Louis Z. Cooper, MD

Interviewed by
Danielle Laraque-Arena, MD

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Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

Danielle Laraque-Arena, MD

Danielle Laraque-Arena, MD, FAAP is currently, a Scholar in Residence at the New York Academy of Medicine (2019) and the Immediate Past President and Health System CEO of SUNY Upstate Medical University. She is the tenured Professor of Pediatrics with additional appointments in Psychiatry & Behavioral Sciences and Public Health & Preventive Medicine at SUNY Upstate Medical University. She is the first woman to hold the position of President. Dr. Laraque-Arena completed her medical studies at the University of California at Los Angeles. She received the Roy Markus Scholarship (1977-1981) in support of her medical studies. Her internship and residency were completed at the Children’s Hospital of Philadelphia, University of Pennsylvania where she was also a Robert Wood Johnson Fellow in General Academic Pediatrics (1984-86).

Over more than 35 years as a pediatrician, Dr. Laraque-Arena has addressed the health needs of disadvantaged communities. She accepted her first academic position at the College of Physicians & Surgeons, Columbia University and Harlem Hospital Center where she rose to the rank of Associate Professor of Pediatrics (1986-2000). She then accepted a position as Chief of the Division of General Pediatrics at the Mount Sinai School of Medicine. During that period (2000-2010) she was promoted to the position of tenured Professor of Pediatrics and also received the endowed chair as the Debra & Leon Black Professor of Pediatrics and became Vice-Chair for Public Policy and Advocacy. Subsequently, she accepted the position of Chair and Vice President of the Maimonides Children’s Hospital of Brooklyn—the first woman and first African-American to do so in 100 years and Professor of Pediatrics (Investigator Track) at Yeshiva University, Bronx, NY. She is boarded in Pediatrics and in Child Abuse Pediatrics. Her scholarly work has focused on adolescent health risk behaviors, injury prevention—especially related to penetrating trauma - mental health integration in primary care settings, and global child health and has resulted in over 100 peer-reviewed manuscripts, multiple chapters and media resource and educational materials. Most recently she has edited the book, Principles of Global Child Health: Education and Research.

Dr. Laraque-Arena was born in Port-au-Prince, Haiti and immigrated to the United States in 1962. She is multi-lingual (French, Creole, Italian, and English). Dr. Laraque-Arena is married to Luigi Arena, MD, PhD and the mother of two, Marc Anthony Arena and Julia Marie Arena and has one granddaughter.
Interview of Dr. Louis Z. Cooper

DR. LARAQUE: This is Danielle Laraque and I’m here to interview a dear friend, colleague, and mentor, Dr. Lou Cooper. I am here at his house at 80 Central Park West in New York, New York.

Lou, thank you for inviting me to your home, and Mady’s [Madeline Appell] home. I’m so honored to come to say hello to you and to have a conversation about your career and your life and what you have shared with us in pediatrics. So, thank you.

DR. COOPER: Well, obviously, the pleasure of being with you is ours. It’s really an honor and it’s flattering to be invited to participate in the [American Academy of Pediatrics] Academy’s Oral History Project.

DR. LARAQUE: Thank you. So, what I’d like to do is to get a little sense of what you could share with us in terms of your background, your childhood, and what you think may be relevant to how you developed as the physician, clinician, and researcher that you are.

DR. COOPER: Well, since I’m old, it’s a long story.

[laughter]

DR. LARAQUE: And we’re honored to have it.

DR. COOPER: I was born in a small town in Georgia, Albany, Georgia, which is where my mother’s family has lived for many years, and I lived there in my early childhood years. Then, it being the Depression at the end of the 1930s, my parents moved to Ohio and left me in Georgia for a few years, as was the custom in those days. When it was time for me to start grade school, my parents thought the schools were better in Akron, Ohio than in Albany, Georgia, so that’s when I moved up there. I went to school in Akron, Ohio, but spent non-school time, until I went off to college, in a very different setting, the small town, Albany, Georgia. It had less than 20,000 people in it during the years I was growing up there. I did all the things that most kids do during that era, including being bored a good deal of the time.

My school years were remarkably pleasant. School was easy for me, and it allowed me to have a good time, to try to play all kinds of sports. I liked playing all of them and wasn’t very good at any of them, but I had a good time trying. My teachers were good teachers. They certainly stimulated my interests and helped me acquire the skills that allowed me to go to college wherever I wanted to go.

That period was marked by two major global events. One, of course, was the
Depression. That had a substantial impact on me and gave me very strong feelings about the impact of both poverty and race. Both those things, I think, have influenced my world view ever since. Fortunately, my family was comfortable, so I didn’t experience the worst of the poverty during the Depression, though certainly it was of concern to my parents.

Racism in the deep south was a way of life. From my earliest memories, I had a lot of trouble understanding. I didn’t understand how I could play with kids in the neighborhood, and then, suddenly, when it was time to go to school, they went one place and we went another. I didn’t understand why I could go places they couldn’t, and the people who cared for me were really treated in a way that I found difficult to understand. I guess that’s a set of feelings that I’ve carried to this day and that probably influenced much of what I’ve done and how I’ve done it.

This was an era of growth in our country, and optimism. I experienced a tremendous patriotism of World War II, where in contrast to our international conflicts since then, everybody in the community was involved. It wasn’t just a few people who fought the war and everybody else went about business as usual. Sixteen million kids went off to the military and served. I was just too young to be drafted, but my family had many people who went off to war, and we were particularly lucky that they all came back.

I had rheumatic fever as a young child, before the days of penicillin, and I think that gave me a sense of the importance of my doctor and my father’s youngest brother, who was a doctor. I think that influenced me so that I really wanted to do what they did. Science matched what I now call intellectual curiosity, and my interest in public service, probably enriched by both things my family did as good citizens and the Boy Scouts of America, made it natural to want to be a doctor. So, there was never any question that I needed to go to college and then medical school, and that’s what I did. I didn’t have any great sense of where to go to college, but some of my friends went to schools in the northeast. I had a friend who went to a school called Yale [University] and, knowing nothing about it but that it was a nice name, I applied and was accepted. In fact, I never saw Yale until I got off the train, by myself, with my suitcases in hand, as a Yale freshman. I haven’t left the northeast since, except for the times that I spent in the [US] Air Force. I didn’t realize it, but I was a quota student at Yale in those days. Yale had a quota on the number of Jewish kids it accepted, 10%.

DR. LARAQUE: Interesting.

DR. COOPER: I didn’t know about it and didn’t think about it. What I really thought of was that I was part of a quota of all the kids who were premed. Of course, a lot of the kids took all those liberal arts courses and were thinking about going to Wall Street, but a handful of us spent our days
walking up the hill to the science labs. We were there from early morning until late at night, all of us struggling to see how we could get good enough grades to get into medical school. I was insecure about that, but was lucky enough because I majored in biochemistry, to spend my third year of college mostly at the medical school.

DR. LARAQUE: You did?

DR. COOPER: Then even more good luck, Yale Medical School [Yale School of Medicine] allowed 5 of us to skip our senior year and use our fourth year of college, really, as our first year of medical school. In fact, I don’t even think I took the MCAT [Medical College Admissions Test] until I had already been admitted.

DR. LARAQUE: So, you were able to enter medical school in the fourth year at Yale?

DR. COOPER: Yes. And it was wonderful to save a year. Yale Medical School, under the so-called “Yale system,” was much more genteel than many places. You didn’t have to go to class. You didn’t have to take tests.

DR. LARAQUE: Interesting.

DR. COOPER: You did have to do a thesis and you did have to pass the national boards [United States Medical Licensing Examination (USMLE)]. The faculty wives, at about 4:00 every afternoon, served tea and coffee and cookies in the tea room, something that would be unheard of today. First of all, the faculty wives, probably most of them have their own careers. There were 5 women in my class of 80, and that was a big step up. I realized that 2 years ahead of me was a woman, Doris [L.] Wethers. I didn’t realize then what a pioneer she was.

DR. LARAQUE: Doris Wethers is a name that I know.

DR. COOPER: Yale Medical School at Yale College assigned senior faculty as mentors to incoming freshmen. My roommates and I were lucky enough to be assigned to Dr. Donald [H.] Barron at the medical school. He was a physiologist. We learned over time that he was one of the fathers of fetal physiology, having learned how to catheterize in utero sheep from a giant in the field, Dr. [Sir Joseph] Barcroft in London. Dr. Barron steered us through college and medical school and allowed me to work in his laboratory. Another protégé of Dr. Barron’s was a pediatrician that most of us greatly admire who was a classmate, Fred [Frederick C.] Battaglia.

DR. LARAQUE: Sure.
DR. COOPER: That’s where Fred became interested in neonatology. I got more interested in cardiac surgery at that point, and particularly interested in why the ductus closed at birth. That’s one of the many problems that I never solved. Then there was a charismatic medical school teacher who was a junior faculty assistant professor of pediatrics, Robert [E.] Cooke. Cooke was an exciting teacher about fluid and electrolyte balance. So, I went into his lab and spent a year trying to understand the impact of high levels of CO₂ [carbon dioxide] on young rats, to see what the stunting was that kids who had cyanotic heart disease had in those days. That was another of those impossible tasks that only students would look at. Of course, I didn’t solve the problem, but it did make me think about fetal physiology and the physiology of young infants. I thought the cardiac surgery, which was then an exploding field, was exciting. Also, I worked in a polio ward during the last polio epidemic in the United States, just about the same time that trials of the [Jonas Edward] Salk vaccine [for poliomyelitis] took place. The impact of working in a roomful of iron lungs was very sobering.

By the time I was a senior in medical school, I was not sure what I wanted to do, because I liked everything. In helping an intern repair an inguinal hernia, it took us so long that the elderly victim of our surgery went into atrial fibrillation. It was very upsetting because neither the intern nor I had the medical skills to know how to handle it. So, I said that maybe I’d better take a year of internal medicine before I did anything else. Donald Barron, my mentor, who was very wise, said, “You’re not going to like surgery and you really belong in public health.” Why he said that I don’t know, because I had cut every public health class except one during my entire medical school career because I thought that was boring.

DR. LARAQUE: Interesting. What do you think he saw in you, because he wasn’t far off?

DR. COOPER: No, no. I guess he saw that I really liked the community and I liked people in the community. It harkened back, really, to my days in Boy Scouts, and community activities, and the YMCA. I guess he saw things that I didn’t, I paid no attention to, because the world of science was exploding then. After World War II, some key congressmen and Mary Lasker helped put huge amounts of funds into the then developing [US] National Institutes of Health [NIH] so that the stars were all people working in the lab. And with the miracle of the Salk vaccine, and the miracle of antibiotics, and the miracles of being able to operate on people’s hearts, it seemed natural to want to stay and participate in some of those things. But my experience of not knowing what to do with this elderly man who we helped put into atrial fibrillation made me say, “You’d better go learn some internal medicine before you do anything else.”

So, I took a medical internship. Good luck sent me to what was then the Mass
MASSACHUSETTS] Memorial Hospital [Boston City Hospital]—which is now BU’s [Boston University] university hospital in Boston [Note: Boston City Hospital and Boston University Medical Center Hospital merged in 1996 to become Boston Medical Center]—because of Paul [B.] Beeson’s interest in infectious disease. At that time, Chester [S.] Keefer was the chief of medicine. Chester had been the czar of penicillin during World War II. My first rotations as an intern were at the now long-gone [John C.] Haynes Memorial Hospital [for Contagious Diseases] that was the infectious disease hospital for all of Boston. There I had the old polios to deal with, but every day had the problems of the kids with fever, with meningitis, and with pneumonia, and the horrors of kids with complications of measles. I never will forget the screams of the kids with measles encephalitis or the difficulty breathing of those with complex measles-associated pneumonia. Those left lasting impressions. Then, like my peers, I had to go into the service. I liked flying, and so I chose to go into the Air Force and spent several years as an internist in a hospital on an isolated base, Goose Bay [Air Base], Labrador [Newfoundland], which was fun because we were an isolated community and you really served as the community doctors.

DR. LARAQUE: Sure.

DR. COOPER: Not only for the service people, but also for the natives who lived in Labrador, and as backup to the hospitals there, to the small outposts that Grenfell Mission had.

DR. LARAQUE: Can you share with me—because I’ve heard before from other colleagues who were probably of your generation, that they began as internists—how you made your journey from internal medicine to pediatrics?

DR. COOPER: During the latter years of my residency, and while I was in the service, Staphylococcus aureus became resistant to penicillin, so this was a period where hospitals had to close their nurseries. I saw too many young people die with penicillin-resistant staphylococcal disease, including Staph pneumonia. So, because things were happening in vaccine, I foolishly thought, well, maybe I should work on developing a staphylococcal vaccine. My mentor during internship and residency was a giant in infectious disease named Louis Weinstein. He offered me a fellowship, a public health service fellowship, to work on developing a staphylococcal vaccine when I came back to Boston after serving in the Air Force.

While I was in the Air Force, I got a letter from one of the guys I’d known who was doing his military service at Walter Reed Army Institute of Research. He told me that he thought he had found the rubella virus. Both of us came back to work in side-by-side laboratories in Boston. I found working on staphylococcal, developing a staphylococcal vaccine, was making me more and more a biochemist, in fact a membrane chemist. Clearly, my
temperament was not to be a membrane chemist, and I got fascinated by the rubella problem, especially having the discoverer of the virus in the next lab.

DR. LARAQUE: Interesting.


DR. LARAQUE: May I ask around what year that was?


DR. LARAQUE: 1964.

DR. COOPER: When I got there, while working in the lab on a vaccine, the whole world experienced an unusual pandemic of rubella, and my lab was the only lab in the New York area that could use the new technologies for isolating the rubella virus and measuring the antibody. So, the health department called on me for help with pregnant women who were thought to have rash illness and maybe rubella in pregnancy. During that time, I discovered how hard it was to make a clinical diagnosis of rubella, and how dependent we were on the lab. As these women delivered—because 75% of them had their pregnancies terminated—suddenly, I had mothers showing up at my lab or I got called by doctors from the New York hospitals all over New York, saying, “Would you come see this baby because I wonder if this baby has rubella in pregnancy because the mother had rubella.” Over the course of a year, I saw some hundreds of babies with what we now call congenital rubella syndrome [CRS]. Because, for the first time, we had laboratory tools and we could confirm what was going on. We discovered this paradox, that these babies were still infected and that they could be sources of contagion to people who took care of them, which I duly reported to CDC [US Centers for Disease Control and Prevention]. Then others began to see the same thing in other places. Well, it’s not my nature to do research on patients and not provide care.

DR. LARAQUE: Right.

DR. COOPER: Suddenly, I was seeing tiny babies with multi-organ disease, seeing them literally in my laboratory, and I’m an internist. Fortunately, because I saw babies in hospitals all over New York City, the kindly neonatologists and pediatricians spent time showing me how to feel a spleen in a 1,500-gram baby. The ophthalmologists began to show me how to
look at their eyes. So, I don’t think I was doing any harm, but I knew I needed help, because I couldn’t do research on these babies who had this paradox of still being infected with virus, but had high levels of antibody.

DR. LARAQUE: Interesting.

DR. COOPER: It was a new era in immunology, and I felt that we could learn something about the immune system and the spread of this disease if we kept these kids together. So, at the end of 1964, I asked the health department to give me some nurses, because all I had working with me are technicians.

DR. LARAQUE: Not clinicians.

DR. COOPER: So, the city health department gave me a couple of public health nurses, and the March of Dimes gave me a $14,000 grant to create a clinic to take care of these kids. That little clinic evolved into a multidisciplinary medical, educational, and social service entity, where, before we were through, we had seen over a thousand kids. But what became important was that I needed to be able to function as a pediatrician. Saul Krugman, who was one of the partners in this, said, “Why don’t you move over from the department of medicine into the department of pediatrics, because we can help you better there.” And so I did. I made rounds on the pediatric wards, and the residents, the other faculty, and the patients became my teachers and made me into a pediatrician. I remember, I still had the attitude and style of an internist, and so after I’d been there maybe 6 or 8 months as an attending, Saul called me in and said, “You’re too hard on the residents.”

DR. LARAQUE: [laughs] That’s funny.

DR. COOPER: And given the style of pediatrics at NYU, in Bellevue, it was in sharp contrast to the style of the department of medicine there and everywhere else I’d been, where everyone senior to you took you to the limits of your knowledge, until he could embarrass you, or she could embarrass you, with your ignorance, which is not the way pediatricians think.

DR. LARAQUE: Right, generally.

DR. COOPER: You’re supposed to teach people to learn. I’ve been very lucky in many, many ways, but I don’t know of anything that was luckier professionally than that my research took me to taking care of babies and mothers. Then Saul Krugman said, “Why don’t you leave the department of medicine and come into the department of pediatrics.” It was just that simple.
DR. LARAQUE: Yes.

DR. COOPER: It was not planned, and I’ve been there a happy 40-plus years since.

DR. LARAQUE: You have an incredible story in terms of the mentors, your own intellectual sort of curiosity, what you experienced, and your own sense of humanity, which I’m hearing together. So, I had some questions for you, and I’ll tell you what they are, but I think you’ve answered many of them. What fueled your passion for medicine? And what fueled your passion—and I’ll come back to that—for the AAP? I know you as an incredible advocate, so what fueled your passion for advocacy? And then, because of your global impact, what fueled your passion to go beyond the borders of the United States to have a major influence on the lives of children around the world? But I do want to ask you those questions, too. You’ve answered many of them for me in just your story, but perhaps you can help me to understand that.

DR. COOPER: Well, while I was doing all that, I had my own 4 children. I had a wife who was increasingly ill with a schizophrenic disorder and I saw how hard it was raising everyone. But, because I was a doctor and had access to resources, we all were able to do okay. My wife’s illness was before the availability of many of the psychoactive drugs, and so she spent long periods of time in the hospital and eventually died.

DR. LARAQUE: I’m sorry.

DR. COOPER: It made me realize how hard it is to raise a family and how fortunate my family was compared to many. I guess it reminded me of my early days and seeing the difference between people who had resources and those who didn’t. As a doctor, how do you give more value to one baby that you’re taking care of versus another? And it matched my sense of social justice—that you have to do something about it. My father was a classic FDR [Franklin D. Roosevelt] liberal, and my religious faith talked about the importance of doing justice and loving mercy, and my professional skills put me in a position where I could sort of do that. But when I suddenly had dozens and then hundreds of babies of all socioeconomic strata, who had bad disease because of congenital rubella, it became clear that what people like Hillary [Rodham Clinton] and others now popularize, “it takes a village.” It made me realize that these families needed a lot of help. And so, suddenly, I was able to take the kids who were deaf and get some of them into the schools for the deaf or into schools for the blind, but because of the size of the epidemic, we very quickly filled all the special facilities. I was suddenly left with dozens of kids who were multihandicapped and going deaf and blind. I guess, in my ignorance, I talked with some school superintendents and others and ended up going to Congress with these people, and collectively, we got Congress to pass the first federal special education legislation, after the
creation of a Bureau of the Education for the Handicapped [now known as
the Office of Special Education Programs]—the first very legislation
[Handicapped Children’s Early Education Assistance Act of 1968]. I was
able to convince Congress because I took them data, and it was real data on
real people. I took the data and their stories with the help of the
superintendent of the [Perkins] School for the Blind, the Perkins School in
Boston, and the New York Institute for the Education of the Blind [now the
New York Institute for Special Education] here, and the superintendents
from Michigan and California. It was a very interesting political force.

DR. LARAQUE: Sure.

DR. COOPER: They were much older, typical superintendents of big
schools, but I had the data.

DR. LARAQUE: Right.

DR. COOPER: So we got a law passed, which by the way is still part of
what then became the Handicapped Children's Education Act [Education for
All Handicapped Children Act (Public Law 94-142)–enacted in 1975], and
then it became IDEA, Individuals with Disabilities Education Act [amended
to IDEA in 1997].

DR. LARAQUE: Sure.

DR. COOPER: But what was exciting was that, we put in that first law, in
about 1968, the characteristic that the schools had to provide the kind of
program the child needed, rather than what was the paradigm before,
namely to get into a school, the kid had to fit what the school was. So, it
absolutely reversed the paradigm and became now known as every child
being eligible for a free and appropriate—and the word is appropriate—
public education. Most people don’t realize that started in 1968 with that
simple law, for which I think we got $4 million for the whole country.
Because it was so little, it also had another quality, which was
regionalization. So its features included appropriate education—the school
had to meet the needs of the kids; it could be regionalized across county or
state lines; and most important, it could start at birth. It was the first early
education and it could be multidisciplinary and provide other services. So,
the characteristics that now people accept as in IDEA, all started when we
put it into that law.

DR. LARAQUE: Interesting.

DR. COOPER: In 1968, I guess, maybe 1969, I can’t remember. In the
meantime, I brought the social service and special schools in the city together
for a big meeting to talk about a community crisis, and that helped to get
them to expand their programs. I promised some of these places that if they would take in kids that they otherwise were afraid of, we would provide the health services. So that created the school health programs.

DR. LARAQUE: Interesting.

DR. COOPER: Everything from the Public School for the Deaf, junior high school, "47" [PS 47 The American Sign Language and English Secondary High School], to the Lexington School [and Center for the Deaf], to the New York Institute [New York Institution for the Blind, now New York Institute for Special Education (NYISE)], to St. Joseph’s [School for the Blind], et cetera. It really expanded my interest in these things. In the meantime, nobody wanted 60 kids who were multihandicapped, deaf, and blind infants, and young children, toddlers. I went to the board of education, then at Livingston Street, and said, “Give me a teacher of the deaf, give me a teacher of the blind, and give me a teacher of the brain injured, and we’ll create a school.” At the same time, I knew Howard [A.] Rusk had just renovated space at Bellevue, and he didn’t know what to do with it.

DR. LARAQUE: Interesting.

DR. COOPER: So I went to Howard and said, “Howard, can I borrow your space?” He got the space and got the money because of a lawyer’s mistake. Anyone who doesn’t believe in serendipity and fate just hasn’t lived long enough. Bernard [M.] Baruch was a great financier and advisor to presidents and a very rich man in New York. Howard Rusk, who founded rehab medicine, charmed all these people, and so Baruch left money to Howard Rusk in his will, but his lawyers had left it to him at Bellevue Hospital. By this time, he’d build The Rusk Institute [of Rehabilitation Medicine] and he would rather have had the money go to NYU, to the Rusk Rehab, but it was for Bellevue. So that’s why Howard had the money to renovate the space at Bellevue and he didn’t have anything to do with it, so I guess he was delighted that I took it off his hands. So, I took these teachers from the board of education and gave them the space and said, “Here are the kids, evaluate them and let’s get this started.” Well, of course, the best teacher in the bunch was a teacher who had been in the board of education infant auditory training program. She had worked with infants at that time. She was at Jacobi Hospital, I think, but had been at Kings County [NYC Health + Hospitals/Kings County]. She joined this group and she was clearly a leader. She built the program and began to teach me things about child development that I didn’t know. In order to keep her from leaving—by then I was a single dad—I had to marry her.

DR. LARAQUE: [laughs] I didn’t see that coming. You snuck that one on me.

DR. COOPER: It’s true. So that’s the person who helped me build these
DR. LARAQUE: [laughs] That was fun.

DR. COOPER: But, that’s how it happened.

DR. LARAQUE: Well, but I didn’t realize it was getting to that, so that’s wonderful.

DR. COOPER: I remember going with her to the then-superintendent of special education in the city on Livingston Street. She was frustrated by the board and she told them she was going to quit, and she quit so that she could take over running the whole program and she did.

DR. LARAQUE: That’s great.

DR. COOPER: That program lasted, you know, another 40 years, until I moved on. After 10 years at Bellevue, I had a chance to take over Ed [Edmund N.] Joyner's [III] program at Roosevelt [Hospital]. One of my frustrations at Bellevue was 30th Street, because Bellevue was south of 30th Street and the University Hospital was north of 30th Street. I was frustrated by the difference in care and facilities up at University Hospital versus what I had to work with at Bellevue, though Bellevue had a C & Y [Children & Youth] clinic, a comprehensive care clinic.

DR. LARAQUE: And I remember the C & Y.

DR. COOPER: It was hampered by the pediatric faculty having to go back and forth and splitting their patients. When I was asked to look at Roosevelt, that also had a C & Y clinic. There was no municipal hospital on the west side of Manhattan. So I said, “Hmm, here I can give one class of care to everybody and I'll be the boss.” And I moved with 25 of my full-time staff from NYU Bellevue to St. Luke’s [St. Luke’s-Roosevelt Hospital Center], then Roosevelt Hospital [now Mount Sinai West].

DR. LARAQUE: What year was that?


DR. COOPER: I stayed there through all of the mergers and related processes. That’s what brought me back to Doris Wethers, and we worked together. What brought me also to Roosevelt was that Dick [Richard E.] Behrman had become the chairman at Babies Hospital [now NewYork-Presbyterian Morgan Stanley Children's Hospital] and had gotten a big
Robert Wood Johnson [Foundation] grant, 2 grants, to regionalize primary care on the west side of Manhattan. At the same time, Solan Chao had gotten a grant to improve maternal care in the Columbia hospitals. So our fantasy, and what the grant said, was that we would regionalize all the services at St. Luke’s, Roosevelt, Harlem [NYC Health + Hospitals/Harlem], and Babies, with certain high tech services staying at Babies, and all of us working in a regional way.

DR. LARAQUE: Hmm. Interesting.

DR. COOPER: It was also a time when regionalization of neonatal care was becoming fashionable. L. Stanley James was doing that at Babies where he trained John [M.] Driscoll [Jr.].

DR. LARAQUE: Sure.

DR. COOPER: So it seemed an ideal way to do the whole western half of Manhattan and to have primary care where it belonged. We had a series of school-based health clinics at Roosevelt, where we used the same concept we used in what had become known as the Rubella Project, namely doctors, nurse practitioners, social workers, family health workers, and public health nurses working with the educational system in team delivery of child care.

DR. LARAQUE: Sure, sure.

DR. COOPER: The goal was to really do that on the whole west side. Well, Dick Behrman couldn’t get the powers that be at Presbyterian Hospital [now NewYork-Presbyterian Hospital] to think in terms of region. They didn’t want to share.

DR. LARAQUE: Interesting.

DR. COOPER: And so Fred [Frederick Chapman] Robbins lured him to Case Western Reserve [University], and I was left to continue hacking away, and I did. I had the good luck to recruit a wonderful faculty at Roosevelt, which then went into a usual dogfight merger with St. Luke’s, that Doris and I worked out, we thought well, on the pediatric side. We enjoyed that relationship until after 25 years, St. Luke’s-Roosevelt, basically, rather than joining with Presbyterian and Babies Hospital, got bought out by Beth Israel [Medical Center], and the leaders then of organized medicine were interested in building temples of hospital care, and high tech care, and cardiac surgery and wouldn’t listen to me. So, 25 years to the day, I walked out. That was 1998.

In the meantime, the Academy had become an increasingly important part of my life, because when New York was in deep trouble, guys who were then
pediatric leaders were very humanitarian and asked me to do a report on unmet health needs for kids and that brought me into contact with Helen Rodriguez-Trias and Doris. Because I was having increasing responsibility to get people paid, that got me involved in the Academy, and then in health financing, and more importantly, Peter [A. M.] Auld, who was the neonatologist at Cornell. I got called by the chairman of the chapter nominating committee saying, “How would you like to run for president of the New York Chapter, Chapter 3?” That was 1978, so I was already doing stuff. So, I said fine and I became chapter president. That brought me into the first, then called annual Chapter Forum, where there were almost fistfights, it was so disorganized.

DR. LARAQUE: Oh, I remember those days.

DR. COOPER: That led me into the whole arena of health financing. I served on the first [AAP] Committee on Child Health Financing, where a lot of smart people taught me more things about Medicare and Medicaid and third-party payments, and I saw what was frustrating in New York. We then had a district committee that met and talked, but we couldn’t get anything done in the state because we were 3 separate chapters. When Dave [David] Annunziato became the district chair, I said, “You know, we have to bring this state together. If you’ll let me work with the other chapters, we’ll build a program that becomes statewide.”

DR. LARAQUE: Interesting.

DR. COOPER: That’s how New York really became a leader in all the child health legislation of the time—the simple stuff, like getting vaccines and so forth. But the most important thing was really that we created CHP, Child Health Plus, 3 years before a federal program, because we saw that it was the working poor who did not have access to care. We created Child Health Plus, which became federal CHIP [Children’s Health Insurance Program]. By the time the federal bill was passed, we already had 400,000 low income working families, kids, in Child Health Plus.

DR. LARAQUE: Sure. And New York has led the way since then.

DR. COOPER: And New York has led the way ever since then.

DR. LARAQUE: Right.

DR. COOPER: We did that by bringing together the child advocacy groups and working with the state medical society [Medical Society of the State of New York (MSSNY)]. I chaired the Medicaid committee of the state medical society. Always the Republicans controlled the Senate and the Democrats controlled the Legislature. The pediatricians had more juice in the
Legislature, but the medical society had more juice in the Senate, so we worked together. Working with David Axelrod, who was then the health commissioner—

DR. LARAQUE: I remember David.

DR. COOPER: —we looked at a number of different ways to expand services for kids. Axelrod and [Governor Mario M.] Cuomo came up with a number of things which turned out not to be palatable. Then I decided, let’s take advantage of the bad debt and charity monies that the hospitals love. And so what we did was with Dick [Richard N.] Gottfried and his staff.

DR. LARAQUE: Who is obviously still here.

DR. COOPER: Who is still here. And Mike [Michael J. Tully], who was the Senate Health Committee chair, now replaced by Kemp Hannon. Dick’s staff helped to design a bill that would make access to ambulatory care available to kids above the Medicaid line. We knew that wouldn’t cost too much money. I then went to the leadership of the Greater New York Hospital Association and HANYS [Healthcare Association of New York State] and said, “You’ve got to give us $25 million out of the bad debt and charity [care] billion that you got,” and they were a little resistant to that.

DR. LARAQUE: [laughs]

DR. COOPER: But I said, “If you don’t do that, I’m going right down to The [New York] Times reporters here in the capitol and I’m going to say, you greedy hospitals won’t give us a tiny piece of your money to keep kids out of the hospital.”

DR. LARAQUE: Interesting.

DR. COOPER: [laughs] And they saw the logic in that, the political and economic logic of that, and that’s how we got the first Child Health Plus bill passed. Then, we also did it for kids under 6. But I knew that next year they’d be 7 and that families that had this insurance were not going to be happy giving it up. So, we got the Legislature to up the age, I think to 8, and then the details are fuzzy. That’s when [Governor George E.] Pataki came in. Pataki wanted to cut state budgets and he did a lot of things that liberal New York was not happy about. We convinced the new Commissioner of Health [for the State of New York], Barbara [A.] DeBuono—

DR. LARAQUE: I remember.

DR. COOPER: I convinced the Pataki administration that they needed, really, a fig leaf to show that they really were not anti-family.
DR. LARAQUE: Right.

DR. COOPER: So we got them to raise the age limit and, even more importantly, to include inpatient services. So that expanded the next cut, and then we added dental and vision. So we did it incrementally, and that was all, I think, in the law by the time the federal law was passed.

DR. LARAQUE: Interesting. So I want to transition a little bit, because I’m listening very carefully to sort of the evolution of this, with 2 questions. One is, given everything that you’ve described—I don’t know how to say it, but I’ll say it in a sort of trite way—the pearls of wisdom with respect to new physicians or young physicians who are entering this profession, and what advice you have or what reflections you have? But the other is that we’re in the midst of a healthcare transformation that obviously resonates with a number of things you’ve talked about—interdisciplinary team-based care, inpatient, outpatient, the continuum of care. I’d ask if you could comment on those 2 things—this next generation of physicians, whose journey is going to be in the next 30, 40 years, and then what our healthcare system is evolving to and whether you could help me understand what you think is the road ahead for us as a profession and as a society?

DR. COOPER: I don’t know the road ahead, but I do know what the principles are that we should fight for. Twenty-some years ago, if you look back to the *New York Pediatrician*, that publication, you’ll see I wrote a piece on the corporatization of American medicine, that what we were doing was being turned into a commodity rather than a service, and that most of us went into medicine as a career of service. The things I wrote 20 years ago have become painful and worse, so the horse is out of the barn. In my judgment, society is suffering, the profession is suffering, and our patients are suffering, there’s no question.

There’s no question you can get the best high-tech care in our best hospitals, but it’s very expensive and it’s often too late because the primary care services weren’t there when they should be, the preventive services weren’t there. And we’ve lost continuity of care and continuity of relationships. The most important therapeutic tool that I’ve ever had has been a trusting relationship with my patients, with their families.

DR. LARAQUE: Sure, sure.

DR. COOPER: And knowing their families. We’re getting more and more away from it, and so we’re losing a tremendous therapeutic tool, a tremendous diagnostic tool, in the interest of a corporate model, which is geared to a cash register kind of mentality. The incentives started on the wrong track with the arrival of health insurance, with Blue Cross [Blue Shield], just before World War II.
DR. LARAQUE: Yes.

DR. COOPER: I remember well, to feed my family, moonlighting in a small town in Massachusetts, where the best thing that would ever happen to me would be an infant who would come in with a fractured clavicle, because I would get more money from Blue Cross for a sling for the clavicle than for spending hours taking care of kids and their families in complex needs, for which I got paid in crumpled one dollar bills, if I got paid. And you know the rest of the story.

DR. LARAQUE: Sure.

DR. COOPER: Procedure based. And it’s gotten worse and worse, and hospital presidents’ salaries have gone up and up. When I was at Bellevue, Randy [Randolph A.] Wyman was the superintendent of that huge hospital and he ran it with 3 old nurses, one of whom was the night superintendent, who was Donna O’Hare’s mother.

DR. LARAQUE: I know the name Donna O’Hare.

DR. COOPER: Whom I talked to yesterday. By the time I finished as a department head, not only did I have a staff of administrators, but my divisions had administrators. If you look at the rise in personnel, there’s nothing in terms of increase in personnel that matches the rise of administrative personnel, obviously some of whom are wonderful, and who we’ve become very dependent on. But part of the reason we need all those administrators is how convoluted our system has become and our financing system has become.

DR. LARAQUE: Sure.

DR. COOPER: The most important guy in the hospital is the chief financial officer.

DR. LARAQUE: Whom I spoke to yesterday.

DR. COOPER: I could find it. I saved a copy of the New York Pediatrician, in which I talked about my fear of the corporatization of medicine. The savior has to be what has saved the Academy, which is remembering our mission, which is always what’s in the best interest of our patient. And then we have to recapture the political high ground. And as we go through what’s a necessary set of convulsions, because we’re a sixth or fifth of the nation’s economy, try to realign incentives to what people need.

DR. LARAQUE: Right.
DR. COOPER: Incentives that don’t exaggerate the redundancies in services that ought to be regionalized, incentives that support preventive care, that support creation of relationships between providers, whether they’re doctors, nurses, physician assistants, because this is at the heart of medicine—whether it’s management of infectious disease, or early diagnosis, or the mental health issues. Increasingly, the behavioral issues are best dealt with through relationships. I can’t counsel you about your weight or your other behaviors if we don’t have a relationship. Our incentives have to realign to do that, and our training programs have to help us have the skills worthy of that.

DR. LARAQUE: Right.

DR. COOPER: So, what’s my thought about the future? You know, I have 2 kids who are doctors, they’re your contemporaries, so they’re in mid career and mid career plus. But if their kids go into medicine, I hope they go because they see it as a service, and that we structure it so that they can be allowed to be good servants.

DR. LARAQUE: Right. So, I want a little bit of your reflections on the following area that loops back to some of the things that you mentioned when you talked about your childhood and your observations of social injustice with respect to race.

DR. COOPER: And gender.

DR. LARAQUE: Right, race, gender, and a number of things, but certainly in this country, in terms of race and gender issues. And my question is this: we know the statistics in terms of the increasing diversity of this nation. It began as a nation of immigrants and it has continued with different waves of immigrants. Can you share with me, a little bit, your perspective on that diversity and a sense of inclusion of individuals in our own profession in pediatrics? You obviously have been president of the American Academy of Pediatrics, and so you know this organization well. Can you reflect with me a little bit of our own sort of journey with respect to diversity and inclusion?

DR. COOPER: Well, I believe the richness of New York City, where we live, is absolutely dependent upon our diversity, and the new people who bring talent, and talent into an environment where diversity is prized—not just tolerated, but prized. It’s easy to remember my childhood, so that gave me a sense of race. It’s easy to remember the stories I heard from mothers who had badly damaged kids, who couldn’t get their pregnancies interrupted. It’s easy to remember the botched abortions in the emergency room.
DR. LARAQUE: Sure.

DR. COOPER: One of the mothers had a very badly damaged child, whose name was Hope. I asked her why she named the child Hope. She was a postman’s wife with 5 other kids, living in the projects. She said that she knew she had rubella and she’d been told that if she stood on a street corner on the Grand Concourse with $200, she could get her pregnancy terminated. A guy showed up to take her and he said, “No, it’s $300.” She didn’t have the money, so she went home and hoped, and that’s how the kid got the name Hope. So between the botched abortions, the failure, especially of poor people, to get terminations when I knew they had a high likelihood of a bad outcome, I ended up testifying before the New York Legislature on the early right to abortion laws, because New York passed it before Roe v. Wade. In fact, I testified in the famous [Jane E.] Hodgson case in Minnesota, which was an obstetrician who was being charged with doing quote, “illegal abortion.” So that reinforced my views about women’s rights to choose and how they were overrun by the male dominated community. And then I had 2 daughters, and one of the things, nicest things, my daughters have said to me was, “Dad, you never suggested that we couldn’t do anything that you let the boys do, that we could do whatever the boys did.” I grew up in a typical male-dominated environment and I told all the jokes and did all the things that guys do, and chased girls just like everybody else—and still would if I could, but I can’t catch them.

DR. LARAQUE: [laughs] I won’t tell Mady. I’m kidding.

DR. COOPER: But I also began to see some brilliant women and realized that, my God, you’re better organized and often more talented than we are, so we’d better make sure that we do have equity in the Academy. As I say, there were 5 girls in my medical school class and my school had no girls. The Academy was totally male dominated when I joined the Academy. But I was in a chapter with people like Doris and Donna O’Hare and Helen Rodriguez-Trias and recognized how superior they were. It just seemed that doing anything except demanding equity was wrong, wrong, wrong—not very complex. That’s my position today and it has been for a long time.

Abortion came difficultly, you know. If you have the sanctity for life, there’s something inherently difficult emotionally for me still about abortion. And my religion doesn’t have any issue there, but it’s not any help either. But what I know is that when pregnancies aren’t wanted or are unlikely to bring us healthy children, imposing society on a woman’s choice is wrong. As I say, just the accident of hearing these stories from mothers because of the rubella stuff, and then I got involved in the political process, and then the court reinforced that along, and of course I had 2 daughters. Being basically curious, there are lots of things I’ve gotten involved in, but always, I think, a sense of social justice and mercy has been at the heart of it.
DR. LARAQUE: Can you reflect with me a little bit in terms of—perhaps I can interject a little bit in terms of being a woman, being Haitian American and African American, the issues that are combined with gender and race, et cetera—to reflect with me a little bit from the Academy in terms of inclusion of not only women, where we’ve made some progress, although we’re not there yet, but with respect to inclusion broadly. And obviously, we’ve broadened to, say, LGBTQ and other areas. Reflect with me a little bit and what you might think we have to do going forward.

DR. COOPER: I’m not sure we have to do very much. I think our children are now way ahead of us, and my children’s children are way ahead of us.

DR. LARAQUE: Yes, mine too.

DR. COOPER: One of the things that keeps me optimistic, in spite of all the horrors of the world, is that in my lifetime, I’ve seen a profound change with regard to race and I’ve seen profound change with regard to gender issues, and that’s historically startling.

DR. LARAQUE: Right.

DR. COOPER: My grandchildren, it’s a nonissue.

DR. LARAQUE: Yes. They see the world differently, right. So perhaps we can take a pause.

DR. COOPER: Oh, and I remember when we had to have these women’s breakfasts in the Academy.

DR. LARAQUE: I remember.

DR. COOPER: Women are taking over the Academy and I worry about that, not because of lack of skill.

DR. LARAQUE: No, I understand what you’re saying.

DR. COOPER: But until we get the equity issues taken care of, teachers get underpaid because they’re women, nurses have gotten underpaid because they’re women. Pediatricians have gotten underpaid, even when they weren’t women. And now that they are women, it only adds to the risk of child services, child services generally, being undervalued—whether you’re a worker in a childcare center or a teacher.

DR. LARAQUE: Sure.
DR. COOPER: That’s my one real concern, that we be careful not to perseverate on this undervaluing of things that women traditionally have been pretty good at.

DR. LARAQUE: Right. Good, so we’ll take a pause.

[break in recording]

DR. LARAQUE: Okay, so, Dr. Cooper, after a lovely dinner—[laughs]

DR. COOPER: Thank you, Madeline.

DR. LARAQUE: I really enjoyed the conversation with you and your company and Mady’s company. I think my last question is whether there were things you want to share with not only me, but our colleagues? I think a lot about the young physicians who are entering this field, so sort of any reflections on that?

DR. COOPER: Working in the Academy has enriched my life and Madeline’s beyond my imagination because I found that there were so many pediatricians in this country and elsewhere around the world who really do care about the well-being of children. That’s been such a privilege, to know these people and to learn their lives, their cultures, their custom, but the commonality of focusing on the world made of kids has just been something very special. What I particularly prize is that the Academy, which is a year older than I am, was founded by pediatricians on behalf of children. In my 40-plus years of working with it, I’ve never seen the Academy make a decision where anything other than the best interests of children was what made the ultimate decisions. Now in that process, we are convinced that having good, strong pediatricians is essential to the well-being of children, and so I don’t think we’ve ever forgotten to look out for the well-being of children, because pediatricians play a critical role in it. What I’m pleased with is that we now realize that we have 4 million new babies a year, and there are a 130 million born somewhere else. We’re trying to use what we’ve learned and what we, just by good fortune, have in the way of resources, to help children born everywhere else have a chance to live and grow and be well, the way we care about our kids. You need some guideposts, because a lot of the issues are complicated, they really are, and there are genuine conflicts in many things. But I’ve always found that it helped clear my thinking when I ask myself what I would want if this child were my child. If it wasn’t something that would be good enough for my child, then I had to feel some discomfort and try to figure out a way to do it better. So as long as pediatricians look at their reason for being, which is the best interest of children, I think the Academy will be able to play an important role. We are in a time of incredible conflict, civil strife, ever-widening gaps between the haves and the have-nots, and there have to be some people who are trying to work for a value system which is the value system that the Academy has had
since it began. That’s pretty neat.

DR. LARAQUE: Yes.

DR. COOPER: That allows me to sleep okay at night.

DR. LARAQUE: Good.

DR. COOPER: Thank you for letting me ventilate, but that’s really what you did to begin with. You asked me questions that made me think about things that I don’t think about every day. You know, we all are pretty much looking at what’s in front of us.

DR. LARAQUE: Sure.

DR. COOPER: I look over at that desk and I see a reminder of what I haven’t completed today. As I told one of my cousins who said, “Why are you still working?” I said, “It’s therapy, to help counteract my progressive senility and fears of mortality.” I think that’s true. Hard for you even—you’re not a kid, but every decade makes a difference.

DR. LARAQUE: Right, right. Well, I’m experiencing it too.

DR. COOPER: I look up and there’s a picture of Sam [Samuel L.] Katz and me up there. Sam is 5 years older than I am, and both of us are lucky that we’re still doing what we’re doing. Where are you up there, Sam? You can see that we take pictures and we throw them up here at random. That’s Mady’s father.

DR. LARAQUE: Interesting. Yes.

DR. COOPER: He died early on. He was a leader in the New York City Fire Department [Fire Department of the City of New York (FDNY)], probably would have been chief of the department, except he got pancreatic cancer in his early fifties and died. There’s Sam, way up there.

DR. LARAQUE: Oh, is that Sam?

DR. COOPER: That’s Sam.

DR. LARAQUE: You know, I looked at that picture, but I didn’t recognize him. I know him certainly later.

DR. COOPER: That was at Katie’s [Catherine Katz] wedding at Duke.

DR. LARAQUE: Yes.
DR. COOPER: And that’s Mady’s mother, who had glioblastoma, and so when Debbie [Deborah] Keenan came down with that, it brought back all kind of memories to Mady.

DR. LARAQUE: Right.

DR. COOPER: But we’re lucky and we know it, and the Academy has been part of that good luck, and it all was because I wanted to do something with rubella vaccine.

DR. LARAQUE: That was a good start.

DR. COOPER: And the guy who found rubella vaccine. Mal [Malcolm S.] Artenstein was really the first to isolate it. He, like me, was finishing his military tour, so we both came back to Boston, to the same lab. He gave the virus to Paul [D.] Parkman and Ed [Edward L.] Buescher, who were in his lab at Walter Reed [Army Medical Center]. He was so frustrated by not having the facilities he needed, that he went back to Walter Reed as a civilian. He was such a great researcher that he's the one who brought Emil [C.] Gotschlich into Walter Reed, and that’s what started the whole business of the polysaccharide vaccines. Mal got an early cancer and died in his early 40s.

DR. LARAQUE: Wow.

DR. COOPER: So nobody knows him, but he was one of the best. I guess the one who comes closest to him would be Stanley [A.] Plotkin.

DR. LARAQUE: Yes.

DR. COOPER: Stanley, thank God, is still with us. That’s what you make me think of.

DR. LARAQUE: Well, it’s good, thank you for sharing your thoughts with me.

DR. COOPER: Thank you.

DR. LARAQUE: For me it’s been a real pleasure and an honor, so thank you.

DR. COOPER: Well, we’re very lucky that these smart 30-some people got annoyed with Congress and created the AAP [American Academy of Pediatrics]. You know that story. You don’t know that story?

DR. LARAQUE: Of creating the AAP?
DR. COOPER: Mm-hmm.

DR. LARAQUE: In part, but tell me.

DR. COOPER: I saw a little piece of it in this month's *AAP News*. In the 1920s, Congress passed a law, the Sheppard-Towner [Maternity and Infancy] Act.

DR. LARAQUE: Oh, of course, in terms of the AAP as opposed to the AMA [American Medical Association], of course. Of course.

DR. COOPER: And that’s what started it, that these guys were so furious with the AMA.

DR. LARAQUE: Yes, I think, in fact, it’s the reason many of us are not members of the AMA. But you know, it need not be that.

DR. COOPER: Well, I became a member of the AMA because I’ve always been of the opinion that you wanted to bring people together, and the best way to create change in an organization was from within rather than outside.

DR. LARAQUE: Was to be part of it. Well, that is the reason that I became very involved with the AAP, as well—the sense of really knowing this country by knowing the people who were in service to populations of children and families. So that’s been quite an experience.

DR. COOPER: Isn’t it?

DR. LARAQUE: It is.

DR. COOPER: Your board is an interesting board. I don’t know it very well, but my guess is that it’s all people who, in their own ways, are dedicated to the Academy mission.

DR. LARAQUE: Yes. It’s a pleasure to be with them, it really is. So thank you, Lou.

DR. COOPER: Well, let me help you get out of here.

DR. LARAQUE: Okay, very good, thank you.

[END OF AUDIO FILE]
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