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VIOLENCE AND PUBLIC HEALTH

BY

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DELIVERED TO THE AMERICAN ACADEMY OF PEDIATRICS

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(GREETINGS TO HOSTS, GUESTS)

I APPRECIATE THIS OPPORTUNITY TO SPEAK TO THIS GROUP ON A SUBJECT THAT IS AN UNCOMFORTABLE ONE TO RAISE: VIOLENCE DONE TO CHILDREN. IT IS UNCOMFORTABLE BECAUSE, IN THE RAISING OF THE ISSUE, WE ARE ADMITTING THAT THE HUMAN RACE HASN'T COME QUITE THAT FAR AFTER ALL. THERE IS STILL A STREAK OF VIOLENCE THAT SEEKS OUT THE MOST VULNERABLE MEMBERS OF SOCIETY -- OUR CHILDREN -- AND DOES THEM PERMANENT DAMAGE.

WE FEEL MUCH SHAME AND MUCH ANGER, WHEN THIS SUBJECT IS RAISED. IT'S DIFFICULT TO DISCUSS CHILD ABUSE WITHOUT BECOMING SOMEWHAT EMOTIONAL. THAT MAY BE ONE REASON FOR THE LATE START WE ARE MAKING IN TRYING TO UNDERSTAND VIOLENCE AGAINST CHILDREN. WE WISH WE DIDN'T HAVE TO. WE WISH IT WOULD GO AWAY...THAT IT WOULD BECOME A CHAPTER OF MANKIND'S HISTORY THAT IS CLOSING, RATHER THAN ONE JUST OPENING UP FOR US TO EXPLORE AND TRY TO UNDERSTAND.

THERE IS ANOTHER REASON, ALSO, THAT WE ARE GETTING A RATHER LATE START IN THIS FIELD. FOR SEVERAL CENTURIES MEDICINE -- AND ITS PREDECESSOR, MAGIC -- HAVE BEEN CONCERNED WITH THE INFECTIOUS DISEASES OF CHILDHOOD. OUTBREAKS OF THOSE DISEASES HAVE RACED THROUGH WHOLE

WHOLE SOCIETIES, WIPING OUT ALMOST AN ENTIRE GENERATION, PUSHING CHILDREN -- AND THE FUTURE -- DEEP INTO THE GROUND. BUT GRADUALLY THOSE DISEASES HAVE BEEN BROUGHT UNDER CONTROL. AND THAT'S A RATHER RECENT STORY. IN 1913, AFTER ALL, DR. BELA SCHICK DISCOVERED HOW TO TEST CHILDREN FOR DIPHTHERIA IMMUNITY. DR. SCHICK DIED ONLY 15 YEARS AGO. THE GREAT BATTLE TO OVERCOME THE INFECTIOUS DISEASES OF CHILDHOOD BEGAN AND HAS BEEN WAGED IN OUR OWN LIFETIMES.

THE PUBLIC HEALTH SERVICE HAD STARTED A VIGOROUS IMMUNIZATION PROGRAM JUST 5 YEARS AGO. IT SET OCTOBER 1982 AS THE DEADLINE FOR ELIMINATING INDIGENOUS MEASLES FROM THIS COUNTRY. IT WOULD GO THE WAY OF SMALLPOX...BECOME EXTINCT HERE AND THEN, COUNTRY BY COUNTRY, IT WOULD DISAPPEAR FROM MANKIND'S ENVIRONMENT ALTOGETHER.

INDIGENOUS MEASLES HAS NOT BEEN WIPED OUT AS OF THIS MONTH, BUT WE ARE DOWN TO THE LAST STRATUM OF EFFORT. BETTER THAN 95 PERCENT OF CHILDREN ENTERING SCHOOL FOR THE FIRST TIME HAVE BEEN IMMUNIZED. AND AS OF THE WEEK OF SEPTEMBER 18 OF THIS YEAR, WE HAD AN HISTORIC LOW OF ONLY 1,230 CASES. JUST TWO YEARS, AS OF THE SAME DATE, WE HAD 10 TIMES AS MANY CASES: 12,843. IN ADDITION, WE ARE NOW DOWN TO THREE KNOWN STRAINS OF INDIGENOUS MEASLES. AND WE KNOW WHERE THEY ARE. IF

WE INTERRUPT THOSE THREE STRAINS OF TRANSMISSION, THEN ALL FUTURE CASES OF MEASLES IN THIS COUNTRY WILL, BY DEFINITION, HAVE BEEN IMPORTED.

DR. SCHICK WOULD HAVE BEEN PLEASED TO KNOW THAT AS OF THE BEGINNING OF OCTOBER THERE WERE ONLY 2 REPORTED CASES OF DIPHTHERIA SO FAR THIS YEAR. THERE HAVE BEEN ONLY 3 CASES OF POLIO. AS FOR THE OTHER INFECTIOUS DISEASES OF CHILDHOOD -- MUMPS, PERTUSSIS, GERMAN MEASLES -- THE RECORD SHOWS HARD GOING, BUT PROGRESS NEVERTHELESS AND TRULY SIGNIFICANT CHANGES IN JUST THE PAST FIVE YEARS.

WE HAVE THE SAME RECORD SO FAR IN INFANT MORTALITY. IN OUR OWN LIFETIMES WE HAVE SEEN THE BIRTH EVENT ITSELF BECOME AMONG THE SAFEST FOR BOTH MOTHER AND CHILD. WHEN I WAS AWARDED MY DEGREE FROM THE CORNELL MEDICAL SCHOOL IN 1941, THE INFANT MORTALITY RATE WAS 45.3 PER 1,000 LIVE BIRTHS. SINCE THEN WE'VE CUT THAT RATE BY THREE-FOURTHS. OUR LATEST PROVISIONAL ESTIMATE FOR THE 12 MONTHS ENDING IN JULY IS 11.3 INFANT DEATHS PER 1,000 LIVE BIRTHS.

AS MANY OF YOU KNOW, THE PUBLIC HEALTH SERVICE HAS SET AS A GOAL FOR 1990 THE REDUCTION OF THAT INFANT MORTALITY RATE TO 9 PER 1,000. I BELIEVE WE HAVE A GOOD CHANCE TO MAKE IT.

OF COURSE, WE ARE NOW ENTERING THE MOST DIFFICULT AREA TO MAKE PROGRESS. HERE, MEDICAL TECHNOLOGY IS STILL HELPFUL -- INFANT INTENSIVE CARE, EMERGENCY AIRLIFTS -- AND WE CAN USE EVEN MORE EXOTIC TECHNOLOGIES FOR MORE PRECISE AND RELIABLE ANTENATAL DIAGNOSIS. BUT THIS IS REALLY THE AREA WHERE MEDICINE AND BEHAVIOR HAVE EQUAL SIGNIFICANCE. IN FACT, IT MAY BE THAT THE BEHAVIORAL FACTORS HAVE THE EDGE.

FOR EXAMPLE, THERE IS NO QUESTION BUT THAT CURRENT INFANT MORTALITY STATISTICS ARE SKEWED BY THE COMPARATIVELY LARGE NUMBERS OF LOW BIRTH WEIGHT BABIES BORN TO ADOLESCENT WOMEN. THEIR SURVIVAL RATES ARE POOR. AS A MATTER OF FACT, IF YOU COULD TAKE OUT OF THE STATISTICAL BASE THOSE HIGH-RISK BABIES WHO ARE BROUGHT INTO THE WORLD ALIVE BUT WHO CAN'T HANG ON TO LIFE FOR MORE THAN A COUPLE OF WEEKS, THEN THE UNITED STATES WOULD HAVE A TRULY REMARKABLE RECORD ON INFANT MORTALITY, SINCE WE DO EXTREMELY WELL FOR JUT ABOUT EVERY OTHER KIND OF BIRTH.

WE HAVE NO VACCINE TO INSURE EVERY ADOLESCENT MOTHER A HEALTHY, NORMAL WEIGHT INFANT IN THE DELIVERY ROOM. THERE IS NO MAGIC POTION THAT WILL SUPPLY ALL THE MATERNAL NUTRITION NEEDED FOR BOTH MOTHER AND BABY THROUGHOUT A FULL-TERM PREGNANCY. THERE IS NO MEDICAL WAY TO COMPENSATE FOR ENVIRONMENTAL INSULTS, POVERTY, MISUNDERSTANDINGS, AND SUCH HARMFUL MATERNAL BEHAVIORS AS SMOKING AND IMMODERATE DRINKING.

YOU HAVE PROBABLY SEEN SOME OF THE MATERIALS PRODUCED BY THE MEMBERS OF THE NATIONAL "HEALTHY MOTHERS, HEALTH BABIES COALITION." THIS IS AN EFFORT BY MORE THAN 50 NATIONAL ORGANIZATIONS -- PROFESSIONAL, VOLUNTARY, AND PUBLIC INTEREST -- PLUS HEALTH-RELATED GOVERNMENT AGENCIES TO GET AN EFFECTIVE HEALTH PROMOTION MESSAGE TO POTENTIALLY HIGH-RISK MOTHERS. IT'S A VERY IMPORTANT EFFORT AND ONE OF THE BEST DEMONSTRATIONS OF INITIATIVE BY THE PRIVATE SECTOR. I WANT TO CONGRATULATE THE AMERICAN ACADEMY OF PEDIATRICS FOR TAKING A KEEN INTEREST IN THIS PROGRAM FROM THE VERY BEGINNING AND A SPECIAL THANKS TO THOSE INDIVIDUAL PEDIATRICIANS WHO ARE USING THE MATERIALS, WHO ARE PROVIDING FEEDBACK TO THE COALITION, AND WHO IN OTHER WAYS ARE CONTRIBUTING TOWARD THE CONTINUED DECLINE IN THE INFANT MORTALITY RATE IN THIS COUNTRY.

THIS IS OUR SLOW BUT STEADY RECORD OF CONTINUED SUCCESS IN CHILD HEALTH. I'M PROUD OF IT AND I KNOW THE ACADEMY IS ALSO PROUD OF IT AND WELL YOU SHOULD BE. BUT, AS I NOTED EARLIER, WE HAVE DIRECTED SO MUCH OF OUR ENERGIES AND ATTENTION TO THESE ISSUES OF INFECTIOUS DISEASE AND INFANT MORTALITY THAT WE HAVE NOT REALLY NOTICED THE RISE OF THIS OTHER ISSUE...AN ISSUE EVERY BIT AS ALARMING AS INFECTIOUS DISEASE AND AS TRAGIC AS DISTRESSED BIRTHS. IT IS THE ISSUE OF ADULT VIOLENCE AGAINST CHILDREN.

THIS IS NOT A BRAND-NEW SUBJECT FOR PEDIATRICIANS. MEMBERS OF THE ACADEMY HAVE TAKEN STRONG LEADERSHIP POSITIONS AT BOTH THE LOCAL AND THE NATIONAL LEVELS IN SUPPORT OF MEASURES TO CURB CHILD ABUSE, TO HELP THE VICTIM, AND TO DEAL MORE EFFECTIVELY WITH THE ADULT ABUSERS -- WHETHER THROUGH HEALTH SERIVES OR THE CRIMINAL JUSTICE SYSTEM.

THIS SUBJECT IS NOT NEW...BUT IT IS TAKING ON A NEW URGENCY, I BELIEVE. WHILE WE MIGHT LIKE A FIRMER RESEARCH BASE AND BETTER STATISTICS BEHIND THE BATTLE AGAINST CHILD ABUSE, THERE DOES SEEM TO BE GENERAL ACCEPTANCE OF THE FACT THAT VIOLENCE WITHIN THE FAMILY -- PARTICULARLY PARENTAL VIOLENCE TOWARD CHILDREN -- TENDS TO ESCALATE DUING PERIODS OF ECONOMIC STRESS.

INDEBTEDNESS...UNEMPLOYMENT...EVICTION...LAY-OFFS...RE-POSSESSIONS ...THESE ARE THE STUFF OF TRAUMA FOR MANY FAMILIES. THEY CAN OVERWHELM PARENTS AND OPEN THEM TO THE TERRIBLE IMPULSES OF VIOLENCE AGAINST THEIR CHILDREN. IN SOME AREAS OF THE COUNTRY WE ARE EXPERIENCING VERY DIFFICULT ECONOMIC CONDITIONS AND, IF THE RESEARCH AND THE ANECDOTAL MATERIAL WE HAVE IS ANY GUIDE, THOSE AREAS ARE ALSO EXPERIENCING A RISE ON CHILD ABUSE.

I WISH WE WERE AT THE STAGE IN OUR DEVELOPMENT OF A DATA BASE THAT WE COULD PRESENT AN ACCURATE STATISTICAL OR DEMOGRAPHIC PICTURE OF JUST WHERE AND HOW THIS IS TAKING PLACE. BUT SUCH A PICTURE IS NOT YET POSSIBLE FOR AT LEAST TWO REASONS -- POSSIBLY MANY MORE. FIRST, THERE IS STILL NO GENERALLY ACCEPTED DEFINITION OF CHILD ABUSE; MANY LOCAL JURISDICTIONS HAVE THEIR OWN UNIQUE DEFINITION OF WHAT THEY CONSIDER TO BE REPORTABLE. ALSO, WE STRONGLY SUSPECT THAT THERE IS STILL A SUB-STANTIAL DEGREE OF UNDER-REPORTING -- EVEN AMONG THOSE HEALTH AND SOCIAL SERVICE PROFESSIONALS WHO HAVE A GENERALLY ACCEPTED DEFINITION OF CHILD ABUSE.

THE EXPERIENCE OF THE NATIONAL CENTER FOR CHILD ABUSE AND NEGLECT IS A CASE IN POINT. THE STAFF OF THE CENTER RECEIVED SOME 400,000 REPORTS IN 1976, THEIR FIRST YEAR. THE ANNUAL TOTALS HAVE STEADILY INCREASED EACH YEAR. FOR 1980, THE LAST YEAR FOR WHICH THEY HAVE A FULL TALLY, THE STAFF RECEIVED CLOSE TO 800,000 REPORTS OF CHILD ABUSE. THAT IS A 100 PERCENT INCREASE IN REPORTING, HOWEVER, NOT IN THE ACTUAL INCIDENCE OF CHILD ABUSE. BUT, AFTER ANALYZING THEIR REPORTING SYSTEM IN ITS PRESENT STAGE OF DEVELOPMENT, THE STAFF FEELS THAT A CONSERVATIVE ESTIMATE OF ACTUAL INCIDENTS OF CHILD ABUSE WOULD BE SOMETHING LIKE 2 MILLION EACH YEAR.

THE CENTER DEFINES ABUSED CHILDREN AS "CHILDREN WHO ARE HARMED," EITHER PHYSICALLY OR MENTALLY. THE OVERWHELMING NUMBER OF REPORTED CASES INVOLVE VIOLENCE BY PARENTS, BUT THE DATA DOES NOT NECESSARILY COME IN THAT WAY, SINCE A PERSON MAKING THAT JUDGMENT ON A REPORTING FORM MAY BE CONSIGNING ONE OR ANOTHER PARENT TO THE CRIMINAL JUSTICE SYSTEM WITHOUT GOOD CAUSE.

I'VE DWELT ON THE STATUS OF REPORTING BECAUSE THAT PROBLEM PROVIDES A KIND OF WINDOW THAT LOOKS THROUGH TO A MUCH BROADER ISSUE FOR THE PRACTICING PHYSICIAN. THAT ISSUE IS THE DEGREE TO WHICH

PHYSICIANS ARE COMFORTABLE WORKING WITH NON-MEDICAL PROFESSIONALS IN SUCH A SENSITIVE AREA. THE DATA FROM THE MEDICAL COMMUNITY SEEMS TO BE OF UNEVEN QUALITY, WHICH, I THINK, MAY BE SYMPTOMATIC OF A DEEPER SENSE OF UNEASE, IF NOT AMBIVALENCE.

THE BEST KIND OF PHYSICIAN COOPERATION AND THE MOST CONSISTENT DATA COME FROM HOSPITAL-BASED PHYSICIANS. IT IS CLEAR THAT THE PHYSICIAN IN THE HOSPITAL SETTING FEELS SUPPORTED BY OTHER PERSONNEL WHO ALSO TAKE PART IN THE DATA COLLECTION AND MOST OFTEN DO THE ACTUAL REPORTING, ALSO. PROFESSIONALS IN NURSING, SOCIAL SERVICES, AND EVEN STAFF CLERGY ARE AMONG THIS LARGER STAFF.

WE KNOW THAT CHILD ABUSE IS NOT A PHENOMENON FOUND ONLY AMONG ONE SOCIAL OR ECONOMIC CLASS. UNFORTUNATELY, AN ABUSED CHILD CAN BE FOUND LIVING IN WEALTH AS WELL AS POVERTY, ITS PARENTS AMONG A COMMUNITY'S LEADING CITIZENS AS WELL AS AMONG ITS MOST DESTITUTE POOR. SINCE THAT IS THE CASE, WHY ARE THERE SO FEW INSTANCES OF CHILD ABUSE REPORTED BY PEDIATRICIANS IN PRIVATE PRACTICE? WHY IS THE LEVEL OF PARTICIPATION SO LOW BY PRACTITIONERS WHO SERVE MIDDLE- AND UPPER-INCOME FAMILIES?

THE FIRST ANSWER THAT MIGHT COME TO MIND IS THE UNEASINESS OF THE PHYSICIAN IN WHAT HE OR SHE MAY REGARD AS A BREACH OF THE CONFIDENTIAL PHYSICIAN-PATIENT RELATIONSHIP. AFTER ALL, THE TREATMENT SITUATION IS MADE POSSIBLE BECAUSE BOTH PARTIES HAVE ESTABLISHED A ONE-TO-ONE BOND OF TRUST. A PHYSICIAN UNDERSTANDABLY DOES NOT WANT TO COMPROMISE THAT BOND. THE RISK WOULD NOT BE JUST THE PHYSICIAN'S LOSS OF A PATIENT AND THAT PATIENT'S FAMILY. THERE IS ALSO THE RISK OF THE PATIENT'S LOSS OF GOOD MEDICAL CARE -- THE KIND THAT IS BASED UPON PERSONAL AND EVEN INTIMATE KNOWLEDGE SHARED OVER TIME IN AN ATMOSPHERE OF TOTAL MUTUAL TRUST. IF THERE IS A BREACH OF CONFIDENCE, BOTH PARTNERS IN THE PHYSICIAN-PATIENT RELATIONSHIP STAND TO LOSE.

I THINK THAT'S AN IMPORTANT CONSIDERATION...BUT IT'S NOT THE ONLY CONSIDERATION AND VERY POSSIBLY IT'S NOT THE MOST SIGNIFICANT ONE EITHER. OF MUCH GREATER CONCERN MAY BE THE PHYSICIAN'S IMPERFECT PERCEPTION OF WHAT MEDICINE'S ROLE ACTUALLY SHOULD BE WITHIN THIS COMPLEX AND HIGHLY CHARGED ISSUE OF CHILD ABUSE AND FAMILY VIOLENCE.

IT'S MY FEELING THAT THE MEDICAL PROFESSION NEEDS TO ACCEPT THE FACT THAT MANY PHYSICIANS ARE SIMPLY UNCLEAR ABOUT THE ROLE OF SOCIAL SERVICE PERSONNEL IN THESE HIGHLY SENSITIVE AREAS. PHYSICIANS ARE

GENERALLY UNFAMILIAR WITH THE EDUCATION AND TRAINING OF THESE PERSONNEL...THEY ARE USUALLY ALSO UNCLEAR ABOUT THE NATURE OF THEIR SERVICES...AND PHYSICIANS ARE NOT FULLY AWARE OF THE HIGH DEGREE OF DISCRETION THOSE PERSONNEL EXERCISE OR THE SIMILARITY OF THE ETHICAL IMPERATIVES SHARED BY BOTH MEDICINE AND SOCIAL SERVICES. BECAUSE OF THEIR UNFAMILIARITY WITH THE VALUE OF THESE SERVICES, PHYSICIANS -- ESPECIALLY THOSE IN PRIVATE PRACTICE -- TEND NOT TO REFER PATIENTS AS OFTEN AS THEY SHOULD NOR DO THEY SEEK THE COUNSEL OF SOCIAL SERVICE PROFESSIONALS WHEN A POSSIBLE CHILD ABUSE PROBLEM COMES TO THEIR ATTENTION.

THIS MAY BE A PROBLEM NOW, BUT I BELIEVE IT WILL BE LESS OF A PROBLEM IN THE FUTURE, AS PHYSICIANS BECOME MORE FAMILIAR WITH THE TOTAL CONSTELLATION OF RESEARCH AND SERVICE THAT IS BECOMING AVAILABLE FOR THE PROTECTION OF VICTIMS OF FAMILY VIOLENCE. LET ME NOTE JUST ONE EXAMPLE WHERE WE ARE MAKING SOME PROGRESS. THIS IS THE WORK OF DR. ELI NEWBERGER AT BOSTON CHILDREN'S HOSPITAL. WITH THE SUPPORT OF THE NATIONAL INSTITUTE OF MENTAL HEALTH, DR. NEWBERGER, A PEDIATRICIAN, HAS BEEN CARRYING OUT A PROGRAM OF INTERDISCIPLINARY TRAINING AND RESEARCH IN THE DETECTION AND TREATMENT OF VICTIMS OF FAMILY VIOLENCE.

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IN THIS PROGRAM, DR. NEWBERGER BRINGS TOGETHER A GROUP OF PROFESSIONALS ON THE STAFF OF BOSTON CHILDREN'S HOSPITAL. THEY INCLUDE PEDIATRICIANS, SOCIAL WORKERS, RESEARCHERS, PSYCHOLOGISTS AND PSYCHIATRISTS, SOCIOLOGISTS, AND COMPUTER ANALYSTS. WORKING AS A TEAM, THEY PROVIDE HANDS-ON CLINICAL CARE FOR CHILDREN WHO HAVE BEEN ABUSED AND THEY SEEK TO UNDERSTAND THE CAUSES OF THE VIOLENCE WITHIN THE FAMILY, IN ORDER TO PREVENT IT FROM RECURRING. THE RESULT IS A PROGRAM THAT DRAWS UPON A VARIETY OF SKILLS RIGHT AT THE TIME THEY ARE NEEDED MOST. RESEARCH INFORMATION IS TRANSLATED INTO DIRECT PATIENT CARE. IN ADDITION, THE PROGRAM ADDS NEW INFORMATION TO THE KNOWLEDGE BASE REGARDING CHILD ABUSE AND NEGLECT.

BY THE WAY, DR. NEWBERGER IS THE EDITOR OF A NEW BOOK TITLED CHILD ABUSE, PUBLISHED BY LITTLE, BROWN FOR ITS SERIES ON CLINICAL PEDIATRICS. THE BOOK BRINGS TOGETHER THE KIND OF RESEARCH MATERIAL THAT CAN BE APPLIED BY THE PRACTICING PEDIATRICIAN. IT WAS JUST RELEASED EARLIER THIS MONTH. I RECOMMEND IT TO ANY OF YOU WHO WANT TO EXPLORE THIS ISSUE IN GREATER DEPTH.

AND I SINCERELY HOPE YOU DO. I FEEL CERTAIN THAT THE PEDIATRICIAN CAN BE THE KEY FIGURE IN OBTAINING LIFE-PROTECTING SERVICES FOR ABUSED CHILDREN AND IN INITIATING A PROGRAM OF TREATMENT FOR THE PARENTS AS

WELL. I AM AWARE OF THE SENSE OF HOPELESSNESS FELT BY SO MANY HEALTH AND MEDICAL PERSONNEL -- PARTICULARLY EMERGENCY ROOM PERSONNEL -- WHEN THEY ARE CONFRONTED BY PATIENTS WHO HAVE SUFFERED THE TERRORS OF FAMILY VIOLENCE. YET, WE MUST RESIST THAT FEELING AND MOVE ON TO THE BUSINESS OF TREATMENT. OTHERWISE WE ARE CONSIGNING THE CHILDREN AND THEIR PARENTS TO A LIFETIME OF CHRONIC SUFFERING AND DECLINE.

WITHOUT GOOD PROFESSIONAL HELP, THE ABUSED CHILD WILL GROW INTO AN ADULT WHO MAY EXHIBIT A RANGE OF ABNORMAL RESPONSES TO FAMILY, FRIENDS, AND THE COMMUNITY: ANGRY OR DEPRESSED...AGGRESSIVE OR WITHDRAWN... PHYSICALLY VIOLENT OR ALMOST TOTALLY IMMOBILIZED. ALTHOUGH THE "CYCLE OF ABUSE" IS NOT A CERTAINTY, THE POSSIBILITY ALWAYS REMAINS THAT THE ABUSED CHILD WILL GROW UP AND, IN TURN, ABUSE THE CHILD HE OR SHE HAS. THESE YOUNG VICTIMS OF ADULT TERROR TEND TO ABUSE ALCOHOL, DRUGS, AND OTHER SUBSTANCES...POSE A CLEAR DANGER ON THE HIGHWAY... PLACE THEMSELVES AND OTHERS AT RISK AT THEIR WORKSITE...REQUIRE CONSTANT CARE FOR THEIR ACQUIRED PHYSICAL OR MENTAL ILLNESSES...AND, IN A WORD, BECOME A CHRONIC BURDEN TO THEMSELVES AND TO SOCIETY.

ABUSED CHILDREN WHO ENTER THE ADULT WORLD HAVE IN COMMON THEIR VERY UN-COMMONNESS: THEY WILL BE DIFFERENT FROM THEIR PEERS, THEY WILL SEE THE WORLD THROUGH A CRUELLY OBSCURED VISION. THEIR ONLY HOPE IS TO HAVE LANDED WITHIN THE CARE OF A PHYSICIAN WHO HAS A SENSE OF WHAT OTHER KINDS OF SERVICES ARE AVAILABLE FOR THE CHILD AND ITS FAMILY AND WHO CAN PROCEED WITH A COURSE OF RESEARCH-BASED CARE.

EARLY DETECTION AND TREATMENT CAN SAVE BOTH CHILD AND PARENTS. AND, AS PEDIATRICIANS KNOW SO MUCH BETTER THAN OTHERS, CHILDREN ARE THE MOST OPTIMISTIC OF PEOPLE AND, MIRACULOUSLY, THE MOST RESILIENT. IT WAS MY PRIVILEGE FOR SOME 35 YEARS TO BE A PEDIATRIC SURGEON AND TO PERFORM SOME OF THE MOST DELICATE PROCEDURES UPON CHILDREN WHO WERE SUFFERING PROFOUND, LIFE-THREATENING IMPAIRMENTS. I AM COMFORTABLE WITH THE KNOWLEDGE THAT I WAS A GOOD SURGEON. BUT I ALSO KNOW THAT IN MOST INSTANCES IT WAS SOMETHING ELSE...SOMETHING MORE POWERFUL WITHIN THE CHILD ITSELF...THAT ABSORBED THE HURT, THE CONFUSION, THE FRUSTRATION, AND THE SHOCK AND CLING TO LIFE AND TO HOPE. CHILDREN ALSO TEND TO BE FORGIVING, LONG AFTER ADULTS HAVE POCKETED THEIR OWN MEAGER CHARITY AND TURNED AWAY.

CHILDREN READ THE DIARY OF ANNE FRANK AS A BOOK THAT IS UNIQUELY THEIRS. ADULTS READ IT WITH UNMIXED WONDER. BUT I WOULD LIKE TO CLOSE WITH THAT MOST-QUOTED SECTION OF ANNE FRANK'S DIARY, SINCE IT SUMS UP, FOR ME, THE EXTRAORDINARY TREASURE EMBODIED IN OUR CHILDREN AND IS THE MOST APPROPRIATE INSPIRATION FOR ALL OF US TO CONFRONT VIOLENCE AGAINST CHILDREN -- AND STOP IT. JUST TWO WEEKS BEFORE SHE WAS FOUND BY THE NAZIS AND DEPORTED, ANNE FRANK WROTE...

"...IN SPITE OF EVERYTHING, I STILL BELIEVE THAT PEOPLE ARE REALLY GOOD AT HEART."

THEN SHE CLOSED HER ENTRY FOR THAT SATURDAY IN JULY 1944 BY WRITING...

"IF I LOOK UP INTO THE HEAVENS, I THINK THAT IT WILL ALL COME RIGHT AND THIS CRUELTY TOO WILL END AND PEACE AND TRANQUILITY WILL RETURN AGAIN..."

AGAIN, THANK YOU FOR YOUR INVITATION AND BEST WISHES FOR THIS MEETING.

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