least twice

yearly in the second year of life and until the child reaches school age. At that time many of the health visitor's duties will be taken over by the teacher, the school nurse, or the school nurse practitioner.

On the basis of our experience to date, my co-workers and I think that one health visitor can care for 50 to 60 children, provided she works about four or five hours a day. Since there are millions of mature women whose children are in school and who are otherwise not gainfully employed, we already have a large number of excellent candidates for a very worthwhile career in which they would make a maximum contribution by helping others. These women have developed important skills of mothering, and I would rather that they share these skills than take jobs in a bakery. On the basis of the current birth rate of 3.2 million per year, we would gradually plan to phase in, over five years, 60,000 health visitors—a goal that could be easily attained.

What would such a program cost? It would cost less than 1% of our defense budget or less than 6% of the requested increase in military spending for next year. But, since most of us don't like to hear what we spend on defense, let me say instead that it would cost one third of the money already set aside for stand-by authority for the bureaucracy needed for gas rationing, if that unhappy event should come to pass.

Role of the Health Visitor

What will the health visitor do and where will she function? She will go out to the home where she will weigh the child and graph its progress on a weight chart, but most importantly she will look at the child, at the mother, at the setting in which the family lives, and determine how things are going, what problems exist, and how the family is coping with these problems. It has been found that health visitors are fully capable of determining which children are at risk, whether they are thriving adequately or not doing well, whether the child is unloved or deprived, whether the mother's inexperience or the father's lack of support are interfering with the care of the child. Is the child seeing a health professional on schedule? Have recommendations been carried out? Does the family understand what services are available and can they be induced to obtain them?

The health visitor will help to educate the family on the need for basic immunization, good nutrition for the whole family, and periodic examinations by the physician. The health visitor can also see the child when it is brought to her office, which may be in a local grammar school, a fire station, a health department office, a neighborhood shopping center, a high-rise apartment house, or a housing development—anyplace.

Of great importance is the fact that the health visitor can, between visits, be available by telephone for parents who are in need of advice and assistance. If the family moves, she can be the one who assists in a transfer to a health facility in another city as well as arranging for a health visitor from the new neighborhood.

Children's Rights to Protection and Health Care

It should be emphasized that the use of health visitors should be a universal phenomenon. This is not a kind of detection service to identify child abuse. It is not a service for the poor or the minorities but rather an expected, tax-supported right of every family, along with fire protection, police protection, and clean water—societal services that we all deserve to have and from which no one can be easily excluded.

The concept of the health visitor as a compulsory, universal service for the child is similar to the concept of compulsory, universal schooling. In preparation for this talk, I've been reading about how public education came about, a hundred years ago. All the hue and cry that we hear about this concept of free, universal, adequate health care for children were precisely the ones raised against the concept of free, universal public education a hundred years ago. But that debate is over; today, free, effective basic education is a right. This came about because society decided that each young person must be able to take his place in the labor force as an independent, self-supporting citizen and, in order to do so, he had to read and write.

By the same token we must now insist that each child is entitled to effective comprehensive health care, and that when parents are not motivated to seek it, society, on behalf of the child, must compel it. It seems incomprehensible that we have compulsory education, with truancy laws to enforce attendance and, I might add, imprisonment of parents who deny their child an education, and yet we do not establish similar safeguards for the child's very survival between birth and age 6.

A free society does not want to interfere with the rights of parents to be let alone and to raise their children in any way that they desire. But, far too often, children are considered the property or chattel of their parents, many of whom think that they are entitled to dispose of them at will. Unfortunately, such a system ignores the rights of children and results in tragic failures that will adversely affect the children's lives or even result in their deaths.

When an airplane takes off, the pilot is required to go through a unvaried series of safety checks. He has no choice—they must be carried out. Often there are double checks of those things that are considered especially important. If the successful operation of an airplane requires such routine supervision, it is all the more important that the takeoff and subsequent passage of a young family be similarly supervised to assure a safe arrival.

Under our traditional system of pediatric care, which depends on parent motivation, we often find that we are spending a good deal of our time and effort in giving excellent service to many families who don't really need much of it. We do so because they come to us for such care, they are delighted to keep their appointments, they are a joy for us to have in our offices, and they make our days pleasant and fulfilling ones. Such motivated families provide a sunny interval in our work and are a great boon to our mental health: in fact we

couldn't practice without it, and they do deserve excellent care. But it is the very isolated families—those who are unmotivated, who break appointments, who are unappreciative and unresponsive—to whom we must reach out protectively. When we see such a family, instead of saying: "Well, we tried . . ." and giving up, we must say, "This behavior is so unusual and worrisome that we must intervene actively." We must do this first by persuasion and education and trying to be as helpful as we can, but if that fails, we must initiate active intervention through child protection services. We cannot sit helplessly by and mistakenly believe that there is nothing we can do. In a very well-organized infant care service, such as is provided by Sweden, where over 95% of all newborns are followed up in child health centers for periodic care in the first year, only 2.5% of the battered babies were reported from these centers. The assumption is that either routine well-baby care, as we know it, misses a lot or the 5% who elect not to be in the system account for most of the problems.

Curiously, professionals are far behind the citizenry in their desire to provide effective protection to the threatened child. Will the health visitor be seen as someone who can be truly useful and accepted like a member of the old, lamented, extended family, particularly to those who are frightened and alone, or will they be looked on as another bureaucratic layer of busybodies who come between those who need help and those who can provide it? I believe that, to a large extent, this will depend on whether the program is started for all people, rich or poor, black or white, brown or red, or whether it is limited, once again, to the disadvantaged or the minorities. To my mind, only a universal program will develop quality and be successful. I think private practitioners will welcome the health visitor as a universal outreach program of their practice that will become operative when patients miss appointments and when follow-up visits in the home seem desirable and more social information is needed. Let me stress that this is not a program to bring every child to a clinic. It is a program to facilitate and make sure there is *access to comprehensive health care for each child.*

Everybody agrees that every child should be under the care of somebody in the health field, particularly in the first years of life, and I think the health visitor plan is the only way to bring this about.

If it should turn out that local or state health departments are not very interested or are unwilling to undertake the health visitor program, there may be other approaches for its implementation. The state of Michigan, for example, has placed the charge on the Department of Education to assure that everyone is "educable." In theory this gives the Department the right to provide screening procedures and comprehensive health care to make every child school-ready. But if neither the Department of Health nor the Department of Education in a given state can be brought to be involved in this program we might then fall back on a system that already exists in many places.

We can utilize our hospitals as a base to establish a system of aftercare. Admittedly, it is aftercare that lasts five years. Once we decide that a skilled delivery is only the beginning and that we then must provide follow-up, then, I think, it's very easy to see that the hospital could extend its postnatal care into the health visitor concept. Some do so now for premature infants and for certain chronic diseases.

It is economically quite feasible to insist that the young child have access to health care in the broad sense. France actually pays families to seek regular and compulsory child care; such a subsidy is thought to be a very good investment in the ultimate health of its citizens. Similarly, a program to prepare all children for regular school in Amsterdam and in other Dutch cities provides excellent, comprehensive day care for a great number of children who are mentally disturbed or emotionally deprived. In many countries, government leaders believe that it is better to invest money in the first five years of a child's life than to have to develop special programs and institutions for the provision of special education for those whose problems were not recognized early in life. Although the United States spends a lot of money to detect preventable disease, to a considerable degree these funds are misdirected. For example, it is hard to believe that there is currently in Congress a bill that proposes that all our newborns be screened for adenine deaminase deficiency disease, which occurs in approximately one in 200,000 births. This would, of course, be an important screening test for the 15 children in whom this condition is detected each year, but even among those 15 children, it would only matter for those who are also lucky enough to have an identical tissue-type twin as a transplant donor—an unlikely event.

The Cost of Child Abuse

We need to bring some order to our priorities. It would seem to be more important that we give sufficient emphasis to the assessment of the child who might be neglected or abused, since suspected child abuse and neglect is now being reported approximately 300,000 times each year in our country. About 60,000 children end up with significant injuries; some 2,000 of them die and 6,000 have permanent brain damage. The cost of institutional care for a severely brain damaged child in our country is $700,000 for a lifetime. Many other children are scarred by sexual abuse, incest, and rape. Those who do recover are likely to have significant emotional difficulties and most manifest this in the form of serious learning problems in school. Although in most fatal cases of child abuse the family's problems have been recognized before the child's death, many others have never been active participants in any segment of the health care system.

The late effects of child abuse may manifest themselves in ways that are not generally recognized. My associates, Brandt Steele, MD, and Joan Hopkins, RN, studied delinquent children on the first occasion they were seen in a detention center in a mixed urban-rural county near Denver. The population of youngsters was approximately 85% Caucasian, 14% Chicano,

and 1% black. Of 100 well-documented cases, which involved interviews with not only the delinquent young but also their parents, all the hospitals, physicians, and schools, it was found that 84 of those youngsters had been abused before the age of 6 years. Ninety-two had been bruised, sustained lacerations or fractures, or were involved in incest in the preceding year or so prior to being identified by the authorities. Only one of this group of 100 delinquents came from a family on welfare, and only three had an alcoholic parent. These were not children from broken homes or the ghettos, but the type all of us are likely to see.

Our country literally wastes hundreds of thousands of our precious children. Even though we confess that they are our future and therefore our most valuable national asset, we don't act as if they were.

Recently, considerable emphasis has been placed on the provision of "early periodic screening, diagnosis, and treatment" (EPSDT), but for only those Medicaid clients who are motivated to present their children for screening. It is another helpful attempt to provide health care for many children. One would expect that this would include extensive attention to the emotional growth and development of the child. But that is not to be. Most of our screening tests ignore the significant problems of parent-child interaction. To a considerable degree the emphasis is on those conditions and diseases that had had the greatest attention from various pressure groups or lend themselves to a quick checklist. It has been argued that it is far easier to have a checklist and a screening test when you are dealing with easily quantitated observations and that in the field of maternal attachment and the child's emotional health such observations cannot be readily made. Nonsense! Pediatricians have for years made such observations competently, and to exclude them from instruments sanctioned as national policy in the health care field of children does not make sense.

Specific diseases, even those that are quite uncommon, should be prevented whenever possible, but this should not be done at the expense of giving adequate attention to the whole child, his family, their total health status, including those emotional as well as physical factors that might affect the child's welfare. There is something I know about every battered child I've seen—he does not have phenylketonuria. There is more to a child's life than teeth, hearing, and vision.

In many ways it would be better to start this program at the grass roots level; perhaps our state governors should take the lead. The people in the community, laymen as well as health professionals, will have to work together in developing an understanding that health is a personal asset that every child deserves and should have even if it would require limited intrusion into family privacy by society. Just as any fireman will enter a burning house and try to put out the fire even though he doesn't receive a specific request to do so by the owners, so those of us who are qualified to assess and correct the problems that produce child abuse and "failure to thrive" should have the authority to intervene effectively for the good of the suffering child. Let us face the fact that there are large numbers of American children living with troubled families whose emotional house is on fire. Something must be done before their lives are forever distorted and destroyed.

When marriages fail, we have an institution called divorce, but between parent and child, divorce is not yet socially sanctioned. I suggest that voluntary relinquishment should be put forth as a desirable social act—to be encouraged for many of these families. When that fails, legal termination of parental rights should be attempted. However, such termination is a difficult thing to achieve in our country because the laws are so vague. In my state of Colorado, for example, parents must be proved to be untreatable, and remain so, before the state will uphold terminations by our juvenile court judges, a process that could take five to ten years. But each child is on a schedule of his own emotional development. He doesn't give us the luxury of waiting five years. He needs loving parents right now, and the same parents, not a series of ten foster homes. For 20 years, courts have lectured me on the rights of parents, but only two judges in my state have spoken effectively on the rights of children. Courts only interpret laws passed by legislators and the actions of legislators reflect us and our communities—they reflect the voters. Regrettably, children don't vote. Unless we change the conscience of our adult voting communities, child abuse will continue to be managed by partial, Band-Aid solutions. I think all of us have the duty to educate and to be a conscience for our communities. It is significant that not one of our nation's presidents nor any one of our many governors in our 200-year history is remembered as a champion of children.

Where the state is supreme, this particular problem is easily managed: in a dictatorship each child belongs to the state and you may not damage state property. The really first-rate attention paid to the health of all children in less free societies makes you wonder whether one of our cherished democratic freedoms is the right to maim our own children. When I brought this question to the attention of one of our judges, he said, "That may be the price we have to pay." Who pays the price? Nobody has asked the child.

"A man's home is his castle," but all too often the child is a prisoner in its dungeon. It is a dungeon of constant anger, dislike, aggression, or even hatred. We must guarantee that the child will be saved when there is danger to his health and life resulting from failure in parenting. In order to do this we must see the child, and the child must have access to us.

Current national health insurance proposals are largely directed toward sickness care and financial management of the high cost of hospitalization. None specifically provide for universal and outreach health care for our young children as a right. For every federal dollar spent on our older citizens, just 5 cents goes to the preschool-age child. Obviously, people of all ages need good health care, but the investment in our children's health care has been tightfisted, frag-

mented, devoid of planning, and therefore in many instances has never accomplished what it set out to do. In the coming battles for health insurance we must be absolutely certain to advance the cause of comprehensive child care; otherwise, most of the money will go to the hospitals. The state of California, to its credit, has mandated a health evaluation for all its 5- and 6-year-old children in order to receive a school health certificate before the child can enter first grade. But, obviously, this new change is far too late for many children.

In the past we have accepted inadequate and limited programs—EPSDT, Mother and Child, and Children and Youth, as well as many other categorical efforts—hoping that, like pieces of a jigsaw puzzle, there would evolve a complete picture when the last piece fell into place. We have settled for small steps in the belief that something is better than nothing and that a comprehensive system would eventually result. Instead we have a nonsystem, fragmented, oriented not toward comprehensive health care, but at the very best, gradually moving from episodic sickness care to screening only for organic disease. But that has never been the philosophy of pediatrics as we know it. It has especially not been the philosophy of this distinguished organization. Let us, therefore, now ask for what really makes sense by placing our priority on "the good start," as George Armstrong suggested, on the infant from conception to school age with the understanding that "the good start" has to involve attention to the rights of the child for tender care and love. No child can thrive without it.

Conclusion

1. In a free society the newborn child does not belong to the state nor to his parents, but to himself in care of his parents. When parenting is defective or blatantly harmful, prompt, effective intervention by society is essential on behalf of the suffering child and also his suffering parents.

2. Universal, egalitarian, and compulsory health supervision, in the broadest sense of the term, is the right of every child. Access to regular health supervision should not be left to the motivation of the parents but must be guaranteed by society.

3. Predicting and preventing of much child abuse is practical, if standard observations are made early.

4. As a bridge between the young family and health services, the utilization of visiting nurses or, more often in most places, indigenous health visitors who are successful, supportive, mature mothers acceptable to their communities, is to my mind, the most inexpensive, least threatening, and most efficient approach for giving the child the greatest possible chance to reach his potential.

It is truly grand that we can pay tribute here to a modest and innovative man, 200 years after his time. George Armstrong serves as a model for us. May we, like him, strive to be "bleeding hearts," hard workers, activists, and visionaries. We are, after all, the principal health advocates of all our children. Let us now resolve to fight for their total civil rights. Let us not, I beg of you, settle for anything less.

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