Advisory Committees and Consultants in Programs for Crippled Children

HELEN M. WALLACE, M.D., ROBERT COHEN, M.D. and ROBERT SIFFERT, M.D.

QUALITY of patient care is one of the most crucial issues in planning and administering new programs such as those provided by title XIX of the Social Security Act. In the final analysis, the most significant criterion of success or failure of a program is the result to the patient and his family.

Official crippled children's programs provide directly or are responsible for promoting the provision of comprehensive care and rehabilitation of handicapped children from birth to their 21st birthday. Included in the spectrum of care under such programs are casefinding; counseling and referral of handicapped children and their families; evaluation, diagnostic, treatment, and rehabilitation services; followup services to insure continuity of care; and preventive services, both primary and secondary. By working with other community agencies, crippled children's programs have provided handicapped children with day care, special education, vocational guidance and training, recreation, and residential care.

A major characteristic of the official crippled children's programs, first established in 1935 by title V of the Social Security Act, is high quality of care. Official crippled children's programs have used the term "medical care" in its broadest sense to describe the many aspects of interdisciplinary services that they have provided. Generally, the programs have included all or most categories of long term and chronic illness, as well as the various conditions which reasonably might be expected to improve as a result of rehabilitative services.

A major contribution toward this goal of providing the highest quality of medical care available in each State has been the direct medical care of each child by qualified medical specialists. Another unique feature in some programs has been the approval of only those hospitals and institutions which meet established high standards for the care of handicapped children.

Basically, therefore, the principles of using only highly qualified medical specialists and selected hospitals with high standards have been prominent factors in raising, maintaining, and safeguarding the quality of patient care. These requirements must be coupled with an ongoing plan for coordinating the various medical and paramedical services necessary to manage these children, many of whom have multiple handicaps. Continuity of services is essential with efficient casefinding, adequate followup, and

Dr. Wallace is professor and chairman, division of maternal and child health, University of California School of Public Health at Berkeley. Dr. Cohen, formerly a student in the division, is now assistant commissioner in charge of mental retardation, Tennessee State Department of Mental Health, Nashville. Dr. Siffert is professor and chairman, department of orthopedic surgery, Mt. Sinai School of Medicine, and orthopedic consultant to the bureau for handicapped children, New York City Department of Health.

participation by social workers, vocational and educational personnel, physical, occupational, and speech therapists, and nurses. There is need for free interchange and cooperation between personnel at medical centers and health personnel distant from metropolitan areas.

An efficient means of developing and maintaining high quality care has been to establish advisory committees and to use the services of medical consultants to official crippled children's programs. This paper describes the use of these two methods throughout the country.

Method of Study

In the fall of 1966 we devised a questionnaire covering questions on the use and membership of general and orthopedic advisory committees and on the use of orthopedic consultants by official State and Territorial crippled children's programs. This questionnaire was pretested with the directors of two State crippled children's programs. Following the pretest, the questionnaire was mailed to the directors of the 53 official State and Territorial crippled children's programs early in 1967. Forty-seven directors responded (table 1).

Study Findings

General medical advisory committee. Almost three-fourths, or 34, of the respondents reported having a general medical advisory committee to the State crippled children's program. All but one of the 13 State crippled children's programs without a general medical advisory committee were located in a health department (table 1).

The general medical advisory committees in almost all of the States which had one included a pediatrician and an orthopedist. About half of these committees also had a cardiologist and a neurologist. Most other medical specialties were represented much less frequently, as were dentistry and other professions. Other official State agencies, voluntary agencies, and the consumer were infrequently represented (table 2).

While one State had as many as 18 disciplines represented on its general medical advisory committee, the predominant pattern was to have about five. Most States had nine or less.

Number of specialties or disciplines	*Number of States*
18	1
14	1
13	1
12	1
11	2
9	3
8	3
7	2
6	2
5	9
4	4
3	2
2	2
1	1
Total	34

While most States had a general medical advisory committee, 20 of 34 did not have advisory committee meetings regularly. These 20 directors reported calling meetings on a "when considered necessary" basis. The other 14 directors reported holding meetings regularly. The frequency of advisory committees' sporadic meetings reflects to some extent the intervals at which the program directors sought their advice. While the replies indicated marked variation in interludes (monthly to seldom),

Table 1. Distribution of medical advisory committees and orthopedic consultants, by administrative location of State crippled children's programs

Administrative location	States and Territories circularized	Respondents	Nonrespondents	Provided general medical advisory committee		Provided orthopedic consultant	
				Yes	No	Yes	No
Health department	34	30	4	18	12	7	23
Welfare department	9	8	1	7	1	1	7
University	4	4	0	4	0	3	1
Special commission	3	2	1	2	0	0	2
Education department	3	3	0	3	0	2	1
Total	53	47	6	34	13	13	34

eight States each held meetings quarterly, semiannually, or annually.

The agenda for such meetings usually was prepared by the program director alone in 17 States or by him and the advisory committee chairman in 14 States. In 28 States committee members had an opportunity to suggest topics or to discuss problems not on the agenda.

Separate orthopedic advisory committee. Only four of the 47 respondents reported having a separate orthopedic advisory committee. One of these four State orthopedic advisory committees consisted of a practicing orthopedist, a professor of orthopedic surgery in a medical school, a State representative of the American Academy of Orthopaedic Surgeons, a member of the orthopedic section of the State medical society, and staff orthopedists from the State crippled children's program. In other words, in this one State, there was broad orthopedic representation.

In the second State the committee was composed of a practicing orthopedist and a professor of orthopedic surgery in a medical school. The third State had a practicing orthopedist and a State representative of the American Academy of Orthopaedic Surgeons. The fourth State had a practicing orthopedist, a professor of orthopedic surgery in a medical school, and a State representative of the American Academy of Orthopaedic Surgeons. The membership of such committees was small.

In lieu of such a committee, some States occasionally used the State orthopedic society or the orthopedist staffing the State crippled children's clinics in such a capacity. Two States used a practicing orthopedist only.

Only one State held regularly scheduled meetings of the orthopedic advisory committee. These meetings occurred from very infrequently to semiannually. The agenda was prepared by either the program director alone or with his committee chairman. There was opportunity to add topics for discussion. Only one State program paid its orthopedic advisory committee members.

All four State crippled children's programs which had a separate orthopedic advisory committee and two which used a practicing orthopedist only also had a general medical advisory committee. Three of these six programs were located administratively in health departments, and one each was located in a welfare department, an education department, and a separate commission.

Ad hoc committee. Sixteen directors reported the use of an ad hoc committee for the orthopedic aspects of the crippled children's program. Membership of this ad hoc committee was restricted almost exclusively to orthopedists. The members usually were appointed by the chairman of the general medical advisory committee or by the orthopedic society, generally in conjunction with the director of the crippled children's program. The purpose of these committees was to provide recommendations on policy matters, specific problems,

Table 2. Membership of general medical advisory committees to State crippled children's programs

Discipline or specialty	Number of States
Medical:	
Pediatricians	33
Orthopedists	33
Cardiologists	18
Neurologists	16
Plastic surgeons	14
Otologists	10
Ophthalmologists	9
Physiatrists	8
General practitioners	8
Pediatric surgeons	6
General surgeons	5
Neurosurgeons	4
Public health physicians	3
Radiologists	3
Thoracic surgeons	3
Urologists	3
Anesthesiologists	2
Obstetricians	2
Internist	1
Welfare department physician	1
Dental:	
Dentist	4
Orthodontist	3
Other:	
Administrators	16
Nurses	7
Physical therapists	3
Social workers	3
Speech pathologists	3
Audiologists	3
Psychologists	2
Nutritionist	1
Miscellaneous	[1] 4

[1] 1 director of vocational rehabilitation, representatives of State department of education, voluntary health agency, and consumers.

Table 3. Certification status of directors of State crippled children's programs, by administrative location of the program

Certification status of director	Health department	Welfare department	University	Special commission	Education department	Total nonhealth agencies	Total
All crippled children's programs:							
In pediatrics	5	2	3	2	1	8	13
In preventive medicine	7	0	1	0	0	1	8
In pediatrics and preventive medicine	1	1	0	0	0	1	2
In orthopedic surgery	1	3	0	1	0	4	5
Not certified	16	2	0	0	0	2	18
Lay director	0	0	0	0	2	2	2
Position vacant	4	1	0	0	0	1	5
Total	34	9	4	3	3	19	53
Respondent crippled children's programs:							
In pediatrics	4	2	3	1	1	7	11
In preventive medicine	5	0	1	0	0	1	6
In pediatrics and preventive medicine	1	1	0	0	0	1	2
In orthopedic surgery	0	3	0	1	0	4	4
Not certified	16	1	0	0	0	1	17
Lay director	0	0	0	0	2	2	2
Position vacant	4	1	0	0	0	1	5
Total	30	8	4	2	3	17	47

SOURCE: U.S. Children's Bureau. State agencies administering services under title V, Parts 1, 2, and 3 of the Social Security Act, Washington, D.C., 1966.

standards, fees, or on individual patients. None of the 16 States with an ad hoc orthopedic advisory committee had a regularly appointed orthopedic advisory committee.

Employment of an orthopedic consultant. Of the 47 States, 13 reported employing an orthopedist part time for consultation at policy level. In addition, four other respondents reported an orthopedist was employed as full time director of the crippled children's program.

Thirteen respondents reported the name of the orthopedic consultant. All except one of these consultants were diplomates of the American Board of Orthopaedic Surgery and Fellows of the American Academy of Orthopaedic Surgeons. The one exception was neither.

In 12 States the duration of the orthopedic consultant's employment ranged from 3 months to 30 years, with the mean of 14¼ years.

Of the 13 respondents of State crippled children's programs with an orthopedic consultant, six had a general medical advisory committee, and three had an orthopedic advisory committee and a general medical advisory committee. Less than one-fourth of the crippled children's programs located in the State health departments had an orthopedic consultant while one-third of those located in nonhealth State agencies had one (table 1).

Most States with an orthopedic consultant reported his functions. In general these functions were related primarily to policy and standards of care. In nine States the orthopedic consultant provided direct care.

Function	*Number of States*
Participated in setting standards for services	12
Standardized procedures for treating specific conditions	11
Participated in policy formation	10
Participated in planning overall program	9
Provided direct care to children under the program	9
Selected professionals to serve on panels	7
Selected and reviewed conditions for which treatment was provided under the program	7
Trained personnel	7
Evaluated effectiveness of program	7
Approved services at hospitals, clinics, and other facilities	5
Approved hospitals for payment by the program for patient care	3
Conducted studies	3
Set fee schedules for participating orthopedists	2

Of the 34 State programs without an orthopedic consultant, four used the orthopedic ad-

visory committee for services which might be expected from an orthopedic consultant, and nine respondents stated that they saw the need for an orthopedic consultant in the program. Respondents in these nine programs perceived the orthopedic consultant as providing guidance on policy and treatment of individual patients, as well as selecting medical personnel to care for patients.

Three-fourths of the respondents were of the opinion that services provided by a standing or ad hoc orthopedic advisory committee or a special orthopedic consultant were adequate for their programs. Only three respondents felt that their systems were inadequate. Of these, one had a general medical advisory committee and also had authority to appoint an ad hoc committee. Several other respondents felt their present systems were working adequately but that they needed an orthopedic consultant to assist with policy matters.

About half the respondents stated that they felt a general medical advisory committee was the most desirable method of providing specialty consultation in an orthopedic phase of the crippled children's program. Other methods mentioned considerably less frequently were selection of an ad hoc advisory committee (eight States) and establishment of an advisory committee with both professional and lay members (six States).

The four State crippled children's programs located administratively within the State university were asked for special comments. In general, their comments seemed similar to those from other States.

Program directors' qualifications and use of committees or consultants. The percentage of directors who had specialty board certification and who responded was similar to that of all 53 directors of crippled children's programs (table 3). Forty-nine percent of the responding directors were board certified compared with 52.8 percent of all directors.

It is of some interest that only 41.2 percent of the directors of programs administratively located in health departments were board certified, compared with 73.7 percent of those directing programs administered through nonhealth agencies. Among the respondents, only 33.3 percent of those directing programs in health departments were board certified, compared with 76.5 percent of the directors of programs in nonhealth agencies.

In general, respondents with a program director certified by a specialty board were more likely to use a general medical advisory committee, less likely to use a separate orthopedic advisory committee, and less likely to employ an orthopedic consultant (table 4).

Discussion

A significant finding in this survey was that three-fourths of the responding directors of State crippled children's programs reported having a general medical advisory committee to

Table 4. Advisory committees and orthopedic consultants, by specialty board status of program directors

Committees and consultants	Specialty board status of director		
	Certified	Not certified	Vacant or lay director
General medical advisory committee	14	5	3
General medical advisory committee and separate orthopedic advisory committee	2	1	0
Orthopedic consultant	2	2	0
General medical advisory committee and orthopedic consultant	3	2	1
General medical advisory committee, separate orthopedic advisory committee, and orthopedic consultant	0	2	1
None	2	5	2
Total	23	17	7
Percent with general medical advisory committee	82.6	58.8	71.4
Percent with separate orthopedic advisory committee	8.7	17.7	14.3
Percent with orthopedic consultant	21.7	35.3	26.6

guide the program. Thus, most of the respondents used this method to obtain guidance in planning and administering the program and were of the opinion that this is a useful device. More programs with a board-certified crippled children's program director used a general medical advisory committee than other State crippled children's programs.

In contrast, only four State crippled children's programs used a separate orthopedic advisory committee to guide the orthopedic phase of their programs. However, 16 other States used an ad hoc orthopedic advisory committee.

It is interesting that, altogether, 22 of the 47 respondents used one or the other of the orthopedic advisory committee methods. Certain questions may be raised about this. Is it that the advisory needs are served by using a general medical advisory committee? Is it that the orthopedic caseload in the State crippled children's programs has proportionately decreased? Is it that the orthopedic aspects of the State crippled children's programs are the oldest parts of these programs and that because of program longevity they were considered to need less assistance from a more specific advisory committee?

Another significant finding was that only 13 of the 47 respondents reported the employment of an orthopedic consultant at policy level. This impresses us as being a relatively low percentage.

It is of some interest that the administrative location of the crippled children's program in State government seemed to make some difference in the use of a general medical advisory committee and of an orthopedic consultant. Also, the qualifications of the State program director, using the criterion of specialty board certification, seemed to make some difference in the use of an advisory committee.

Careful scrutiny of the composition of the general medical committee (table 2) revealed that relatively few had representation from disciplines other than medicine. For example, only a few respondents reported representation from dentistry, nursing, physical therapy, social work, speech pathology, audiology, or psychology. Because many handicapped children are likely to have more than one handicap, and because social and psychological problems frequently occur in the child or his family, this was a surprising observation. The present trend is to consider comprehensive and continuous care as essential, so it would seem that greater representation of professions in addition to medicine would be advisable for the guidance of the multifaceted care of handicapped children and their families, especially in policy making, program planning, and implementation. Consequently, a more appropriate name for such a committee may be "general professional advisory committee."

Comprehensive continuous care of handicapped children or anyone with a long term illness and their families has become so complex that no single profession can be expected to provide all aspects of patient care and management. Only through a team effort can maximum rehabilitation be accomplished. Because there is a dearth of evaluative data on the results of the multidisciplinary approach to the management of the handicapped child and his family, compared with the fragmented or solo approach, we suggest that such evaluation be undertaken.

Some of the reasons program administrators gave for opposing the use of advisory committees were (*a*) local circumstances (such as the size of the geographic area), (*b*) the manpower shortage, (*c*) unwillingness to establish or proliferate committees, (*d*) reluctance of the program to intervene in the details of the services being given to individual patients, and (*e*) fear that an advisory committee may take over and perform administrative functions which belong to the program administrator. In the experience of two of us (HMW and RSS), these reasons do not appear to have been well founded. However, a study of the experience of others in the use of advisory committees might serve to substantiate or dispel these reasons.

We believe that the ability of official crippled children's programs to provide services of reasonably high quality to handicapped children and their families has been due to a number of factors. These factors include making services of medical specialists available for consultation, direct patient care, and establishing high standards of medical service within specialized institutions and in institution-based programs.

Advisory committees and medical specialists with an interest in the community have served

as special consultants at policy levels. Also, funds have been spent generously for developing and operating multidisciplinary centers for handicapped children. Requirements for high quality care given by medical specialists have been integrated with the services provided by members of other disciplines through the team approach.

Summary

Responses from 47 of 53 directors of State or Territorial crippled children's programs showed that 34 programs had a general medical advisory committee and these usually included a pediatrician and an orthopedist. Twelve of the 13 programs without such a committee were administratively located in the health department.

Only four States had a separate orthopedic advisory committee and these same States also had a general medical advisory committee. Sixteen directors reported use of an ad hoc committee for the orthopedic aspects of the State crippled children's program. Thirteen States employed an orthopedist part time for consultation at the policy level, and four States employed an orthopedist to direct the crippled children's program.

Of the 13 States with an orthopedic consultant, nine had a general medical advisory committee and three had an orthopedic advisory committee in addition to the general medical advisory committee.

Three-fourths of the respondents believed that services provided by a standing or ad hoc orthopedic advisory committee or a special orthopedic consultant were adequate for their programs. Several other respondents felt they needed an orthopedic consultant to assist with policy.

States with a crippled children's program director certified by a medical specialty board were more likely to use a general medical advisory committee and less likely to use a separate orthopedic advisory committee.

Sanitarians Academy Extends Deadline for Founder Diplomates

The American Intersociety Academy for Certification of Sanitarians has grown to about 130 founder diplomates. Through a recent change in the bylaws, applicants for certification as founder diplomates now have until December 31, 1968, to apply. The original closing date was June 30, 1968.

The academy, incorporated in March 1966, began accepting applications in January 1967. Its purpose is to certify and give recognition to professional sanitarians whose educational background, competence, and leadership in environmental health have been outstanding.

Minimum qualifications for certification as a founder diplomate are a baccalaureate degree with not less than 40 semester hours of academic credit in the physical and biological sciences plus 12 years of acceptable experience. Other provisions, made for professional sanitarians holding a master's or higher degree, reduce the required number of years of experience.

The academy is an outgrowth of recommendations by the Sanitarians Joint Council, which includes representatives from the International Association of Milk, Food and Environmental Sanitarians, the National Association of Sanitarians, and the American Public Health Association.

Professional sanitarians wishing more information about the academy or seeking membership may write to Darold W. Taylor, Secretary, American Intersociety Academy for Certification of Sanitarians, Inc., 2101 Wakefield Street, Alexandria, Va. 22308.