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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Dr. M. Edward Keenan is in private pediatric practice and is assistant professor in clinical pediatrics at Harvard Medical School. He graduated from Middlebury College and Albany Medical College. He did a pediatric internship at Boston City Hospital and completed his residency at Massachusetts General Hospital where he is an attending physician. He served 2 years in the Army, completing his tour as chief of pediatrics at Letterman General Hospital. He served as chapter chairman of the Massachusetts Chapter of the American Academy of Pediatrics. In 1995, he became vice president of the American Academy of Pediatrics and was elected president of the American Academy of Pediatrics in 1996. He has a commitment to international child health.
Interview of Joel J. Alpert, MD

DR. KEENAN: This is an interview of Joel J. Alpert, MD conducted by M. Edward Keenan [MD] on November 21st, 2013 in Wayland, Massachusetts. Thank you very much, Dr. Alpert.

DR. ALPERT: Ed, I can’t think of anyone more enjoyable to interview me than you as a longtime friend and colleague and former president of the Academy [American Academy of Pediatrics].

DR. KEENAN: OK, here we go. Dr. Alpert, just discuss your family background. Tell me a little about where you were born and about your parents and your family life. Were there any events in your childhood which influenced your career choice?

DR. ALPERT: Ed, I was born in New Haven, Connecticut. My father was a solo accountant in his own firm. He had been born in Russia. My mother was born in this country. She was a homemaker and a community activist. For 9 years I was an only child, and then along came my sister.

I went to public schools in New Haven, Connecticut. I was an extremely good student all the way through. By the time I got to high school [James Hillhouse High School], for me my crowning achievement was that I was editor-in-chief of the Hillhouse Sentinel, a nationally recognized weekly high school newspaper which received numerous national awards. And part of me thought that I might have a career as a journalist.

DR. KEENAN: Excellent. Did that make you think you wanted to be a politician or a physician?

DR. ALPERT: A Jewish son of Jewish parents certainly thought of that son becoming a physician. There were other occupations of course. I don’t really remember consciously thinking of being a physician.

I graduated from high school first in my class. I went to Yale [University]. I was interested in medicine, but I did not major in science. I took what was called a [Special] Divisional Major which allowed me to take a minimum of science courses and then concentrate on areas of economics, American literature, [and] sociology.

While I was in college I was a camp counselor. In one camp I cared for, or was a counselor of, about 9 children from the Lexington School for the Deaf in New York. The camp was in New Hampshire. I also taught Sunday school, and I was a group leader of a group of adolescents in Ansonia, Connecticut. These interactions with children and, at that time, my view of a career
possibility cemented in my mind that I would, indeed, not only (I would hope) go to medical school, but [that] I would be a pediatrician.

DR. KEENAN: That’s a wonderful choice you made to be a pediatrician. Tell me about your medical education. How would you characterize your years at Yale Medical School?

DR. ALPERT: No. I went to Yale as an undergraduate and did well enough to get into Harvard Medical School.

DR. KEENAN: Where was your residency done?

DR. ALPERT: First 2 years at Children’s Hospital Boston, now known as Boston Children’s Hospital. It’s had numerous name changes through the years. I had 2 years there.

I’ll return to an earlier mention or reference to my mother as an activist. A lot of my political views and social values came from my mother, who dedicated herself to helping the underprivileged. Both in college, but especially in medical school and certainly in residency, I found myself an outlier. And that particularly took place at Children’s Hospital [Boston], where I had 2 of the most wonderful basic years of training, and knew so much about the physical disease of children. Indeed, there was a point in time somewhere in the middle of your second year—Ed, maybe you remember this—where we were absolutely convinced that we knew everything. But I was fighting the system all the way. I’ll explain a little more about that in a moment.

At the end of 2 years I really wanted to go to another institution and see another way of looking at the pediatric world. In those days—this would be in the late 1950s—it was expected, indeed very easy, to move around from one program to another. Boston Children’s had an exchange program with Saint Mary’s [Hospital] in London. And Barbara [Alpert] and I made a decision, and Charlie [Charles A.] Janeway, my chief, thought it was a good idea that I be the resident that would go on the exchange in 1958 and 1959. That was a career-changing decision.

In making reference to my mother, she was an organization lady. In those days my father was active in the Masons. My mother was active in the order of the Golden Chain, which is a parallel organization to the [General Grand Chapter, Order of the] Eastern Star, which did not accept Jews. My mother eventually became the grand matron of the organization. Their principal activity was running a camp for underprivileged children in New Jersey. So constantly in the house were discussions of poverty, being underprivileged, being vulnerable, and doing something about it. I’m very proud of the fact that I got those values from my mom.
Now, what did I mean when I said I was fighting the system? As a medical student, my 4th year rotating through pediatrics, there was a 12-year-old girl with nephrotic syndrome. She had been conceived in the woods in Poland by her partisan parents [World War II resistance fighters] and felt guilty that somehow there was a punishment, because she had developed this disease. She told me that she was going to kill herself. I’ll shorten the story. I repeated it to the senior resident on the team. He didn’t want to hear anything about it. It was not relevant to her care. That made no sense to me.

About the 4th or 5th day she was in the hospital I went into her room, which was on the 5th floor. She was on her way out the window. We got her back in. And in front of the attending that day I lit into—if you can imagine this—a 4th year student lighting into the senior resident—and really let him have it. No one said a word, because they all knew I was right. But the value system of those individuals and the system that day I felt was focused on the importance of the disease and less the importance of the person.

Same thing persisted during residency. And you get caught up in it. You and I both know how proud we were that we could have the patient come in with meningitis and have it all done in 45 minutes: the diagnosis, the lumbar puncture, the Gram stain, [and] the treatment. But there was more to pediatrics than that, and that’s what I was looking for. I didn’t fully realize how much that decision would be supported in going to England. I arrived in England, 1958-1959, as a registrar. Incidentally—you remember this, Ed—interns got nothing. Second year residents got 100 bucks. But I got 1,000 pounds in the UK [United Kingdom], and I was on every 4th or 5th night. In any event, I was told that they would watch me carefully, and after 5 or 6 weeks decide whether I was good enough to work in the outpatient department. I was working in the outpatient department reasonably quickly. The value system was totally different.

The value system appeared to be the importance of listening to the patient and of a careful physical exam. As an American I was subject to repeated criticism—not just of me but also of those who had come before me and after me—for reliance on investigations and tests. Indeed, there are many clinical events that prove the value of that history and physical examination. And I learned so much. When that year was over and I had military service ahead of me, I was convinced that there was a career for me. I didn’t know whether it was going to be in the practice or the academic world. But it was going to be a patient-oriented career.

DR. KEENAN: How has pediatric training, specialty training, and medical education changed since your time in school? You mentioned that they were oriented more toward the disease than the patient. Is that changed now because of some of your efforts?
DR. ALPERT: Well, I’m not sure of some of my efforts. Certainly, if we jump ahead, when I got to [now Boston Medical Center and Boston University] I went there because the needs of the patients, which were common, high prevalence disease, matched my educational goals. So, it was easy to put together a program that would emphasize that.

But the core of your question is answered, in part, by the dramatic change in pediatrics. I did over 400 exchange transfusions in my 3 years—2 years in Boston and 1 in the UK—and not 1 pelvic exam. Today, it is much more likely that our residents have done hundreds of pelvic exams and a minimal number, if any, exchange transfusions. Then, of course, with immunizations they don’t see polio. They don’t see measles. I mean, clearly, the content of pediatric disease has changed. There are still and always will be unusual, challenging, difficult organic diseases that require the best scientific effort and evidence-based medicine. But so much more of pediatrics is in the broad, patient-based, family-linked area—with its emphasis on growth and development—and the content of primary care, and what goes on in what we call the medical home today.

DR. KEENAN: That’s been a concept that pediatricians have talked about for years and now seems to be embraced by other medical specialties like internal medicine and so on. Is it the same concept—the medical home—that pediatricians value so much?

DR. ALPERT: Mostly yes. Clearly the current efforts that we put into the medical home, so much credit goes to Cal [Calvin C.J.] Sia from Hawaii as he developed the model as a way in which we would integrate services—especially for those who were disabled, handicapped physically—and be able to get their care in a coordinated, single place. But if you go back in the history, not just of pediatrics but academic medicine as well, you find even before World War II people at Johns Hopkins [School of Medicine] and [Weill] Cornell [Medical College] talking about the whole patient or comprehensive care. Just after the war at Case Western Reserve [University School of Medicine] you hear about family-focused care and family care. At Colorado [University of Colorado School of Medicine] you hear the same thing. At Harvard Medical School you hear [about the] Family Health Care Program. One at Mass General [Massachusetts General Hospital], one at Boston Children’s Hospital. And, beginning in the mid-1970s, the term primary care begins to describe all of this. In many ways the medical home is an evolutionary idea.

[Interview paused as Dr. Alpert takes a phone call.]
DR. KEENAN: We are resuming the interview with Dr. Joel Alpert. Dr. Alpert, what have been the major scientific advances over the past years that have affected pediatrics the most?

DR. ALPERT: Well, clearly the great triumph of the 20th century is immunization, a public health advance that has protected millions of children from disease, disability and death. And isn’t it tragic that today seemingly well-informed but really ignorant people critique immunization when they have no idea of the horrible specter of polio or measles? When that actress Jenny McCarthy said, “I’d rather have my child have natural measles than the MMR [measles, mumps, and rubella vaccine].” I mean she didn’t know what she was talking about. If there is a risk to MMR—if—maybe it’s on in a million, and probably by chance. But the risk of significant death or disability from clinical measles is probably 1 in 600. Who in the world would accept those odds?

And then you add to that the tremendous advances in antimicrobials. Today we’re just beginning to scratch the future of what our DNA and the genomic makeup of who we are and the contributions that our genes make to our illnesses.

But coming back to what impacts on children, it’s poverty. We thought it was going to be AIDS [acquired immunodeficiency syndrome] but that has materialized in a less dramatic fashion. It’s obesity. And I can use all kinds of other examples, but they all come back to the common denominator of poverty. I think poverty is the greatest curse that our children in this country, let alone the rest of the world, face today. The idea that the United States, the wealthiest nation in the Western world, has the highest percentage of children living in poverty—whether it’s 22% or 26%, it is the highest. It is just a disgrace. And no one’s out there walking to defeat poverty or establishing charities and charitable contributions to defeat poverty. So, it is an elusive challenge and one that our country today is failing to meet.

DR. KEENAN: Do pediatricians have a role here? Should they be more proactive outside their organization?

DR. ALPERT: Absolutely. I think one of the things about pediatricians is that the overwhelming majority of us who went into pediatrics are, first of all, nice. Secondly, we went in because of the patients we would take care of. The AAMC [Association of American Medical Colleges] annual questionnaires continue to show that those who go into pediatrics go into it because of children—because of the patients that we take care of. We can be powerful advocates. It was a number of years ago that the Wall Street Journal ran a lead article that talked about the influence that pediatricians have because of that crucial role they play in the health and welfare of the families they care for.
I think we fall far short of the mark in taking advantage of that role. We do so not only as individuals but as an organization [American Academy of Pediatrics]. So, for example, in today’s current debate about the Affordable Care Act or Obamacare—whatever you wish to call it—we, like so many of the other professional organizations, have been behind every effort to support universal coverage. We’re in favor of that. But we do so too quietly. We talk to ourselves. We don’t talk to the public. The public does not know that America’s pediatricians support the Affordable Care Act. And that silence is hurting the country because of the ignorant statements that are made in opposition to what is clearly an imperfect law. You haven’t identified this yet, but you could probably figure out that I’m of a liberal persuasion and would support Medicare for everyone in this country.

DR. KEENAN: That’s a very insightful comment. And thank you for it. Let’s talk about your career. Who helped you most in your career?

DR. ALPERT: You have to start with family because family has to be supportive. And I’ve had a marvelous wife, Barbara, at my side, who has supported almost every choice that I have made—the overwhelming majority of which have been good, but not always. Certainly, in the academic world there were those who taught you in high school and who inspired you in college. There were people in medical school. And that’s where I begin to really see people mentoring me. The outstanding professors and teachers at Harvard, and then in residency it really becomes specific people. It becomes Charlie Janeway. It becomes Bob [Robert J.] Haggerty. It becomes Louis K. Diamond. Giants in pediatrics. It becomes Bob [Robert] Schwartz who, as an assistant professor of pediatrics, was the one who advised Barbara and I to go to England. And, in a very sustained way, I return to Charlie Janeway as providing the umbrella that allowed me to thrive. And, of course, Bob Haggerty, who provided me with the very specific career opportunities to pursue what I wanted to ultimately do—which was primary care in an academic setting—and do so at first with Bob and then, subsequently, at Boston University [School of Medicine].

DR. KEENAN: When were you involved with the AAP [American Academy of Pediatrics]?  

DR. ALPERT: I was involved with the Massachusetts chapter. I think it was around injury prevention. At that time, of course, it was called accident, but we got rid of that and used the term injury. I really don’t remember very much in the way of activities in the Mass [Massachusetts] chapter, but [I] certainly became active in the Injury Prevention Committee [known then as the Committee on Accident Prevention] and the Subcommittee on [Accidental] Poisoning, of which I was chairperson for AAP—the national.
was chairman of a subcommittee of the [Committee on] Community Health Services, which at that time we called the “conscience of the Academy.”

DR. KEENAN: You also were very involved in getting pediatricians and, I think, the state chapter involved in legislation. Could you just comment on that briefly?

DR. ALPERT: Bob Haggerty left for Rochester and I assumed the directorship of the Family Health Care Program at Harvard Medical School and the Children’s Hospital [Boston] Child Health Division. In order to supplement my income—and we were certainly not well paid as faculty—I became the executive director of the then Boston Poison Information System. It was a voluntary program. The phone was rotated between the teaching hospitals in Boston: Tufts Floating as one [now Floating Hospital for Children at Tufts Medical Center], Mass [Massachusetts General] Hospital the second, Children’s [Hospital Boston] the third, Boston City [Hospital] the fourth. It was a pretty amateurish operation, but it was the best that there was around.

The first thing to do was to get it recognized in that front page of the telephone directory where the number was put. As the calls went up it became clear to me that we needed something more than that. I spent 3 years and was successful in getting the legislation passed in Massachusetts to take it on as the Massachusetts Poison Control System [now the Regional Center for Poison Control and Prevention]. That happened after 3 years of hard work. First year it doesn’t go anywhere. Second year it stays in committee. Third year it goes on the floor. Of course, it helps if a senior senator’s grandson ingests aspirin and they call the center. That was certainly a help.

But I forgot to ask for any money, so it took a couple more years to get money from the state. I was not a toxicologist and my emphasis in directing the center was definitely on prevention. We had programs with the Mass [Massachusetts] Pharmacists Association distributing ipecac in the state. And we had pediatricians giving out ipecac or prescriptions for ipecac in their offices. I know today we’re inclined more towards the use of [activated] charcoal than ipecac. That’s a debate that I would have frequently with the late Michael [W.] Shannon. When I went to Boston City [Hospital] and Boston University, I thought I was done with the poison information system, but they kicked me upstairs and made me chairman of the whole thing, which I did for a decade.

DR. KEENAN: Thank you for doing that. Now what other medical organizations were you involved with? I know you were president of the Ambulatory Pediatric Association [APA] and you were very active in the Academic Pediatric Society.
DR. ALPERT: Well, of course the APA and the Academic [Pediatric Society] are the same thing [now the Academic Pediatric Association]. I was the president [1969-1970] and then I became a historian of the organization. I have to confess I was not successful in this one—in being more romantic than sensible and wanting the APA to keep the name Ambulatory. It finally became the name Academic. Yes, I recognized the inevitability of a need for name change, because Ambulatory was perhaps too constricting. But as Abe [Abraham B.] Bergman from Seattle [University of Washington] would have said, calling it the Academic Pediatric Association was a sign of ultimate hubris.

DR. KEENAN: He was articulate and lots of fun and wrote a wonderful book on pediatrics. I understand that you were very involved at the Institute of Medicine. That certainly is important that pediatricians were recognized by the Institute of Medicine.

DR. ALPERT: I was very honored by my election to the Institute of Medicine, which is a branch of the National Academy of Sciences, in 1978. I think I was elected principally because of my work in primary care. We had talked earlier about my third-year training in the UK [United Kingdom]. Our family, now 13 years later in 1971 and 1972, went back on sabbatical to the UK. At the same time Evan Charney who was in Rochester [University of Rochester] and then chair [Department of Pediatrics] at U Mass [University of Massachusetts]—he was also at Sinai Hospital in Baltimore—was also on sabbatical. We were given a contract to write on primary care by the Bureau of Health Professions [now the Bureau of Health Workforce] and what is today the AHRQ [Agency for Healthcare Research & Quality], but was then the [Bureau of] Health Services Research. Evan was the creative part. I was the grunt. We were very proud of what we produced, which was a monograph published in 1973 entitled The Education of Physicians for Primary Care. [Alpert J., Charney E. The Education of Physicians for Primary Care. Rockville, Md. U.S. Dept. of Health, Education, and Welfare, Public Health Service, Health Resources Administration, Bureau of Health Services Research. 1973.] They distributed 50,000 copies. Lost my chance to become a wealthy author, because it sold for a buck 95.

In the monograph we created a definition of primary care. I’m not going to repeat the definition here, but its elements were first contact care that is comprehensive and provides coordination and continuity. That definition was adopted by the Bureau of Health Professions for the Title VII program—Social Security Act Title VII—which was so important for the education of physicians in general medicine, pediatrics, and family medicine. Incidentally, the key players in this were neither pediatrics nor medicine but were the family medicine people. General dentistry, nursing was in there as well. To this day that program, despite attempts by many to sunset it, has continued. The program has, I think, been enormously successful and has
provided resources that made it possible, for example, in our own program at Boston City Hospital, where we were one of the first 3 contracts awarded in the country to go out to neighborhood health centers. It provided the financial underpinning for residents having their continuity experiences in neighborhood health centers. Then in the early 1980s, the IOM constituted the Committee on the Future of Primary Care. I was honored to be put on that committee, and worked with wonderful, distinguished people. [Institute of Medicine. Defining Primary Care: An Interim Report. Washington, DC: The National Academies Press, 1994.]

It’s interesting. As a very small part of that, we took great objection to the use of the word provider, and demanded that the word provider regarding any health professional be retired. We were clinicians, we were health professionals—but provider was a business term. And I must say that although that is there in black and white on paper [in the committee’s report] and solid, it certainly has been ignored. Physicians today, as do other health professionals, continue to be called providers.

I was elected to the governing council of the Institute of Medicine when I was 63 years old. So that would be about 1993. I could only serve 1 term because IOM rules said that you couldn’t be on the Council after age 66. But that was an extraordinary experience. Mary Ellen Avery had preceded me on the [IOM] governing council and I don’t remember who followed me. I’m not suggesting there was a pediatric slot, but certainly it was always important to have a pediatric presence on that governing council. So, I think I have a lapel button for the Institute of Medicine. Those of you who know stories about colleges and so on know that the secret societies at Yale like Skull and Bones, you’re always supposed to have your ring on somewhere on your body. I’m pretty much never seen without my lapel button saying I belong to the Institute of Medicine.

DR. KEENAN: Where do you think pediatrics will go in the next 10 years?

DR. ALPERT: Well, 10 years is at least a horizon that we can make a reasonable guess about. I’m not certain that things will change a lot. There are so many forces—both positive and negative—today. The increasing challenges to overall health on the part of children. The need for pediatricians, and yet the cap that has been put on the number of training places because of inadequate reimbursements. Of course, pediatrics is particularly vulnerable because most of medical education and residency is paid for by Medicare and we don’t take care of very many Medicare patients.

It fascinates me, on a very positive side, the enthusiasm. I’m now an assistant dean of student affairs at Boston University School of Medicine, and I mentor each year anywhere between 20 and 25 students, almost all of whom
are going into pediatrics. Their enthusiasm, their love for children—whether they think they’ll be going into primary care or a subspecialist in pediatrics—it’s there, just like it was for you and me. I just admire their dedication to children’s issues, and their debts scare the heck out of me. The average debt that I’m seeing today is probably $200,000 to $250,000. When you and I were residents, if we managed to fall in love—if we did not that was OK—but if we managed to fall in love with a fellow resident or fellow medical student we ensured our economic future, because both would be good earners. Today, if you fall in love with a fellow student you get a mortgage without a house when you graduate. So, I worry about that. But I am so confident of their dedication. They will be as enthusiastic in the practice of pediatrics as we have been in our careers.

I think reimbursements will be better. Certainly, in the short-short term the Affordable Care Act raises pediatric reimbursements to the level of Medicare. I think we as pediatricians are, by and large, undervalued and underpaid. And I’m certainly supportive of every effort that we can make to see that there are adequate reimbursements, so a pediatrician can, in a practice setting, succeed financially. No one’s going to become a millionaire. But going to work hard and earn a good living and lead a good life. I want to think that that will continue.

We’ve always talked about teams. Sometimes more talking than doing. And I think the whole idea of a solo-solo practice—which we’ve said for years now was a dinosaur—I think that’s become even more true today. We see different kinds of organizations putting people together so that you can have the resources to have not only pediatricians but also the nurse practitioners, the social worker, and the appropriate kind of guidance or psychological support person. I’m not necessarily a fan of a very large multispecialty group practice model, but clearly the Mayos [Mayo Clinic] and the Geisingers [Geisinger Health System] of this world deliver outstanding care—and many would say very effective, efficient and cost-effective care. But I don’t see that model developing everywhere in the country. I think the challenges will be those high prevalence challenges and the children with the unusual, difficult, complex diseases who will almost entirely be cared for in regional children’s hospitals.

DR. KEENAN: So that is a significant change with the advent of pediatric hospitalists and the primary care physician spending more time in the community. Is this a dichotomy that diminishes the pleasure of practice, not to follow your patients in the hospital?

DR. ALPERT: I’m very conflicted on this issue. I think it is incumbent upon a pediatrician to enjoy going into the hospital. I think it makes us better doctors, especially as pediatricians taking care of newborns. I don’t see how we can or should give that up. I was recently a patient in the hospital, cared
for by a different hospitalist every 12 hours. It was awful. I’m sure they were technically on top of things and they were there, but there was no relationship that was established and I would have much rather had seen my own doctor come in and see me—even if he or she couldn’t take responsibility for me, depending on the nature of the illness. So, I’m very conflicted about this. I do see an important number of our residents completing training unsure of what they’re going to do in their career and becoming hospitalists for a period of time. I hope someone out there is studying the impact of the hospitalists. As I say I am conflicted.

The major conflict is what happens when, as a pediatrician, a patient in your practice develops a complex and demanding illness. We cannot be good at those things that we don’t do regularly. I mean when you and I started out managing a diabetic was bread and butter. Thyroid disease was bread and—I could add to that list. But what happens if you only see 1 or 2 a year? And certainly if a child develops a malignancy—I mean in practice what is it, 1 in every 5 years?

DR. KEENAN: More frequently than that.

DR. ALPERT: But not terribly often.

DR. KEENAN: Correct.

DR. ALPERT: You can’t be good at it. You can’t possibly know what the latest drugs are, what they do and the interactions. So it is more and more, especially in pediatrics. And I see those diseases being concentrated. I would rather see in-hospital subspecialists rather than hospitalists, because the hospital subspecialists would be your doctor in the hospital. They would see you every day, etc., etc.

DR. KEENAN: Good. Do you think children are better off today than they were 50 years ago?

DR. ALPERT: Yes, but not as good as they should be.

DR. KEENAN: Excellent answer. Dr. Alpert, you saw long ago the benefit of international exchanges in pediatric education. Does this added educational opportunity for residents help the American Academy of Pediatrics to enlarge health care for all children?

DR. ALPERT: It could. My personal experience, as I recounted with the exchange at Saint Mary’s in London, was career-defining for me personally. I learned so much in such a different way. Today, those bilateral exchanges are not possible, because of the cost, because of their political barriers and visa concerns. Certainly, within our own programs [in the United States], the
ability to move from one program to another is much more limited. Families are settled. So many more are married, etc. I think our Academy—and I’m now moving away from my personal experience—does an outstanding job in bringing programs overseas like the Neonatal Resuscitation Program to China.

Because of my associations with the UK, I’m well aware that there’s competition out there for the international marketplace, and the Brits see themselves also in this marketplace of helping. I do not consider myself knowledgeable in terms of the area. I’ve been a regular attender of the International Pediatric Association. Disappointed I didn’t make this last year in Melbourne, but since 1968, I have been to almost every one. And I’m well aware of the importance of international activities. I think our Academy, especially in terms of its programs and publications, does an outstanding job.

DR. KEENAN: Do you think the Red Book is a great book? [Laughter]

DR. ALPERT: A great book indeed. [Laughter]

DR. KEENAN: That’s a very broad-based answer, and I think that the Academy has been in the forefront of many of these programs. I just hope it will continue. And I want to ask you some other questions. You wrote with M. [Margaret] C. Heagarty and R. [Robert] J. Haggerty about comprehensive pediatric care in 1969. [Alpert JJ, Heagarty MC, Robertson L, Kosa J, Haggerty RJ. Comprehensive pediatric care. Am J Dis Child. 1969 May;117(5):604.] That was over 40 years ago. Is it here now?

DR. ALPERT: That particular article that you refer to was an early report on a randomized controlled clinical trial. And I’m very proud; I think it was the major research accomplishment in my career. We took 1,000 families, randomized them into 2 control groups and an intervention group. The intervention group was provided with continuity of care, that primary care definition that we talked about. There was a subsequent article, a final report in Pediatrics in 1976. [Alpert JJ, Robertson LS, Kosa J, Heagarty MC, Haggerty RJ. Delivery of health care for children: report of an experiment. Pediatrics. 1976 Jun;57(6):917-30.] There were 2 books that were published. [Robertson LS, Kosa J, Heagarty MC, Haggerty RJ. Alpert JJ. Changing the Medical Care System: A Controlled Experiment in Comprehensive Care. New York: Praeger Publishers. 1974.]

The results of that experiment showed that we, indeed, made a difference. If you had a regular source of care, you were hospitalized less often. Medical care costs were less because laboratories were used less. Everything worked in a positive direction. And, indeed, we achieved statistical significance. It
took 10 years, from beginning to end, to do that study. Longitudinal studies are extremely difficult, especially if they’re randomized clinical trials. But that part of my career, that study, was carried out at the Family Health Care Program at Children’s [Hospital Boston] and [at] Harvard. I think we had over 40 publications from that effort.

I remember some years later the president of the [American] Academy of Pediatrics came to me and asked would I rewrite the paper using cost figures from that period compared to the period in the mid 1960s. I did not follow through. I wasn’t sure that the methodology would have been correct.

I want to tell one anecdote about the advantages of a randomized controlled clinical trial. The care period for the study started in 1963. In 1965 Medicaid came into operation and we observed the following phenomenon. In the experimental group we had an important number of African American families. Almost none of the African American families crossed into Brookline, the private suburb, but rather continued with their care. In the control groups both white and black families crossed into Brookline to get care, but the black families quickly moved back, because they were not made to feel very welcome—even in what you and I know as a welcoming community today. So, the racial barriers to access to care were there even when the financial barrier was removed. That was a fascinating finding, an observation which could not have been made if we did not have random assignment.

DR. KEENAN: That’s a very important observation.

DR. ALPERT: I think it’s still true today.

DR. KEENAN: I also believe that. Your efforts to link pediatric residencies, community pediatricians and health centers with hospitals has been effective. What skills did you bring together to effect this change?

DR. ALPERT: Luck, timing, and the fact that we were able to finance it. I think it was a major benefit to the residents who we got out into the communities and to the communities themselves—both to the patients and the faculty who became teachers of our residents. We also, in Boston, were blessed with a very strong neighborhood health center network. Names that are familiar to you, Harvard Street [Community Health Center], East Boston [Neighborhood Health Center], Whittier Street [Health], Upham’s Corner [Health Center]. We had a consortium of health centers; many of the pediatricians there were those we had trained. And it worked.

What I feel badly about, as I watch today—mind you, this is now 30 years later—is the pressure of resident hours. Limiting work hours has made it much more difficult to deliver on the promise to the neighborhood health
centers that your resident will be there on his or her day—or days, because we had more than 1 day a week of continuity. I’ve watched the commitment to continuity become compromised, and I worry about that. I think it’s much more difficult today. I think because, in our case, the long history that we have with the neighborhood health center organizations is such that they understand what the pressures are, and their expectations—if this had happened 25 years ago, they would have gotten mad at us. Today I don’t think they get mad at us. They’re helping us try to figure out how we can find satisfactory solutions.

DR. KEENAN: Does the word persistence in your life come to mind?

DR. ALPERT: Oh yes, persistence and passion.

DR. KEENAN: Good. You have always championed underserved children. Did your childhood influence this tremendous effort?

DR. ALPERT: I was very blessed. I grew up in a loving home. As I noted before, my mother was an activist. I saw their values. I was born in May 1930, and one day I said to my father, “I don’t understand it. The market crashed in October of 1929 and you still had me.” And he said, “I thought you were smart. Why don’t you count backwards?” And I did of course, and I was conceived in September of 1929. [Laughter] So I grew up in a very comfortable, very middle-class home. Very loving.

DR. KEENAN: Well, let’s hope that all children in the world can somehow come to having a loving home and parents who, regardless of their social situation, can support and prepare them for the vicissitudes of life. I’d like to ask you to talk about your legacy, and the times with the AAP presidency.

DR. ALPERT: Well, let me begin talking about the presidency. As you and I know, we campaign. It’s now a political campaign. I came out to the [American Academy of Pediatrics National] Nominating Committee. I was not selected. I was told I came within one vote of being selected, and that I should apply the next year. I was going on sabbatical to New Zealand, and you had to pay your own way to be interviewed. I wasn’t going to leave New Zealand. So we skipped that year, and the next year I came out and I was selected. I was honored and felt even being selected was a sufficient recognition of what I had done. I learned—maybe because I was in a political environment like Boston City Hospital—of the importance of looking at everything as a political challenge. And, indeed, that’s what the campaign turned out to be.

One of the bits of advice I got from Bob Haggerty, my important mentor, was something that Morris Green said to him when Bob was running. Morris said, “Be careful what you say when you’re running, because after you
become president then you can say what you want.” I looked at Bob and I said, “But that’s not me. I’m going to say what I believe. What is important to me are children. Yes, pediatricians are important, but the theme in my campaign will be children first, and that pediatricians will do well if children do well.” And that, indeed, is what I did.

As we know, I was successful and elected. But what I learned was that while I could say anything I wanted campaigning for president of the Academy, once I was president I could no longer say what I wanted but rather had to listen carefully to what our policies were. As a consequence, I found there were occasions where my passion moved a little faster than the Academy itself was prepared to move. Two examples would be gun control and the most important one, universal insurance. And, of course, I was ready to go for the whole shtick and single payer. The Academy, as an organization, was not. I remember [former AAP executive director] Joe [M.] Sanders [Jr.] advising me, “Remember we’re a member organization. You can’t be too far in front of the members.” I remember reacting and saying, “But if you’re a membership organization you’re always going to have a variation of views within that organization. I don’t think it’s always one-third for, one-third in the middle, one-third against. But, certainly, there are always people who will feel differently. And you have got to lead.”

So, we ended up creating a task force for access to health insurance [AAP Workgroup on Access and Health Care Coverage for Children], and I was very pleased to have that task force created. Rick [Richard] Bucciarelli became chair. And I saw compromise come out of that. The committee was not ready to adopt single payer or Medicare for all, but we came up with what we called MediKids, which was subsequently submitted by Representative Pete Stark from California and Senator Jay [John D.] Rockefeller from West Virginia. And it was just like Obamacare, or Obamacare was just like it, except it had a public option, which I think is a flaw in today’s ACA [Affordable Care Act]. It had been resubmitted year after year after year and, obviously, the ACA has taken all the headlines today.

At the same time, in saying that the Academy couldn’t be too far in front of its members, how proud I was of the Academy—not during my presidency, but subsequent to that—when we came out with our statement about gay parenting. If my memory is correct we were, at that point, about 60,000 members. When the Academy came out and said, “It’s okay for gay parents who provide a loving home to adopt children,” 24 individuals resigned from the Academy and 3 joined. Out of 60,000, I don’t think that that statement was too far in front of the members. The Academy can be brave. It can be bold. And when it does, it speaks with a powerful voice. That statement made the front page of the New York Times.
But it was an interesting lesson to learn that I could say what I wanted when I was running, but I was bound by policy when I was actually president. [Laughter]

DR. KEENAN: Are the policies pretty good for the most part? [Laughter]

DR. ALPERT: Oh yes, for the most part. Ninety-five percent of what the Academy does is absolutely superb. I think we are the most important, effective, potentially powerful professional organization for children. But—I think I said this earlier—too often we’re silent on issues that we should not be silent about.

DR. KEENAN: Talk about your legacy.

DR. ALPERT: Not yet. I want to go back to Title VII. And [then] we’ll put that together. After the Title VII legislation was passed, Dick [Richard W.] Olmsted and I were asked to be the pediatric representatives to the Bureau of Health Professions. Al [Alvin R.] Tarlov from [the University of] Chicago was in medicine. And [Larry A.] Green from Denver [University of Denver] was family medicine. We were to help write the regulations. And the big controversy was continuity and the percentage of continuity. And 35% was what the family medicine people wanted, which was easy for them, and would have been a killer for pediatrics and medicine. Medicine wanted 10%, which for them was going from zero to 10%. We settled at 25%, which was a hurdle but achievable; I think, was a reasonable number. There were other regulations that we all settled on. Anyway, I remember going to the next meeting at AMSPDC [Association of Medical School Pediatric Department Chairs]. The vast majority of chairs got up and were damning this new program and the 25%. For one of the few times in my life I didn’t say a word. I just sat there and thought to myself, “And we worked so hard to get it down to 25%.” That was another key role that I played in the Title VII program.

DR. KEENAN: Explain the 25%.

DR. ALPERT: What it means is that 25% of the year a resident should spend taking care of a defined population of families. Can be in the traditional continuity setting. Can be—if it’s the same families—in a subspecialty setting. Can be in a neighborhood health center. Can be a hospital outpatient department. Can be in a school. There are many ways of massaging the 25% continuity. It’s deliberately intended as a hurdle to flush out the programs that really were not committed to making that effort of training in continuity. Of course, through all these years, the RRC [Residency Review Committee] rules and regulations change, and the RRC incorporated the continuity requirement into its regs. And I think the
requirement has subsequently been modified. I do not know what the current number is.

DR. KEENAN: Well, that’s very important that this brings forward the fact that we are committed to families and the homes that children grow up in. And the home is where the loving parent is and pediatricians should support that. Do you want to talk a little bit about some of the other things that you’ve accomplished?

DR. ALPERT: Certainly in a personal sense we’ve talked about the Institute of Medicine and its importance to me and, the [American] Academy of Pediatrics and its importance to me. I would add incidentally about the importance of the Academy. A medical student in February of the campaign [when Dr. Alpert ran for AAP president] came into my office and said, “Dr. Alpert, I didn’t know you were running to be president of the American Academy [of Pediatrics].” And I said, “Yes.” And she said, “Good, because if I were a member I would vote for you.” I said, “Why is that?” She said, “Because it’s obvious.” We were posting the writings of the 2 candidates. She said, “He’s for pediatricians and you’re for children.” So, mind you, she got the real message of what I was saying. What was my reaction? “Oh my God, I’ve lost the election.” Because obviously, once again, children don’t vote.

[Laughter]

Anyway that was a very funny incident, and there were other instances along the way. I think going to Boston City Hospital and Boston University was a major career decision, and it was a good one. It was not an easy one. It was certainly not an easy place to work. Franz [J.] Ingelfinger, the distinguished adult gastroenterologist and former editor of the New England Journal of Medicine, described Boston City [Hospital] as “a crucible of turmoil and change,” and it sure was. It was a dysfunctional hospital in so many ways. And yet because it was dysfunctional and because of the times and because we were able to get extramural support, we always could find an end around. We could always figure out, it seemed, the ability to accomplish what our goals were, no matter what the hurdles.

And the hurdles were, at times, substantial. I remember a commissioner of [the Boston Department of Health and Hospitals], about 3 weeks before Thanksgiving in the mid 1980s, calling me in and saying, “Joel, I want a report from you in 3 weeks as to why we have pediatrics.” That’s really a nice sign of support and affection. And, indeed, a committee was created, chaired by one of his own deputies. And the report came through glowing that we need pediatrics. So, you expected those hurdles, not always anticipating when they were going to happen.

I was undergoing my first colonoscopy and there was a medical student there. And the gastroenterologist said, “Do you mind if the medical student stays?” I said, “No, no, of course not.” And of course the colonoscopy is done,
and I wake up and I say, “When are you going to do it?” We’ve all had that experience, those of us who are older. “It’s all done.” “Where’s the medical student?” “We had to send him out of the room.” “Why did you send him out of the room?” Our surgeon-in-chief had just fired our pediatric surgeons, and apparently as I was going down I started talking and expressing an opinion about the surgeon-in-chief. They had to send the medical student out of the room. [Laughter] So there were the humorous moments along with the confrontational moments at Boston City Hospital.

Today it is remarkable. Boston City Hospital is a safety net hospital called Boston Medical Center. It’s a merger of the university hospital and Boston City [Hospital]. It has its challenges. It is functional. It is different than my time. I’m not sure which I would have enjoyed more. I can certainly do without some of the humps, bumps at Boston City [Hospital], but there are bumps and humps today, only they’re different. And there are fewer ways of finding an end around.

DR. KEENAN: Do you want to talk anything about your legacy now?

DR. ALPERT: Sure. We’ve been very blessed. One of the most difficult things for me when I was chair [of the Department of Pediatrics at Boston Medical Center] was that, after having figured out the budget for the upcoming year, invariably someone would come in to me and would say, “Joel, I got this great idea.” And it was a good idea. It was a pilot project that had merit. But it needed a few thousand dollars, and I didn’t have that few thousand dollars. I would write a letter to Bob Haggerty as president of the [William T.] Grant Foundation or Margaret Mahoney at [The] Commonwealth [Fund] and [in] later years Ruby Hearn at [The] Robert Wood Johnson [Foundation]. These officers were able to give you a small grant, $5,000 or $6,000, without going through a big process. But I wanted to do something about that.

There was a model that Morris Green had established, a grant program at Riley Children’s [Riley Hospital for Children at IU Health]. And I thought, why not establish a small grant program in our department? With the support of the department, family and friends we were able to establish the Joel and Barbara Alpert Children of the City Fund. And I’m very proud to say that after it started, we’ve made something north of 100 awards with a net value of maybe $700,000 to $800,000 dollars over the years. About $40,000 to $50,000 dollars a year, with a multiplier effect of something approaching $20 million where people have used the data from these pilot projects and will have moved forward with that. Now we have a mini-NIH [National Institutes of Health] system with a committee reviewing the projects. We have 2 cycles a year and the medical school contributes. We have annual contributions. Our family continues to contribute, and a bequest in our will will make it a permanent endowment. And [I’m] very very proud
of that. So the Joel and Barbara Alpert Children of the City Fund exists at Boston University and Boston Medical Center.

The second thing in terms of a material legacy is in 1993, when I indicated after 3 years of effort to then-dean Aram [V.] Chobanian that I was ready to step down. He had talked me out of it for 2 years for obvious reasons from his point of view; it costs money to get a new chief, But the third year I really insisted, and so he accepted my resignation for a year from then. He said, “Joel, you’ve done such a wonderful job, the university wants to honor you. We would like you to have a professorship named after you and Barbara.” And quite frankly I was overwhelmed, and I said, “May I go home and think about it?” He said, “Yes, go home and think about it.” Barbara thought it was wonderful. The Barbara and Joel Alpert Professor of Pediatrics. I came back and said, “Yes.” He said, “Good. Now go raise the money.” [Laughter]

Again, we were in a blessed position. We were able to raise the money. And now the person who’s the incumbent professor, chair of the department, is the Joel and Barbara Alpert Professor and Chair of the Department of Pediatrics at Boston University School of Medicine. My immediate successor was Barry Zuckerman. And most recently, after Barry stepped down, it’s been Bob [Robert J.] Vinci, who is now the Joel and Barbara Alpert Professor of Pediatrics.

In that regard, I’d like to talk about a failure of mine which may, in fact, be indirectly connected to a legacy. From almost the first day I arrived at Boston City Hospital, for all kinds of reasons, I recognized the limitations of Boston City Hospital as an educational sole site for the training of pediatric residents. Yes, we heard earlier what my values were, and what I thought. But you have to have cardiology, you have to know endocrinology, and you have to know a little of nephrology. We needed a partner. My attempts to find a partner were singularly unsuccessful. Maybe I wasn’t up to the task. Maybe I was ahead of my time. Maybe others weren’t interested. Hard to say. I have no reason to tell stories that will cast any shadow on anyone else. But I will tell one, because I was good friends with Mel [Mary Ellen] Avery. She and I would go out every 6 or 7 weeks. We’d have various arrangements about cardiology at [Tufts] New England Medical Center [now Tufts Medical Center] and with Allan Goldblatt and Don [Donald N.] Medearis, [Jr.] at Mass General. And I said, “Mel, we really need a partner for the residency training program.” She said, “Joel, why should I? My ship is sailing full speed ahead. The ocean is calm. We are full ablaze. Why?” I said, “Mel, you could be the Titanic. Secondly, I’m the little guy out there in the rowboat and the rules of the sea say help me.” She laughed and we both laughed. So it never happened.

But it did happen with Barry Zuckerman as chair at BU [Boston University School of Medicine] and David [G.] Nathan as chair at Children’s [Hospital
Boston]. The resulting Boston Coordinated Residency Program, as far as I’m concerned, there’s nothing better in the country today. I will now say nice things about organic-based subspecialty disease. [Laughter] The strengths at [Boston] Children’s, put together with the advocacy emphasis and the high prevalence, challenging, poverty-linked diseases at Boston Medical Center, creates this incredible program. And while it was Nathan and Zuckerman who were the leaders, it was Bob Vinci and Fred [Frederick] Lovejoy who were the doers. And they did it. The faculty at [Boston] Children’s wanted no part of it: ‘We don’t need anyone else.’ The faculty at Boston University: ‘We don’t want any part of this. We’ll be swallowed up; we’ll never be ourselves again.’ They overcame all of that, and the residency staff, the residents are absolutely outstanding. I consider that an Alpert failure, but also part of the legacy. So, we have the Children of the City Fund, we have the professorship, and I think we have the memories of a very exciting, very fulfilling, and very challenging career.

DR. KEENAN: An important career, and one that I’m very proud to have been with you at times, and to have learned from you. And the Academy has been well served by you.

DR. ALPERT: Those are very kind words, Ed. But now I want to add something somber to this, which perhaps will make this story somewhat unique. There was an article in the New York Times. Let’s see. Today is the…?

DR. KEENAN: The 21st.

DR. ALPERT: Twenty-first of November. So the article was published 2 days ago, on the 19th of November. “When Doctors Die” is the title of the article. It’s the front page of the third section. And I’m going to die. I mean we’re all going to die, but I know when. I’m sorry—I know what I’m going to die from. In June of 2012, because of falling platelets, I was diagnosed with myelodysplastic disorder, or MDS [myelodysplastic syndromes]. And 3-1/2 weeks ago that converted to AML, acute myeloid leukemia. No cure. I’m 83 years old, going to be 84.

What’s important to me is quality of life. We’re making judicious decisions. And as to that article, I was pleased to point out to my family, the doctors who are faced with knowledge of impending end of life know enough from their experiences to plan for it. So, we have planned, and our plans are in shape. I may have 6 months, may have less, may have a year, can have more. We don’t know. I’m not going to have aggressive treatment. No fun being in a bubble and getting your marrow wiped out for 3 to 6 months and living in a hospital to marginally gain a few months. That’s no quality of life. So that’s been ruled out.
The change took place so quickly that doing nothing would be unfair to my family. And fortunately, there are intermediates. There are methylating agents, and I’m on one of them. Minimal side effects. Potentially modest benefit. And we’re doing that. We just started, finished the first cycle, went well. I’m upbeat. But to those who would read this history at some point, I hope there is a message here.

Now there is something in our family that perhaps prepared me to do this. I had an uncle, Sam, a physician, a diabetologist, who was a health nut long before it became fashionable to be a health nut. He exercised, he ate nuts before all of us did these things! And very close to age 85 he has a tarry stool, goes in to see his physician. Colon cancer with multiple metastases. His physician says to him, “Beyond surgery, next week we’ll start chemotherapy.” And my uncle said, “No you won’t. I’ve lived a good life. I’m going home. I want to be comfortable. I don’t have any symptoms now. I will have symptoms. You’ll make me comfortable. Going to get things in order.” And he died 4-1/2 months later. I think the ability, because we are physicians, to see the wisdom of end-of-life planning—which brings me to a last, hopefully insightful and passionate comment about today’s sometimes ugly and stupid debate.

When you hear end-of-life planning characterized by certain people on the far right as death panels or pulling the plug on grandma, you really want to vomit. You really just don’t understand. Imagine what we would do. I’m not suggesting—every person has to make his or her individual decision. But just imagine if—what is the latest figure—70% of what we spend on medical care is in the last 6 months of life? Plus or minus whatever. Just imagine if we were able to cut that because people made what was for them their appropriate decisions. Because we made what’s appropriate for me, and by the time this is all done I may not be here to edit it. But I think I will be.

DR. KEENAN: I think you will be too, Dr. Alpert. I think that you will come through this and you will be a role model for people to realize that the good life is not forever. Could you just comment on the book you’ve just written?

DR. ALPERT: Oh yes, that’s funny. This is totally independent, of course, of what I just said. We have 3 children. I really haven’t said very much about our family. Three children, 8 grandchildren. We are very blessed. Five or 6 years ago, our daughter, who’s the youngest, says to me one day simply in passing, “Hey Dad, someday when that event occurs I’m very frightened that we will leave out something you think is important. Would you please write your eulogy and obituary for us now so it’s all done?” I thought that was a very reasonable idea, and I sat down to write it. I have now just finished a 310-page book which I’ve called Joel’s Story, working with a photographer in terms of selecting pictures which will go back to Central Europe to talk about our family and where we started. It will be self-published. My wife
read it very carefully, took out all of the X-rated stuff and said, “The kids don’t need to know that.” [Laughter] It would never have been a bestseller anyway, but be that as it may, it will be there for the family and future generations.

I hope in telling this part of the story—we’re ending on a high note—that I think that one of the things that has helped me cope, succeed through all these years at whatever, is the ability to laugh, to have a sense of humor. Even in the most trying of circumstances. Doesn’t mean that you don’t lose it. After one day at Boston City Hospital, I came home—our daughter was then about 11—came in the house, I said to my wife, “Barbara, you won’t believe this. There was someone in my office, they left and I got so angry, I took Nelson’s [Textbook of] Pediatrics and I heaved it across the room. Didn’t break anything, but I was furious.” And this little voice from upstairs said, “Good, Daddy. Then maybe you won’t lose your temper tonight.” The lesson for me was—if you’d asked me was I bringing anything home from work, the answer was no. But I sure as hell was. So that was also a lesson that reminded me of the importance of laughing in spite of whatever adversity there is. So, it’s been good, and it’s continuing to be a good run. And it’s been a delight to have you interview me.

DR. KEENAN: Well, thank you very much. It’s been a pleasure to hear this important story, especially as it affects children of the world. I heard a story once I’d just like to share with you from one of my medical students whose mother had survived the Holocaust. She would say, “Son, life is too serious to take seriously.” And I think you’ve always had that light touch and that persistence, and I admire it very much. Thank you.

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CURRICULUM VITAE

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1980 Recertified (#R80008109)

Organizations, Memberships, and Committees:
1961- Ambulatory Pediatric Association (Executive Board 1966-98; President, 1969)
1961 - Massachusetts Medical Society
Joel J. Alpert, M.D.


1963- New England Pediatric Society

1964-70 Society for Research in Child Development

1964-70 The American Association of Poison Control Centers (Member, Executive Board 1965-68)

1964-92 American Public Health Association, Medical Care Section

1965-92 American Association for the Advancement of Science

1966- Physicians for Social Responsibility

1968-75 Society for Pediatric Research (Emeritus, 1975)

1968-72 Society of Teachers of Family Medicine

1972-93 Association of Medical School Pediatric Department Chairmen

1974- American Pediatric Society

1978- Member, Institute of Medicine, National Academy of Sciences

1982-95 American Medical Association

1989-00 Member, National Advisory Committee, Healthy Tomorrows Program, Bureau of Maternal and Child Health, DHHS

1985-91 Noonan Foundation Advisory Committee (The Medical Foundation)


1993-95 Member Governing Council, Institute of Medicine, National Academy of Sciences; Board on Families and Children; Task Force on the Future of Primary Care
Joel J. Alpert, M.D.

1996-03 Consultant, Healthy Steps, The MEM Foundation and Commonwealth Fund
1999-03 Member, National Advisory Committee, Healthy Steps, Commonwealth Fund
2000- Physicians’ Working Group For Single-Payer National Health Insurance

Honors and Special Lectureships:

1961 Army Commendation Medal
1978 Chairman, International U.S. Delegation to Poland on Child Development and Medical Education, Krakow, Poland, September
1979 Dozer Visiting Professor, Ben Gurion School of Medicine, Beer Sheva, Israel, May-June
1983 Raine Foundation Visiting Scholar, Department of Child Health, University of Western Australia and Princess Margaret Hospital; Resident Tutor, St. Columba College (UWA), Perth, W.A., September-November
1984 Leonard Erlich Visiting Professor, North Shore Children's Hospital, Manhasset, Long Island, New York, December
1986 Colin Stewart Lecturer, Dartmouth Medical School, Hanover, New Hampshire, February 26
1986 Stacey White Visiting Professor, Emory Medical School, Atlanta, Georgia, March 24-26
1987 Alpha Omega Alpha (Boston University Chapter)
1989 George Armstrong Award, Ambulatory Pediatric Association, May 4
1991 Job Lewis Smith Award, American Academy of Pediatrics, October 28
1993 Lifetime Achievement Award, Massachusetts Poison Information System, January 7
1994 Paul Bevan Lecturer, Rochester General Hospital, Strong Memorial Hospital and University of Rochester School of Medicine, May 23-25
1995 Jane and John Davis Prestige Visitor, University of Otago (Dunedin, Christchurch, Wellington) New Zealand, Sept. 1-22
1995 Pew Foundation Award for Achievement in Primary Care, Education (Honorable Mention) September 29
1995 Keynote Speaker, Graduation exercises Scheider Children’s Hospital, Lake Success, NY
Joel J. Alpert, M.D.

1996  Key Note Speaker, Spanish Pediatric Association, Granada, Spain November 2
1996  Honorary Member, Spanish Pediatric Association
1997  Gillian Abbott Visiting Professor, Primary Children’s Hospital and University of Utah, Salt Lake City, April 3-4
1997  Robert C. Storrs Lecturer in Pediatrics, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire, October 21-22
1998  Milton Markowitz Lecturer. Connecticut Children’s Medical Center and University of Connecticut School of Medicine, Hartford, Connecticut, October 6
1998  Pew Foundation Award for Achievement in Primary Care, Education, October 3
1999  First Combined American Academy of Pediatrics and Royal College of Pediatrics and Child Health Lecturer, Kings College, London, UK, April 23
1999  Roland B. Scott Lecturer, Howard University School of Medicine, Washington, DC, May 4
2000  Honorary Member, Philippine Ambulatory Pediatric Association, March 10
2000  Career Achievement Award, Ambulatory Pediatric Association, May 15
2000  Alpha Omega Alpha Lecturer Louisiana State University Health Science Center, Shreveport, Louisiana, April 26
2000  Keynote Speaker, Graduation exercises Scheider Children’s Hospital, June 16
2000  Graduation Speaker Wright State School of Medicine, Dayton, Ohio, June 9
2001  James Rosenfeld Lecturer, University of Oregon Medical Center, Portland, OR, April 12
2002  Public Policy and Advocacy Award, Ambulatory Pediatric Association, May 3

Federal Review Activities:

1968-73  Member, Health Services Research Study Section, NCHSRD, Department of Health, Education and Welfare, HSMHA
1972-90  Consultant, Center for Health Services Research and Development, Department of Health and Human Services

1976-   Consultant, Public Health Service, Health Resources Administration, Division of Medicine, Bureau of Health Professions

1985-89  Member, Health Services Developmental Grant Review Subcommittee (HSDGRS), National Center for Health Services Research and Health Care Technology, Department of Health and Human Services (DHHS)

1988-  Ad Hoc Reviewer, Research Grants Committee, Bureau of Maternal and Child Health, PHS, DHHS

1989-  Ad Hoc Reviewer, Healthy Tomorrows Program, Bureau of Maternal and Child Health, PHS, DHHS

**Editorial Activities:**


1984-92  Member, Editorial Board, Pediatrician

1985-00  Associate Editor, Pediatric Reviews and Communications

1994-  Member, Editorial Board, Journal of Urban Medicine, New York Academy of Medicine

2001-  Reviewer, Journal of the Ambulatory Pediatric Association

**Other:**

1962-  The Yale Club of Boston

1969-71  Treasurer, Winchester Council for Community Action

1970-72  Town Meeting Member, Winchester, Massachusetts

1971-78  Health Advisory Committee, UNICEF

1971-79  Member, Advisory Committee on Children with Learning Disabilities, Winchester Schools (Chairman, 1977-79)
Joel J. Alpert, M.D.

1975-82  Member, Executive Committee, Massachusetts Committee for Children and Youth
1976-    The Aesculapian Club
1977-04  The Harvard Club of Boston
1982-    Member, Class Council, Yale University Class of 1952
1989-93  Yale Club of New York
1991     St. Botolph Club, Boston, MA

PUBLICATIONS:


Joel J. Alpert, M.D.


68. Alpert, J.J.: The Role of Health Professionals in Initiation of Change in Primary Care Delivery: An Education View. In Proceedings of Factors Promoting or Inhibiting Change in


102. Alpert, J.J., Pelton, S., Mathieu, 0.: Primary Care Graduate Education: Where Do We Go From Here? In Future Developments in Primary Care Graduate Education, DHHS, PHS, HRSA, 1985, p. 38-40.


144. Kemper, KJ and Alpert JJ. Presidential Welcome to Journal of the Ambulatory Pediatric Association Peds (J. Amb Ped Assoc) 1999, 103:a11-12


ABSTRACTS:


Joel J. Alpert, M.D.


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