

# American Academy of Pediatrics



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## **Benjamin Silverman MD FAAP receives the AAP Section of Pediatric Emergency Medicine “Jim Seidel Career Award for Distinguished Service at AAP NCE in October 2007.**

Dr. Silverman: I am very appreciative and humbled by this award that was created as a memorial to one of the founders of the subspecialty of Pediatric Emergency Medicine, Jim Seidel --- Jim working on the left coast; Steve Ludwig and Gary Fleisher and Fred Henretig in the east; others in the heartland.

Jim’s early death, of course, was a sad and serious loss to everyone here today. His promotion of the concept of dedicated Peds Emergency Care and his innovative political and legislative pioneering upgraded the training and facilities necessary to properly care for children. Those reforms constitute much of the basis on which our Section thrives.

I first worked with Jim during development of the first APLS course manual. One of my roles as Editor was to join with Martha Bushore and Errol Alden to achieve common ground, short of fisticuffs, between Jim and Gary on the many issues where their strong feelings and intelligent disagreements were delaying our publication deadline.

I was later fortunate, though, to have the wonderful opportunity to work closely with Jim, for a few years prior to his death, on the resourceful peds emergency service he had founded at Harbor, a general hospital.

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I’d like to take a few minutes to remind you that -- long before there was a Section on Pediatric Emergency Medicine, there were indeed – pediatric emergencies – many of them the same emergencies we manage today – but our early experiences were a great deal different.

Here are a few examples which illustrate those differences and from which you can extrapolate the progress that has ensued.

### **SECOND SLIDE (dehydrated babies)**

This is 1949. There was a serious epidemic of non-bacterial gastroenteritis in Baltimore that winter. We didn’t know from Rotovirus, but we could determine that bacteria were not involved. The children were markedly clinically dehydrated. We had no microchemistries. It took 5cc of blood for a serum sodium. Specimens had to be drawn

and set aside for Dr. Harold Harrison's technician to run a day or two later. . We managed to hydrate the children parenterally by hypotonic fluid under the skin of the back (known as hypodermoclysis) -- or occasionally with IV fluids which were difficult to monitor -- or orally with an improvised salt/sugar combination. When the sodiums came back, almost all showed severely lowered levels.

One baby, however, who didn't look as dry as most, expired while I was attempting an IV and my Assistant Resident was holding. Her eyes came together; she could not be resuscitated.

Her sodium reported the following day was in the 170's. That Assistant Resident, pictured here with me, holding two other babies from that epidemic was named Larry Finberg. Larry jump-started his career with that epidemic and that baby – and became, of course, one of the most highly recognized pioneers in electrolyte management and particularly hypernatremic dehydration.

### **THIRD SLIDE (heading of cardiac failure article)**

This is 1952. We understood, or thought we understood, cardiac failure in infancy. We had only stethoscope, chest film, EKG and Dr. Nadas' remarkable clinical acumen – no ECHO, no CT, no MRI.. We knew digitalis and diuretics and salt restriction. And we thought we knew all the etiologies of cardiac failure in the neonate (**congenital – truncus, large PDA, critical PS --, atrial tachycardia, myocardial disease, severe anemia**).

Two neonates in cardiac failure, who did not fit our known etiologies of failure, came to our care within a month of each other. We could not resuscitate these two babies. Had we thought of evaluating the cranium, as we did with the second baby, we didn't have a definitive means of examination. With permission, however, we did have access to autopsy.

### **FOURTH SLIDE (brain with AV malformation)**

A massive arteriovenous malformation, with coils of arteries and veins bypassing the capillary bed, and resulting in intractable high output failure. Never previously reported. Now high-tech diagnosable – and even treatable.

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While we didn't have a lot of technology for diagnosis and management, we were active in the prevention of serious pediatric emergencies

### **FIFTH SLIDE (mass administration of oral polio vaccine)**

This is 1965. The inactivated polio vaccine (Salk's) given by injection had been effective for almost a decade. By 1965 the attenuated live virus vaccine, given orally, (Sabin's) had been tested, and found safe. In a program I directed, we immunized 10,000 people in the Princeton NJ firehouses. This was done on 3 weekends, a month apart, using in sequence virus Type I, Type III, and Type II.

Here, Governor Richard Hughes of NJ, a throwback to the days of truly dedicated political leaders, his wife, and his 9 children are in line to receive their doses. That's me in back.

Salk and Sabin were two Jewish boys from New York immigrant families who waged verbal warfare -- the equivalent of the Seidel/Fleisher APLS battles -- as to whose vaccine would be more effective and safer. It seems that Salk has now forged ahead.

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Emergency departments in those days, even in the Children's Hospitals, were run by the surgeons and the orthopods. They took care of almost all the trauma -- and everything else that had lucrative potential.

#### **SIXTH SLIDE (applying band-aid to minor wound)**

Here, a bit facetiously, is a demonstration of the contributions to trauma care they allowed us to make -- - We could apply Band-Aids.

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But in the late 70's and early eighties, came the epiphany, the nirvana

#### **SEVENTH SLIDE (Pediatric Emergency Medicine - first edition, with editors)**

This first edition of the Textbook of Pediatric Emergency Medicine is symbolic of the birth and dynamic growth of the subspecialty. After many years of less than adequate care for children in emergency settings --- in a short time, there developed our dedicated pediatric emergency departments --- pediatric emergency courses -- CHOP course, PALS, APLS, and others -- ped emergency fellowships, our own textbooks, our own journal, our own Academy Section of Pediatric Emergency Medicine, our research programs, our equipped mobile services for children, our diaspora to foreign lands -- Poland, Bulgaria, the Caribbean, South America -- to all the world.

We had arrived -- in a rapid, overwhelming manner

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*Our future clinical mission will depend on the perpetual fine-tuning of the knowledge gained in the past 30 years and on the application of yet undiscovered technology --- while traveling down the new genetic pathways.*

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We also have exerted our considerable influence politically and legislatively – in the promotion of safety medicine bottle caps, of seat belt requirements, of car seats. But we have other continuing legislative battles to win – S-CHIPPS, age limits on off-road vehicles, keeping guns out of the hands of psychotics – both adult and adolescent.

We will miss the determined, bull-dog political capabilities of Jim Seidel,, but we must maintain a vigorous legislative presence -- for the good of children.

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We have thrived as a specialty.

We have given the children of the world a stronger voice, and they are better for it. Carry on with the good things you do.

I thank all of you – particularly Beverly, my children, and my grandchildren.

Benjamin Silverman MD FAAP  
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