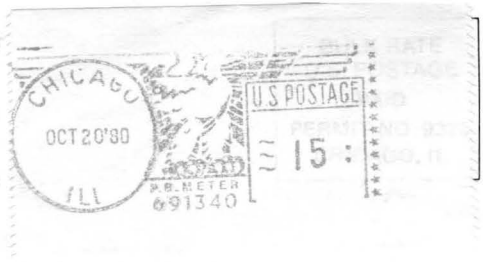
the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

VOL. 4, NO. 10

P.O. Box 982 Evanston, Illinois 60204



Sylvia Lockshin 12-80-12
120 Shelborne - Apt. 909
Toronto, Ont. M6B 2M7
Canada

IN THIS ISSUE:

Child Abuse

Dr. Robert Mendelsohn

What is child abuse? Is it a clear and present danger to children, or is it American Medicine's biggest new growth industry? Headlines in both the mass media and in medical journals reflect this growth: "Abused children don't always become abusing adults," Pediatric News trumpets. "Pair in suburb child abuse face deportation," banners the Chicago Sun-Times. "$5.5 million asked to curb child abuse," reports that same paper, adding that the money will enable the State of Illinois to hire 300 new caseworkers. Back to Pediatric News, "Immunity not absolute for MD reporting child abuse." And, wonder of wonders, in that same august journal, "Diaper rash may actually be indication of child abuse."

In this month's Newsletter, I'll be giving you my thoughts on this subject. But for purposes of introduction, let me quote from Christine Winter, writing on the subject, "Sweden bans spanking" in the Chicago Tribune of May 1, 1979:

"No longer may moder and fader give little Ingmar a good swift slap in the seat of the pants, no matter how richly deserved. Should they try, the little dear can trot off to the local constable's office and turn the folks in.

"...Perhaps the most serious aspect of this law is the yet undefined section forbidding parents to treat their offspring in any humiliating way. Early interpretations indicate that refusal to talk to a child, sending him to bed without dinner, or taking away his privileges would be illegal. In other words, just as 'mental cruelty' is now grounds for divorce, it could be the basis for having mom and dad thrown in the slammer.

"If the section on humiliation is granted a wider application, its ramifications could be quite serious, especially if the fever of 'children's rights' extends to this country. The horrors conjured up in 1984 would look amusing in comparison if 'Big Brother' turned out to be "Little Brother" after all."

As Ms. Winter's words illustrate so well, the child abuse industry is the classic example of the road to hell being paved with good intentions.

Q My 2-year-old child is very shy with strangers. He runs away or starts to cry if someone he doesn't know comes at him with hand extended to shake hands.

I recently read about a doctor who said he could spot a victim of child abuse because such a child would cringe or start to cry if you extended your hand toward him.

Does this mean I'm abusing my child in some way that isn't obvious to me?--N.M.

A

It sounds to me as though you're training your child to be leery of strangers--a very wise thing to do in this day and age. My first advice to you is to stay away from the nonsense offered by that doctor you read about.

Child abuse or fear of strangers?

No one would deny that child abuse exists or that parents who beat their children need help. Yet federal and university grants have turned the study and treatment of child abuse into one of the country's largest "growth industries." Child abuse has become a specialty in itself within the fields of medicine, education and psychology, and this field now supports large numbers of "professionals" whose ultimate goal often appears to be the discovery of at least one child abuser per family.

In many areas, the definition of child abuse is being broadened to include "emotional neglect," a condition so difficult to define that federal experts predict child abuse cases may increase to 10 million under the expanded definition. Even the best parent in the world may at some time be accused of "emotional neglect."

Bring up your child to the best of your ability and don't worry about the countless theories of well-funded "experts."

"Health visitors": An immodest proposal

About a decade ago, I began to develop concern about child abuse, not only about the problem itself (the sight of a battered child is one that no doctor ever forgets) but also about the solutions. As I watched a growing number of professionals enter the area of child abuse, I predicted to my students of medicine, social work and education that child abuse would soon become a growth industry. I facetiously advised those who were interested in a rapidly expanding field to consider a career in child abuse.

My worst fears seem to be turning into reality--the airwaves are full of public service advertisements claiming that a million children a year may be victims of this "disease." Articles about child abuse occur with increasing frequency in the print media. A distinguished pediatrics professor at the University of Colorado (who published his lecture in a distinguished medical journal) recommended the creation of a corps of 60,000 "health visitors" who would go into the homes of ALL babies in this country on a regular schedule until the child reached school age.

The professor, a leader of the National Center for the Prevention of Child Abuse and Neglect, would send these health visitors into every child's home because he feels this kind of service is the "right of every family, along with fire protection, police protection and clean water." He likens the family to an airplane, pointing out that a family, just as a plane, should go through a series of safety checks. He is willing to effect his program through persuasion and education, but if such methods fail, he believes in mandatory intervention through child-protection services. And he does not hesitate to approve limited intrusion into family privacy, voluntary relinquishment of children and legal termination of parental rights.

Obviously, no one is in favor of abusing children. Yet the prospect of this 60,000-person army with legal authority to enter our homes regularly makes one wonder whether the cure is not worse than the disease.

Three obvious dangers present themselves: First, since their economic interests lie in discovering the maximum number of cases, there is little question that many "experts" in the field are doing a great deal of overdiagnosing. Second, since the definition of child abuse now includes child neglect, and since "psychological damage" is included in the definition, any parent who raises his voice at his child might well be included in the category of abuser. Third, the transfer of children

from parents to institutions or foster homes is far from a satisfactory solution. In many cases, such separation has led to even greater damage --or death.

It seems to me that if things are to be kept from getting out of hand, this highly emotional situation must be viewed and evaluated rationally. Child abuse must be defined very carefully and family rights and integrity must be protected fully--and not by the same people who have a vested interest in the diagnosis.

Let me give you one final quote from the distinguished professor's "modest proposal":

"Doctors will have an invaluable resource in the health visitor when they are troubled about the progress of a young infant, and they will be able to gain great insight into the possibility of a postpartum depression, serious marital problems, financial crises or existing attachment difficulties."

As one whose desk is literally buried under letters from readers complaining about "busy doctors," I cannot understand how financial crises and marital problems come under the doctor's purview. He generally is not equipped to deal with such matters. He has enough trouble dealing with the conventional problems of medicine, such as drugs, surgery and x-rays.

Family life in the United States seems to be under increasingly severe attack from a variety of sources, not the least of which is the professional who is "trying to help." The problem of child abuse will not be solved by professionals who abuse parents. You cannot save children by destroying families.

Child abuse by the State

Child abuse stories usually are accompanied by pictures of abused children standing as mute evidence of neglect and injury often attributed to parents. The outcome of many of these cases is removal of children from their homes to placement in state institutions or foster homes.

But in Chicago, one case made headlines a few years ago because a 3-year-old child, who already had been removed from her parents, was beaten to death while in a state-approved foster home. The natural parents previously had complained to the responsible agency, the Department of Children and Family Services, that this child and other children placed in foster homes were being abused.

After the death of the 3-year-old, Judge Mary Hooten of the Cook County Juvenile Court took the family's other children from the guardianship of DCFS and awarded custody to their grandparents. The judge said she had no confidence in the Department's ability to protect these youngsters.

The judge's evaluation of this case coincides with the experience of many who have closely observed the handling of abused and neglected children. While it is common knowledge that some children are beaten by parents and others while in their own home, what is not nearly as well appreciated is the amount of abuse that takes place in foster homes and state institutions which project the image of protecting these unfortunate children.

In his aptly named book, Our Kindly Parent...The State (Viking, $8.95), Patrick T. Murphy, legal expert in the juvenile justice field, has given chapter and verse documenting state abuse of children--abuse that took place despite the best of intentions. "It became my conviction," writes Murphy, "that too many people employed in and around the juvenile court quagmire, whether they were parents or not, were devoted

'lovers of children.' The aroma of love, compassion and best interest permeates juvenile courts. Everything that is done to each child is accomplished in the name of this love. 'This hurts me much more than you, but it is in your best interest.'"

I often have wondered why social welfare agencies, both public and private, are so quick to place children among strangers without carefully exploring the other blood relatives who often are not only available but also eager to take them in. It is as if social agencies and other helping professionals had a built-in anti-family bias. Therefore, I was immensely pleased when I first read of Judge Hooten's decision to place the children with their grandparents.

But what did Judge Hooten gain from her pro-family action? The governor of Illinois said the judge had probably overstated the case against DCFS, and he recommended placing more children in state institutions rather than in foster homes. DCFS then went to court to attempt to prohibit the judge from hearing cases involving child abuse and neglect.

In my opinion, the best way of placing the unfortunate victims of child abuse or neglect is to have the judicial system require social agencies to explore every possible blood relative and to prove all of them unfit and unable to provide care before the placement of children in institutions or with strangers is even considered. I would also like to see financial incentives offered to social workers who manage to place children with other members of the children's own families.

If we Americans really believe all our public statements that our society rests on family strength, Judge Hooten deserved applause for her landmark move in this direction. She should have had all possible support in her attempt to give a family top priority, rather than the anti-family forces that now dominate much of the child-care field.

Q After reading what you wrote about the Illinois judge who took two children out of a foster home and turned them over to their grandparents, I had to write and tell you how much I agree with you. Over and over, I have read in newspapers about cases of child abuse in state-approved foster homes and state-run institutions. My heart bleeds for these youngsters. I often have wondered whether there is any solution to this problem, and what you said about blood relatives caring for these children makes more sense than anything else I have heard. This solution has been forgotten in our "modern" days. Family members need to help one another again, and neighbors also should be called upon to help occasionally.

What is happening in our country today frightens me--mothers are no longer at home, and children are being left alone more and more. And those mothers who DO stay home are made to feel inferior because they have no jobs. Many times, they take their frustrations out on their children. Old people also suffer because of weakened families--no one wants to be bothered with either the old or the young.

God bless you for your old-fashioned values; you are doing a much-needed service. And we need more judges like Judge Hooten.--Mrs. J.D.

A Your letter is typical of the responses of many of my readers. But there is a wide gulf between ordinary readers and some professionals in the field. For an example, please read the next letter.

Q When someone who is poorly informed and knows no better really screws up, I can somehow be tolerant. But when you write about child abuse the way you did, I find all tolerance has vanished. Where in the world do

you think abusive parents learned how to rear their children? Would you place a child with tuberculosis with a grandfather who has active TB? Bob, you know better!!--Ray E. Helfer, M.D., Professor, Department of Human Development, Michigan State University

A

Even though, Ray, you are an old and valued friend of mine, as well as a national authority in the field of child abuse, I must take issue with your analogy. While I might not place a child with tuberculosis with a grandfather who has active TB, I would oppose any doctor, case worker or other "helping" professional who tries to take that child away from his healthy mother, father, aunt or other blood relative.

Family members must be considered innocent until proven guilty; therefore, the burden of proof rests on those who argue that a stranger can better care for a child than can his own blood relatives.

Child abuse or impetigo?

I have often said that the best part of American medicine is emergency care--the treatment of shock, hemorrhage, meningitis, fractures, and the acute abdomen. But, after reading a UPI report of what happened to a 2-year-old child in an emergency room in Parma, Ohio, I am no longer so sure. According to the UPI report, because Dr. Mark Medveneff, working in Southwest General Hospital in this Cleveland suburb, could not tell the difference between impetigo and cigarette burns, he forced Mr. and Mrs. Gilbert Tomitz to surrender custody of their 2-year-old and held the child in the hospital for 2½ days. Quick to jump to the erroneous diagnosis of child abuse (since all medical students are carefully indoctrinated to harbor a high degree of suspicion against parents), the doctor completely missed one of the most common skin rashes in children. A consultant pediatrician who was called in on the case made exactly the same mistake, and the parents were formally charged with "child endangering." The parents were able to spring their baby only after the mother also developed the rash of impetigo.

Now wouldn't you think that, after this kind of error, the doctors might show some sign of embarrassment, maybe even chagrin and remorse? Not according to UPI. Dr. Medveneff "made no apologies for his original suspicions." Furthermore, wouldn't you think the hospital administrators might apologize and, just like any other business, attempt to placate the parents of the damaged child by at least cancelling the bill? Not at all. With the arrogance so often characteristic of health care providers, the hospital asked payment for services rendered under the heading, "Treatment for cigarette burns, suspected child abuse." The parents, of course, have refused to pay the bill and at this time are maintaining a discreet silence on contemplated legal action against the hospital and doctors. The only item missing in this case is the standard doctor-answer, "It's one in a million."

As a result of this not so one-in-a-million case, I now must revise my recommendations for use of emergency rooms: If your child has a skin rash, first talk to relatives, neighbors and friends who may have better judgment in diagnosing impetigo than do some hospital doctors. Above all, if you do see a doctor, and he looks at your child's rash with a glint of suspicion, don't tell him you smoke. If the doctor wants to do further tests, make sure he doesn't rush for the x-ray beam, since in the case of the Tomitz' child, doctors "took x-rays of every bone in his body." Finally, if a hospital threatens to take away your child, you have the same right granted any common criminal, i.e. the opportunity to make one phone call to your lawyer.

Potpourri

Pap test controversy

The fur continues to fly in the wake of the American Cancer Society's February 1980 recommendation that annual Pap tests no longer are necessary for most women between the ages of 20 and 65. At that time, the Society said that a Pap smear once every three years was often enough to determine cervical cancer. But as of mid-August, the American College of Obstetrics and Gynecology has pronounced that all women should continue having Pap tests annually, and a National Institute of Health panel has said the tests should be performed "regularly every one to three years."

So what's a woman to do? Does she listen to the Cancer Society and have a Pap smear every three years? Does she listen to her gynecologist and have the test annually? Or does she listen to the National Institute of Health and run in "regularly every one to three years"?

Perhaps the best way to answer the above question is to understand what the Pap test is all about--it is a smear that is taken to detect abnormal cells in the cervix. As I have pointed out previously (but it bears repeating in light of the present controversy), recent studies have confirmed the link between cervical cancer and the number of men with whom a woman has sexual intercourse, and doctors have known for decades that cervical cancer hardly ever occurs among nuns. Ten years ago, Drs. C. L. Sharp and Harry Keen pointed out in Presymptomatic Detection and Early Diagnosis (Wilkinson), "Several studies have shown declining death rates from cancer of the cervix, but since these were evident even before cytologic detection (Pap test) was commonly in use, there is as yet no conclusive evidence that this type of detection method has played a definite part in reducing mortality....In none of the areas where cervical cytology has been in use for a considerable period has there been a significant fall in the death rate for the condition."

Recently, those 10-year-old conclusions were reaffirmed by Dr. Anne-Marie Foltz of New York University and Jennifer L. Kelsey, Ph.D., an epidemiologist at Yale University School of Medicine. These two researchers also pointed out that there is a 20 to 30 per cent incidence of false negatives in the performance of the Pap test, and they further state that the test became standard recommended policy without ever having been subjected to controlled trials to determine its efficacy.

In light of the above evidence and of the American Cancer Society's recommendations, it seems to me that the burden of proof now rests with the individual gynecologist. In order to justify an annual Pap smear, he must be able to explain to his patient just why she is at risk from cervical cancer. And he must be able to refute the claim of David M. Eddy, M.D., of Stanford University who states that a Pap test every three years would have 99 per cent of the effectiveness of the annual test.

Jewish Bioethics

For those of you who have expressed interest in the sources of my own ethical standards, I call to your attention the latest book edited by Fred Rosner, M.D. (co-editor J. David Bleich), Jewish Bioethics (Sanhedrin Press, N.Y., $7.95). Presenting the Jewish viewpoint on such issues as test tube babies, contraception, population control, artificial insemination, abortion, genetic screening, transsexual surgery, homosexuality, euthanasia, suicide, organ transplants, and human experimentation, this collection of essays by outstanding authorities is expertly edited by hematologist Fred Rosner who also is director of medicine at Queen's Medical Center and professor of medicine at the State University of New York.

Medical News

Are you a woman who has been on Abbott's Tranxene (obviously a tranquilizer)? The July 11, 1980 issue of the Journal of the American Medical Association reports apparently the first case of a severely malformed baby (absence of the penis, scrotum, and anus; shortening of the right thigh and only four toes on the right foot; shortening of the left hand; other deformities of the abdomen, pelvis, vertebrae, femur, fibula, heart, lungs, large intestine, kidney and spleen). The authors of this report, Dr. Daksha Patel and Dr. Ashok Patel of Chicago, conclude, "There was a striking similarity between abnormalities seen in this case and those found in thalidomide-induced abnormalities. Presently the use of clorazepate dipotassium (generic name of Tranxene) is considered ill-advised for pregnant women."

The Physicians' Desk Reference carries a bold-type warning about the use of Tranxene during pregnancy, pointing out, "Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided." But your busy doctor may not have passed on this vital information to you. Nor may he have informed you that other medications in the same (benzodiazepine) group include Librium, Libritabs, Valium, Dalmane and Verstran. Caveat emptor!

Back issues of *The People's Doctor Newsletter* are available at $2.00 an issue from:
The People's Doctor, P.O. Box 982, Evanston, Illinois 60204

Vol. 1, No. 1: Pregnancy & Childbirth
Vol. 2, No. 1: High Blood Pressure & Anti-Hypertensive Drugs
Vol. 2, No. 2: Women as Guinea Pigs: DES... The Pill...Menopausal Estrogens
Vol. 2, No. 3: Anti-Arthritis Drugs: Are the "cures" worse than the disease?
Vol. 2, No. 4: The Truth about Immunizations
Vol. 2, No. 5: The Dangers of X-Rays
Vol. 2, No. 6: The "Disease" of Hyperactivity
Vol. 2, No. 7: How to Talk to Your Doctor (and other medical professionals)
Vol. 2, No. 8: Feeding Your Baby
Vol. 2, No. 9: Fluoridation...Microwave Ovens... A Test-tube Baby...A Special Baby
Vol. 2, No. 10: Psychiatry and Counseling
Vol. 2, No. 11: Coping with Hospitals
Vol. 2, No. 12: Coronary Bypass Surgery
Vol. 3, No. 1: Day Care Centers and Nursery Schools
Vol. 3, No. 2: Tranquilizer Drugs
Vol. 3, No. 3: Interference with Childbirth
Vol. 3, No. 4: Ulcers and Tagamet... Caesarean Sections
Vol. 3, No. 5: Radiation Leaks at Three Mile Island...Sudden Infant Death...Children's Problems
Vol. 3, No. 6: Acne and other problems of adolescents
Vol. 3, No. 7: Hysterectomy
Vol. 3, No. 8: Diabetes
Vol. 3, No. 9: Allergies: Part I
Vol, 3, No. 10: Allergies: Part II... DES Lawsuits
Vol. 3, No. 11: Hazards of Amniocentesis and Ultrasound
Vol. 3, No. 12: Infertility, Birth Control and Vasectomy
Vol. 4, No. 1: Birth Control Pills
Vol. 4, No. 2: Nutrition
Vol. 4, No. 3: Steroid Drugs
Vol. 4, No. 4: Breast Cancer
Vol. 4, No. 5: Immunization Update
Vol. 4, No. 6: Tonsillectomy and the legacy of x-ray irradiation of tonsils
Vol. 4, No. 7: Jaundice and Bilirubin Lights
Vol. 4, No. 8: Cancer Therapy
Vol. 4, No. 9: Unusual Childhood Diseases: Reye's Syndrome, Gille de la Tourette Syndrome, Cystic Fibrosis

---

Dr. Mendelsohn's book, "Confessions of a Medical Heretic," is now available in paperback (Warner Books, $2.75).

Your questions about the medical problems that trouble you most will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, P.O. Box 982, Evanston, Illinois 60204

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $18.00 annually.
Robert S. Mendelsohn, MD, Editor
Vera Chatz, Associate Editor

Another View

by Marian Tompson
President, La Leche League International

An oft-told tale in our family concerns the time our daughters, Allison and Debbi, then four and five years old, were playing house and Allison decided to take back a doll she had given to Debbi just the day before. Unperturbed by her older sister's cries of outrage at this injustice, Allison calmly explained, "That's all right, Deb, I'm growing up to be an Indian giver!" So while I know one person who wanted to be an Indian giver, I've never met anyone who expected to be a child abuser. Yet the number of parents who fall into this category appears to be growing, and it is my feeling that many of them have become unwittingly desensitized toward their children. They are therefore more likely to harm them as a result of what we accept as conventional, safe, maternity care. This care prescribes rigid weight restrictions during pregnancy, routine fetal monitoring, induction of labor, a forty per cent chance of having a Caesarean section, and hospital routines that defeat success at breastfeeding. These procedures result in premature and low birthweight babies and sickly, handicapped infants who, separated from their mothers during the newborn period, are much more likely to be battered later.

Such separation interferes with the unique mother-baby attachment (probably the strongest of human bonds) which is both crucial to baby's survival and development and is the genesis of future relationships. Restricted weight gain during pregnancy can result in a baby who is born prematurely or underweight and is subsequently isolated in a nursery for special care. Induction of labor often results in a drugged delivery and a jaundiced baby who spends days with his eyes covered under bilirubin lights and who often is not allowed to breastfeed.

Since the rise of Caesarean sections following routine fetal monitoring and its negative effect on mother-baby relationships have been well documented, I highly recommend the new booklet "Unnecessary Caesareans--Ways to Avoid Them" by Diony Young and Charles Mahan, M.D. (ICEA, P. O. Box 20048, Minneapolis, Minnesota 55420 for $1.50 plus $1.00 handling). This booklet should be read during pregnancy and should be taken along to the hospital once labor begins.

Drs. John Kennell and Marshall Klaus of Case Western Reserve Medical School have pointed out that when birth was brought into the hospital from the home, it was stripped of many long-established traditions and support systems. Before the rise of hospital births, adjustments to parenthood were made in familiar surroundings with some family support. Babies were put to breast soon after birth and often remained in bed with their mothers. Today, despite many careful studies on the importance of early and frequent contact between mother and baby, many hospitals still keep them separated most of the day, thus sending the mother home with a veritable stranger. Breastfeeding still is poorly handled in many hospitals and this leads to early weaning to a formula, making it much more likely that the baby will be hospitalized for illness which will result in even more separation.

I am quite alarmed at the possible long-term effects of a new drug, Parlodel, which is being given to women who do not want to breastfeed. Parlodel suppresses milk production by decreasing a woman's secretion of the hormone prolactin. Since prolactin actually makes nursing mothers feel "motherly" and more tranquil, it seems to me that reducing its secretion very well might increase the number of abused children.

By stripping the experience of childbirth of so much of its personal impact and unique rewards, we have set the stage for a multitude of problems. Recognizing that birth is an experience which touches all of us, it would seem we all share some of the responsibility for the abuses of that once-natural process. Accepting that responsibility, aren't we all obliged to become part of the solution to the problems of child abuse?