SELMA DEITCH

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Dr. Fitzhugh Mullan,
interviewer

Deitch: Selma Deitch, 11/15/24.

Mullan: I'm sitting with Dr. Deitch in the office of the Child Health Services of Manchester, New Hampshire. It is the seventeenth of July, a sunny afternoon. Dr. Deitch has been good enough to share her lunch with me, which makes it a generous repast, and a much better interview than most when I go hungry. We're in the conference room, I gather, of what's an impressive facility.

Deitch: This is our adolescent meeting room.

Mullan: Terrific.

Deitch: We all love this room better than any other room.

Mullan: I want to hear the story of Child Health Services, but let me get your story first. Tell me about yourself. Where were you born and where did you grow up?

Deitch: I was born in Manchester, New Hampshire, and I lived here until I was sixteen, when I went away to school.

Mullan: Was it something that was on your mind when you were a young person?

Deitch: I was going to be a veterinarian as an elementary grade student. I loved dogs. I was always bringing home people's dogs. So I was sort of into it, the caring business. Probably a late maturer emotionally, and I think I had a father who probably identified me as the child who he was going to promote. I think that's fairly characteristic of girls in those days. You didn't encourage them. Not visibly, but it could be felt as an unspoken investment, and made it easier for me to go to school. It was harder for women to get into undergraduate schools and professional schools in those days--gender ratios and ethnic ratios were a known entity.

Mullan: Was this in terms of institutions that were not going to accept you?

Deitch: Well, colleges where they were more likely to take girls, and certainly when we were trying to get into medical school, it was harder for girls.

Mullan: Did you work with your dad at all in his practice?

Deitch: That was my first job, cleaning his office. No, never worked in his office.

ıllan: What was it like growing up in Manchester in those days? t must have been through the Depression.

eitch: Right. It was during the Depression. But in our family didn't feel the Depression as much as the stories that we used o hear about patients and families, people that didn't have ıollars. We used to hear the stories about how a patient would ;ome in one door in his office, and they would say, "How much is :his, Doc?" He would say, "Two dollars." By the time they came ıround, he'd be out in the hall giving them back the two dollars.

ıullan: So as you approached college, what decision did you ıake?

Deitch: I went to college, probably unfortunately planning to be a physician. I started pre-med.

Mullan: Where'd you go?

Deitch: Tufts. But that was Jackson. That was a women's part of Tufts at that time. It wasn't long after I was out that I realized that being intimidated by the advisors, I took a pretty narrow educational program, sneaked in The Novel occasionally or Contemporary Religion or something of a more liberal arts type as a course, but I was told that I had to take the biology, the chemistry, the qualitative, the quantitative, the organic, the comparative anatomy, the epidemiology, all those courses that

Mullan: Of how many?

Deitch: In the class? I don't know. About a hundred.

Mullan: That was more than would have been typical in the past, do you think?

Deitch: Actually there were probably eight women when we started. Yes, certainly, it was more.

Mullan: Did you have any sense of breaking ground in being a woman in medicine when there had been relatively few?

Deitch: I never understood that at that time. Now I'm very gender-oriented, and as I think back on those times, I was sort of one of the boys. My friends were my classmates. I wasn't necessarily more friendly with the girls in the class. As a matter of fact, I wasn't.

Mullan: Were there palpable prejudices or attitudes, either anti-women or super-male in a sense that made the environmental generally or periodically inclement?

Deitch: The girl that I liked most in my class was a far more mature woman than I. She had been married, had two children, and he husband had died. She came back to medical school, had a little rumble seat Ford that she used to drive from Cambridge to

school. She had different values. She wasn't in the thing that I was in terms of doing the things that you're supposed to do as you're supposed to do them. Medical school was something she was doing, so she used to be late for class occasionally, or she would ask questions that were different from what the rest of us. And those of us that were there, I used to wish that she didn't, because that made her stand out. You know what I'm saying?

Mullan: Yes.

Deitch: Yet she became my very best friend as I matured. She's in England and I visit her. She knew far more what she was going to be doing with medicine. I was very young.

Mullan: You really were.

Deitch: One of my other friends who was even younger than I. As we consider our times now, we laugh about it. We probably went to medical school when we should have been in college. I enjoyed medical school. It was a good social and professional experience.

Mullan: You did choose Tufts. Was that because you had been there as an undergraduate, or because of your dad?

Deitch: You've got to know that Harvard wasn't even taking women then. The first class graduated from Harvard the year I

Deitch: Yes, he was. Trained at Children's Hospital in Boston.

Mullan: When you said many internships were not open to women at that time?

Deitch: I wanted a rotating internship, and couldn't go to City Hospital, because, first place, they had no place for the women to stay. We would have to stay at the Franklin Square House. It was like a YWCA for businesswomen or something, and it was well off the campus. It wasn't a good idea to do that. Mount Auburn was the other hospital that I wanted to go to, but they wouldn't take women in a rotating internship. So I went to Springfield.

Mullan: Were rotating internships at the time the usual and straight internships were exception, or had straight internships become more--

Deitch: I think rotating internships were the usual.

Mullan: So you went to Springfield and your first pediatric quiverings. What happened next?

Deitch: Well, the first thing that happened to me was my first assignment was with ENT and emergency room.

Mullan: This is at Springfield?

Deitch: Right. ENT I had to do the anaesthesia for the ENT who was taking out tonsils.

Mullan: This is as an intern.

Deitch: As an intern. With the patient on the stretcher--the little kid on the stretcher, and I'm dropping ether on the gauze, and I'm rolling the kid in, and then I put the kid in the chair and strap him in, and sit him up so the ENT can take out the tonsils. And put in a retainer of some sort so his mouth would stay open, and I'll never forget the young boy saying, "Take that thing out of my mouth." [Laughter]

Mullan: What year is this?

Deitch: 1950. Emergency room was an interesting experience. I was with a wonderful group of house officers, and that was a nice experience.

Mullan: Did most stay on at Springfield, or was it just the one year and then they went elsewhere?

Deitch: Some of them finished and stayed there to practice. I was going on.

Mullan: What did you do?

Deitch: I finished my year there and applied to a program in pediatrics. The first year I took a fellowship.

Mullan: This being Boston Floating Hospital.

Deitch: Right.

Mullan: Which is Tufts-affiliated?

Deitch: Yes. The first year I took a fellowship doing home medicine. When you said, "What did you remember in your life about medical school," the thing that I did, the home medicine parts, one of our assignments was to do home medicine as a student rather than just ambulatory care. We were assigned to a district. My district at that time was East Boston, and I loved it.

Mullan: This as a student?

Deitch: As a student, right.

Mullan: What meant home medicine, precisely?

Deitch: It meant that those patients who were followed in the clinics at the Boston Dispensary were being followed also in their home by the same cadre of health professionals that saw them in the outpatient clinic, or who were being followed and

then being discharged. So that I had a preceptor, and I had a bunch of records, and I made house calls.

Mullan: Without the preceptor?

Deitch: Without them, and we'd meet in the preceptor's car or something like that.

Mullan: This was a service of the city?

Deitch: Tufts.

Mullan: And it was limited pediatrics, or was it full service?

Deitch: No, general. I had to go in sometimes and do the B-12 injections.

Mullan: East Boston was what sort of neighborhood at that time?

Deitch: Italian.

Mullan: Fairly poor?

Deitch: I'm sure it had to be poor, but you wouldn't know it was poor. Homes were well kept, and people were home when you went to visit. I didn't get the feeling of poverty being the primary reason for being eligible for the service.

Deitch: Right. I also worked under supervision of a staff Boston Hospital pediatrician and saw patients in the outpatient department.

Mullan: But you were thinking pediatrics?

Deitch: That's right.

Mullan: And this was kind of a transition. This was not a typical way of starting a pediatric training.

Deitch: No. But just something that I liked the idea of. South Boston became an area that I really got to know.

Mullan: What was South Boston like?

Deitch: Irish.

Mullan: Similar in terms of income and--

Deitch: Well, there were several housing projects in South Boston. I also worked in the clinic, the outpatient clinic. So it was the same people that I would see in the clinic.

Mullan: This was outpatient clinic up at the Floating or--

Mullan: --streptomycin.

Deitch: Penicillin. Maybe sulfa and chloromethane and its complications. Dr. Domeshek who made the observation re chloro was a department chair at the N.E. Med Center.

Mullan: And the nursery side of things?

Deitch: See, we didn't have a nursery. Sick babies were referred, but Tufts didn't have an obstetrical service. We had sick infants, a whole floor of sick infants.

Mullan: As opposed to premature babies. You weren't dealing with premature babies?

Deitch: Yes, babies that needed to be hospitalized from a normal delivery or complicated delivery. Replacement transfusions were common. Trement of meningitis, severe lead, encephalopathy, etc.

Mullan: And oxygen, I guess, was a fairly new phenomenon available. This was the epoch of retrolental fibroplasia, I guess.

Deitch: We were before the recognition of the actual causation of retrolental fibroplasia.

Mullan: It wasn't recognized?

particularly Maine, to be diagnosed. But the female residents didn't have a place to stay the nights we were on, so we all shared one room on Farnsworth Five. Sometimes there were more of us than there were beds, but that's where the women had to stay. I read that in the paper, and a matter of fact, it prompted me to call one of the other women who shared that space and is now a prominent psychiatrist in Boston.

Mullan: One of the Farnsworth Five group.

Deitch: Right. I saw my first and most tragic case of a child who died of lead poisoning, my first week as a resident.

Mullan: Were there treatments for lead poisoning at that point?

Deitch: The child came in with acute encephalopathy, and was the only child of older parents. I remember that. The anaesthetist put four burr holes in his head to relieve the pressure. And he died. He'd been eating his crib paint, and his parents kept repainting it. Well, people didn't know all paint contained lead at that time. We knew all about pica. I'll never forget that. We did a lot of replacement transfusions.

Mullan: Replacement transfusions for--

Deitch: For RH incompatibility. Many children came in with meningitis.

Mullan: Successfully?

Deitch: I think so. I can't tell you follow-up, but successfully treated for the acute component.

Mullan: Penicillin?

Deitch: Penicillin and sulfur and chloromycitin.

Mullan: Were there particular illnesses or conditions that you remember in looking back in retrospect were period pieces?

Deitch: I guess the kinds of things that don't happen anymore, the acute upper epiglativiz. The children would come in with very severe asthma, poorly treated seizure disorders, acute rheumatic fever and carditis.

Mullan: Polio? Did you see a fair amount of polio?

Deitch: Polio was endemic, practically, during my time as an intern and resident. I think the polio vaccine came out in '54. And the last epidemic was just about that time.

Mullan: Did you have iron lungs or treatment?

Deitch: Yes, we treated some of the less involved patients in the acute state but they went over to the Mass General for the severe (unclear) respiratory paralyses. That was the center.

Mullan: You you'd gotten married along the way. Tell me a bit about that and how marriage and [unclear] and all fit together.

Deitch: Well, my husband was overseas for most of the time while I was a resident.

Mullan: You got married when?

Deitch: In '50. He went shortly after we were married.

Mullan: To Korea?

Deitch: Yes.

Mullan: How long was he there?

Deitch: For two years. My first child was born in the September 1953, after I finished my residency. He's now forty-two.

Mullan: What did your husband do?

Deitch: He was a surgical resident. That marriage didn't continue after 1960.

The other thing that was happening while I was at Tufts. Our director of pediatrics at that time was a wonderful generalist. His name was James Marvin Baty. We still chuckle about him, those of us who have had him and those people who had him after I did. He made wonderful rounds. He was a person who was terribly sensitive to preserving and making good clinical decisions. We'd make rounds with him. You saw a whole child. He was instrumental in starting at Tufts a psychiatric unit, as well as a wonderful playroom at the hospital, which was on the top floor.

Mullan: Was that a new idea, a playroom?

Deitch: Yes. So that all the children that were there that didn't have to be in their beds for one thing or another were brought up in something like grocery carts, or wagons, or something, and they all went up to the playroom. There was a person who was an early childhood educator specialist, who was one of the most wonderful people in the world, from whom I learned a whole bunch about children, who was in charge of the playroom. And parents could go up there and visit their kids. All the children who could be were there for the day, while whatever had to be done to them was done, and the diagnostic tests took place or they were recuperating. I learned a whole bunch about pediatrics, about environments, public health, and developmental pediatrics from that experience.

Mullan: From the playroom or the--

Deitch: Right.

Mullan: And you had a child.

Deitch: Yes, who used to go stay in that playroom while I was working in the dispensary. That was good, too.

Mullan: So your interest in behavioral medicine really stemmed from that, that there was another dimension that wasn't encompassed by the biomedical.

Deitch: Right. And all the different systems that I learned about when I was on the home medical service, which I continued to know more about when I was in the outpatient department, because the other thing that was unique about it is we had a nutrition service, which has since became the Francis Stern Clinic But there was right there in our outpatient department an ongoing nutrition program where they served food to the kids, and taught people how to budget and purchase, do all those nice things. So that was an integral part of the outpatient component.

Then I was able to get a psychiatrist to be a consultant to the clinic. Because when I was doing the clinic, I also had to teach the residents.

Mullan: As I understand it, the clinic work then sort of took over as your principal?

Deitch: Well, when the pediatrician came back from the service, the agreement was that his patients belonged to him. So I continued to do the outpatient department program. And I teamed up part-time with another physician out on Route 9, in Natick, where they opened a multi-specialty practice center, and they asked the two of us whether we would cover pediatrics. So I did that, too, for a while, but I continued to do the outpatient every morning.

Mullan: Was this a large ambulatory clinic with a lot of house officers and staff, or was it a small clinic?

Deitch: At Tufts?

Mullan: Yes.

Deitch: It was a general pediatric outpatient department at the dispensary, for the people from the neighborhood, meaning the area surrounding the hospital and we had access to all the specialty clinic as well. It was not where many of the inpatient cases were followed up as they were sent in from all the suburbs and New Hampshire and Maine. The clinic followed those from the low-income community.

Mullan: The area in this case being East or South Boston?

Deitch: Well, it was the South End and South Boston, and East Boston, and Charlestown.

Mullan: People from round about.

Deitch: Yes.

Mullan: These were the people who didn't have a private physician?

Deitch: Right. Yes. I think so. Yes. But that's where they came for their general care. Ones that didn't necessarily go to Boston City, which would have been the other place where people would have gone. And the residents rotated through. The physicians who used to work there were the physicians who had privileges at the Floating, who had to give their time, so to speak. So they would give a month or two; coming into the clinic to precept the residents and the medical students.

Mullan: Your job was to direct and coordinate all that. Is that right?

Deitch: Right.

Mullan: And see patients and teach?

Deitch: I didn't see too many patients. I would see some patients. The teaching was in terms of checking on what they saw, listen to their presentations, and then sit down and go over it, if it seemed appropriate, with the psychiatrist who used to sit there with us, too.

Mullan: So in today's parlance, it would have been an ambulatory care facility doing pediatric teaching.

Deitch: Right.

Mullan: Was it a good operation? How did you feel about it?

Deitch: I learned a lot. I learned a lot about how people practice. One thing that I never forgot is never assume that a person who's in training knows how, for instance, to look at an ear. I always had to look for myself. The other thing about the home medical, I had new experiences. I never knew about what social workers were. Obviously, this was all evolving. The other wonderful person I learned from who I won't forget. Her name was Liz Wheeler. She was a Mass General social worker prior to being at the Boston Floating/Boston Dispensary. She was assigned to the outpatient department. She was part of my team. I learned much about families from her. So that was all new to me, too.

Mullan: So how long were you involved with the dispensary? That was a number of years?

Deitch: I'd already remarried and moved up to Manchester, and I continued to commute to Boston for five more years.

Mullan: So that takes us--

Deitch: I finished at the Dispensary in 1965. I commuted for about five years.

Mullan: You stayed involved with the practice in Needham on and off for that period as well?

Deitch: Yes. I used to stop at the Boston Lying In Hospital and the Newton Wellesley Hospital on my way home and see my newborns. Remember that those hospitals all had residents, so if I sent patients in to the Floating Hospital that were sick, they were covered by the resident when I was out of there. So that as far as the sick population was concerned, it wasn't the running back and forth that you would do in a town like this where there was no residency staff and still is no residency staff.

Mullan: With an academic model.

Deitch: Yes, right. So that if you had a nice office practice, which I did have a nice office practice--

Deitch: Still! That's why I have to get home today. Marjorie's here from Minnesota.

Mullan: When did you get married and when did you move up here?

Deitch: 1960.

Mullan: What did you envision doing then? If we push the pause button in 1960, career-wise, how would you have characterized yourself? You were clearly a pediatrician. Were you a private pediatrician, an academic pediatrician, public health oriented, clinically oriented?

Deitch: I didn't know what public health was then. Obviously I was a public health-oriented pediatrician, but I didn't know that. I don't know if it was because I was provincial or what, but I didn't know that I was a public health pediatrician. I certainly enjoyed working with other disciplines, and I certainly was respectful of the more comprehensive needs of families and the home environment. I know that the people in the clinic appreciated that in me, but I didn't know it. I didn't know what that meant. But I was also a good doctor, I mean a good doctor by the standards that we set for doctors; that is, I had some smarts about making diagnoses and providing treatment.

Mullan: This is Dr. Deitch, tape one, side two.

Deitch: Towards the end of my time at the Boston Dispensary--well, when I first came up to Manchester, I thought I would investigate private practice, but I inherited a family. My husband had regular hours. That was nice. I expected I might go into general practice, but I couldn't pull off being the good mother and also doing general practice in this town. Every time the IV came out, I had to go down to the hospital, and every kid who walked into the ER I had to go see. I investigated it by covering for other physicians, and then made the decision that I wasn't going to be able to do that and all the other things that I saw as my responsibilities. Though I had an extended family in the community and all those nice supportive services that I wish everybody had. So I continued to commute to Boston. I continue to cover for pediatricians here.

Mullan: Then what happened?

Deitch: Guess what. Sidney Gellis didn't really like women physicians. And towards the end of, I guess, '64, '65, he became the chief of pediatrics.

Mullan: At Tufts.

Deitch: Right. And he didn't come to see me, but he sent somebody to say that he had someone coming with him for that job.

Deitch: No. Not then. There was one black family, I think, at that time I grew up in Manchester. Even then, when we had HeadStart it wasn't.

Mullan: Has that changed now? Is the mix different?

Deitch: Yes.

Mullan: What is it now? We're talking about the Medicaid population? The poor population?

Deitch: Oh, the poor population is still primarily a white population, but we have an increasing number of people who are black in the community and lately we have an increasing number of Hispanics.

Mullan: So 1965 or '66, you got yourself successfully moved up here. You've got a newly minted MPH from Harvard.

Deitch: Right.

Mullan: What happened?

Deitch: I became the Director of Maternal and Child Health for the State of New Hampshire. But while I was at Harvard was the time when there was the beginnings of something called Comprehensive Health Care that emanated from people in Minnesota,

and I became excited about that concept. That meant a program of projects. Do you know about those things?

Mullan: Tell me.

Deitch: It was a concept that talked about the development of programs that included children's health care that was comprehensive, that included a social component, as well as the nutritional components of general health care. There was a program for family planning, and prenatal, and all those delicious things that were going to be funded in support of populations who hadn't had access to care, and the beginnings of thinking about something called comprehensive health care that was adapted to the needs of the population. So that was terribly exciting.

I became the director of the Maternal and Child health. There was one well child clinic in the state of New Hampshire at that time, and that was one that was developed by a pediatrician who didn't want the poor people coming into his office, so he developed a clinic that met once in a while in a fire station, in an adjoining town, and what he told people was, "I'm not going to charge you for this, but save your money so when you come when you're sick, you'll be able to pay." That was the first well child clinic.

So part of what I was doing was establishing programs where parents could bring their children for [unclear] developmental

orientation, and helping parents know how to get attached to their kids.

Mullan: Was that an exciting time? This was, I guess, the latter years of the [Lyndon B.] Johnson Administration.

Deitch: That's the Johnson Administration. Great Society.

Mullan: Right, and federal money was coming in and allowing you to open--

Deitch: Yes. What I used to say; New Hampshire used to get the end of season sale money, because we weren't large, and we never had had anything started, so we didn't have anything to add it on to, and we had nothing to match with, so we got what was sort of left over from other States.

Mullan: Was it hard working in state government here where it is a state that has a long tradition of small state government and low tax?

Deitch: Yes. It was hard to get people to want to do these programs.

The other thing that I did when I was at the School of Public Health was, when I was covering for physicians here in town, I used to see people in the ER, and then when I was covering, if there was a kid who was sick in a daycare center,

I'd visit the daycare center. I'd never known anything about daycare. So I wrote my thesis on daycare in Manchester. So that got me going on daycare.

Mullan: You're remained director of Maternal and Child Health through 1974?

Deitch: Right.

Mullan: Did it grow?

Deitch: I got many programs going. We established family planning sites all over the state. We had well child clinics all over the state, and we had four Children and Youth (CNY) clinics. Couldn't get one going in this town, though.

Mullan: Was it resistance to what you were doing?

Deitch: Well, there was this business about you don't want to get any federal money because the federal money's going to go away, and then we're going to be stuck with the program, so let's not do anything the government pays for. At the same time Medicare was coming in. So like VNA, which in Manchester would have been the likely place to link up with a program like this, would not touch it. The nurse in charge was a very rigid lady, and it was one of the most well-endowed agencies so that they had their money for their things that they did, but they really

didn't want to get stuck with anything that was just for the poor, because what's going to happen when the government decides not to fund--so we never got one going in this town. I tried to through the local Health Department, too, but couldn't get anything going.

So I think we were quite effective in getting programs started around the state that evolved into other things as time went on. North Conway picked up their program and did delicious things with it. And the Exeter area did nice things with the program that was started. My theory always was that in the beginning you go where there's likely to be people who are going to be receptive. There was need everywhere.

Mullan: Was it a Democratic/Republican split at all? Can you count on people who are Democrats being supportive, and Republicans not?

Deitch: When I first started, it was a Democratic governor. For a long time after that, it was a Republican. Family planning was the hardest thing for me to try to get.

Mullan: Because of religious opposition?

Deitch: Well, I think just the idea. I think people associate condoms with abortion. If you don't talk about one, you don't talk about the other, so you don't use the word. It was sort of like ignorance. So we had a hard time putting through things

related to family planning. But we were very successful after a while with community groups that got going. The Dover area and the Rochester area we got prenatal and family planning together, because there were enough people that were excited about working on it and there was good leadership.

Then a community action program sort of came in at that time, and they picked up on some of the community part of the support had to be for those programs. We had a wicked governor for a while, [unclear].

Mullan: You were out of MCH by that time?

Deitch: No, that was '74.

Mullan: You were still working?

Deitch: Yes. '74, I quit the state position.

Mullan: What decided to do that? There were a number of things you picked up then.

Deitch: While I was at MCH I also worked in one of the clinics, the one that was in Suncook. I also was the pediatrician in the Crippled Children's Clinics, because that was a way for me to see children with complicated medical conditions and keep on planning for their coordinated care.

Mullan: So you kept your hand in clinical.

Deitch: Yes. I consulted in the cleft palate clinic, and the seizure clinic, and the cystic fibrosis clinic. So I also got to know the other physicians around, and respected the public health nurses. I learned a lot from public health nurses.

Mullan: When you left government, had you had it with government, or what was your view then?

Deitch: Well, I decided that really the programs that I was trying to work on were not satisfying me as a human being, that I wanted to have more laying-on of hands, and I'd become much more aware of the underserved populations, with my experience in daycare and also through the state clinics, seeing who came to them. Because actually, what we were seeing is the kids who came for the special needs, but they weren't getting any primary care.

So I became anxious about doing something here in Manchester. I had had a good experience with a social worker from the School of Public Health, who had a wonderful idea, I thought, about family functioning characteristics, and being able to identify strengths of families and risk characteristics. She had done all her studies based on the Harvard Longitudinal Study of Families in the Roxbury and Boston area. I felt there was enough theoretical truth to what she was showing that it would be

Deitch: Durham, yes.

Mullan: At Durham and Hanover.

Deitch: Right. Yes. Where the people up there can vote in a very liberal way, but they don't in any way affect what goes on in a community like this.

Mullan: And you say Manchester idolizes the mill lady because it's a sort of--

Deitch: Work ethic.

Mullan: But it isn't leavened by academic, or scholarly, or idealistic thinking at all.

Deitch: Very little.

Mullan: Yes, but I just wanted to make sure I understood. All right. I got it.

Deitch: So anyhow, our sponsor was herself a leader in the manufacturing community that had redeveloped in the 50s.

Mullan: What is her name?

Deitch: Her name is Gruber [phonetic] now. It used to be Sidore.

Mullan: What's her first name?

Deitch: May.

Mullan: May. So she provided support to start a Child Health Institute.

Deitch: To start and maintain. She continues to be a person who likes to promote creative programs. Institute. At that time we were providing consultation to daycare centers, to preschools, to programs for children with special needs. We were training their staffs and providing consultation to them around children who had special needs. I continued doing the special clinics, but I did this, and we brought the daycare people over to our place to do training. Then we became involved with the Division of Welfare, did some training for them on children with special needs and that perspective.

As we went along for two or three years, I developed the courage to say, "We've got to have a program here in Manchester to provide health services."

Mullan: As a clinical outlet.

Deitch: Yes.

Mullan: That was the concept of what became Child Health Services?

Deitch: Right.

Mullan: How did that get going?

Deitch: It got going because she was restless about being our only resource. That stimulated me. We had been looking for support for what we had been doing. We had gone outside the community. We basically had been turned down in very discouraging ways. We'd gone to the March of Dimes, and we'd gone to the Children's Foundation in New York, and we'd gone to a variety of different places looking for money for more of what we were trying to do, and didn't get anywhere.

So we applied simultaneously to the Bureau of Maternal and Child Health to start a more traditional well child clinic for Manchester, but at the same time went to the United Way, and the United Way agreed to give us a little bit of money. I also had been on boards of things in this town, and there were people there who knew that what we were talking about was something that should happen for Manchester. At the same time, as much as I have reservations about Marion Wright Edelman, I'm always thankful, because the Children's Defense Fund was in operation at that time, and I was in desperate shape for getting some credibility for what we were planning. If we could do what we said we could do, we might reduce the cost for children in

school. I was about to appear at a school board meeting asking for a reasonable amount of money for us to get started.

There really wasn't very much Medicaid money then. Massachusetts had a generous Medicaid reimbursement long before we got going. There were clinics in the Boston area that were running on Medicaid, and we really had nothing comparable here, so that fee-for-service was something we couldn't even count on. We needed community dollars for support staff.

I called Children's Defense Fund, and I got a fellow there who was able to give me some actual figures. He sent me some articles so that I could show that if our program was more like HeadStart, i.e., comprehensive, the Perry School Study had shown the long-range positive effects of such early interventions. The superintendent of schools was my classmate in high school, and I asked him to go up before the city mayor and aldermen to show that even if 10 percent of the children we saw in our clinic were more healthy and ready for school, we could reduce by 10 percent the number of kids who were going to need special help. It would therefore save the city money. So they gave us our first amount of money and have continued to support us with about 8 percent of our budget.

Mullan: So a combination of city, United Way--

Deitch: And Maternal and Child Health.

Mullan: The focus was this was not a general pediatric clinic, but it was a clinic for children with special needs?

Deitch: Low income.

Mullan: It was a low-income general pediatric service.

Deitch: Yes.

Mullan: This was 1976 when you opened?

Deitch: No, '79. For three or four years we had the Institute, and the last year of the Institute we planned Child Health Services.

Mullan: The Institute was more policy and theoretical, whereas the Services were hands-on?

Deitch: Well, yes, and we developed, I think, our support group. For instance, our board was made up of all the different people that we'd worked with. Our first agency board was made up of people from other agencies, hospital personnel, private physicians, bankers, business and professional persons.

Mullan: Why don't you give me a quick history of the Child Health Services, which I gather has been your principal occupation from '79 to the present. How large was it when it

opened, and how large is it now, and what's been the trajectory? Just in general terms.

Deitch: Maybe you'd like some Annual Reports.

Mullan: How many docs are we talking about?

Deitch: When we opened, I was the only physician.

Mullan: One full-time equivalent, in bureaucratic terms.

Deitch: Right. Right. And a full-time social worker, and a family support worker, and a part-time nutritionist, and a secretary.

Mullan: How busy were you?

Deitch: I can't remember.

Mullan: You were pretty busy?

Deitch: It grew rapidly. But we had in the very beginning restricted ourselves, because of our model of the parent and the child, we made the decision that we would not accept any families unless they had at least one child under the age of two, because according to the standard pediatric schedule, we were counting on people's conventional acceptance of visits so that we would get

to know parents, so that we would be able to do some interventions, so we would be able to see them more frequently and develop trust.

Mullan: So if they had a child under two, you would accept the other children?

Deitch: Oh, yes. Then we took the whole family.

Mullan: When you say family, you take the mother?

Deitch: Not for illness.

Mullan: For pregnancy?

Deitch: No.

Mullan: So it was just pediatric.

Deitch: Just the children. Lots to do with the parents, of course. More to do with the parents sometimes than with the child.

Mullan: And to finish the trajectory, what is the staffing like now?

Deitch: We have myself and four part-time pediatricians.

Mullan: That's out how many--

Deitch: How many equivalents--full-time equivalents? Probably I guess three and a half.

Mullan: How about the staff? Clinical staff?

Deitch: We have the equivalent of one and a half MSWs, and I'm not sure whether it's ten or eleven family support workers.

Mullan: These are community representatives?

Deitch: These are people who are categorized as level one, level two. Level one are people who don't have a degree necessarily, but their major role, it would seem, would be transportation, but it isn't. I mean, they're the people who hear everything, and take people places, and one of them does our bicycle safety clinic, and helping with enrichment opportunities. Right now they're involved with getting the kids into camps, into summer programs, and art classes, and music lessons, music performances and the like. The other nine family support workers have a college degree. Most have a degree in sociology or psychology. Usually they come here having been out of school for a couple of years.

Mullan: Are they from Manchester for the most part?

Deitch: No. Some are, some aren't. I can't say we draw them from very far away. Some of them have assigned families, and some of them don't. They all have assigned families, but in addition to the assigned families, one worker is scheduled for every clinic session. We have three part-time nutritionists, so that every clinic is covered by a nutritionist. They do delicious things, you know. They make sure that the children get extra snacks at school who are not being fed at home, send some snacks over for to the Boys' and Girls' Club to make sure inconspicuously that the kids get fed and make sure they're getting all the other things that they should be having.

The nutritionists have a class here in the afternoon for the young teens, teach them how to cook. Then they sit down and eat their supper! They do a lot with budgeting with the parents of our clients who are failing to thrive, and much to do with the children whose parents don't know how to actually feed their children. Plus, of course, the children who have conditions like diabetes, and galactosemia, feeding disorders and tube feedings.

Mullan: How have you supported the Child Health Service over the years? You've described the first generation. It's year-to-year hand-to-mouth, different benefactors involved?

Deitch: The major change that's happened in our funding source, is that Optima, which is the non-profit hospital merging the

Eliot and Catholic Medical Centers, now contributes almost a third of what our costs are to maintain this program. The rest of our money comes from the city, from the county, from Maternal and Child Health, from the Bureau of Special Medical Services. Medicaid, Foundations, an annual fund drive and three annual fundraisers.

Mullan: Do you take Medicaid or payment?

Deitch: Of course.

Mullan: And if they have health insurance?

Deitch: Well, if they have private health insurance and can make the private system work for them, we help them get into other programs. We figure that our current critical number is a thousand children.

Mullan: This is a thousand visits a year, or a thousand kids on the books?

Deitch: No, a thousand kids on the books.

Mullan: Which breaks out to--

Deitch: Which makes about 1,200 and some, because there's a changeover.

Mullan: How many visits a year then will you be doing?

Deitch: Five, six thousand for the clinicians, and an equal number for the family support workers and about 1,300 visits per year for the nutritionists. We feel that we shouldn't be creating an empire here. What we should be doing is adapting our model to the private sector.

Mullan: Which means--

Deitch: That the HMOs should be doing what we're doing. The recognition of a critical role of our program should be introducing the concept of family support workers and nutritionists to the offices of the private providers of pediatric care. That the physicians should work as a team with other disciplines who can contribute to the comprehensive health care of the children who go there. One step that we've made so far is with the Foster Care Grant that we're doing with the Child and Family Services Agency. We're participating in a demonstration to show how children in foster care have not been getting comprehensive continuing care, that with more of what we have learned in our model were adapted to the private care model, that their care could be improved for that population as well. We've been working with the Matthew Lahey Hitchcock group and then we've moved over to Keene, and to Concord, introducing our model into those places using the foster care population.

Our goal would be that the medical dollar would pay for family support services for coordinating care of follow-up as recommended at the visit, and nutrition services, and extended doctor time to take more time with the visit and planning time with the plan.

Mullan: I'm confused.

Deitch: What we find is that there's a population of health providers who enjoys doing the kind of practice that we do, a population of physicians, physician assistants, and nurse practitioners. But there's another population that (not to negate the fact that they're good doctors), isn't interested in this orientation. We have to find a cadre of physicians who are sensitive to working with the team, who know that that has to be done in order to address the many prevalent psychosocial issues, in conjunction with true medical diseases, that bring families to an office. This can't be done by all physicians. One of our missions is to find a way that we can adapt our model to the private practice setting.

Mullan: Or get the private practice setting to adopt your model?

Deitch: Yes, pieces of it. Eventually, maybe we should be considered a tertiary center. Our special children--those from poor families or more dysfunctional families or have complex conditions that need much coordination with other medical sound

systems. Maybe we, or perhaps a place like ours, and which ones could be handled, or whether a place like us should be an integral part of another private health provider system. We're trying to change the way health care is traditionally given, recognizing that there's a critical piece that cannot be provided the way it's currently organized.

Mullan: You're trying to get them to modify the way they do things to provide this more comprehensive.

Deitch: Yes. Yes. That's one of our goals.

Mullan: Plus restrict your services to those who really need them, who have not been picked up by systems.

Deitch: We have to have a few of the children in families that aren't so complex or we'd lose our staff. It's very stressful. Very stressful.

Mullan: Well, surely you have undifferentiated kids who have mega family problems.

Deitch: Yes, but scratch a little and there aren't too many.

Mullan: What means a family support worker? What is the scope of that?

Deitch: Their united roles in the sequence is to register families that we have accepted through a formal process. Nowadays, we get a high percentage of referrals from other agencies, hospital emergency rooms, the intensive care units, the nursery, plus the private doctors. There are patients that they refer to as a CHS type.

Mullan: CHS?

Deitch: Child Health Services. So that once a month we sit down and go over requests for service. If it's priority, e.g., a call that says "This mother's going to be discharged, and we doubt the family's ability to provide consistent parenting" we can take her right away. We have one social worker, for instance, who meets the family at the hospital along with the social worker at the hospital. Then we go through a routine of identifying where the family strengths, so that we have a clue as to where we are, who else is in that household, how old is this mother, how old is her friend if she has one, what's her level of education, what's the living situation, how many rooms do they have, and what's their experience using resources, then projecting to what extent that family will need more intense or less intense involvement of us as an agency. Meanwhile, obviously, taking the traditional steps of collecting all the medical information so that we can go over it prior to the first visit.

We don't have a waiting list, but we do have some families that are more priority than others, obviously. If it's a child

that was born with spina bifida, for example, and was born up in Hanover, and is coming home, and we have to make all the needed connections--educating, transport, treatment--we take that one right in, an infant that has an enlarged liver, jaundiced, two weeks old and all those red flags we would accept that family every quickly.

Then we make a decision as to whether that client needs an assigned worker, at least for a while, so that they get to know us, they get to trust us. There's a family worker that's assigned to every clinic. We have clinic every day, and some days we have one in the morning and one in the afternoon. When I say clinic, I mean we're open to see patients, some scheduled and others acute, you know, like any office would be.

Mullan: But they have to be your patients. You don't just take a walk-in kid off the street?

Deitch: We don't take walk-ins. No. But we may take them in, ask them some questions, and register them. All summer, all year around actually, people from other agencies are asking, "Would you mind doing a short-order complete exam," and then we say to each other, "They really belong here." But no, we're not a walk-in clinic. We're trying to develop one for adolescents, though.

Mullan: Yes, and the adolescent side of things. How does that fit into the mold of taking the two-year-old and--

Deitch: Over a third of our clients now are adolescents, just by virtue of the fact that when we started--

Mullan: So the families stay with you.

Deitch: Absolutely. 'Til the children finish school.

Mullan: So those kids who are teenagers, you address adolescent problems.

Deitch: Absolutely.

Mullan: Both one on one and, I gather, you have group programs?

Deitch: Well, Planned Parent Teen Options meets here. So some of our patients go over there for reproductive health care if they want to. Some of them don't want to and stay right with us.

Mullan: Planned Parenthood, Teen Options as a program of Planned Parenthood?

Deitch: It's a drop-in clinic for teens from the greater Manchester area. It meets here. But it's strictly reproductive--

Mullan: That's girls and boys?

Deitch: Yes. Strictly reproductive health. So we have an American Academy of Pediatrics CATCH grant right now, to develop an adolescent clinic for all Manchester kids, because our way isn't working.

Mullan: What do you mean your way isn't working?

Deitch: Our way is still too traditional for adolescents. We need more staff to be able to have drop-in discussion groups, "hang around" things for teens, peer counseling-type activities, that we need to aerate our system for them, in order for it to be done properly for the teens, and for their parents. Some of them continue--

Mullan: Come to the doctor, as it were.

Deitch: Yes.

Mullan: That's the traditional mode, and you're saying that doesn't make it for teens.

Deitch: For some teens it doesn't. It depends upon from whence they come, who their peers are. If I say, "Josie, why you smoking?"

She'll say, "Peer pressure." [Laughter] You know. But we need far more of that kind of orientation to our adolescent population, and I haven't been able to get the right grants to do

that. I get turned down every time. I'm waiting now to write another one to get the MSW, just for our teens, for our follow-up, and also to establish that kind of "hang around" environment. We've got the space. That's what it's here for. Hang around, drop-in-type things, after school, later on in the afternoon.

Mullan: The population that you treat, both the teenage as well as the younger kids and families, is for the most part definitionally poor?

Deitch: Yes.

Mullan: Ethnically they are mixed? They are still white, or many French Canadian of origin?

Deitch: The younger ones, many more of them are Hispanic and black, because that's the new population coming in.

Mullan: Are these people from Manchester proper?

Deitch: Greater Manchester. Manchester and the surrounding towns. One of our family workers, obviously, is a special family worker who speaks Spanish. We're getting many more new Spanish families because he's here and because the Spanish community is now referring them.

Mullan: Is that Puerto Rican, or Salvadorian, or Mexican?

Deitch: Everywhere. An increasing number of Mexican that are illegal.

Mullan: Is it industry in Manchester that sort of draws these families, but doesn't always pay the price?

Deitch: The ones that we get are illegals who are working for low pay, without enough insurance. That's some of them. The numbers aren't large, so when I tell you that it represents a lot of time involvement of our staff. It's not huge numbers. The ones that we have recently registered and have recently immigrated seem to have a larger number of complex medical issues.

Mullan: This is Dr. Deitch, tape two, side one.
Let's go back a little bit and look at the big picture and its transition. If I could ask you to describe what you see as the market niche, the position, the role of Child Health Services as it's matured now fifteen years in, seventeen years in, what is somebody coming from the outside, such as myself, if you were going to say Child health Services does X for the greater Manchester community, how would you characterize that as a sort of summary statement?

Deitch: I would like to say that as an agency we have had the privilege of retaining our flexibility so that our program changes as we see the need for providing care for people who

don't have insurance, who don't have access to the more traditional health care systems, or that system doesn't work for them. We find ourselves changing as we mature and as our population changes and we learn More about needs to be provided. So I think that is what is more unique about us. What we were doing at one time seemed to meet certain needs, but as we have been here, we have discovered other things that we have to be doing, because we discover more gaps that we consider critical to promoting children's health.

Mullan: Given the changes in the system, particularly managed care in the private sector, and now potentially Medicaid managed care in the public sector, and then the continued existence of folks who aren't covered by either system, what is going to be the effect of those changes on Child Health Services?

Deitch: Right now, we're busily trying to identify ourselves as an agency that deserves to have a demonstration grant to reflect the need for reimbursement for those components of our program that we see as specifically needed at least for the population that we serve. We have had a little bit of a breakthrough with Medicaid in that they are paying for some of our family support services if they are given directly to the client. They don't pay for any of the calls and things that a family worker makes when the patient isn't present, but they are beginning to reimburse for some face-to-face (unclear) with families. The pest is that you have to document every minute of it in order for

be billable--but at least it is being recognized a wee bit as a need--that is the skillful integration of social functioning capacity with the direct prevent/ and treatment services for the child.

Our staff is represented at all the meetings that talk of the caretaker and the RFP that's going out to the insurance companies for capitation contracts for services to AFDC families, and trying to plant our seeds for the need for our services. We are on the planning committees for talking about indicators of health and what the services have to be in order to make sure that population of concern, the underserved population of poor people has the care provided as it should be.

Mullan: You have worked clinically and administratively and politically through a period of great change in American medicine. Let me go back now to that level and ask your thoughts on that, particularly an area of growing, first of all, specialization, or subspecialization, where concepts of generalism have not necessarily fared very well. Pediatrics has perhaps been less impacted than internal medicine in terms of being sliced up into ever smaller pieces. But has that, as you've observed it, [unclear] well or [unclear] poorly for those things that you value? What impact has that had on health care as you've seen it?

Deitch: I think what Dr. Haggarty has talked about years ago as the New Morbidities, and now we talk about as psychosocial health

care, is a component of care that I see as the major forte of the generalist, and I see it also as the condition that is mostly likely to result in, but not recognized as the great risk for resulting in more dysfunctional human beings far more than the so-called kids with special needs who have physically disabling conditions. We see so much of it, I don't think it's our skewed sample. I think we truly know that if the children's health needs aren't addressed more broadly it is going to result in less functional members of our community.

Mullan: By that you mean drugs, alcohol?

Deitch: Not finishing school, not being able to provide for themselves, not being able to provide for their own families and yes, early use of alcohol, early use of narcotics, and risky sexual behavior.

Mullan: If I understand what you're saying, you're saying that that epidemic, if you will, that trend in morbidities presents and will present a heavier burden in society than traditional children with special needs populations, spina bifida, or the epilepsies, or the what have you.

Deitch: I do. I think, the medical developmental needs of children from poor families are being less well addressed than they should be in families and in communities. I consider this Health, and I consider that it falls to the skilled generalist

together with a team of knowledgeable health support staff and a caring community to keep this population well.

Mullan: I don't want to put words in your mouth at all, but understanding that point, and that being a lucid, important point, what is its bearing on the professional decisions that go into whether we produce more generalists or more specialists?

Deitch: If your definition of a generalist is my definition of a generalist, then we need more generalists. But I want every generalist to be very smart, and I don't want anybody as a generalist to miss a specific medical diagnostic condition, but at the same time, not by ruling out medical conditions, but understanding it's the simultaneous need for recognition of the other aspects of that child's development that are part of that child's health. So the generalist has to be a pretty skillful person. But I have great respect for the accessibility of the precision and knowledge of the specialist as needed.

Mullan: Do you consider yourself a generalist?

Deitch: I'm not sure. I think that over the past sixteen years I've learned that I knew less about the health of people who were poor than I should have known. I just was mouthing things. I used to say that nobody was sexually abused except up in North Conway in the wintertime. Well, that was based on the stories of the incestuous relationships of people that were all bundled

together in the crowded household in the cold winter. Right? I have learned so much about how people live, how families perceive their children, how children are handled in families, and how the community itself has not responded to the needs of children, the rigidities and the provincialism, and the actual pathology that takes place that I hadn't been alert to, and then how hard it is to get people to really believe that it's happening here. It's sort of like, "Oh, the plane crashed in Guatemala. Glad it wasn't here." People aren't really accepting the fact that the kinds of things that we're talking about are happening in our town.

So in answer to your question, "Am I a specialist?" I think I am a more knowledgeable person in the provision of care for a population, and does that make me a specialist? It is if you consider the community our patient. I guess that's what makes me a "public healthier." So I probably am increasingly more specialized in understanding the health needs of the poor. Does that make sense?

Mullan: That makes sense.

Deitch: We aren't having a conversation, right?

Mullan: Well we are going to have a conversation , although this is your oral history, I shouldn't put my two cents in. But I would count you a generalist because, I think, at least for the purposes of the distinctions I'm making, a specialist is a

practitioner of reductionism, and in that process, becomes quite expert at a narrow slice of knowledge, but at the same time, dismisses or abdicates responsibility for the larger field of knowledge. It seems to me that intensivity of knowledge, which is what you characterized, is different than reductionism. You're saying that there should be a high level of expertise in not only biomedical pediatrics, but psychosocial pediatrics, if I could simplify it.

Deitch: That's it.

Mullan: But you're not advocating the creation of pediatricians whose sole area of interest is psychosocial problems, who would hang out the stethoscope. Let's continue the interview assuming you're still a generalist.

Deitch: We've just written our third five-year plan, and one of the things that I wrote as a challenge is, where will we be five years from now? Where should this agency be right now? Should we be planning to stay as a separate entity? Should we be identified as a tertiary care component of a multi-disciplinary program? Should we be connected up with the Community Health Center as a component of what they're doing over there?

Mullan: There is the Community Health Center here in town?

Deitch: Yes. The traditional Community Health Center with hard-working people who have a turnover like you wouldn't believe, because they're seeing all the people in town who nobody in town has seen for years, adults as well as children. They don't have a staff for it, and they don't have any social support component. It's wicked. We stayed away from them because we hadn't sold our model enough. We would just get devoured by a traditional model at this time.

Mullan: Let me pursue just a sub-issue, because it piqued an interest of mine in general, and that is a question of certain elements of what you've characterized, or Bob Haggarty characterized as the new morbidity, but child abuse, spousal abuse, sexual abuse, which is burst on the public scene in the last five years, seven years, at least burst on public attention. Is this a new epidemic, or was it simply there and we didn't recognize it? You were suggesting, at least to some extent, it was there and we didn't recognize it. Is that right? And tell me a little more about what you're observing across these child abuse, sexual abuse, spousal abuse phenomena we're hearing so much about.

Deitch: I think until we began having parenting classes where young mothers who came to talk about how to raise children are found out by the second or third session, that parents want to talk about themselves, and to tell us about how they were abused in their own lives. Those were the big secrets. So that we

would learn from a group of ten mothers, who we had gathered together because their children are going to start kindergarten. We had wanted to get the parents ready for that sort of thing, and they begin to talk about their own association with that period in their life, and really want to begin to talk about it. "This is what happened to me. I thought I had the big secret." We learned from our small samples that the behaviors now freely discussed had been suppressed and no doubt effected their own development and how they perceived the community and their children's needs.

Mullan: Meaning that they had suffered either physical abuse or sexual abuse themselves?

Deitch: Yes. Right. Exactly. We became much more skillful in gathering histories. It's not always the right time to ask those questions, but there is a time when it's important to learn more about the parents themselves. As we have matured, we have become increasingly aware of the questions that we have to ask about sexual abuse of young children. And also, obviously, the kids come in that are symptomatic. It's not a huge part of our population to be having blatant sexual abuse, but certainly we have children that are more physically abused and neglected than they should be, and we often feel that the Division of Children, Youth, and Family should become more involved in their care earlier. We can't get them to become involved at an early stage

of what we think is a pathological situation. They require visible evidence.

Mullan: To get them involved.

Deitch: Right. We know some of the relationships of our parents, the mothers who are threatened by their spouses. Two nights ago, one of our young mothers of three, who's nineteen, was in the house with her husband who was drunk and with two or three of his friends. He had a fight with one, and then began to have a fight with another, and then got out a knife to go after her because she was telling him to stop. So she called the 911, and he went to jail. And now he's already out because she said she was sorry. And the children witness all this.

It happens frequently among the young families that we see. Restraining orders are not uncommon but frequently the young mother renege. We give our mothers a crisis number that they can call. Many of them continue to remain secretive about the abuse to them.

Mullan: Is your conclusion--

Deitch: Is this a new phenomenon?

Mullan: Yes.

Deitch: I think there's an increase in numbers. It's not only that we've scratched and found more, I think it's going on more. We have more of our young families that are using drugs. I can't tell you about the amount of alcohol, but we certainly know that they are using drugs. We see their names in the paper. They're being picked up for using drugs; they have increasing access to drugs. I would say that some of the abuse is related to the fact that they are not as in control of their behavior. Poverty itself is more prevalent and with it more stress in the population that we see.

Mullan: Is it more with the more newly arrived populations, the Latino or the black population, versus the resident French-Canadian population?

Deitch: In our population? It's too small for me to say. I can only tell you from what I read in the paper.

Mullan: Well, back to the big picture. Apologies for the digression to the small picture. Let me take on the question of pediatrics versus family medicine or more comprehensive approaches to care. Obviously there've been enormous benefits to the role of pediatrics and child care, and the maternal/child health movement is the sort of public health custodian of that role, if you will. On the other hand, as we move to more comprehensive thinking about population care, and as we now have a cadre of residency trained family practice physicians who have

at least passable confidences across the spectrum, does the notion of continuing a focus on care for children, as opposed to care for the family, present barriers to you that would be best managed in other ways or not?

Deitch: It depends upon how extensive that training is. We have a great urge to say that the training for family practitioners and for pediatricians has to include a greater understanding of practice as we do it here, that there is a great need for people to be exposed to how to serve the underserved, that doesn't happen in a lot of outpatient clinics, or certainly in the north country. Dartmouth should have been in Manchester. We find, even when I had been called up there to do grand rounds or something like that, and talk about what is unique about certain populations and how there are certain elements of functional characteristics of families and communities that have a bearing on a child's health, I found that the person who introduced me said, "That's all very well, but we don't see people like that up here."

So, if generalists have had the exposure to what is unique about certain populations, and what youth bring into an office and the family's strengths and risks, or what school people are doing for kids, or what daycare centers are doing for kids, then I would say what a generalist and a pediatrician have a great contribution to make to the health of young people. But unless they have had that experience, they aren't going to contribute to the well-being of that child. Is that what you're talking about?

Mullan: That's fair. I was actually sort of asking the flip side of it, and this is sort of a long-standing question in my mind as a pediatrician who has interest in the community as a whole. The limits of my care, my clinical domain, both knowledge-wise and definitionally, begin to peter out at fifteen, sixteen, eighteen, whatever, and I can't treat the mother and child as a unit, I can't treat the father and the child as a unit, etc. While the focus on the child, both clinically, individually, and population-wise in terms of MCH kind of programs, has brought great benefit, this sort of power of that focus has brought great benefit to child health, it also can be argued to be limiting and parochial in certain senses if family health is the ultimate issue. I struggle with it in my mind, and I just wondered, you've been in the field so effectively and so long, if you've had thoughts about it.

Deitch: I guess I'd have to stop and say, "What are the health needs of the early adult years?" and do it that way. What are the health needs of the adolescent? What are the health needs of the early adult? What are the health needs of the mid-adult years? How can you put those together? In what components can a program like this serve in the life of that young adult? And how much of it needs the continuum from adolescence through their childbearing years in another environment? I'm not sure.

There's something to be said, I think, for the recognition of the rapidly changing health needs of the growing child and adolescents that need persons who understand that fact and put it

into the framework of a biomedical psychosocial model that is not quite the same as when adults have sort of leveled off with respect to their growth. We probably develop but we don't mature. So that the things that you would be addressing in those adult years, certainly in women, are more related, I suppose, to their having children--their individuality, physiological differences from their male counterparts, and men, what their health needs are in that period of life with respect to the preventive of and early detection of illness associated with , probably takes someone with skills related to the healthy environment is of those people.

I'm not saying that a generalist wouldn't have or shouldn't have a broad understanding of all those things, preventively and promotionally, as well as therapeutically. But certainly in the children up to the age of, I say, through adolescence, to about twenty-one or twenty-two, when their bodies are still changing and we have to consider their physical, social and psychological adaptations, you should want to make sure that someone is taking the time to address these critical factors.

Is that what you're talking about?

Mullan: I think you've stated eloquently what the rationale is for a focus on child health, even expanded child health through adolescence. You make the point, I think well, that there are a separate set of needs for the young adult, and for the elderly adult, etc. I don't think it's a question we're going to answer here, but I just find myself constantly sort of probing at the

walls. I think the walls between internal medicine and family practice are the least defensible. I think at some point they may collapse.

Deitch: I wouldn't have a problem if you could have a construct that said you start at this end of Pearl Street with a baby. I mean, I don't know where you come in when you start with the adolescent, which comes first, but and then you sort of move along the same orientation towards health and disease, and there may well be some people who can move right along with the population so long as the components of care are addressed all along the way, so that you get the preventive and the promotional and the therapeutic, and have the kinds of supportive services that are the fillers from the beginning to end. I don't have a problem with that. You take it away from the straight medical model. I think what we're talking about here, in our clinic, applies to all developmental periods.

Mullan: The same principle, the same issues.

Deitch: Yes. What is the role of the clinician in that? What is the role of the family? What is the role of the community?

Mullan: As you look back on your accomplishments and your contributions, what gives you the most pleasure, the most joy, as you look back on it? What has meant the most to you in your work?

Deitch: We have a great group of people working here. It's a very refreshing kind of environment, except for the guilt that they're not paid as well as they should be, of people who aren't necessarily idealists, but they're people who have a great desire to give people opportunities for a good life, a healthy life. So that, to me, is a reinforcement type of thing.

Mullan: Is recruiting those people, and nurturing those people, something you've done in particular? Is that gives you pleasure from it?

Mullan: I like that, too, but I don't have any connection with them. Is what you're telling me that you feel accomplished for having recruited.

Deitch: As a unit. I'm not talking about me as a human being. I'm saying that I like the feeling here at Child Health Services.

Mullan: Talking about you as a human being, and the things you've done, things of which you've been executor, and there have been hundreds, what stands out in your mind as things that are particularly gratifying?

Deitch: I have nice children. [Laughter]

Mullan: I want to pick up on the family story. The second marriage has worked well?

Deitch: It was a fine relationship. Love, compatibility, fun things but my husband died 14 years ago.

Mullan: I'm sorry. The kids melded and meshed?

Deitch: Pretty well.

Mullan: What are they all doing now?

Deitch: The youngest and his wife have just returned to New Hampshire. They're living here and have an infant daughter.

Mullan: What do they do?

Deitch: Richard is a lawyer, very active in the current gubernatorial campaign and she's a land planner.

Mullan: That's the one that you had with your second husband?

Deitch: Yes. He's the one who's related to all of us. The next one up is John. He's a lawyer in Boston. He's married to a lawyer, and they have two delicious kids.

Then I have the three stepchildren, the youngest of whom just arrived one o'clock this morning. She's a social worker in an HMO in Minnesota. Started off with [unclear] not for profit agency, but everything's gone HMOish now. She has a daughter who's in college.

I have another one who is a teacher in the bowels of Boston, teachers English in one of the central city schools. Another one is a psychiatrist in Boston in a low-income area clinic affiliated with a teaching hospital.

Mullan: Great. Terrific. One of the most interesting things, I find, when reading about people's lives is as they went back over them, what they think was very meaningful to them, as opposed to what resonates with me because of my interests. It might be a patient, it might be an institution, it might be some people you mentored.

Deitch: Well, it's all of those things. I don't know. Ask the question again.

Mullan: I'll put it a different way, at the risk of being a touch morbid. If you could write the epitaph on your gravestone that would reflect what was really satisfying you, it would say, "Selma Deitch," dot, dot, dot, dot. What would it say?

Deitch: I don't know.

Mullan: I can't help but think that Child Health Services which is your creation, as I understand it, wouldn't exist.

Deitch: No. Child Health Services as such probably wouldn't. I was at a point in my career, had a sort of vision, extensive

informal consultive resources, some energetic backers, and a nucleus of idealistic and intelligent persons to work with.

Mullan: AT the risk of putting words in your mouth.

Deitch: And then at Child Health Services, I've had the privilege of having been a free agent. The way I've sort of been able to have the time to do the thinking and I'm not bound by what'll happen to me if, so that I've enjoyed being able to say what I think has to be said, and have the energy to do what I think has to be done without being bound by, "Be careful, you'll lose your job," or "What if this person doesn't like you anymore?" I really have found it comfortable in trying very hard to stick to what I feel is close to the truth, and what I feel has to be said. That's a privilege.

When my husband died, I went through a period of panic, thinking, "That's going to limit me now. I've got to be careful. What if I lose my job?" People come up and say, "I hear good things, but I hear sometimes..." You know, that kind of stuff. I got a little nervous for a bit, because, you know, if you're a two-parent working family, and you've got the other income, so what if you don't. I mean, I still had kids that were in college, or graduate school, or something, and things still had to be paid for. Part of you wants to be careful. But I always felt that I had the privilege to be able to say what I thought, and because I had the energy to do what I thought had to be done.

Those are things that helped me the most. If you say ultimate satisfaction, I don't know. I don't know.

Mullan: One final area. You clearly have had a continuous motivation, or continuous thrust, to deal with the less fortunate, with those who haven't been dealt such a hot hand. Where does that come from? Is religion a factor at all?

Deitch: I don't have any.

Mullan: How about parents?

Deitch: They didn't have any either. Oh, you mean-- [Laughter]

Mullan: That's a good point. In terms of influences.

Deitch: Oh, definitely. Yes.

Mullan: Other people at all that you point to that have given you inspiration to continue this path of work?

Deitch: I've always gotten support from my own family, my own kids, my sisters, my husband, and in the community. I always feel you meet a few people that say, "Troublemaker," something like that. My strength is in my trust in people, and that people do for people, and I look for those kinds of people and also trust that they're going to do what they've set out to do, and I

don't rely on outside forces. I do know that for the sake of the program and people supporting it, I try not to go out on a limb alone and risk the limb being chopped off.

Mullan: It sounds good New Hampshire position.

Deitch: No, that's not New Hampshire. You mean live free or die? No.

Mullan: I resisted saying that.

Deitch: Don't say it. No, I'm not live free or die. As a matter of fact, I consider that a very destructive statement. I don't live free. I live within a broad definition of what is socially acceptable.

Mullan: And civic.

Deitch: Yes, right.

Mullan: "Live free or die" is not a civic definition of the world, or of a state.

You've been very generous with your time. It's been a terrific interview. Is there anything else you'd like to say, or any area that I haven't touched on?

Deitch: Well, I'd like you to know some of the delicious things we've done here, but that's not what you're into. We have a wonderful youth theater, for instance. Kids that go out and do skits and get people to talk about adolescent issues.

Mullan: Great.

Deitch: There are nice things that happen here. A little girl that wasn't going to be able to play the flute. One of our family workers got one of the music stores to donate a flute to this little girl. Now she's got her flute lessons for the summer from a real flute teacher in the music school. Those are nice things. Those things make me very happy, because I know that little girl when she was five years old was sexually molested by her mother's boyfriend. This was a little mother herself. She was thirteen years old when this girl was born. I did an oral history on her once, just on the number of daycare settings that that little girl had been to. Her mother finally quit school because she just couldn't get coverage for her baby. This mother works full time. She's now married to another man--settled. But in between, all these terrible things happened to this girl. [unclear] when she was five or six. She was so seductive. [unclear] I would say, "You sure? You sure?" I would look and I didn't see. Then finally about four or five years later, it all came out, what had been going on. This summer we helped her find a role as a volunteer at the local social agency. She's taking her flute lessons and she was recommended and participated

for two years in a summer program for capable students. She asked to play her flute for me at her last check-up and she did! Then we talked about tobacco, drugs and sexuality.

Mullan: How old is she now?

Deitch: She's twelve. Those kinds of things make me feel good. Every single thing that's good is however somewhat dampened a concern that there are so many other factors that are still going on that are likely to result in something terrible that I'm generally a bit anxious. I mean I am satisfied, relieved, relaxed, because the family and community can affect this vulnerable child negatively.

Just recently I read a wonderful paper by a woman talking about kids who were abused. She showed a wonderful graph that doesn't show the child within the family and the family within the community as we usually see it in concentric circles. It shows that the circles overlap, so there is a child, and the child then gets into a family that itself is probably pathological, and into a community that has its own pathological states. So if a child who's been abused goes along into a fairly nurturing enriching environment, the abuse itself wasn't such a terrible thing in her overall life. But the fact is that the pathology in which the kid was living doesn't go away, so that it keeps injecting itself into that child, so that when she's eighteen and moderately dysfunctional, they'll say, "Well, you know, she was abused when she was six," or something like that.

But the fact of the matter is, that what was going on, still went on, and the community didn't help with continuing nurturing.

Those things really bother me, because we see so much of what was a major trauma. If we could shake up the environment, then not all reunifications with parents could take place, or if the community itself was made up of people who came from value systems that were not so screwed up, and we weren't trying to impose unrealistically upon them. Some of my patients get kicked out of school because of administrative absences. The big teenager who wears a chain who never did anything wrong to anybody, got a little bit defiant just halfway through his third year. He had so many administrative absences, he quit. I know him. He was born when his mother was a sophomore in high school. She's functionally illiterate. She is a caring lady, his mother. He is a very bright boy but he's so angry, and now he's out. He wants to be an artist. He's very talented. He says that as soon as he turns eighteen he'll get his GED and go around to some fairs and take his portfolio, and maybe find a cartoonist who will be his preceptor. I could not get the school to make any exceptions for him.

When you say, "Have you done any good things here?" I screwed up on this boy. I called the principal. I went down to see the superintendent, and they said, "Look. He just doesn't fit the model." So you see Child Health Services, isn't that great. There are so many kids that are being screwed.

Mullan: [unclear].

Deitch: Awful. Awful. I went to my fifty-fifth high school reunion for about ten minutes, two weeks ago. They had it during the day. Right next door to our clinic there's a restaurant where older citizens driving old Cadillacs pull up and they all get out and they go in for the special lunch. One side is for smokers and one is non-smokers. I walked in one day and somebody yelled--"You coming to the reunion?" "Why is it from eleven to four"? I asked. "Well, we're going to dance," he said, "in the afternoon."

I said, "Well, I was never much of a dancer."

I went to the reunion, and the current principal of the high school was the featured speaker and was telling these people how wonderful the high school is now. They all were listening to him, pleased to hear what he had to say about "our" school. It was the same guy who wouldn't keep my patient in school. Not all good things are happening, you know. These graduates were fed just what they wanted to hear and went on dancing.

Mullan: Anything else you'd like to add?

Deitch: I'm through.

Mullan: Good. Thank you.

[End of interview]

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