PREFACE

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.

Historical Archives Advisory Committee, 2015/2016

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ABOUT THE INTERVIEWER

Danette Swanson Glassy, MD

Dr. Danette Swanson Glassy is a primary care pediatrician and child advocate. For 26 years she has been a managing partner, practicing at Mercer Island Pediatrics, and is clinical professor of pediatrics at the University of Washington, School of Medicine. Dr. Glassy is the co-chair of the executive committee for "Caring for our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd edition", and is the editor of “PedFACTs: Pediatric First Aid for Caregivers and Teachers”- an American Academy of Pediatrics (AAP) publication. Recently finishing an appointment to the Head Start Research and Evaluation Committee, she contributed to the “Advisory Committee on Head Start Research and Evaluation Final Report”, available at http://www.acf.hhs.gov/programs/opre/resource/advisory-committee-on-head-start-research-and-evaluation-final-report.

Dr. Glassy is also a passionate child advocate at the national, state and local level, involved in the promotion of access to health care for all children and quality early learning. Her advocacy opportunities have been facilitated by a long association with the national American Academy of Pediatrics (currently on the executive committee of the Council on Early Childhood), the Washington Chapter of the American Academy of Pediatrics (she is a past president of the Washington Chapter), and now as a founding board member of BestStart Washington, a non-profit organization dedicated to community collaboration to build resilience of all children.
Interview of Susan S. Aronson, MD, FAAP

DR. GLASSY: This is Danette [S.] Glassy. I’m in the home of Susan S. Aronson and for this interview. We’re in her lovely home in Penn Valley, Pennsylvania to hear her story.

Sue, maybe we can start. I’d like to hear about your family and where you come from.

DR. ARONSON: Well, my family heritage was an important part of setting the values for my life. I’ve heard many stories from my grandmother, my mother, my father. They were often repeated in bits and pieces. I’m not sure about whether these stories were accurate, or how accurately I remember them, but they have been a foundation for the kinds of things I’ve chosen to do.

I'm a third-generation American on my mother’s side. My maternal great-grandparents emigrated from Eastern Europe. My mother Jeanne Lazarus Shane was born in Buffalo, New York. My grandmother, Lucy Cogan Lazarus, was born in Boston as the second and only surviving child of her immigrant parents Rebecca Levidoff and Gregor Cogan, who took the names of Vera and Henry in the United States. My great-grandmother, Rebecca, for whom I was given my middle name, grew up in Vilnius, Lithuania, and my great-grandfather (Gregor who became Henry) came from Kazan along the Volga River in Russia. The story I was told was that he graduated from law school in the year when the Czar ruled that Jews could not practice law. The only alternative for him was to go into the Czar’s army, which was a lifelong commitment that he did not want. So he picked himself up, and with the contract in hand for the arranged marriage to Rebecca in Lithuania, he traveled to Lithuania and married her. I have a commemorative silver necklace – a chain with a round pendant engraved on one side with RLC and on the other side with the words in German/Yiddish that say “our wedding” and the date “September 14/29 1891” on it. My mother gave me this necklace to give to my granddaughter, Rebecca, with a note to Rebecca when my granddaughter reaches maturity. My granddaughter was just an infant at the time Mom gave this package to me. Gregor and Rebecca traveled to England. Gregor left Rebecca in England, presumably with relatives, to wait for him to send for her when he had established a home for her in the United States. He entered the United States in Boston.
My great-grandmother, Rebecca, was the daughter of a quartermaster for the Czar’s army, and her father thought of her as his favorite. She accompanied him as he traveled all over Europe procuring material for the Army. At some point, Rebecca was sent to Moscow to be trained as a midwife. This training was a reaction to the concern about having non-Jewish women having to deliver Jewish babies, so the local authorities decided to educate more Jewish women as midwives. When my great-grandparents left Eastern Europe, they brought their education and their skills.

Although educated as a lawyer, Henry became a tailor at first because he spoke no English. He didn’t like his life in Boston, so he sailed to Argentina to see if life there would be better. There must have been some relatives or friends in Argentina, but I was not told what made him choose to go there. What he didn’t like was working as a tailor, so he came back to the United States. Henry learned English by reading newspapers and having conversations with English speakers. He had a thirst for education and wanted to improve his economic prospects. He had cousins who were in the United States, one of whom was a pharmacist. Henry asked his cousin what you had to do to become a pharmacist. His cousin said, “Well, to be a pharmacist you have to learn the pharmacopeia and you have to be able to pass a licensing exam.” Henry proceeded to do just that. He knew Greek, and he knew Latin, so it was pretty easy for him to read and use the pharmacopeia and pass the licensing exam once he mastered some English. He began to work as a pharmacist and sent for Rebecca to come from England to join him. They lived in Boston long enough to have 2 children there – a girl who died of diarrhea as a toddler, and my grandmother.

The story is that much later, when my grandmother was in high school, my great-grandparents had employed a young man for the summer to work in the soda fountain in the pharmacy. The young man was to be a medical student in the fall. When the fall came, the newly minted medical student came into the pharmacy, put his books on the counter and proudly said, “I am a medical student.” My great-grandfather, so the story goes, went over and started thumbing through his books and said, “What do you have to do to become a medical student?” This was after 1910 when the Flexner Report about the poor quality of many medical schools stimulated a closure of all the apprentice schools, leaving only the 4-year medical schools that met then current medical education standards. All the apprenticeship schools were closed. Henry enrolled at NYU [New York University] medical school while my grandmother was a high school student. He graduated from NYU
medical school, did his internship on Rikers Island, and then went to Paterson, New Jersey as an obstetrician-gynecologist. He continued to practice medicine as a specialist in OB-GYN for the rest of his career.

DR. GLASSY: So the 2 of them were the midwife, and now the obstetrician-gynecologist, who happened to just run the pharmacy as well.

DR. ARONSON: Yes. At some time before Henry enrolled in medical school, the family had moved to New York from Boston, and Henry and Rebecca set up a pharmacy in the New York area. During the daytime while Henry was in medical school activities, Rebecca ran the pharmacy. Henry would come home from medical school in the evening and take care of the things only a licensed pharmacist could do.

Henry was a very strong person. I knew him as a widower and retired physician. I was 9 when he died. I remember hearing him tell my grandmother to be sure to hold my education to high standards and his asking her what I was learning. He started to teach me how to use my fingers as an abacus, lessons interrupted when he moved to Florida from my grandmother’s house in Buffalo, New York in his 80s. I wish I had paid more attention to those lessons. As a physician, he was known as a very stern and strong person, but at home, his wife, my great-grandmother, Rebecca, was called “the general.” She would tell Henry what to eat and what he needed to do at home. There have been strong men and strong women in my family.

Henry joined the US Army as a physician during World War I—I don’t know whether he actually joined or whether he was drafted into the Army—but he was known in the US Army as the doctor who insisted that soldiers dig latrines to reduce the infectious disease rates in their camps. And in fact that benefit was realized. In World War I, more soldiers died from disease than they did from battlefield experiences.

Both my great-grandparents, Rebecca/Vera and Gregor/Henry, were very committed to education. Rebecca learned to speak English – although she could not write in English. They encouraged and financed education for their daughter Lucy, who was my maternal grandmother. After my grandmother completed high school and while Henry was completing his medical education, Lucy went to Barnard [College] earning a Bachelor’s degree, and then went to Columbia [University] where she earned a Master’s degree in psychology. Higher education degrees for women were not
common in my grandmother’s time. Lucy married my grandfather Samuel Lazarus, a British-trained chemist and school teacher who came to the US during WWI. He was teaching chemistry at a boys’ school in Britain when he became ill with pleurisy and was told to go to the US where the climate was better for his recovery. He intended to return to Britain when WWI was over and he could escort his sister and her children back to Britain from Canada where they had been sent for safety from the war. My grandfather Lazarus is the source of my British relatives. Lucy’s and Sam’s children were my mother (Jeanne) and my mother’s brother (Victor). Both earned bachelors and higher education degrees. My mother's Bachelors was in psychology from the University of Chicago, awarded one month before I was born. After my younger sister was born, Mom earned a Masters degree from the University of Pittsburgh that gave her the skills and credentials she needed to be a remedial reading specialist in elementary schools. My maternal uncle became a physician and specialized in urology.

My father was Robert Shane. My father’s family came from Russia with much less formal education and some skills. Both of my father’s parents were dead when I was born. I only know about them from my father’s and mother’s stories. My paternal grandfather (Jacob) was a shirt ironer in Russia. This required a man of great strength because the irons were heavy, actually made of iron. You had to put the iron on a stove and heat it, then you did the ironing. At that time, they needed shirt ironers in the garment industry in New York City. Recruiters came from the US to Europe to offer passage and a job to work in the garment industry to willing people with needed skills.

Jacob was in trouble in Russia because in addition to his work as a shirt ironer, Jacob was also a private tutor who would come to a village and teach children in the village while living with one of the families of the village. Jacob was said to travel from village to village with printing plates hidden in his coat. He would use them to print up sheets to teach the children in the village how to read. As peasants were not allowed to learn how to read, what Jacob was doing was considered a crime, and the police were on his tail. So with the police chasing him and a means to use his skill as a shirt ironer to get to the US, he left Russia for New York. He was in his early 20s at the time. Because of concerns about his getting into trouble in New York, relatives arranged for him to move from New York to Chicago where he married my paternal grandmother who was his first cousin. They set up a delicatessen and then borrowed money from family members to set up a highly successful laundry business.
My paternal grandfather taught himself English and educated his children by having challenging discussions with him and making sure they went to school, even when going to school involved challenging routes through hostile neighborhoods of other ethnic groups. After completing high school, my father Robert studied at the University of Chicago where he earned a PhD in organic chemistry and was heading for an academic research career. My father’s younger sister (Evelyn “Dolly”) earned a master’s degree in social work from the University of Chicago, and his younger brother (Leonard) went to the University of Chicago too. Unfortunately, Leonard was not a serious student. I was told that he never accrued a credit in the years that he attended the University of Chicago. That was another story. Len was the youngest sibling and only 11 years old when his mother died. To manage his household and care for his son, Jacob married a woman who had been educated as a physician in Germany before immigrating to the US. She was kind and indulgent in her supervision of Len.

My father was 27 when he married my mother. She was 18 and had completed one year at the University of Michigan. She transferred to the University of Chicago after their marriage. My father’s research career abruptly ended when his father died after a series of heart attacks. With a partner, Jacob had developed a successful laundry business. Dad’s stepmother was working in a nursing home. His sister was working as a social worker. By this time, Dad and Mom had had their first child, my brother. A month after Mom’s graduation from college, I was born. To some extent, all these family members were dependent on the income from the laundry business. The family needed a larger source of income than Dad was earning as a post-doctoral fellow at the University of Chicago. As the eldest sibling, my father was expected to run the laundry business with his father’s partner and generate sufficient income to support the family. Dad worked with the partner in the laundry business for a little while. When he found that the partner wasn’t honest and was not sharing profits fairly, Dad sold the family’s share of the laundry business to the partner and gave the funds to his siblings to use for their support. Dad found a job as a chemist in Detroit. We moved there when I was 8 months old. That began the chapters in my story of moves from city to city related to Dad’s work.

So far, I have talked about some of the members of my family of strong women and strong men. I learned from family stories about them how to overcome adversity through education and hard work.
Lucy was special to me. She was the only grandmother I knew. Sam met my grandmother not long after his arrival in the US when he came along with a friend and a welcomed dinner guest at the table of Rebecca/Vera and Gregor/Henry who had set up medical practice and household in Patterson, NJ. After only a few months in New York, Sam accepted a job to work as a chemist while waiting to return to Britain. He was employed by a dye company located in Buffalo, New York. It was wartime, their courtship was brief as they wanted to go together to Sam’s job in Buffalo. Grandpa remained employed by that chemical company for his entire career, retiring as head of the patent department at the age of 65. I spent a lot of time at my grandparents’ house in Buffalo, NY. I was with them for many weekends and holidays when my parents needed child care.

My parents had moved our family from Detroit to Rochester, NY where he worked for short periods for a couple of chemical companies. Dad’s intellect and ability made significant contributions to the companies for which he worked. For example, he developed a valuable rose polishing process used by Bausch and Lomb in Rochester, for lenses used by the military during WWII. Dad developed a waterproofing chemical to treat the tents used by soldiers. When he left the chemical industry to set up a laundry/dry cleaning business in Rochester, he used this process to waterproof civilian raincoats.

My parents worked very hard to make the laundry business run profitably. They were very busy seven days a week, and worked long hours every day. On school days, I was supervised by one of what became a string of housekeepers. Some of them were wonderful. Others were incompetent. When the laundry/dry cleaning business failed after nearly 10 years in Rochester, when my father was 40, he returned to his work as a scientist. From that point forward, he often resigned one position for better paying opportunity in another company, usually in a different city.

Beginning when I was 9 years old, I was sent to overnight camp for the summer. When I went to camp, my grandmother came weekly, bring me home-baked cookies and taking my laundry home to wash and return it to me every week. My grandparents were very important in my life. My grandmother, Lucy, was never gainfully employed although she was highly educated. My grandfather Sam felt it was his responsibility to earn the money for his family and he didn’t want her to take a salary that another man could use for the other man’s family, especially during the recession. Lucy involved herself in lots of community activities. She became president of the Buffalo chapter of the American Association of University Women.
[AAUW]. She often organized the community of women, who were also educated, to do good things in neighborhood and community.

My Dad also contributed to community activities. He was a Boy Scout troop leader and remained involved in the scout organization for most of his adult life. My brother was an eagle scout. Providing community service was a value that I learned was self-satisfying and inspired my future work. Working with our neighbors and with the community is something that I continued in my life personally and professionally. For example, I use a list I created, maintain and share with those who OK sharing our neighbors’ street addresses, phone numbers, emails, and the ages of the children who are potential local playmates for one another. Whenever there are changes in the information, I give the updated list to the families on the street where I live, often at the occasion of a neighbors’ party held about every 2 years at our house. Neighbors use it to share information about good contractors, notices about services provided by the local government and community events, things like that.

My mother arranged child care for the times when I was not with my grandparents using a variety of different caregivers. Some caregivers were extraordinary. For example, one housekeeper was an opera student at Eastman School of Music. I learned from her how to breathe when singing. I practiced singing with her, and singing remained a very important part of my life. Until the end of my first year in medical school I was a member of choral groups. Other housekeepers taught me less appropriate behaviors. One taught me how to smoke when I was nine years old, including how to steal the cigarettes from my father's pocket in his bathrobe. My parents were both smoking at that time.

The post WWII era was hard for my family. This was during my elementary school years. The laundry business failed because of some unethical business and political practices of city and military procurement officers that resulted in cancellation of promised contracts that my dad had won for doing the uniforms of the local police force and the officers on a nearby military base. The contracts were signed, and dad bought equipment to meet the contract deliverables. The contracts were cancelled before they could be fulfilled, throwing the business into bankruptcy. We lost our house since it had been used as collateral for a loan to buy the equipment to fulfill the contract. At that point, Dad left the laundry business for a second time and went back into industry as a materials scientist. He began again to work his way up the corporate ladder through intellect and hard work. He was 40 years old when
he returned to industrial science work, with a job in Wyandotte, Michigan.

Prior to leaving Rochester, when I was 9 years old, my sister (Jacqueline) was born. When we moved to Wyandotte, my mother enrolled my sister in an early childhood education program for peer socialization opportunities she thought were important for my sister’s development. This was my first exposure to early childhood education programs and their value and importance. My mother approached the director of a nursery school and offered to become an assistant to help teachers in lieu of the tuition. The director said, “I can’t exchange the tuition for your services. It would ruin my budget. You need to pay the fees. But why don’t you go down to the local school district. They’re desperate for teachers and you have a bachelor’s degree. Why don’t you offer yourself as a teacher?” So my mother went, and the story is that they said, “We need you, we want you. You start on Monday teaching kindergarten.” My mother said, “Well, I don’t know anything about how to teach kindergarten.” They said, “Here’s the curriculum, study it over the weekend and begin on Monday.” This began my mother’s long teaching career. Each time Dad moved our family to a new city, she would go to the local school. I went to junior high school in Wyandotte. We moved from Wyandotte to Danbury, Connecticut where I was a freshman in high school, and then to Pittsburgh, Pennsylvania where I completed my sophomore and junior high school years. In Pittsburgh, Mom continued to teach and simultaneously earned a Master’s degree in remedial reading education from the University of Pittsburgh and began to serve as a remedial reading consultant. She finished her whole career being very proud of her role and recognition as a competent and valued teacher. I learned from her that teaching is an important and valued role.

I’ve talked about some of the women in my life. The men were strong and resilient too. I already mentioned Samuel [M.] Lazarus, my grandfather, who was married to Lucy. He worked for his entire career in the United States for National Aniline and Chemical Company (originally Standard Aniline Products Corporation until it merged in 1917 with Beckers Aniline and Chemical Works to become National Aniline and Chemical Company).

My grandfather was British to his core even though he became an American citizen. He possessed wonderful English language writing skills and mercilessly edited to British English standards anything I had written and presented to him. These experiences honed my skills as a writer. It was hard for me to have him work on what I wrote. It was sometimes very painful. He would accompany his constructive criticism with a hug, and we would get
through those lessons. I loved sitting with him at his big, beautiful oak desk. The desk was passed from Sam to my father and now I have it. Even now I think of him as I write or edit the many articles and publications that I have produced. I think he would’ve said, “Is that the right word? Why are you putting hurdles in the way of your reader? Take that phrase out. It doesn't add anything. What are you trying to say? Well just say it.” Grandpa Sam’s words continue to echo in my head to this day.

My dad, Robert [S.] Shane, was a very strong individual who expected nothing less than the best you could do as long as that was the best you could do. He would stand up for me when I was in trouble. During fifth grade, he went to my elementary school teacher to negotiate a resolution of a conflict I had because I stood up for a fellow student whom I thought was being unfairly treated by the teacher. The student had been out sick for a couple weeks, and the teacher was standing over her saying, “Where is your work? Where is your work? Why don't you have your work done?” I said, “She doesn’t have it because she was out sick.” That was enough to turn the fire of the teacher on me. She said to me, “You just mind your own business until you have your own work done.” And I said, “I have my work done,” which got me sent to the principal’s office. Dad went to negotiate the situation and was quite successful. The teacher pulled in her claws, and I got through the rest of fifth grade.

My Dad offered love and affection unconditionally. However, at times his affection and interest took the form of a bruising intellectually challenging conversation. Dad’s father had used this challenging approach, his version of the Socratic method to teach his son. Dad’s father was the guy who came from Russia escaping punishment for teaching peasants how to read. He was the man who built and ran the laundry business in Chicago. It was hard to have a conversation with my Dad. He would question everything you said, ask you to give the rationale for it, and ask what the evidence was for it. This exposure to evidence-based decision making was painful but helped me to think critically.

In the research world, Dad, now in his 40s, continued to climb his professional ladder. His last employed position was as a staff scientist for the National Academy of Sciences in Washington, DC. He was a well-educated material scientist who served as a consultant and wrote textbooks about materials and processes.

Even in retirement, my dad was helpful in my work. For the first edition of
Caring for Our Children [National Health and Safety Performance: Guidelines for Early Care and Early Education Programs, 2002], he provided his material science expertise and contacts with others who had expertise around issues related to facility and materials. The particular thing he was cited for in the first edition is regarding a standard we had that didn’t allow the use of latex balloons in early childhood programs because of the choking hazard. I was looking for what we could offer as an alternative to taking the balloons away from children and from those who want to use balloons to celebrate with children. I asked my Dad about Mylar and whether Mylar would be safe. My Dad managed to find the specs on the tensile strength of Mylar and measurements of the jaw strength of young children in the early childhood age group. We used that information to let us allow Mylar balloons in the standard.

My parents modeled how to navigate personal and professional life throughout my life. This is different from the commonly cited need to balance your personal and your professional life. The reality is that these aspects of life are not distinctly separate. They are interwoven and you make choices as you navigate throughout life. We can come back to that and talk a little bit more about that concept. It was something I really understood best when it was explained to me by Ellen Galinsky. The idea that we need to polarize work and family life is really not an appropriate representation of what we truly experience. My Mom’s and Dad’s approaches epitomized that reality.

I’ve mentioned my brother. My brother Steve is 3 years and 8 months older than I. As my big brother, Steve has always been available to help when needed. He teased me mercilessly when we were children, but we are very close now. Steve is a retired attorney who lives in the suburbs of New York City. Our sister, Jacqueline is 9 years younger than I am. I helped care for her as an infant, toddler and preschool-age child. She is a retired teacher and physically-challenged adult. My sister became an elementary teacher. When she was in her 40s, she became disabled and retired in her 50s. She lives with her husband as her caregiver in a suburb of Rochester, New York. We are a reasonably close family. While our parents were alive, we always got together at our parents’ home for Thanksgiving. In addition to the wonderful food, stories were told like the ones I’ve just shared with you.

DR. GLASSY: It’s amazing to me how many people in your family are so resilient—that an obstacle would come up, and they'd change careers. And the theme of education as, well, that love of it, not afraid of it, not seen as a barrier to
the next step in your life for both the men and women at an extraordinary time when, especially for the women in your family, maybe that wasn’t necessarily valued. It sounds like that’s a theme running through both sides of your family, and even back to your great-grandparents.

Is there anything else that you think they shaped for you, or anything else you want to share about your present day? You gave us hints about navigating your life as women and also for child care and education of young children along the way as influences. Are there any other pieces that you wanted to call out about your family?

DR. ARONSON: Family values and expectations were frequently articulated and very easily understood. Education was absolutely expected. It wasn’t a question. You were expected to do what you could. Dad had certain things (aphorisms) that he would say over and over again. I find myself, as I grow older, saying the same things over and over again to myself, and also to other people to whom I’m trying to give SOCOs [Supreme Overriding Communication Objectives] to go by. I was taught by the Academy media folks about the use of SOCOs. Dad always said, “Do the best you can. That’s all you can ever do.” He also said, “The meaning of your life is in the good that lives after you.” He often reminded others of what he called “enlightened selfishness.” We do things for other people because it makes us feel good to do it. So it’s a kind of selfish thing, but one that we value. He also would say, “As good as something is, it is even better if it is possible and it’s worth striving for.” My dad didn’t judge performance by school grades but by our perception that we had done the best we could with what we needed or wanted to do.

In my adult life, I’ve adopted the concept that “perfect is the enemy of the good” to modulate the impact of that forever relentless concept that maybe you could have done better. So we try to do what is good and try to find ways to make good things happen, accepting what good we can do, even if more might have been possible. It’s very insightful of you to note the principle of not accepting obstacles or barriers as dead ends because that was certainly something that was modeled for me all through my life. If you run up against something that’s a problem, you look for a way around it, a way to do something else to solve the problem. No blaming and complaining; focus on solving the problem.

My father taught me about the value of technology transfer. Dad co-authored a book — published in 1982 by Marcel Dekker [Inc.]— called What
Every Engineer Should Know About Technology Transfer and Innovation. My father was a materials scientist with a broad range of experience gained by working with chemists and engineers on many very different types of projects. Except for his work with a tetracycline ointment when we lived in Danbury, Connecticut, Dad's work was not in the biological sciences or in medicine. Still, he was always looking for some solution that had worked in some other field or used by someone else that could be transferred to a different situation. Dad’s work as a technology transfer agent inspired much of my work in early education and childcare. My experience in pediatrics merged with my work in early education through technology transfer, often from some other field or business or from social service. It often is not necessary to think up new things. There are lots of things that have been tried and found to be true and applicable to other situations. One of the courses in college I thoroughly enjoyed was the philosophy course I took about Plato and his work. One of Plato’s principles rang bells for me. Plato said that there is one truth and we all keep rediscovering it and applying it, but there is a truth. That's something I’ve used in my career. Often, what somebody else made work somewhere could be modified and adjusted to resolve a current problem in another field. Medicine has been very slow to adopt approaches that have been developed and successfully implemented in other fields. An example of this is the technology transfer used by Larry [Lawrence L.] Weed, MD, at Case Western Reserve [University] where I went to medical school. He taught us to use the concept of the “problem-oriented medical record, SOAP” based on approaches used in business and non-medical industries, transferring these concepts to apply to patient care. Dr. Weed taught us how to use the SOAP approach to be more effective in our work with patients. The problem-oriented approach is similar to the concept of strategic planning — identifying the relevant subjective and objective data, making an assessment of the problem, and then developing a plan with actions, a planned evaluation of the results of actions and follow-up. That approach had been worked out in industry many years before being adopted in medicine.

My maternal grandmother shared words of wisdom that stuck with me, too. For example, she often said, “There’s no limit to the amount of good you can do if you don't have to take credit for it.” Most of the things I’ve accomplished have not been my accomplishments, but the accomplishments of others, who have joined with me to make good things happen. We can and should give credit to all those people who participated to achieve a successful outcome. It is the right thing to do and keeps all the participants fueled and invested in accomplishing the goal.
Another aphorism that has become part of my values was something that I saw on an Amish whiteboard when I was visiting in the Amish country of Pennsylvania. It wasn’t said by someone in my immediate family, but I tend to think every good person is part of my extended family. I’m sure it’s probably a quote from something, but I don’t know the original source. I quote it a lot to other people. “You may not be able to do everything, but the fact that you cannot do everything does not give you the right to do nothing.” That has been another guiding principle for me. Whatever small increment of progress you can accomplish, that’s one that's worth having. Don’t walk away from the whole because it seems formidable. It is important for all of us to contribute in whatever way that we can.

DR. GLASSY: Sue, I’d like to switch gears here a little bit and talk next about your education, and then choices for your career and how you navigated all of that.

DR. ARONSON: Career choice for me began early in my life. When I was 12, we were living in Wyandotte, Michigan where my father had his first job back in industry. We lived in a community where only 2% of the high school graduating class went to college. It was a tough community. I went to junior high school in a building that was built in 1865 named for Abraham Lincoln. The building and surrounding grounds were old and poorly maintained. Some of the people who were in that school were like me. Others were older kids who had been held back several grades and were big, tough, and rough. I watched several knifings on the playground. There were public paddlings in the hall. Since I had skipped a grade in elementary school I was a year younger than most of my peers. I had been shielded from violence, had only seen violence on a few occasions before – when my parents had to take me to the laundry plant in Rochester for lack of alternative child care.

Part of the junior high school experience in seventh grade was a career choice class taught by Mrs. Hartwig. She was a wonderful mature woman and dedicated teacher. She was my English teacher and really in command of her class. The class was essential since most of the students needed to plan how they would get their career education when they moved on to high school. We were required to choose a career we wanted to pursue. This class included learning about wages and benefits and how to find a job. The culminating project involved making a notebook with specific information. After picking a career we were to interview 2 people from that profession and write up what we learned. We were instructed to collect newspaper
clippings about our chosen profession and write up our expectations for how
we would approach preparing for the role we chose. Most of the students in
my class were choosing to be mechanics, carpenters, secretaries or nurse's
aides. I remember thinking about what it was that I wanted to do. I was 12,
and my sister had been born when I was 9. I was involved in her care a lot
and I liked interacting with her. Although I didn’t realize it at the time, I
was practicing parenting and childcare skills under the supervision of my
mother. I learned to value Mom’s pursuit of education and career while
meeting family life responsibilities.

One memory of an interaction with my Mom during this time was a
conversation I had with her while riding in the car. We were taking a violin
to the violin maker to be repaired. My junior high school offered violin
lessons. Although I already played the piano and was taking piano lessons,
the school needed someone to play the violin in the school orchestra. They
didn’t have very many people in the orchestra and I thought I might find
peers and friends by participating in the orchestra. The plan was that I was
going to learn to play the violin that had been my mother’s as a girl. Mom
had never played the violin in my presence, nor talked about playing it.
After so many years being carted around with our household goods, it was
necessary to have it repaired. I remember we were turning a corner from
one street to another, and my mother was driving. I turned to her and said,
“Would you laugh at me if I said I wanted to be a pediatrician?” She took a
very deep breath and said, “Oh, honey, I would never”—I remember these
words so clearly — “Oh honey, I would never laugh at you at all. I would be
just delighted to have you pursue that career.” That conversation turned a
corner in goal-setting for me. Coming from her, at that moment, when she
was really struggling to make ends meet, that was just a totally wonderful,
selfless kind of support. Much later, when she was 90 and dying, she told me
that she wished she’d become a pediatrician. She had not shared that with
me before. Whether true or only retrospective thinking at the end of her life,
that she valued what I had become was meaningful to me.

I knew I was interested in how human bodies work as well as in science
generally. I was fascinated by whatever information I could get and wanted
a career that involved interacting with young children. I wanted something
that had leadership opportunities. From a very early age, I liked being in
charge of things. I organized a club of classmates when we lived in
Rochester. I was at that time about 8. We met at my house. I learned some
key life lessons from that experience. My enthusiasm and imposition of my
ideas to organize the group turned off some of my classmates. I had to learn
to tune my enthusiasm to the interest of people who were participants, be collaborative and involve everyone in making the activity successful.

So that was the beginning of my career path to become a pediatrician. I don’t think I even realized that I had to become a physician first. Amazingly, when I was in the junior high school career class, one of my interviews was with a woman pediatrician in the town. She was encouraging and supportive of my goal. She had successfully integrated career and family life. Not many women were entering medicine at that time. But I was convinced it was what I wanted to do and had my family’s support to pursue this goal.

When I went to high school, my Dad was selling his know-how to support our family and rebuild the assets needed to achieve our goals. By this time, my brother was at the University of Michigan. During my high school years, we moved to 3 different states. My first year of high school was in Danbury, Connecticut, my second and third in Pittsburgh, Pennsylvania. My senior year was in Kenmore, New York, which brought me in contact with the New York State Regents system. Until my senior year, I was in classes with people who were not necessarily as interested as I was in learning. It was pretty easy to get all As on my report card in my freshman, sophomore and junior years in high school. I brought my “all A” academic record from other states to my senior year in Kenmore, New York. While all the other students had a GPA derived from their Regents exam scores, my letter grades were assigned a score of 95 by the school. So I easily acquired a high GPA score, was assigned to honors classes, was inducted into the National Honor Society and was awarded a scholarship to the University of Rochester. This financial aid was a terrific help for my family who were paying for my undergraduate education at the University of Rochester while paying for my brother in law school at Columbia University.

On entering the University of Rochester, I knew what career I wanted and I wanted to get on with it. I planned my course work at the University of Rochester to finish college in 3 years. I took summer school courses at the University of Buffalo and packed my schedule with course work during the semesters that I was at the U of R. I took 3 sciences at once in my sophomore year. I received a special monetary prize in my sophomore year for having raised my grades the most from freshman to sophomore year. I earned Bs in my freshman year and all As as a sophomore. It took me a year to learn how to be a college student. I loved college. It was so much better and broader education than I had experienced in high school. But I was eager to be on to medical school.
I applied to medical schools and was interviewed by faculty or representatives of Harvard [University], the University of Chicago and Case Western Reserve. Choosing the University of Chicago would’ve filled my father’s heart and soul with great joy, but I decided, even though I was accepted at the University of Chicago medical school, to go to Western Reserve University, later merged with Case as Case-Western Reserve University.

I recall my interview at Harvard as particularly unpleasant. One of the interviewers, a psychiatrist, said to me, “Well, young lady”—I was all of 19—“Well, young lady, what will you do about marriage and a family?” In those days, you could ask those questions. I said, “Well, you know, it isn't in my life right now, but I certainly hope that someday it will be.” He slammed his fist on the desk and said, “Do you know what percentage of people I interview can answer that question?” I said, “I have no idea.” He quoted some statistic that didn’t interest me. My interview with him didn’t leave me with a very good impression of Harvard. My second Harvard interview was with a woman who was an endocrinologist across town. I navigated my way across the city of Boston by public transport to get there. Sitting across her desk from me, she said, “Oh, my dear, why do you want to go into medicine? There are so many other professions that would be easier on your life. Why don’t you reconsider?” This was my first of rare experiences with sexism as I moved toward my goal.

DR. GLASSY: Oh my gosh!

DR. ARONSON: I withdrew my application from Harvard. Those interviews convinced me that Harvard was not a place I wanted to go. At Western Reserve, Jack [John Lyon] Caughey, “Cactus Jack” they called him, was the one-man interviewing committee for admissions, and the one-man recommendation committee for internships. He was in charge of the interview and I was doing my best to behave very much together. Here I was, 19 years-old with good college grades and activities (e.g. belonging to a choral group) applying to medical school. I remember that the grey wool suit I was wearing had a red lining. Jack Caughey smoked at that time. I smoked at that time. He offered me a cigarette, and I tried to be very debonair in my gray suit, sitting very primly and accepting a cigarette while we talked. He asked me things about myself, and then he told me about what Western Reserve was doing with its curriculum. At that time, at 13 years old, the curriculum wasn’t exactly new, but it was innovative and student
friendly. The primary innovation in the curriculum was the integration of traditional courses like anatomy, microbiology, physiology, pharmacology and biochemistry by the faculty into cellular systems during Year 1 and organ systems during Year 2. This was coupled with an early introduction to clinical care through Family Clinic for which entering students were assigned a pregnant woman on day 1 of medical school. We were supervised to play as much as we could of the role of the “Obstetrician” and subsequently the “Pediatrician” during the pregnant woman’s clinic visits for herself, and subsequently for the baby. After Dr. Caughey finished explaining what to expect as a student at the school he said, “Well, young lady, do you have any questions for me?” I said, “Yes.” I was ready to negotiate and show my sincerity as an applicant. I said, “I have an acceptance in my hand from the University of Chicago. How soon might I hear from you about your decision, because you know I’m only allowed to hold one acceptance at a time.” He said, “Young lady, we do not play games here. We will accept you. You can pick up your acceptance on the way out the door if you like. And I promise you, we will do everything we can to make sure you’re successful.” That was a powerful selling point. I left his office with my decision made. Cactus Jack later said when Jerry (my husband) and I met with him—Jerry was a fellow medical student in my class—to tell him about our getting married, “Damn it, I'm running a matrimonial agency here.” He was really a wonderful fellow.

In medical school, I did find the kind of support that Jack Caughey had promised. Everyone there was trying to make sure that you were successful. If you were having difficulty, you were invited to get help. There were no grades in the first year. There was just pass/fail and that was very, very helpful. After the first year of medical school, the grading scale included honors, so you could earn pass, fail or honors. So there was sort of a grading system, but it wasn’t anywhere near the pressure that I understood was used for example, at the University of Chicago. The University of Chicago lost many of their students between first and second year. It was said to be a, “Look to the left, look to the right, one of you will be gone” kind of place. Western Reserve wasn’t like that.

Jerry, my husband, best friend, and partner for nearly 53 years now, was a classmate of mine. My mother came to sit in on a class in the first year of medical school. She saw this handsome young man sitting there and was in awe of him. At that time, I thought Jerry was a terrible person. The very first day of medical school he walked me home to my apartment and at the entrance to my apartment building asked me a question I didn't understand.
He asked me, “Are you M.O.T. [member of the tribe, a Jew]?” I said, “What’s that?” Even though my family heritage is Jewish, I just never identified myself as a Jewish person. That was part of my life, but not something that I broadcasted. I didn’t like to engage in religious activities. He said, “Well, I’m asking you if you are Jewish?” And I said, “That’s none of your business.” I wrote a letter home to my mother and said that I had met a guy today, my very first day, and that if they were all like this, I was going to have a miserable 4 years.

Jerry was a leader and organizer. He chaired the Student Committee on Medical Education. I was the secretary because women in organizations in those days usually got assigned to be the secretary. We had one member of the committee. We were thinking of a project that we could do. Jerry had come from New York to attend Adelbert College at Western Reserve. He had chosen it for its characteristics and affordable cost. I had come from the University of Rochester for the reasons I’ve outlined. We wondered what brought the other students in our class and in the medical school to Western Reserve. We planned and fielded a survey, then studied the data. We wrote a paper with the results and presented that paper at a medical education conference in Denver, Colorado. It turned out that most of the students at Western Reserve came there because they lived in Ohio and it was close to home. That didn’t match our hypothesis. But oh well. It was the first professional publication on my CV [curriculum vitae]. Working together let us get to know each other better. My opinion of him gradually shifted into friendship and by February of our second year in medical school, we decided to get married at the end of the year.

The unique curriculum was terrific. At Case Western Reserve, I had an opportunity to become involved with Marty [Martha L.] Lepow, who was working on immunology associated with the use of the oral polio vaccine. Under Dr. Lepow’s supervision, I did a project to see whether the mumps skin test actually caused an immune reaction to the mumps antigen so that it couldn't be used repeatedly. I tested whether you were immunizing people with the skin test material. That was a very important project. I had some research experience from my senior year in high school when I worked in the laboratory of [Dennis] Bernard Amos, an immunologist at Roswell Park Cancer Institute. I was doing research on cancer cells and how to produce immunity. Bernard Amos said, “You know, it may not happen in my lifetime, but there's going to come a time when we will conquer cancer by developing responses that use the immune system.” And boy, we're there right now. Bernard Amos was very supportive and taught me about the
things that I need to learn, not only lab technique, but also about immunology. I worked in his lab for 2 summers. Then he arranged for me to spend a summer working at St Mary's Hospital medical school in London with one of his colleagues. Dr. Amos's colleague was Dr. , a pathologist who arranged for me to work with cockroaches to see what the resilience of cockroaches was to anaerobic environments. I learned a lot about insects at that time. I learned that it's very hard to kill a cockroach by depriving it of oxygen. That's another whole set of stories.

The mumps skin test project I did with Marty Lepow was a valuable medical and sociological learning experience for me. I applied the mumps skin test to patients recruited in our continuity clinic after learning and mastering the practical challenges of obtaining informed consent to participate in a clinical study. If the patient’s parent agreed, I'd get their addresses and tell them I would come to their house to read the test. Then I would retest the child later to see whether or not, with the same interval, the mumps skin test was more positive. This project was a real eye-opener for me. These patients came from the Hough district of Cleveland, Ohio, a low socio-economic area which later was where race riots erupted in the 1960s. Prior to my home visits, I had taken histories from the parents in clinic that included what their home life was like. Medical students are taught to take a long social history and have the time to do it. Families would tell me: yes, they had a refrigerator; they had no problem with food and having clothes for their children. But when I went to their homes for my home visit, I found it was mostly not true. I'll never forget going to the homes in the Hough community and seeing rats run across the floor, seeing piles of bedding on the floor, seeing a refrigerator door open because it was not plugged in and there was nothing to put in it. When I went back to those homes for the re-test and re-test reading, I saw the parade of different people going through them. It was a real eye-opener for a side of life that I had not previously experienced. I had been exposed to some of the seedy side of life when my parents were running the dry cleaning laundry plant in Rochester. On weekends when the housekeeper was off and I was not sent to my grandparents, I would go down to the plant with my parents, which was in the area in Rochester that later had race riots of the 1960s, and wander the streets because there was no one to pay attention to me. I would go visit the lady in the house next to the plant who didn’t have any electricity, didn’t have a refrigerator, and used ice delivered by the ice man to keep her food from spoiling quickly. She heated her curling iron on a coal stove. I was not supposed to go into her house, but I liked to hear her tell stories. I found that fascinating as a young girl. From the sidewalk in front of the plant, I
watched parents sending their kids out to the street to cut a switch off the tree so that they could be beaten as punishment. I saw ladies walk down the street, who were accosted by men, reach into the top of their stocking and pull out a razor to defend themselves. I really didn’t understand all that at the time. My experiences in Rochester, New York, in Wyandotte and the Cleveland Hough neighborhood experience made me appreciate that life could be really, really hard for some families and that the advice we were giving in clinic was not necessarily relevant at all.

Back to medical school. I worked with Arnold [E.], PhD, in his laboratory on the homograft response. We all had to write a paper for graduation, and mine was on the homograft response that I was testing on rodents. I thought it was interesting because I was interested in immunology, but I had no idea that somebody would think it was worthwhile. I won a $100 research prize at graduation. Jerry and I married at the end of our second year of medical school. My father and mother said they would continue to contribute to us what they had been paying for my education. It was not easy for them to pay those costs, but they promised to do it and to continue that level of support when I married. The prize money was helpful. To subsidize his expenses, Jerry had been a live-in caregiver to an elderly, physically-challenged man during his second year of medical school. Money was tight for us.

DR. GLASSY: Because you married at the end of your first year?

DR. ARONSON: Second year.

DR. GLASSY: Second year.

DR. ARONSON: At the end of our second year in medical school, Jerry’s sources of money were very uncertain. Jerry’s father was a wholesale furrier in New York City who supported his family and his brother’s family. His work required him to be away from home 8-9 months a year as a traveling salesman selling furs made in New York to fur stores across the country. Jerry would receive a small check from his father when he had money he could spare, which was often not the case. Jerry’s mother worked as a paralegal. She worked very hard just to make ends meet. We earned extra money for our household by the two of us working in the University Hospital's blood bank. In addition to blood bank work, he sold his A-negative blood for which a premium was paid to try and make the money that he needed to pay for his tuition expenses.
Our joint efforts worked. When Jerry and I graduated from medical school in 1965 we had no financial debt, unlike so many students today. We had worked our way through and we lived, as Jerry said, “Two sort of living as cheaply as one, but not quite.” As I previously shared, I had a long standing desire to become a pediatrician. Jerry decided to select pediatrics too. One of my preceptors was Benjamin Spock MD (noted pediatrician and author of parenting advice). After discussions with pediatric faculty at WRU Medical School, we sought a pediatric residency with sufficient numbers of interns and residents that the 2 of us could have on-call night and weekend rotations together at the same time. Jerry and I wanted to be able to spend as much time together as possible.

DR. GLASSY: How many people were in your class?

DR. ARONSON: There were 85 in our class, but only 5 women. Actually, 6 women, but one of them left the class to get a PhD. Being a woman in medical school at that time was not usual. The men in my medical school class felt like brothers to me in my class, but one of them was too close. He was very affectionate and wanted to sit next to me and hold my hand while slides were being shown. He would turn up at my door at my apartment and want to come in and talk to me. It had become uncomfortable. So I said to Jerry, “There is this guy who is being more persistent than I feel comfortable with. Would you please just sit next to me in class so he can't sit next to me? And we'll get the other member of our committee to sit on my other side so that he won't be able to try to hold my hand while they are showing slides.” Jerry said, “Sure, we'll do that.” and he and our committee member did.

Jerry’s relationship motivations were mixed. He wanted my microbiology notes because I took copious notes. I’m a better visual learner than an auditory learner. I’d write things down and I'd look at the notes I had taken again and again. He knew I took these notes. He said, “I want to borrow your microbiology notes.” I said, “You can come and use them, but you cannot take them away.” He said, “I also want to see what you’re doing to learn the Krebs cycle, part of our biochemistry curriculum.” We were memorizing the Krebs cycle, and I was writing it in chalk down the hallway of my apartment, then erasing it and doing it again. So I said, “OK, you can come over and you can look at my notes, but if this guy comes to the door you answer the door.” Which is exactly what happened.

DR. GLASSY: Oh, perfect.
DR. ARONSON: That sort of stopped that problem. But while Jerry was using my notes in my apartment, I decided we needed something to eat, so I made rolled cabbage, which was an easy recipe to make, and we ate it together. He says that was what made him want to pursue me as a permanent partner, my rolled cabbage recipe. [Laughter]

Jerry and I traveled together from Cleveland to New York at Christmas break in 1962. Jerry was going home in his car and wanted to split the cost with a rider. I was going to visit my brother, who was newly married and living in New York City. So we each needed to go on that very long trip from Cleveland to New York. We agreed to split the expenses. During those many hours traveling in the VW [Volkswagen] beetle, he seemed less obnoxious to me. By the time we got to New York, we were close friends. He asked me if I would spend New Years Eve with him. I said, “I’ll have to think about it because I’m not involved with you romantically.” I talked to my brother about it. He said, “For goodness sake, just go. Have a good time. You know you’ll enjoy yourself.” I said, “But I’m uneasy about going off with him. He's inviting me to a weekend, a skiing weekend. There’ll be other girls going and other guys going, and we’re supposedly going to be sleeping in separate rooms in a dormitory, but you know, it may not really be like that.” He said, “No, no, you’re fine. You’ve got your morals intact. You go and do what you want to do.” It turned out that there were single gender dormitory sleeping arrangements available for those of us who wanted to use them. One of Jerry’s friends, his best boyhood friend, was at that weekend and he came to me while I was stirring a big pot of spaghetti in the kitchen along with others in the group who were cooking and preparing the meal. He said, “You know, I can see he loves you, and I can see you love him, but you’re no good for him. Get out of his life.”

DR. GLASSY: Oh my gosh!

DR. ARONSON: Well, I didn’t like that friend of Jerry’s or his advice! It was true that we were becoming more involved, and by February of 1963, we were seeing each other regularly. Jerry was working in the blood bank a lot. We decided that we would get married. We decided to go pick out a ring together. Jerry had somehow put together enough money to buy a ring. Even though he’d been up all night at the blood bank, he insisted that we have this date to go down to see a jeweler in Cleveland. We went down Cleveland’s Jewelers Row and we picked out a setting and diamond stone that he could afford. We used our newly minted microscope skills to evaluate different diamonds to give the impression that we knew what we were doing.
On the way home, he said, “I’ll drop you off at your place and I’m going to go home. I’ll take a nap, and then we can use the tickets I have to the Cleveland Symphony tonight.” I said, “You’ve been up all night. Why do you want to do this? Why don’t you just go home? And it’s going to snow, so why should we go to the concert?” He said, “No, we’re going to go to the concert tonight. I will pick you up. We’re going to the Cleveland Symphony.” It did snow. There was more than a foot of snow on the ground, and I said, “We don’t need to do this.” He said, “No, we’re going to go.” So, we went to the symphony, where he napped. We were walking back, because we lived within walking distance of the concert hall, and he said, “I want you to come over, and we’ll just have a little drink together and we’ll sit by the fire and talk.” I said, “You’ve been up all night. That’s crazy! Go home.” He said, “Nope, I want you to come back with me to the house where I live.” We went back to the East Cleveland house of an older gentleman for whom he was serving as caregiver and driver in return for free room and board. Jerry made a fire, and we sat by the fire. I said, “OK, we can talk. What would you like to talk about?” He got off his chair, got down on his knee, and presented me with the ring the jeweler said would take a week to set. What Jerry had done was not go home and take a nap, but he left me to go back down to the jeweler and pick up the ring. He asked me to marry him.

DR. GLASSY: That’s a great story

DR. ARONSON: We were married in June at the end of our 1963 school year in Utica New York where my parents had moved for another job change, this one for Dad’s employment at General Electric.

Jerry and I went to Jacobi [Medical Center] [Albert Einstein College of Medicine] in New York, Bronx Municipal Hospital Center [now Jacobi Medical Center] for the first 2 years of our pediatric training. Henry Barnett, MD, was the chair of the department and Lewis Fraad, MD, was the director of the education programs. It was a very good experience because it gave us a different outlook on patient care from what we had experienced before as medical students in Cleveland. At Western Reserve, it was all about supporting families. The kinds of approaches that we learned led many of us to become pediatricians or mental health professionals. The New York experience was different. It was a very good opportunity to get our edges polished with what was a very much more medically, biologically, but less psychologically-focused training. We tried to share our commitment to the approaches we learned in medical school, doing things which sometimes
were appreciated and sometimes not.

We begin pediatric training in 1965 as the Vietnam War was ramping up. Men were being drafted to enter military service. Usually, physicians in training were being allowed to finish their specialties as Berry Plan participants. However, in 1965 that stopped for pediatricians. Jerry was deferred from military service for only 2 years, not enough for completion of his pediatric residency. Jerry chose the US Naval Reserve in part because he thought they would not assign a pediatrician to either ship duty or to Vietnam and would assign him instead to one of the bases on one of the US or European coasts. That would be good living and a good experience. Well, that was entirely wrong. The US Navy assignment officer in Washington DC was prepared to send him to Vietnam as a General Medical Officer assigned to the Marines. He offered to get me an assignment with AID [US Agency for International Development] in Vietnam.

We politely requested that he explore other assignments. We were very lucky because he assigned Jerry to The Naval Dispensary on Constitution Avenue and 20th St. in Washington DC. This Dispensary was housed in temporary Quonset hut buildings dating from WWI. Lady Bird Johnson eventually had the buildings torn down as part of her beautification project for Washington several years later. Jerry’s assignment was to provide outpatient care to children of the military officers.

Since we knew that we would be leaving residency after 2 years, we planned to have our first child at the end of our second year of residency. Our daughter Lori was born July 18, 1967 at Einstein College Hospital, 2 weeks after our residency ended. I traveled with Jerry to Washington lying flat in the back of our Volvo station wagon as I was recovering from a spinal fluid leak from failed epidural anesthesia. Lori was beside me in the bed portion of her pram. This was before our days of car seat advocacy!

With 2 years of residency behind me and our first baby at home, I obtained a part-time pediatric position at a local pediatric practice in Springfield, Virginia. The owner of the practice was interested in ultimately developing a partnership relationship. I worked there part-time while taking care of our first born, running home at lunchtime to breastfeed and making sure that I had competent child care for my own child. Finding and hiring competent caregivers was very challenging!

We enjoyed living in suburban Northern Virginia and initially had plans to
make this our permanent residence. We stayed in Washington after Jerry finished his service to complete our pediatric education. Jerry took his third year of pediatric residency while I worked in the pediatric practice. When the practice owner took a European vacation when I was due to deliver our second child, and left without telling me about a child he had admitted to the hospital, we decided we would not continue that practice relationship. The next year, I went to DC Children's, now National Children’s Medical Center for my third year of pediatric training as an ambulatory fellow, combining residency and an ambulatory fellowship. As a part of that ambulatory fellowship, I was assigned to be the Howard University Head Start health consultant. The Head Start Program at Howard had a contract with Children's Hospital, and I was the person to fill that contract. It was a wonderful opportunity to learn about early education, supported by the Head Start model. I doubt that I did anything for them that was of much use, but they did a lot for me. They taught me about early education and the profession of early educators. During my ambulatory fellowship, I was assigned to work with Margaret [Peg] Gutelius, MD who was on the faculty there. She was planning to start an infant-child care center for the babies of teenage parents. Her group of consultants and people who were going to help create this center were mostly people with newborn nursery experience, from the neonatology service. Dr. Gutelius designed something that was very much like a hospital nursery where the babies were all in cribs, and there was someone attending to 6 of them. It seemed wrong to me. It was not what babies should experience. I had 2 children of my own and I knew that you couldn’t park kids in cribs and have something good happen. These parenting, Head Start and infant child care experiences were the seeds for my subsequent work in early education and child care.

At the same time, Jerry took advantage of an NIH Fellowship Opportunity to provide primary care physicians with mental health training and began a one-year pediatric fellowship in behavioral pediatrics at Hillcrest Children’s Center.

So that was kind of the culmination of our basic educational experiences.

As soon as I was eligible to take the pediatric boards [American Board of Pediatrics], I took those exams. We began our first post-training jobs in Philadelphia.

DR. GLASSY: OK then, Sue.
I’ve enjoyed listening to your history of your family and your education and the culmination in residency. I’d really like to hear how all those influences came together for you to choose your career path—your first jobs and what influenced you to become involved in your community and with the AAP.

DR. ARONSON: As 1971 approached and Jerry and I were finishing our pediatric training in DC, we realized that we needed to find our first regular jobs. We had, by that time, decided that we did not want to enter into a partnership with the local pediatrician for a variety of reasons. We now had 2 children, our daughter, Lori (born 7/18/1967 at Jacobi Hospital) and our son Bruce (born 3/31/1969 at Bethesda Naval Hospital). We’d purchased our first house with the financial assistance of my parents; and we’d saved a little income from the Navy, as well as the income from my working in the private practice. We knew that we needed pediatric positions that would allow us the lifestyle that we felt we wanted to lead with our family and to avoid the need to frequently move from one city to another as my family had to do. Family had priority for us. We recognized that we both needed to find paths where we could grow professionally, recalling the tongue-in-cheek blessing of the Rabbi who married us who said: “May you compete productively!”.

Our decision to move to Philadelphia was primarily based on a recommendation from Fred North, MD, FAAP (former Medical Director of the National Head Start Program) to Doris Howell, MD, FAAP (Chair of the Department of Pediatrics at The Medical College of Pennsylvania, formerly Women’s Medical College). Dr. North was aware that Dr. Howell was recruiting for a pediatrician to replace Vince Hutchins, MD, FAAP who was leaving to Direct the Title V Maternal and Child Health Bureau in Washington. Dr. Howell needed someone to direct the Title V federally funded Children and Youth program at MCP. Jerry’s interest in medical care administration and developmental and behavioral pediatrics after his year of pediatric psychiatry made him a particularly strong candidate. However, both of us went to interview with Dr. Howell on Dr. North’s recommendation.

Prior to our visit to Philadelphia, I reflected on my career path. I enjoyed clinical pediatrics and I wanted to continue pediatric practice. However, I was looking for more than practice as we considered the next steps in our career path. The more I thought about it, the more I thought about the Willie Sutton [Rule] law. That’s the quote that people attribute to Willie Sutton when someone asked him, “Why do you rob banks?” He said,
“Because that's where the money is.”

I reflected on my own experiences with finding child care for our children. We had struggled with different caregivers during those early years. I thought about my fellowship experience working in the Head Start Program. I recalled the interest that I had developed in early education from the fellowship.

Our daughter had gone to an early education program when she was 3 that wasn’t consistent with what I had learned about Head Start and what the Head Start objectives were. I had learned a lot about early education and felt that the integration of health and early education, as in Head Start, that was part of the Head Start program from the beginning was very important for all children, not just the disadvantaged. As I took a step back and looked at what I wanted to do, I thought, “Where are the kids? Where can I influence their health and safety?” I could do it one at a time in a clinical office and that was fun. Really, it was fun to do clinical medicine, but it was not going to affect a lot of children. I realized that a lot of kids were in some form of non-parental care, either home-based or center-based, and that was likely to be a place where there would be some value in investing my expertise and experience.

Doris Howell toured us around the neighborhood and talked with us about the opportunities that could be available to us at the Medical College of Pennsylvania (MCP.) The pediatric department consisted of all women at that time and the academic and clinical culture was well established.

Doris asked me, “What do you do, dear?” I described my work with Peg Gutelius on the child care program nursery look-alike at DC Children’s, indicating my dissatisfaction with elements of the approaches that were being used there. I expressed my interest in looking at what could be done to more effectively transfer pediatric knowledge to early education program performance and early education expertise to pediatric practice. I knew from my father’s experience that technology transfer is more than the passive transfer of knowledge. It is important to make sure that knowledge gets used. I wanted to make early education programs better for all children, not just for those in Head Start. Head Start was aiming public programs at children who were seen as most needy. Like universal K-12 education, the principles of quality early education are appropriate for all children. This was the time of the US “War on Poverty.” Dr. Howell said, “Well, that's interesting because we were just given a contract from the state to start a
child care center for children of teenage mothers.” This was a time when federals funds were being dispersed to states to start child care programs to provide early education for children of people who were low income. This federal funding was subsequently modified and expanded to provide substantial new money to the states as the Child Care Development Fund, which remains the largest federal source of subsidy for child care and is separate from Head Start. Dr. Howell said, “Well, would you like to implement that contract to make this child care center for children of teenage mothers?” That idea was similar to what I had experienced with Dr. Gutelius in Washington. I said I thought that would be a good place to start.

Dr. Howell offered me an academic placement in the Department of Pediatrics and also negotiated with Ira [W.] Gabrielson, who was chair of the Department of Community and Preventive Medicine, to give me a joint appointment in his department. With this arrangement, I was housed in his department.

Now we had 2 offers of employment at the same academic institution. Jerry would become the Director of the C & Y [Children & Youth] Program of the Department of Pediatrics and I would begin the process to establish a child care program. What we built was an innovative program called The Learning Center (TLC) at MCP; a model early education and child care program serving children of nursing students and MCP faculty as well as children of the teen and mature parents in the community – integration of heterogeneous participants supported by multiple funding streams. Jerry’s advice was actually pretty influential in my decision to accept Dr. Howell’s offer. He said to me, “You know, there’s nobody else who is going to be competing for that role as a pediatrician working with early education. Nobody thinks work in early education and child care is a legitimate function for a pediatrician. So I think that would be a great place for you to go and build a new field and a career.”

Jerry and I looked at relocating to Philadelphia in the same manner that we considered Jacobi Hospital for our residency program. Philadelphia was large enough to accommodate the 2 of us to pursue our individual careers with a variety of transfer options among the 6 different medical schools in the city at that time. It would not be necessary for our family to move if one of us accepted another job. So we accepted the positions that Dr. Howell offered.

I enjoyed clinical pediatrics; I loved my family life, especially being a mother.
Jerry and I were a great parenting team. I also was very interested in academic pediatrics. I liked teaching. At MCP, Waldo [E.] Nelson’s office was just down the hall from the pediatric wards. He would put his head around the corner as I was instructing the residents and medical students. I was in an environment that was richly endowed with someone who was so well-recognized. I’d say to him, “Dr. Nelson, do you have anything to add?” And he’d say, “No, I’m here to learn.” He was the editor of the most widely used text book of pediatrics [Nelson Textbook of Pediatrics]. Dr. Nelson also lived 2 houses up the street from where we live right now in Penn Valley. He was a very interesting person and was very kind to us.

As soon as I was eligible to apply to the [American] Academy [of Pediatrics] following passage of my pediatric boards, I joined. I was eager to find colleagues, so together we might do things that I could not do alone. I hoped to find other pediatricians who might be interested in early education.

As soon as I joined the AAP, William Mebane, MD, FAAP, the President of the AAP Pennsylvania chapter called and said: “Welcome to the Academy of Pediatrics. What do you do?” I told him about things I was interested in. He said, “Would you be willing to chair an infant and preschool committee. You would be the only member until you can recruit other people.” Thus began my PA AAP and AAP leadership path. Throughout my career, I have interwoven my pursuit of multiple paths of involvement. Often, one has supported the other. I have navigated multiple paths of work and family life. I knew that simultaneous multi-tasking was not possible, but navigation of closely packed and integrated work and family life could be rewarding.

DR. GLASSY: Let’s delineate those 4 careers that you’re going to tell us about going forward. You have your family and your career as a mother and wife. You have your clinical work. You have your academic work—teaching, publishing, academic responsibilities. And then you have your advocacy work.

DR. ARONSON: My AAP and PA AAP advocacy work enables me to carry forward a longstanding commitment modeled in my family to make things right. I told you I got into trouble for trying to make things right for someone else in my fifth grade class. If something’s not right, even though it’s not specifically, personally my problem, then it’s not right to me. And if it bothers me enough, it’s something I should do something about. Even if it sometimes takes a long time, I get great satisfaction from getting things that are not right to be right.
DR. GLASSY: I think the things that we’re going to hear about next also draw from your experience of technology transfer. I would say, even going farther, collaboration, that openness to work with others from different fields to learn what they know and then bringing that to bear to improve the projects that you're working on.

DR. ARONSON: I was very fortunate, actually, that I had opportunities that were not necessarily directed specifically at me, to learn more about how to collaborate effectively. An early experience that Jerry and I had when we came to MCP occurred the weekend after we moved to Philadelphia. Dr. Howell had arranged a strategic planning retreat for the members of the Department of Pediatrics with Peter Brill, a psychiatrist with an MBA from Wharton School of Business [University of Pennsylvania] who specialized in organizational development. Dr. Howell recognized that dysfunction existed within the department; younger faculty were not made very welcome in part due to a salary differential between the established faculty and new faculty; there was a lot of “blaming and complaining.” Peter Brill used that weekend retreat to teach and encourage application in our work setting of principles of organizational development. I learned. I mean, I was eager. I was a sponge. It all was wonderful because it was the way to do technology transfer. How do you take knowledge and put it to use? Peter started by pointing out that the common dysfunctional behavior of the large majority of people is to complain and blame and spending time complaining and blaming was dysfunctional. It didn’t go anywhere. Nothing good happens. But you could reroute that energy to problem solving and ignore who is to blame for it. He said, “Stop complaining. Figure out what the problem is and how can we start working together to solve that problem.” He also taught the principle that I have used many times in my career—that to solve any problem, you are most effective if you have those who are affected by the problem, those who have authority to implement change, and those who have expertise in the area of the problem involved in working on the solution. You need those who are affected, because otherwise what you plan to do may not in fact be in any way appropriate or relevant. You need those who are in authority to be involved, because if you don't have them involved, they will sabotage what you’re trying to do because they didn’t think it up, and if it isn’t theirs, they won’t own it. If you want them to make sure it happens, they have to be part of planning it. And you need people who have expertise, because otherwise you’re likely to do things that are stupid.

DR. GLASSY: Or reinvent the wheel?
DR. ARONSON: Well, it’s OK to reinvent the wheel, if the wheel is a good one. It’s OK to do something that others have found works and implement it in your situation. It is using what is true. Those principles were key principles that Peter Brill taught that weekend.

I also learned about a key tool of organizational development—nominal group technique. I continue to teach nominal group technique at advocacy seminars I’ve done for residents. The idea of nominal group technique is that you want to make sure everyone involved, no matter what their status or their source, is equally engaged in offering what they can contribute to the solution. The way to do that is to brainstorm a problem, have people independently think through what they would do, and then round-robin collect ideas in the group. You collect one idea from each person, then move on to the next person until all ideas have been presented. That way, no one can dominate the group by just taking over. You know that happens commonly in groups.

I learned that optimal group size is between 7 and 10 for something like this. You go around round-robin, collect everyone’s ideas, and then go around again. You keep going around collecting more and more until you’ve exhausted all the ideas that everyone who is participating has contributed. Then you have a secret, silent vote where everyone in the group gets to rank the ideas that have been suggested. From that, you select the top 5 or 10, and then have the group re-rank that 5 or 10. This is a way to get collaboration going, with everyone feeling fairly involved and not allowing the quiet people to be overrun by the noisy people.

I also learned from the management and leadership training provided by AAP to its leaders. At the Children’s Hospital of Philadelphia, I was exposed to conflict resolution and negotiation as a member of their faculty.

Peter Brill described group development in a manner similar to the stages of child development. If you know and can recognize what those stages are, you can enable movement, progression through those stages to become a more effective, functioning group.

How do separate individuals become and act as a group? The first stage is forming. We form lots of groups. We come together in clinical rounds and we form a group. Forming is the most basic element of being a group, and it may end there. You go away and leave the group. You go off to your things without anything more happening than that you sat there and listened to
someone preach at you. So forming is the first stage.

The next stage is norming, where you share with one another what it is you have in common. If you don’t go through that stage, the next steps don’t occur well. You need to hear about each other’s life view and what you plan to do about whatever it is you’re trying to work on. What do you share? We all have some common threads to recognize. We do that in social situations. “How many children do you have?” How many children do I have? Am I a grandmother? “Tell me about your grandchildren.” So forming, and then norming.

The next stage is usually the one that groups fall apart on. It’s the most threatening and difficult. It’s storming. Storming is where people are comfortable enough with one another—they no longer are behaving in a socially aloof way—to disagree with one another. That is like the 2-year-old phase where they’re becoming independent and able to express themselves and push away from being entirely subjected to other people’s influences. Successful storming takes negotiation skills. They teach negotiation in law school. We need to learn negotiation as health professionals. The trick is to find the things which you agree on and (figuratively) hang the things you disagree about outside the door. Agree that you’re going to disagree about those you hang outside the door, at least for now, and work on the core of what you agree on. That takes the bite out of the storming. Not everyone will follow through with this or agree to it, but a leader can really help enable that progress by being a facilitator.

Then you come to the fourth stage. So, you've got forming, norming, storming, and now performing. At this level, you have worked out a lot of the kinks. You can go back over the steps you’ve gone through, and have people feel good about themselves. Again, my grandmother's saying, “There's no limit to the amount of good you can do if you don't have to take credit for it.” Give everybody credit.

Also, there’s another principle, which is a sociology principle—the sociology principle of the doctrine of reciprocity, social reciprocity. If you give something to someone, they want to give you something back. You welcome people by giving them credibility, giving them some recognition, giving them food. It’s a reasonable thing to meet their creature comforts. Whatever you give tends to generate that desire to give back. The giving back may be for participation in what you’re trying to do or in other ways, such as contribution of funds or whatever. So social reciprocity is another of the
principles that I learned in my college sociology course and from those wonderful organizational training experiences.

Forming, norming, storming, performing, topped off by social reciprocity to achieve effective group behavior. Try it; it works!

DR. GLASSY: Very good. So now you are in Philadelphia. Tell me what comes next.

DR. ARONSON: Well, I already said that I had been employed at the Medical College of Pennsylvania in a joint appointment in both pediatrics and in community preventive medicine. I was engaged in trying to implement the contract that Doris Howell had received from the state to start a child care program. I took a little bit of a step back and look at what I was really good at, what I might be able to do, and what I wanted to do in those 4 areas—family, clinical pediatrics, academic pediatrics and AAP leadership.

I tend to take a larger view in almost any situation. I recall a story that impacted me greatly about the 2 fishermen sitting on the bank. While they’re fishing, some babies start floating down the stream, and they rush out and rescue the babies. Then while they’re sitting there, more babies come down. They keep rescuing babies until one fishermen just walks upstream. The other guy says, “Where you going? I need your help getting these babies.” The first guy says, “I'm going upstream to see who is the damn fool throwing these babies in.” That’s really an important concept. You can stand there in a clinical role, continuing to try to take care of problems that are, in fact, being caused by things for which the best approach would really be to prevent those problems. Prevention is better. I understood and learned about primary, secondary and tertiary prevention. I like primary prevention. I realized that what gave me my biggest thrill was primary prevention. I wasn’t likely to go into the fields that were focused mostly on secondary and tertiary prevention.

My Dad helped me understand the linkage between serendipity and opportunity. Serendipity is the concept of unintended opportunities that you didn’t anticipate, but which you don’t let go by. You take advantage of them. That was something that I did throughout my career. I may not have thought about it much the beginning. Sometimes, if what you first start out to do doesn’t seem to go in a positive direction, you want to have the flexibility to recognize alternative approaches that you can pursue until things lighten up and you can get around the obstacles that prevented you
doing what you initially wanted to do.

The value of communication is very important—both written and oral communication. Teaching is something that involves both writing and speaking. I knew that I was pretty good at this, that I actually could engage people. My grandfather’s teaching about how to write was very helpful to me. I knew I could write grants. That was something that was a surprise to me, but with Doris Howell’s mentoring, I applied for additional money and grant funds to do things that I thought we needed to do beyond the basic support grant that we had. I could follow the grant writing instructions. I knew how do make a successful ask, and then deliver more than was promised, which then got me up on the board of the grant funding agencies, public or private. As Doris used to say, “Once your name is up on that magic board for federal funding, you're more likely to get your proposal accepted in the future.” She helped me by opening doors where her name was already up on the board, and then my name got on that board, too. Good ideas can come from anywhere. You don’t have to be restrictive about it. I formulated a concept of how we could build bridges to integrate early education and health by working with the professionals of both fields, each of whom were operating in a totally separate world where they had their own vocabulary and their own approaches. They were doing the same things. They were trying to help families and children succeed.

So I adopted a concept of a river of life in which families are carried along with their children down the river, struggling with the current, and trying to end up successfully navigating that river. Health professionals and allied health professionals are on the bank on one side of the river and educators and others from other professions are on the other side of the river. What we need to do is build a bridge and help the professionals on opposite banks identify that the lifejackets they were throwing independently to these families floating down the stream and their suggestions for how to swim could be better achieved, better used, if they worked on it together and coordinated their efforts. It improves quality and saves resources by leveraging them more effectively.

I began to work on the development of a child care program for more families than those whose children had teenage parents. I felt teen parents could benefit from peer support, but also by being included in a child care using community of mature parents and parents who were in health professional roles. I knew from my own parenting experience about how hard it is to find competent child care for anyone. Teenage parents needed
parenting too. They needed to be supported as members of their own community. Many of the medical students were having children. I had young children of my own and I was a young faculty member. If I could, I wanted to my children involved in a program where they were getting good quality education and care. I wasn't afraid of interacting with people from lower economic circumstances or other cultures because I had experienced that myself and knew that broadened my perspective. The plans for the child care program changed to one serving medical students’ and faculty members’ families, teenage parents, and mature community parents’ families, all in the same place and intermixed in the same groups. We believed in families as a good child care model with both male role models and female role models. I decided we would have a male-female caregiver team take care of family-style groups with one infant, one toddler and 3 preschoolers assigned to each caregiver as their primary caregiver, but working as a male-female caregiver team for all 10 children. So the group actually consisted of 2 infants, 2 toddlers, and 6 preschoolers. That type of caregiving was going to be challenging because mixing those age groups meant there was increased need for individual curriculum and possibly increased risk of infectious disease from exposure to more children. It would be necessary to manage this within a mixed age cohort family group that didn't mix with other cohorts. I thought it was possible and I thought it was a good thing to study and to see if it worked.

I went to Temple University, and with Doris Howell's help, I met with [Emanuel] Kuno . Kuno was one of the psychologists involved in the first Head Start study to demonstrate the long-term outcomes from Head Start involvement. His work was well known and well regarded in the research world of early education and I invited him to design a research study using our proposed center. Dr Beller eagerly took that on and helped to frame a study design that included other centers with homogeneous groupings of upper socioeconomic children, homogeneous groupings of lower socioeconomic children, homogeneous groups of only infants and toddlers, and homogeneous groups of only preschoolers. He studied what the outcomes were for the integrated program that we had at the center I designed. We called the program “The Learning Center” or “TLC.”

Finding a location for this center was also challenging, because at the Medical College of Pennsylvania, space was at a premium. I knew there was no future for trying to put the child care program on the campus of the Medical College. I recall walking around the neighborhood and coming across an essentially abandoned parish house of St. James the Less Church in
North Philadelphia whose congregation had moved out to the suburbs. The church was still being kept together by the people who had moved out to the suburbs who liked to come back for services; however, the parish house was crumbling. With help from some advisors Doris Howell put together for me, we identified how to navigate the Philadelphia zoning and building permits and all the rest that was necessary. We proposed a creative renovation funding plan to the vestry of St. James to have them pay for the renovations, against which we would rent the renovated facility and pay off the money they had invested. Our grant did not have funds for capital development and MCP was not contributing any funds. That proposal for the facility renovation was pretty gutsy because our funding was not guaranteed for any long term. But we thought it would be likely that we would be able to make a significant dent in whatever they invested, and then they would end up with a building that was renovated that they could use for other purposes if we failed. But we didn't fail.

The Learning Center was founded on the family model that Ellen Galinsky described in her book, *The new extended family: Day care that works*. For TLC to become the wonderfully creative, warm, functional, developmental child care program that we’d envisioned, I recognized that I needed an early childhood educator to run the program from day to day. I successfully recruited Marlene Weinstein from Boston. Ms. Weinstein had co-authored a book that was published about how to operate a child care program. I brought her to Philadelphia and established her as my partner and the day-to-day operator. Marlene and I are friends to this day.

Dr. Beller’s research study demonstrated that most of the children who were enrolled at The Learning Center, including those from different socioeconomic levels, did exceptionally well; their developmental outcomes were excellent; and the positive impact of the heterogeneity model extended to the teachers as well. This was not necessarily because they had degrees, but because they had an intuitive and experiential good approach to early childhood as demonstrated in observations of their interactions with children and family members, and in selection committee discussions with them. Being involved in an innovative program stimulated them to excellence in their day to day work with the children and families. Over the years, many of them have become education and community leaders in their own right. TLC was really a wonderful, wonderful program.

My MCP clinical role included teaching in the clinics and on the wards as a young academic. At The Learning Center, we established a primary care
satellite program of the outpatient Title V-funded clinics at which the nurse I hired to work with me at The Learning Center and I carried on a small private pediatric practice. We took care of children from the community around TLC whose families wanted them to get health care at TLC and those who were enrolled at The Learning Center who wanted their children to be in our practice. We took care of community children who came to us just like any other satellite pediatric practice operated by MCP that was available to them. So as my colleague and I continued to provide clinical care and health and safety consultation for the operation of TLC, I continued my academic work at MCP. My work within the PA AAP and AAP was also beginning to expand as I searched for and recruited pediatrician colleagues who might be interested in infant, toddler and preschool early education.

DR. GLASSY: And did you have residents and medical students come through, too?

DR. ARONSON: At The Learning Center?

DR. GLASSY: Yes.

DR. ARONSON: Yes. Our plan for TLC included education of early childhood students as well as medical students and residents about early childhood development and behavior. We constructed The Learning Center classrooms so there were one-way mirrors and microphones connected to observation rooms for every classroom. We wanted to be sure that observations of care by staff and/or students wouldn’t disturb, interrupt or affect the care being provided. This enabled us to teach from a location where the students and residents could observe what was going on in the classroom and be guided in their observations by an instructor in real time. Pediatric medical students and residents from MCP, as well as psych residents from the nearby mental health facility could perform observational developmental assessment using the special observation rooms. TLC was used by psychiatry students who focused on the dynamics of the interactions, as well as nursing students and early educators whose instructors guided them in making real-time observations. The people who were doing these observations indicated that it was one of the most effective learning approaches they had experienced. As much as 40 years later, I continue to receive informal feedback from those who were involved in this learning. Indeed, just last week (2015) I met an educator who reminded me that she did her student teaching at The Learning Center. Now, she’s a leader in a highly regarded regional organization of early childhood education.
An additional objective for TLC was to provide support, not just for the children, but for the parents. Frankly, the neediest parents were the medical student parents who were in such conflict over their family role and their career role that they needed a lot of support. Often they would come and make inappropriate demands about how their children were to be cared for. We understood that their demands derived from guilt, in some cases fostered by the teaching they were receiving with over simplistic citing of the necessity of bonding by mothers spending nearly exclusive time with their infants to ensure healthy attachment. Dr. Henry Parrens MD, a child psychiatrist who lectured at MCP about child development, said it’s a mother’s job—never mentioned father—a mother’s job to establish secure attachment with children. If the mother isn’t there to enable this attachment, then the child will be damaged. It was horrible for young parents to hear this dire prediction for which evidence was lacking. A few years ago I met Dr. Parrens while I was walking in my neighborhood and he said he didn’t remember ever saying this – although I was present at one of his lectures where he said it, and some TLC parents quoted him too.

T. Berry Brazelton, MD, wrote in his book in the edition published around that time that any mother who leaves her child before the child is 4 months of age may risk damaging her child. Dr. Brazelton and I subsequently had a vigorous discussion about this issue. He ultimately reversed his prior statements based on the lack of evidence supporting them. It was an empiric assumption that success in early childhood required a mother-child relationship of a unitary design; dads were left out of this altogether. TLC worked hard to mobilize and educate fathers, if available, and parenting pairs to assist in addressing parental guilt.

DR. GLASSY: TLC had early educators who were male, which is a novel approach, too. You must have had to recruit like crazy to get those guys.

DR. ARONSON: We recruited carefully. Our overall goal was to have extensive diversity in the program; gender, racial, and socio-economic. Some of the male caregivers were unemployed fathers of the TLC children from the low income community surrounding MCP. We also sought racial diversity within the caregiver teams, as well. Each male-female team was made up of one person of color and one person who was Caucasian. It could be reversed either way. We had 2 African-American males and we had 2 Caucasian males for our 4 classrooms. We had African-American female
caregivers, as well as those who were white or Hispanic. It was very challenging to make that all work and get the groups and the teachers organized to make sure the distribution was right. Each group of children was also socio-economically mixed from community and medical college families. Setting up and filling the slots from waiting lists was very challenging to say the least, but it was accomplished. There were always waiting lists.

The center opened in 1972, and by 1973, it was running fairly smoothly under Marlene's management. During a 3-week recovery from an ectopic pregnancy, I thought deeply about my career direction. “How can I bridge the medical-professional world and the early professional educational world that I have come to treasure, value and recognize? How can we make that bridge?” I realized that except for Head Start, children and families in early education lacked a school health program. Health professionals were not linked or integrated into early education. It was just assumed that early educators would have their own wisdom about health, safety, and nutrition based on grandmothers’ teachings, their moms’ teachings, to keep children safe and healthy in their programs. Parents would take their children to their doctors and that would be it. My observations were, in fact, that grandmothers’ teachings were not necessarily applicable to the group care setting. As an academic pediatrician, I began to consider the broader issues that needed to be addressed in terms of health and safety of children in group care. I thought, “My Dad has taught me about technology transfer. I'm a pediatrician. There must be a way to use technology transfer between pediatric medicine and early education and put what is proven to be good prevention to use.”

The first challenge was that even if we could define what is appropriate health and safety policy and procedure for children in group care, who would provide it? How would it get paid for? As I began to think about that more and more, the concept of the child care health advocate came to mind. The Child Care Health Advocate role was a modification of the idea of a health coordinator in Head Start. The person did not have to be a nurse. It could be an educator with an interest in health and safety, who could receive education and support for assuming that role. The Child Care Health Advocate would be a person who would be selected by her own program to be the gadfly about health and safety in day to day operation of the program. The CCHA would not be expected to do everything, but the CCHA would raise awareness about health and safety issues and make sure that people think about and act on them. The CCHA wouldn’t necessarily have a lot of
health expertise although receiving training for this role should be expected. The CCHAs should be sensitized to the things to know and equipped with skills to reach out to health professionals for program health consultation. While the CCHA would consult people with health professional knowledge it is likely that the CCHA would need to inform the health professional about the ways group care settings in early education operate. Neither educator professional training nor health professional training at this time and still, so many years later, routinely includes more than superficial understanding of each other’s approaches to promoting wellbeing for children and families. Health professionals need education about caring and consulting for children in group care settings, and educators need to learn about prevention of harm and promotion of health to minimize risk and promote wellness for children in their programs. The CCHA should be the on-site change agent or champion responsible for bringing up health and safety in day to day program operation. That thinking spawned the health advocacy training program and curriculum (HAT) that I launched with my nurse partner at TLC in 1973. To implement and evaluate the CCHA concept required applying for grant funding. Dr. Howell introduced me to the Director of the federal Office of [Early] Child[hood] Development at that time. I also applied for a grant from the Robert Wood Johnson Foundation. I hoped that one of these grant applications might be successful and was very grateful when both RWJ Foundation and the Office of Child Development awarded grants to do the proposed work. As a result, we were able to expand the initial operational plans for HAT to include a very strong evaluation component, with findings that proved to be very important over the years.

Since I lacked formal training in program analysis and evaluation, I sought assistance from the Director of the Institute for Survey Research of Temple University. I learned about survey research, checklist development, and non-biased interviewing. That was wonderful education for me. The nurse in our TLC satellite practice, Herberta Smith and I created a curriculum to educate the CCHAs nominated by the participating early childhood programs. The original HAT curriculum was a 12-day (one day a week) professional development course taught over a period of 3 months. Successful completion earned the participants a certificate. We rotated CCHA nominees in 3 month cycles through the evaluation and curriculum components of HAT from as many as 20 facilities at a time over the course of the first 2 years of the grants. A total of 150 sites were involved and somewhat less than that number of health advocates. Some of the health advocates worked in 2 centers and some early education systems had more than one center in the study.
My work put me in contact with many different types of community-based health and safety professionals. I got involved with the Philadelphia Poison Control Center and joined the Board of the Philadelphia Poison Control Center — learning more about poison prevention from my association with that valuable service. I became involved with the lead program in the Philadelphia Health Department [Public Health, City of Philadelphia] by working with those public health professionals to teach about lead poisoning prevention in the curriculum. We recruited environmental sanitarians from the Philadelphia Health Department to teach sanitation and hygiene principles in the program. My role as TLC’s Executive Director let me follow the advice in an Indian prayer that was left on my desk when I was at DC Children's in my role as health consultant to Head Start. The Indian prayer, on a little card placed on my desk simply said, “Let me not criticize a man until I walk a mile in his moccasins.” That was an arrow straight to my heart and my psyche, because I knew I could be brash and assertive —and that I had to tune my actions as a champion to produce desired outcomes when collaborating with others. I had to learn about the roles of the people I was trying to help, not start too soon to launch into suggestions for change. I needed to look at what could be improved, and what could be done incrementally. We could do our best by working together to identify and find ways to solve problems.

I served as Executive Director of TLC for the first 10 of its 12 years of operation before resigning from MCP to accept a job at another medical school. All my experiences during those first years of my academic career were rewarding. I wrote up the findings of HAT with a researcher from Temple who knew how to handle data and taught me about how to write a publishable paper. The report of the approach and outcomes from HAT was published in 1980 in Pediatrics. A detailed report was prepared, copied and distributed widely as the report of the Health Advocacy Training program. To this day, health advocacy training has been an important part of my professional role.

So, that brings us up to the period when I left the Medical College of Pennsylvania.

DR. GLASSY: Why did you end leaving the Medical College of Pennsylvania?

DR. ARONSON: Well, my husband had been director of the MCP Pediatric Outpatient Department and the Title V program. He enjoyed medical care
administration but recognized that he lacked sufficient public health and medical management education to function as effectively as he wished in these roles. With Dr. Howell’s support and mentorship, he enrolled in an innovative On Job/On Campus education program in the Department of Medical Care Organization at the School of Public Health of the University of Michigan to get his MPH [Master of Public Health] in medical care management. The program convened one weekend per month on campus in Ann Arbor, Michigan for 2 years. Jerry’s focus on the course work with his regular absence from our home during this period, coupled with his “day” job was challenging for our family.

Shortly after completing his MPH, Jerry reached a professional “glass ceiling” at MCP and began to explore his options. The School District of Philadelphia recruited him as its Director of School Health Services following a national search. As part of his employment, the School District waived the City requirement mandating employees to live within Philadelphia. We were living in Lower Merion Township, a near suburb of Philadelphia. After 3 years of challenging, fulfilling work the school district, a new superintendent decided to remove the residency waiver for Jerry. For him to remain in his job, we would have to look for housing within the City of Philadelphia. To which I said, “You can look for a place in the City that will give us the quality of life we enjoy where we are, and I will look at the alternative with you so we can make our decision together about uprooting our family to move.”

DR. GLASSY: —And your decision was going to stay out here.

DR. ARONSON: I said, “Our kids are now in school. If you find something really wonderful in Philadelphia, let me know. I'll look at it, but I'm not getting engaged in looking for housing in Philadelphia.” Ultimately, Jerry decided that instead of looking for housing, he'd look for a new job. This was 1977 and many medical schools were actively pursuing efforts to provide programs in teaching, research and community care. Jerry was recruited to be the Center Medical Director of a newly funded medical school HMO [health maintenance organization] demonstration project, Health Service Plan of Pennsylvania. Federal grant and loan funds were being provided to medical institutions for a 5-year period to assess whether or not quality care and cost containment could be achieved through the HMO model. Jerry established and began to grow a small pediatric practice in the newly developing HMO. However, his increasing medical administrative responsibilities with the HMO began to interfere with his clinical care. Jerry
recruited me to build the pediatric practice at one of the HMO multi-specialty offices. I left the Medical College of Pennsylvania and went into part-time pediatric primary care in a private practice. Prior to my departure from MCP, I had become Clinical Associate Professor of Community and Preventive Medicine.

DR. GLASSY: Let’s circle back around to your involvement with the American Academy of Pediatrics during these times. Tell me more about that.

DR. ARONSON: As soon as I passed my oral Pediatric Board exam in 1972, I joined and was accepted as an AAP and PA AAP member. Pediatrician and PA AAP Chapter Chairman, Bill Mebane welcomed me as a new PA AAP member and immediately appointed me as chair of the infant and pre-school committee [Committee of Infant and Pre-School Child] of the PA AAP chapter. I was the chair and at the beginning, the only member. I served in that role for almost 10 years, until 1982. By 1982, the Committee had 11 members. It was no longer just me. Within the PA AAP, I was selected for and held sequentially higher leadership positions. I served on the PA AAP Executive Committee, elected as PA AAP alternate chairman, and then became what we now call the president of the PA chapter in 1984.

My national AAP advocacy role was increasing too. In 1979, I was invited by the national AAP to represent the PA AAP at an AAP conference to receive training to implement objectives for the 1979 International Year of the Child. At the conference, the AAP Tennessee Chapter reported about the child passenger safety initiatives that Bob [Robert S.] Sanders had launched there. Chapters were encouraged to consider measures to improve child passenger safety as an International Year of the Child project in their state. I thought it was a very good idea because Jerry and I had young children of our own and we were very concerned about their safe travel in the car. The issue of car safety seats was something that I thought really deserved some attention. It affected a lot of people and was a major cause of death. Child passenger safety advocacy fit my preference for primary prevention. I starting thinking about how we could do a child passenger safety project in Pennsylvania. How could we work child passenger safety principles into safe transport of children to and from early education programs? How could we educate pediatricians to teach families about child passenger safety and finally, how could we present child passenger safety as a priority for coverage by the media? The AAP provided some of the necessary tools for this project. I received media training from the Academy as part of the
organization’s leadership training.

At the International Year of the Child training session of the Academy, I thought, “I’ll take this objective home and try to do it.” At the International Year of the Child leadership training, the AAP leaders and seasoned representatives of other chapters learned that I was not shy. Toward the end of the meeting, they asked the young people who were in the audience who had not previously attended a national Academy leadership conference whether they had anything to say about how the meeting had gone. I put my hand up to respond. I said, “We’re health promoters, and you’ve been feeding us sweet rolls and coffee for breakfast. Could you consider providing yogurt and fruit so that those of us who want to can eat healthy food?” For several years after that, I was known to my colleagues at the AAP as the yogurt lady.

DR. GLASSY: It only took them 20 years to change the menus.

DR. ARONSON: That was just one example of how challenging and how long it can take to get others to join in a variety of change efforts. On returning to Pennsylvania from the AAP meeting, I learned that Dick Thornburgh, Governor of Pennsylvania, had appointed Ginny Thornburgh, his wife and the first lady, to chair the Pennsylvania International Year of the Child, the IYC activity in Pennsylvania. Since I was on the executive committee of the Pennsylvania chapter and had gone for the IYC training from the Academy, I was identified to represent the PA AAP as a member of the Pennsylvania IYC. At the first PA International Year of the Child Committee meeting, the discussion was about what project the PA IYC committee could do. I said, “I have a suggestion. I’ve just come back from the Academy of Pediatrics and we (the PA AAP) believe that child passenger safety needs attention in Pennsylvania at this time. Pennsylvania needs a law that requires that infants and young children to be safely transported using car seats; that new parents get educated about car seat safety; and that mandates the establishment of car seat loaner programs for low income families in our state. We ought to have a law that says that if you’re not buckled up you get a ticket.” The International Year of the Child committee adopted this mission and began to work on it. It took about 4 years to get a car seat/seat belt, legal requirement, loaner and education law passed. There’s another long story to that, but I won’t go into it. We did get a modified law passed stating that you could get a ticket if you got stopped for any other purpose and you had a child loose in the car—
DR. GLASSY: Secondary enforcement.

DR. ARONSON: Secondary enforcement. We ultimately were able to change that, but we settled for half a loaf and ultimately got the full loaf.

I was now president of the Pennsylvania AAP chapter. PA AAP had successfully inserted language in the child passenger safety bill that included a requirement for parents of newborns during their post-partum stay to receive car seat training and for hospitals and/or communities to establish car seat loaner programs. The legislation assigned this responsibility to the Pennsylvania Department of Transportation, who had no staff to do it. Pennsylvania took pride at having the one of lowest per capita number of state employees at that time. Pennsylvania needed to outsource this task to a contractor. The PA AAP was asked to step in. Could we do it? We would need to hire staff, establish a physical office for the chapter. The PA AAP leadership thought we could do this.

I had just been elected to my position as PA AAP chapter president. I sought and obtained the PA AAP Chapter records from the Pennsylvania Medical Society [PMS] that had provided professional staffing to the chapter by a PMS staff member who served 5 or 6 professional organizations. The PA AAP records given to me did not include a list of members or evidence of dues collection. The PA AAP had no community or legislative or service initiatives planned or in progress. Although there were officers the, the organization had basically become inactive. The records of the PA AAP were delivered to me in a shoebox, literally and figuratively. The shoebox contained a checkbook with a balance in the bank of $50!

Serendipity and opportunity played a role in the next steps. The Pennsylvania Department of Transportation was interested in providing a sole source contract to implement provisions of the new Child Passenger Safety Law. About this time (around 1983) Jerry and I were attending an AAP national membership meeting in San Francisco. On one evening where we did not have other arrangements for dinner, we went to a Japanese restaurant that was recommended to us. Jerry and I were by ourselves, drinking sake and eating delicious food in this nice Japanese restaurant and I said to him, “You know, being president of the chapter and trying to move this every ride a safe ride initiative forward is more than I think I can carry by myself. Could you help?” He had had at least 2 glasses of sake by that time and he said, “Sure. I will help. I’ll take this one on.” In fact, he not only
took it on, but he implemented the PA AAP Child Passenger Safety Prevention [CPSP] project with our first grant of $40,000. We rented 2 rooms in a nearby office building, hired a half time bookkeeper and part-time CPSP director and we were on our way forward!

The Pennsylvania Traffic Injury Prevention Project, as it is now called, is over 32 years old and is still functioning as an important PA AAP program. Now it addresses school bus safety, bike safety, pedestrian safety, car seat technician training, youth drinking and driving, etc. During the early years, our daughter worked in the Project during her summer off from school. She got the 1-800-CarBelt telephone hotline set up. The second CPSP, Director was Suzanne Yunghans. She became the PA AAP Executive Director, earned an MBA and provided terrific administrative support for what became a growing number of child health projects. She provided oversight and staff contributions for our growing numbers of PA AAP Fellows serving as Volunteer Champions and PA AAP Pediatric Advisors to collaborate with staff hired for these projects. The PA AAP became a regular winner of the AAP Large Chapter Award. The chapter has matured into a multi-million-dollar contract and grant-funded non-profit organization with a broad reach of programs that serve the community and educate physicians in their offices. The issues include early childhood education linkage with health professionals, child abuse, hearing screening, medical home, child death review, breast feeding, smoking cessation, and more. The persistent advocacy of PA AAP pediatricians has raised the consciousness of the public, the politicians, and the bureaucrats on the value of pediatric care and pediatricians. This has enabled Pennsylvania’s pediatricians to be at every table in Pennsylvania when child health issues are discussed. The chapter has provided support for the voices of pediatricians in ways that they might not have been able to achieve by themselves, individually.

DR. GLASSY: And the garden that grew the Pennsylvania chapter as well.

DR. ARONSON: It absolutely did. Let me tell you more about Suzanne Yunghans, the second executive director of the PA AAP, who still serves in this position. In the beginning of the Child Passenger Safety Program, we hired Suzanne Yunghans who had been one of my former child care health advocate trainees. After having her second child, she resigned her role in the child care program to spend some time at home with her new infant. I was in private practice at that time, and she brought her children to me for care. When her baby was about a year old, she told me she was interested in part time work. We were in need of more staff for the PA AAP work. She
became the second PA AAP executive director and has been a remarkably able staff leader. She has educated herself about business and organization management earning an MBA from Penn State University and has mentored chapter directors all over the country. Suzanne leads PA AAP efforts in grantsmanship, state advocacy, and PA AAP members’ services managing a multimillion-dollar grant menu at the Pennsylvania chapter with many different programs. The over 14 different state-funded and private-funded programs make it possible for many PA AAP members to have an advocacy voice. PA AAP has come a long way since its first grant for CPSP – a program that continues to serve Pennsylvania as The Traffic Injury Prevention Project more than 3 decades later.

The second program that was launched at the Pennsylvania chapter was ECELS – The Early Childhood Linkage System. ECELS was inspired by my desire to create a bridge between health and early education professionals with a program that would reach out and bring health and safety to early education programs as well as educate health professionals to be health consultants. ECELS had its genesis in the relationships I was developing with people in federal government, school districts, and in private foundations. Everything gets done by relationships, really. It’s often not what you know, but who you know and how you can transfer technology that will work from one field to another, in collaboration with those people with whom you have a good relationship.

In 1988, I received a call from a colleague at the regional office of the federal Maternal and Child Health bureau based in Philadelphia. My colleague said, “We have a grant program to improve the quality of early education and child care programs. I think if you apply for the grant, you might get it to be able to implement this entity you've been wanting to get funded.” ECELS was the name that I chose for it—the Early Childhood Education Linkage System. It has forever been a problem for people who want to spell it with an “X,” but its key function is expressed in the title: The Early Childhood Education Linkage System. Our objective was to create a system to identify and link resources for promoting health and safety in early education.

ECELS was conceived in 1988 and funded as an MCH [US Maternal and Child Health Bureau] Demonstration Program in 1989. Although ECELS was a PA AAP program, the PA AAP office lacked sufficient space for an additional program. Thus, ECELS first office was my study in our home staffed by my nurse colleague from TLC, Herbertha (Bert) Smith. We began to build a program drawing from our experiences we had when we ran the
HAT project at TLC. Research was not required but we were obligated to evaluate our work serving early education programs by sharing information with them and educating and linking health professionals to be their health consultants.

In 1976, Peggy [Daly] Pizzo and I had collaborated on the preparation of a congressionally mandated report about the health and safety component of what was then proposed to be the Federal Interagency Day Care Requirements. During the 1970s, there was a growing recognition that early education was important in this country. All the other developing countries in the world had recognized that long before. For example, France has had a mandatory early childhood education preschool program for over 100 years. French children start universal schooling when they're three years old – learning to be competent French citizens. In the US, there was a lot of interest in expanding upon Head Start concepts to embrace the entire population. Congress had commissioned The Federal Interagency Day Care Requirements (FIDCR), derived from a Congressional study of how the proposed broad, community-wide programs could be regulated, with regulations that were to apply to any program that received federal subsidy.

Peggy Daly Pizzo, and I worked on the Congressional Study. One of the primary conclusions of the study in 1976 was to call upon the federal government to establish health and safety standards for all early childhood programs. Our report included sample standards that we recommended for consideration. Unfortunately, the [Richard M.] Nixon administration determined that child care did not honor and support families in a politically correct manner. He said that child care interfered with parents’ rights and was basically a communist plot. Nixon vetoed congressional legislation that would have funded expanded early childhood education in this country. The new legislation would have launched a broader implementation of early education – for more children than Head Start was reaching. It took many years following the Nixon veto to regain momentum for federal support of early education.

During those years, we kept talking about the need for national standards. In 1988, the federal government, through the Maternal and Child Health Bureau, funded the American Public Health Association to staff the development of national health and safety performance standards, which in 1992, became the first edition of Caring for Our Children—National health and safety performance standards: Guidelines for early care and early education programs. Caring for Our Children is now in its third edition. I am
proud to have been a part of each edition over the past 30 years.

While sowing and nurturing the seeds of my career in early education and child care, I worked in private pediatrics in primary care as well as and teaching medical students and residents as a Clinical Professor of Pediatrics at Hahnemann Medical School. I also was raising my children. I arranged for them to join the child passenger safety advocacy activities. I recall while trying to get the Pennsylvania child passenger safety law passed, I took my children to lobby legislators with me. We drove to the Pennsylvania state capital in Harrisburg Pennsylvania, went door to door in the Pennsylvania House and tried to talk to the staff about the importance of this legislation. I’ll never forget during one visit that my son turned to me and said, “Mom, can you believe what that guy said?” A state representative had just said to us, “You all want to have us enact legislation to require kids being put in car seats? The next thing you’ll want is for us to ban children riding in the back of pickup trucks.”

DR. GLASSY: Yes, as a matter of fact.

DR. ARONSON: This was an eye-opener for my kids. I’m not sure how much that affected our son’s choice of career. He is now a lawyer.

DR. GLASSY: How old was he at that time?

DR. ARONSON: He was probably about 10.

DR. GLASSY: See, even a 10-year-old can see merits of health and safety more than a representative.

DR. ARONSON: His sister was 12. Lobbying was a very interesting experience for both of them.

I was PA AAP chapter president from 1984 to 1988. During that time and to the present, I continued to work at the national level as a consultant to the AAP Infant and Preschool Committee [Committee on Infant and Pre-School Child], later called the [Committee on] Early Childhood, Adoption, and Dependent Care Committee. Adoption was separated out as a separate committee later. Still later, the Council on Early Childhood was formed from the Early Childhood Committee merger with the Section on Early Education and Child Care that I had helped establish. Other AAP committee/council roles within AAP in which I’ve been involved included
serving on the ad hoc national AAP committee of the child passenger safety that was a part of the Accident and Poison Prevention Committee [Committee on Injury, Violence and Poison Prevention, now Council on Injury, Violence and Poison Prevention]. I was a member of the Communication and Public Information Committee [Committee on Communications and Public Information, now the Council on Communications and Media]. I valued having these opportunities to learn from others and to participate in AAP national affairs.

My early education writing and publishing career was continuing as well. I collaborated with Hannah [M.] Nelson to draft a manual for health and safety in child care [*Health power: A blueprint for improving the health of children*]. The objective of Health Power was to translate what Head Start already was committed to—to broaden both the Head Start implementation of health and safety and to bring health professional expertise (over the bridge) to early education. Health Power became the health and safety manual of the Massachusetts Department of [Public] Health. Then, with my rewriting and editing, Health Power was adopted by the National Association for the Education of Young Children [NAEYC] as their health manual called *Healthy Young Children: A manual for programs*. *Healthy Young Children* is now in a fifth edition (about 2014). A writer’s job never ends! Once you write something, if it seems useful, you are regularly asked to update the publication as new editions.

As President of PA AAP I became involved with the AAP Chapter Chairman's Committee and got involved with the development of elements of the AAP constitution and bylaws. I also served on the national AAP Nominating Committee.

While working as a Pediatrician, serving the PA AAP and AAP, I was also engaged with my husband in the development of independent, strong-willed children. Parenting was not always easy. But we are very proud of them. They have done very well. Our daughter Lori is a pediatrician and an AAP member. She is a graduate of Case Western Reserve University School of Medicine, as Jerry and I are. We proudly attended our 25th CWRU Medical School reunion during her 1st year of medical school. We were delighted to introduce her to Cactus Jack Caughey, WRU Dean of Admissions. Lori recently transferred out of 12 years of private practice to become the first pediatrician in a federally qualified community health-centered network serving low income immigrant families. She has a special interest in mental health and is planning to pursue opportunities to combine her primary
pediatric and mental health support skills. Her patients make her feel wanted, needed and happy. She is the mother of 3 of our young adult grandchildren.

Our son Bruce was never interested in medicine. He chose to not take biology in high school and seemed unhappy over the regular dinner time interference of pediatric telephone calls about sick children that we received when on-call. Bruce chose law school instead and became an intellectual property/contracting attorney. He worked at the Smithsonian as a contracting attorney for about 10 years and now works at the United States Holocaust Memorial Museum in a similar role. He is a fun-loving supportive father of 2 of our grandchildren, sharing family life responsibilities equally with his wife, a high achieving, competent academic and feminist.

So, family life was moving along with the academic and clinical care and with my AAP role all sort of flowing along paths like streams, merging with one another.

DR. GLASSY: Sue, we’ve been talking about your early childhood work and integrating health and safety into early childhood. You, at this time, were working with many different professionals to improve the quality in child care, working as partners with them. You were working on the integration of health and safety into child care and out of home care, and you were writing and publishing about this on many levels. At this time, clearly, you were becoming recognized across fields as the leader in the concept of health and safety in early learning settings. Can we talk about some of the other projects that you are doing at this time and the movement of this as a field by your work?

DR. ARONSON: Well, I had been invited back in the late 1970s to start writing a column for Exchange magazine. Exchange is a publication for child care directors. Under my pen name “Ask Dr. Sue,” I wrote the column for over 20 years. “Ask Dr. Sue” gave me recognition and acceptance as a bridge person between early education and health professionals. The regular column gave me a platform from which I could share and translate health professional information that would be useful in the day-to-day operation of child care programs, drawing on my clinical role, my academic role and the work I was doing directly with early education programs. During this period, I’d been involved with the drafting of Caring for Our Children – the national standards for health and safety in early education and childcare, a joint project of the American Public Health Association and the American
After serving on the steering committee for the first edition of Caring for Our Children, I agreed to be the co-chair on behalf of the AAP for the second edition. The other co-chair was a pediatrician, Al Chang, who represented the American Public Health Association that had been the home for the first edition. I learned a lot from my participation with other experts who shared their expertise and the collaboration that produced the much improved second edition of *Caring for Our Children* standards. Together, we drew on the format used in other fields to develop each standard – a bit of technology transfer. The template for each standard included 4 key elements: the performance desired to be observed, documented or reported through interviews, the rationale for the standard that will encourage adoption of the standard, and implementation recommendations including comments from the technical experts who drafted the standard and from the large panel of reviewers. Each also included the references so users could find and review the research-based evidence that made the standard necessary.

Dad was very helpful and supportive in the work I did on the standards. He shared process and outcome expectations that made the work go well and have credibility among the many users. He was working as a member of panels at ASTM on development of technical standards related to materials and processes. ASTM was called the American Society for Testing and Materials at the time. Dad was very active in development of ASTM standards. He shared the basic process that ASTM used and helped link me with people who could provide technical information or teach me about how standards should be written. For the second edition of *Caring for our Children*, which was published in 2002, 10 years later after the first edition, I was very intimately involved in the work. Since you (Dr. Glassy) are the co-chair for the AAP for the 2011 third edition and ongoing online updates of this publication, you know and appreciate how much work is involved with drafting and ensuring necessary review and revision of the standards – even more so since they are now being widely used as the primary source for regulations, technical assistance, consultation and professional development.

By this time, early in the 21st Century, Jerry had retired from clinical and administrative practice and really wanted to travel and to “snow bird” in Florida during the snowy winters in Pennsylvania. From the time our children were young, we had spent the December holiday period with my parents at their Florida vacation mobile home. We continued that tradition of visiting them in Florida when they moved their permanent home to Florida after their retirement. We had good memories of traveling with our
children on our vacations in rented RVs -- in the Northeast and the National Parks in the West. When our grandchildren started to reach preschool age, Jerry and I had decided to purchase a 38-foot diesel RV. Our plan was to travel throughout the summer in the RV with our grandchildren, one at a time for 2 weeks at a time, to bond with each of them via shared memories of our trips together. We used the RV as a place to live during our visits to Florida to my aging parents, especially during times when they needed medical support. The RV allowed us to travel, to do professional work when we were in Florida and continue to use our house in Penn Valley as our permanent home.

When we drove back and forth across the country when our grandchildren were not with us, I used the dashboard desk in front of my passenger chair to edit drafts of the *Caring for Our Children* standards or write other early education and childcare publications. That was not without challenge, however. When we were traveling east in the morning or travelling west in the afternoon, the sun poured in through the huge front windshield making it impossible to read the text on my laptop screen. However, I was able to do half a day’s worth of work on any day that we were travelling across the country.

DR. GLASSY: I would like to interject here and say that that is the beauty of what you set up with *Caring for Our Children*. That concept of not just, “here’s what you need to do,” not simply a list telling people what they have to do, but asking them to join you in the conversation about it, with the rationale, and then the comments providing tools and resources so they may implement that. If you so compelled them now with your rationale, then there’s the evidence to support why you’re out there on it. And of course, the concept of inviting all of the stakeholders who have a part to play in quality early education to be part of that process is truly the legacy and beauty, I think, and why, to this day, *Caring for Our Children* is that recognized pinnacle of health and safety in child care. So, I want to take this moment to thank you for setting it up that way, because it was very easy to take the baton you passed me—because you created such a worthy baton—and carry that forward. So, I think that is a culmination of, an example of all of your work, coming together.

DR. ARONSON: Well, thank you for those comments. I appreciate that. It’s wonderful to have that feeling of legacy you're describing. But, you know, one of the pressures on me was, how do we get people to use it (*Caring for Our Children-National Health and Safety Standards for Childcare*)? Before CFOC, I’d reviewed other things and had been involved in an international
pediatric infectious disease symposium organized by Michael [T.] Osterholm, MD, FAAP to look at infectious disease issues related to child care. These activities produced wonderful papers and wonderful information – but too little of that information reached the programs and professionals to promote quality performance. The challenge always was, how to get people to adopt and to use the standards as the basis for policy development and good practice. I began to look at translational tools. One of my early childhood education friends said to me, “Can’t you just set up a model program where you can show what it looks like when it's right, and we can all come and visit that program and we can see it.” I was thinking, “How can we take people from all over the country and bring them to a model program, even if we could create such a model?”

DR. GLASSY: And how could we afford it?

DR. ARONSON: About that time, Dan Huber, a video producer, asked me to consult with and help him with a video about playground safety. I don’t remember now why or how Dan got that commission, but it enabled me to get to know him. He educated me about the power of visual learning. Dan Huber is a very committed and ethical person who took time to learn about the topic being discussed in the video and do what was necessary to make sure that the topic was presented properly. He was willing to redo the scripts and redo the shoots as often as it took to have those who were expert in the field, as a panel of reviewers he organized—find as many things as they could see that needed to be fixed if possible, and then he would fix them. Changes in the videos may be required not because the focus of the camera shot was technically incorrect, but that something in the background or with other individuals in the shot was not correct. Lots of video was reshot by Dan to remove secondary messages of something inappropriate that could be seen in the background of a scene. Dan Huber became a career-long colleague and friend of mine.

I called Dan to talk about the model program idea. I remember holding of the phone in my hand and I said, “Dan, we’ve got to show what it looks like when it’s right. Can we take Caring for Our Children and use it as the basis for a set of videos that can show people what it looks like when it’s right?” He said he would be interested in such a mammoth project. Together, we went to NAEYC, the National Association for the Education of Young Children, to seek financial support and backing. My colleague, Abby Shapiro Kendrick, had been in the Massachusetts Department of Health when Health Power that Hannah Nelson and I wrote was adapted there. She
now worked at NAEYC. Following our presentation, Abby picked up the phone and called people she knew at AT&T and the Brotherhood of Communications Workers of America and explained that this video project would be a good thing for the children of their employees. If we could produce this video it would make their children’s child care safer and better for them. AT&T and the Brotherhood organization agreed to fund the making of a video series. The outcome was a wonderful series of videos that showed how to implement the CFOC standards in a meaningful way. The videos became a very important early education and childcare quality improvement tool that is still available, in part, in digitized form, as training material on the internet on the ECELS website today.

We developed other translational tools to improve the quality of health and safety in childcare. We developed workshop curricula for health professionals to teach early education and child care professionals; we submitted publications to the journals of the early education field; I taught some of the ECELS workshops at AAP district meetings to educate and motivate pediatricians to engage in early education and childcare consulting as the AAP began to discuss concepts of the medical home. As mentioned before in paraphrasing what bank robber Willy Sutton reportedly said: “I rob banks because that is where the money is!” Pediatricians engaging in early education and childcare was a natural application of that aphorism for me.

In 1995, during the Clinton administration, the federal government decided they needed to do something about improving health and safety in child care programs. The Clinton administration staff floated the idea of establishing a national initiative called Healthy Child Care America that would have every state funded to start a program to improve health and safety in child care programs. The Federal agency staff brought a group of experts together to brainstorm how that could be done. ECELS and the California Childcare Health Program were selected as models for what state Healthy Child Care America (HCCA) programs could look like. In 1995, the HCCA initiative was funded by the Child Care Bureau and Maternal and Child Health Bureau funds and managed within the Department of Health and Human Services Administration for Children and Families. HCCA was initially funded for 9 years to the states. This funding stream helped many states establish child care health and safety components, some of which still exist today with state funding, including ECELS. This is a great example of federal leadership, as you said before in your comments, on how to collaborate, how to find the common interest in a group and how to use the
organizational development techniques to create programs and support structures that are actually going to be useful.

Sometimes I feel frustrated that after writing a myriad number of articles and publications on health and safety in early education and child care, when even today, too many people still don’t know about best practices described in them. I’ve learned that it is not enough to just write and publish ideas and concepts. It is critical that someone becomes an advocate and a champion for getting them implemented into practice.

With wise colleagues, I’ve looked at ways to enable that adoption of best practice approaches. Gwen Morgan, of Wheelock College, became a mentor and a friend. Gwen is a very well-known early educator, famous in the early education world, but probably not known to most health professionals. Gwen taught me that while you can have regulations and regulatory inspections to try to force people to do things, you need to incent them to act and perform desired practices. For example, you can combine educating them about the value of doing what is best while either giving them some financial support to do it or providing them with public recognition for their accomplishments – or both. Gwen suggested and advocated looking at how to incorporate the desired practices into the educational stream when early educators and health professionals are students -- getting their degrees, and to look for other ways to incentivize change. That was very helpful. I began to work on those ideas then and continue to work on them today. For example, I have written and update a curriculum and teach as volunteer faculty for a 3 credit hour, on-line course about how to be a Child Care Health Advocate, for directors and lead teachers in early education programs. I mentor the nurses/child care health consultants who are the faculty who teach the course at Northampton Community College in Pennsylvania.

DR. GLASSY: Excellent, excellent.

DR. ARONSON: OK, my early education and childcare belief system was also influenced by my exposure to the early childhood work in other countries. During personal visits to other countries, Jerry and I always tried to observe some examples of local childcare. For example, in 1985, Jerry and I went to Russia in the Soviet Union on a People to People [International] exchange mission. We returned to the Soviet Union in 1989 to visit our son who was doing Russian language immersion by spending a junior year semester in Moscow at East Moscow State University. Bruce had studied
Russian language since high school and selected Northwestern University for his undergraduate degree, in part, because of its Russian studies program on campus and abroad. During the 1989 trip, we traveled to Moscow in the dead of winter, and then to Ukraine, Uzbekistan, and Georgia, then Soviet Georgia. We visited detskiy sad, which are kindergartens and preschools, and infant toddler programs (Yasli). We visited Children’s Palaces, which are before and after school child care programs where children were involved in activities when their parents went to work before the school day began and after the school day finished.

DR. GLASSY: Marvelous names.

DR. ARONSON: We saw that in every town we visited, those children’s facilities were the best maintained buildings, were staffed by caring adults and were offering comprehensive education and physical activities.

My work as a pediatrician in the early education and childcare field was recognized by the organization known as the Child Care Action Campaign. They invited me to join their Board. CCAC was organized in New York City by a wealthy philanthropic individual to try to improve the quality of child care. The German Marshall Fund [GMF] funded CCAC to organize a study team to go to France, sponsored in part by the French-American Foundation, which is a friendship foundation with French entities. Their study team plan was to enable representatives of different sectors of American life view what the French have done with early childhood education. As the German Marshall Fund representative said, “We don’t want you to come back the US and try to exactly duplicate what you've seen. We don’t need to have you get an accurate impression of what you're looking at and understand it fully. Instead, we want you to be inspired by what you see to do things in the United States to improve the quality of care in our country.”

In 1989, the CCAC study team formed as a 10-member team plus 4 staff, for a total group of 14. I was the only health professional. There was a labor union person. There was a state agency regulator. There were several early childhood education professionals at the top of their careers including Bettye [McDonald] Caldwell and Carol Howard. Hillary [Rodham] Clinton was the political person on the team. Hillary, at that time, was the wife of Governor Bill [William] Clinton of Arkansas. During our 2 weeks of work, I got to know and admire Hillary in the various aspects of her persona. Our team started in the morning at 6:30 or 7:00 o’clock by going out in small groups to observe the arrival of children at various programs and to watch the
morning care at different sites. We observed at 2 or 3 different sites before re-convening as a group to observe lunch in an early education program. Lunch in a French child care is an impressive educational experience for children. Lunch staff take over from the classroom teachers while the classroom teachers have a 2-hour lunch break to recharge themselves for the afternoon session. The special educators were responsible for teaching the children how “to savor and eat French food properly.”

DR. GLASSY: Of course!

DR. ARONSON: The culinary educators would come and help children learn how to taste their food, how to savor it, how to recognize it. There were special chefs who were educated to prepare food for child care programs, who were specialists in child care cuisine. That was all very interesting. After observing the children’s lunch, we were served lunch. After lunch, we would visit government agency staff and academics. During the afternoon, many children were napping and there were limited program activities to observe. All of this was beautifully organized to give us a variety of experiences. The study team had translators but I was able, after the first week, to draw on my several years of studying French to understand what was being said. We interacted with many different people, sometimes together as a group of the whole, but often splitting up. Our work continued in the evening. We reconvened at 7:00 o’clock each night, had dinner, and then worked until 10:00 o’clock, exchanging what we had learned that day. It was an incredible experience. I was affected by it. Everyone—the economist from American University [Washington, DC], the labor union person, Hillary Clinton who has been a strong advocate for early education since her first employment after law school at The Children’s Defense Fund with Marian Wright Edelman—took home from that experience a commitment to doing something about the sorry state of child care in the US. My development of ECELS and implementation of quality improvement initiatives were strongly influenced by my experience as a member of the French-American child care study tour.

My work in the early education and childcare included other activities. I served on the NAEYC Accreditation Commission that prepared accreditation criteria for NAEYC, the National Association for the Education of Young Children, to use to accredit early childhood programs. The NAEYC accreditation program is the largest in the world, and, at least last I heard, the military child care programs are all required to be NAEYC accredited. I was the only health professional on that commission and
formed wonderful relationships working collaboratively with members of that group. I particularly value my relationship with Debby Cryer, from North Carolina who was a fellow NAEYC Accreditation Commissioner. She was one of the 3 authors of the Early Education and Childcare Environment Rating Scales (ERS) now used all over the US and in some other countries. The ERS tool is used to assess classroom quality as part of quality rating improvement systems. Working with members of the NAEYC Accreditation Commission taught me about their roles and how we could collaborate and infuse each other with one another’s ideas.

During the 1980s and 1990s, Jerry’s and my children were growing up and transitioning from early childhood, later childhood, adolescence and young adulthood. As our children went off to college and we became “empty nesters,” Jerry and I embarked on adventures as international health volunteers. Jerry travelled to Ecuador with Interplast [now Resurge International as of November 2010], organized by Stanford University to provide plastic surgery experiences for their residents. The following year, he and I travelled to Peru to provide pediatrician pre and post op care as a part of the Interplast initiative. Again, everywhere we went, we looked at child care. In Peru, there was not much organized early education, but there were the same family needs that exist worldwide that in some countries were mostly supported by extended families. While in Peru on R&R time after we completed the surgeries, we visited Machu Picchu, a World Heritage Site and climbed 1000 feet higher to the top of Juana Picchu to look back on the ancient city.

My long-time colleague, Herberta (Bert) Smith, RN, who’d worked at TLC and taught in the health advocacy training curriculum, earned her pediatric nurse practitioner credentials with our practice and my oversight as her preceptor while working at TLC. A long time later, following Bert’s retirement, she volunteered as a medical missionary in Uganda to serve her church’s mission of taking care of children who were in the bush and didn’t have any health care. When we said, “We’ve got to come to Uganda and make sure you're OK,” Bert responded: “Go to Kenya, go on safari, have a little vacation, then come here, because when you get here, I’m going to put you to work.” She kept her word. She arranged meetings with key pediatric and public health professionals. I was a member of the AAP Board of Directors at that time and could see ways that international collaboration between Uganda’s pediatric society and the AAP. Bert took us with her several hours into the bush in the back of a Land Rover to provide a village medical clinic under the trees. Together, Jerry, Bert and I saw about 150
men, women and children with a multitude of problems.

We’ve also enjoyed opportunities to visit Israel, Egypt, Greece and China. We looked at child care in those cultures. As a member of the AAP Board of Directors representing AAP District III, I was selected by my peers to represent the AAP Board of Directors at the first joint meeting of the AAP with the Indian Academy of Pediatrics held in Mumbai in 2000. Once again, as I do everywhere, I went looking at early childhood programs. India has a variety of early education programs as well as a tradition of affluent child care by servants. India’s middle class population is as large as the whole population of the United States. In recent years, Jerry and I accepted the invitation of Qyunh Kieu, MD, FAAP, Founder of Project Vietnam, to join one of their missions to Ho Chi Minh City, Vietnam. Pediatricians at Nhi Dong 2 – the provincial Children’s Hospital, had requested assistance to implement the AAP Bright Futures Program. My assignment was to assist them to begin a program of preventive care screenings including developmental and vision screening. Following observations of their ambulatory clinic in which a pediatrician and an RN would see 4-6 families in the same examining room at the same time, and discussions with some of their staff, Jerry decided to guide them through a strategic planning process. This resulted in their implementation of a “pilot” Bright Futures Medical Home Clinic. As a consequence of our Project Vietnam experience, Jerry and I began to mentor a young Vietnamese physician, Dr. Tam, who served as the coordinator and translator for our team’s work at Nhi Dong 2 Hospital. Since our visit, with our encouragement and support, she has obtained a Master’s Degree in Public Health in New Zealand and has been a finalist for both Fulbright and Hubert Humphrey Fellowships in the US. We value our continued contact with her.

We enjoy combining pleasure and family contacts with these cross-cultural education trips. As I described before, there is a strong English connection on my mother’s side of my family. My second cousin, Peter Harris, became known to us through his genealogy searches. As a consequence of meeting him at the 90th birthday party that my father held in Florida, Jerry and I went to visit him in his various station assignments. Peter is a British diplomat. When he accepted my Dad’s invitation to his birthday party in Florida, Peter was completing his tour of duty in Poland. We visited him in Poland and had a delightful time touring Poland, Lithuania and Latvia with Peter and his wonderful wife. Peter is very fluent in multiple languages. Thus, he could easily converse with local people as we traveled to learn more about our “roots” in Eastern Europe. All of those potpourri of experiences
and observations influenced my thinking about what people had done that might work in the US. I learned about the need to have different ways to accomplish objectives – how to walk up the mountain and reach the top without having to require only one path.

DR. GLASSY: All right, so now we're up to the time when you were elected to the Board of Directors at the national American Academy of Pediatrics. Why don’t you tell me more about that?

DR. ARONSON: As an AAP officer at the chapter, district and national level, I really had wonderful opportunities to learn about many facets of pediatrics. I became involved with the issues related to funding pediatric clinical care—what kind of payment structure can work and the barriers that insurance or lack of insurance pose. I expanded my interest in injury prevention. In addition to the child passenger initiative I started in 1979, I looked at how to prevent other types of injury, focusing on causes of the most frequent and most severe injuries.

First aid is a major issue in early education in which the AAP became an important player. I taught first aid and subsequently developed an early education and childcare first aid program and curriculum for the American Red Cross (ARC). The national ARC endorsed and provided this curriculum to each of the Red Cross chapters as the curriculum they should be teaching and it was used for a number of years. When the curriculum needed revision and renewal, the American Red Cross decided their business was in disaster relief and they were not going to continue to maintain the curriculum. As an AAP member, I facilitated the Academy of Pediatrics in carrying the ARC first aid course forward in a modified form. I chaired the panel involved in the development of the first AAP child care first aid course called PedFACTs, Pediatric First Aid for Caregivers and Teachers. Once again, Danette, this is another initiative that I’m glad that you have now taken on to continue to make it relevant, appropriate and accessible to early educators.

As AAP District III chairperson, I visited each of the chapters in the district, listened, and took their concerns as challenges I really needed to respond to. I was elected to and served 2 terms as AAP District III for 6 years. Members of the AAP Board of Directors have become life-long friends. AAP Fellows are my professional family and good friends. Sometimes, we did things at AAP Board meetings that were kind of novel. I mentioned to you and showed you the scarf juggling kits I put together so that we could break up
our meetings with some fun and laughter. Some of the people at those meetings remembered me for a long time as the scarf juggler. I learned about the value of breaking up meetings for relief and to improve productivity from Head Start. One of the Head Start programs where I did a workshop used scarf juggling to break up their meetings to keep people attentive and interested. I made up sandwich bags with 3 square nylon scarves and a photo copy of the instructions for how to juggle them and where to buy the scarves. I still use this technique with groups to refresh their interactional energy.

At the time of my election to the AAP Board of Directors, I was the only woman on the board. It was an interesting experience both for them and for me to figure out how we would relate to our different styles of communication. My focus is usually on getting the business done. It was necessary for me to learn and appreciate that there were some other means of social discourse that many of the men on the board used to form their relationships. They talked about football games and basketball games and baseball champions, much of which I didn’t know much about nor cared to talk about. But I had to be respectful of their interests, even though it kind of annoyed me to be using precious hours of bringing us together to do good work for this type of conversation.

Another AAP activity in which I became involved was vision screening. I noted that clinical vision screening was really pretty simple, but was not done routinely until children are 4 years of age. Our own son had undiagnosed amblyopia ex anopsia (blindness in one eye from lack of use) detected when he was 4. This was due to having different visual acuity between his eyes so his brain suppressed the vision from the weaker eye. With patching of his good eye, we got his vision back up in the weaker eye, but he has never had binocular vision. I learned of the Prevent Blindness program’s training for volunteers to do simple preschool vision screening using wall charts, with successful screens for more than 80% of 3-year old children. Pediatric practices were not doing vision screening using those simple techniques. The techniques pediatricians were using involved having 3-year-olds look into a machine, which was not developmentally appropriate to successfully screen children who are less than 4 years of age. Thus, 3-year old children were being declared by pediatricians as un-screenable. Their vision screening was postponed until they were 4 or even sometimes 5 years of age when it may be too late for some children to optimal management of their vision problems and possibly lose the prospect for vision restoration. If my son had had better vision screening when he was 3, he might have had a better visual
Thus, I began to focus my advocacy on working on improving vision screening in early childhood and work on and address the problems of incomplete or delayed vision screening beyond the optimal time for correction and prevention of amblyopia ex anopsia. I was able to bring together the Academy of Pediatrics and Prevent Blindness to develop a manual on how to do simple wall chart vision screening on which I worked and that is still available today. Wall chart vision screening for preschool age children is not only more appropriate developmentally but data shows that it is more likely to be successful in identifying children who need referral for ophthalmological evaluation than with any kind of commercial vision screening machine. While some are using vision screening machines that measure eyeball distance, this does not translate to an assessment of functional vision.

Another issue that was of interest to me was the referral process and communication between primary physicians and specialty physicians. Then, and probably still today to some extent, kids with complex problems often get sent off to specialty clinics for care and their primary care needs get ignored. The concept of the medical home seemed novel. When the medical home idea was initially presented, I was AAP District III Chair. I organized a regional District III conference that brought together teams from each of the District III chapters to look at how the medical home concept could be promulgated in their states with their systems. Wonderful national AAP leaders came and presented. But the meat of the meeting was when the state chapters went off to figure out what their problems were and what they were going to do to solve them in implementing the medical home initiative. Recently, I looked at the report of that Region III Medical Home Conference. It was pretty impressive to me so many years later, how many of the things the chapters planned were actually carried out and are in existence today.

As a member of the AAP Board of Directors, I was exposed to different aspects of the Academy. I chaired the board committees on the rotation assigned to each board member, and learned from staff about AAP initiatives underway throughout the organization. AAP Board members review policy statements about many different things involved with pediatrics that are not necessarily in their field of interest. This provided me with a wonderful education and broader perspective on child health and provision, including financing, of pediatric health care. My period of service as an AAP Board member both enhanced my professional knowledge and increased my
academic credibility as I worked and taught medical students and residents. AAP service was, and continues to be an invaluable part of my professional life.

DR. GLASSY: Do you think having a woman on the board of directors—and now there've been a few more, although it still lags behind the demographics of pediatrics now both racially and gender-wise—but do you think it changed the way the Academy functions or influenced the way the Academy functions that more women are becoming involved through your work?

DR. ARONSON: I am proud that my work as a woman in AAP and chapter leadership roles may have modeled, inspired and assisted other women who felt that they might not be welcomed within the AAP structure in leadership roles. The cultural education of women capable of leadership roles in our society tends to make them function in ways that differ from what men do. Women are more likely to be collaborative, and less competitive. My sense is that in pediatrics, there's less male competitiveness than there may be in other fields. I often brought a point of view to the discussion table that differed from what the men were thinking. My style remained assertive and my contributions were not always welcome. On one occasion, I recall being invited to a “woodshed” session where I was given some private counseling from certain members of the AAP Executive Committee seeking to facilitate my effectiveness by decreasing my assertiveness.

This was a time when men were learning new ways to relate to women at a peer-to-peer level as increasing numbers of women entered business and industry and the professional world. It was also the time when the demographics of medical school admissions and pediatric postgraduate programs began to change dramatically from a profession whose majority were men to a profession whose majority were women. This would ultimately impact on the AAP in a very significant way. Women were stepping forward and seeking AAP leadership positions in increased numbers. I recall working with some really wonderful women leaders. I value Toni [Antoinette] Eaton’s attribution of her decision to run for AAP president to my insistence that she put herself into the position to be nominated during my time on the AAP Nominating Committee. I simply took it as a privilege to be able to encourage someone who was very competent and encourage that person to run whether male or female. Toni Eaton is a special person. So, I just kept encouraging her. I said, “You know, you went before the nominating committee twice before, but that was before they really understood that they need to listen to women. Go again
because you bring a wonderful set of skills.” I’m very glad that Toni Eaton was elected AAP President. I believe that she was a wonderful president. Now there are many more women who have demonstrated excellence in AAP leadership roles. I’m delighted to see Sandy [Sandra G.] Hassink, MD, FAAP, a former president of the Delaware chapter president in my AAP District and subsequently District III chair and member of the AAP Board of Directors, doing a wonderful job leading the Academy as the Academy’s president.

DR. GLASSY: Right, first from the Board of Directors and now from the executive committee as the president. Very good.

I want to talk a little bit more about some of the communication tools that you've developed, including those that have had so much longevity, and you're still supporting and updating today, that are still very important to the work you do.

DR. ARONSON: Well, we talked a bit about Healthy Young Children, which is now a continuing publication of the National Association for the Education of Young Children. It’s a manual that people who work in early childhood use. It’s also used to teach in early childhood education courses about health and safety, often taught by people who don't have health professional expertise, sadly. But they at least have that book to use as a textbook.

DR. GLASSY: Another publication that has had longevity is Model Child Care Health Policies.

DR. ARONSON: I feel very good about the early education and child care publications that I have either solely authored, edited, or authored with colleagues. Model Child Health Policies was one of the first. Model Child Care Health Policies is a compilation of administrative health, safety, and nutrition template policies that ECELS offered to early education programs so they really could easily draft their own unique policies. The selected health policies in the first edition of Model Child Care Health Policies were derived from submissions of more than 150 programs as part of an evaluation of a study of Child Care Health Consultants. The intent was to assess the changes that took place as a result of CCHC consultation as measured by review of program policies pre and post child care health consultation. We combed the policies for the best policies, and compiled them as templates for the first edition. Ultimately, these templates were made available in Microsoft Word format to ease the task of child program policy development. This compilation task was a part-time summer job performed
by my son. I’ve always credited him with great pride for the tedious task of combing through all those policies and selecting ones he thought might sound coherent for me to assess, and then putting it together as a single document. *Model Child Care Health Policies* is now in its fifth edition as a joint publication of the Pennsylvania Chapter and the American Academy of Pediatrics. It’s available from the bookstore of the Academy of Pediatrics in hard copy. However, I negotiated for and the AAP agreed that in return for the contributions made by PA AAP ECELS to the project, PA AAP would be permitted to place the electronic document on the ECELS, the Early Childhood Education Linkage System, website to enable child care programs to access it without cost. *Model Child Care Health Policies* are very widely used since it is difficult for many to draft good policies from scratch. The fifth edition incorporates many new suggestions from users and additional examples of policies that we have had shared with us. The collaboration between PA AAP and the AAP on the publication of this book has been wonderful. I have tremendous gratitude for the high degree of professionalism shown by the AAP marketing and publications division in bringing this collaborative project happen.

*Managing Infectious Diseases in Child Care and Schools*, currently in its third edition, and soon to be released in its fourth edition (2016) is an example of a book that serves both the pediatric and the early education professionals. I am quite proud of this book that I’ve co-authored with Tim Shope, MD, FAAP. This book takes pediatric knowledge about infectious disease for health professionals published in the AAP *Red Book*, and translates it for use by parents and early educators. Pediatricians have also found this publication helpful and use it to provide families and/or early education programs with information about how to handle a particular infectious disease issue related to a child’s participation in a group care setting. I think that the most useful part of this book are the quick reference sheets. The Quick Reference Sheets, in 1-3 pages briefly describes what an infectious disease is, what causes it, how you control it, the role of families and early educators. That provides pediatric office staff, unfamiliar with early education environments, with a good and easy to use tool in the very pressured environment of a pediatric practice.

DR. GLASSY: My nurses in my office love that book. They use it probably every day.

DR. ARONSON: I’m glad to hear that. *Managing Infectious Diseases in Childhood and Schools* was published in a spiral-bound format so that copies
of Quick Reference Sheets and other material can be easily made in accordance with publisher permissions. My co-author/editor, Timothy Shope, MD, FAAP and I encourage users to provide us with feedback and ask questions when things are not clear. That allows us to improve succeeding editions during our review of new editions of the Red Book for changes in the current understanding of what is appropriate. For example, early education and child care programs regularly have to make decisions, referred to as “exclusion criteria” as to when should children not come to care. Managing Infectious Disease in Child Care and Schools provides the narrative that explains the exclusion criteria. Unfortunately, there’s a tremendous lack of congruence and agreement between what families believe, what early educators believe, and what pediatricians think is necessary or the evidence shows truly is necessary in many instances of disease, for example for lice or diarrhea. We point out repeatedly, that children do not need to be excluded if they can participate in the program, if their care does not require more effort than teachers and caregivers can give without neglecting the needs of the other children, or thirdly, if there’s not a special problem with that particular disease that requires exclusion. Research has shown that exclusion criteria are often misunderstood and are a frequent point of contention among parents, early education professionals and health professionals. It is important to recognize that the teacher or caregiver has the right and responsibility to refuse to accept a child whom they think cannot participate in the program scheduled for that day. The book attempts to support with evidence the early educator’s exclusion decision over the parent’s insistence that the program take their child because of the difficulty parents have finding alternative care for a child who is feeling too ill to participate,

DR. GLASSY: Or a pediatrician’s.

DR. ARONSON: Right. In a group care situation, staffing and facility factors govern whether the staff can care adequately and safely for an individual child and that may change from time to time. In general, early educators want to exclude children more than parents want children excluded, and both of them want children excluded more often than many pediatricians think is necessary. So it’s a question of trying to broker that understanding of what circumstances and conditions do require exclusion.

For example, the teacher may have already accepted one child who needs a little extra attention; thus she may not be able accept the second one, even if the second one has the same problem. Early educators have to decide
whether or not the care a child requires or the condition of that child makes it difficult for the child to participate in what’s going on.

Educators and physicians must be aware that exclusion policies cause a lot of stress for the parents who are trying to carry out their work roles. They may be docked income, experience increased work pressure, or even have their continued employment threatened as a consequence of the implementation of exclusion policies. Some parents may wind up taking their child to work with them and have the child lie down under a desk in the office when they have no other place for the child or cannot afford the income loss of staying away from work.

Parents need to plan ahead and have alternatives for sick children. While there are community programs that care only for ill children, we know about those—we call them hospitals and sometimes “sick child care centers,” that generally is not a good place for a child to be. When a child is ill, it is best to have that child cared for where they’re very familiar with that site and have experience with those caregivers who know them. We counsel parents and caregivers to avoid punishing a child for being sick by putting a caregiver in charge of him who doesn’t know him. These are examples of issues related to exclusion coupled with the documentation form and other administrative tools in Managing Infectious Diseases in Child Care and Schools.

In my work I’ve also created a number of publications and learning tools that uniquely focus on the professional development of early educators. The ECELS website is filled with self-learning modules on early education topics of common concern. My collaborative professional relationship with “Video Dan” – Dan Huber of Video Active Productions, has produced many videos that demonstrate visually either early education health and safety practices, e.g., physical activity and healthful nutrition, or address specific focused topics like safe active play, which can be both indoors and outdoors. Safe and active play requires educators to be sure that physical activity is not just running around where it is not safe to run, or climbing on unsafe structures that lack appropriate impact absorbing surfaces to safely absorb impact from the height of the fall.

As noted earlier, we have put a great deal of effort into the recruitment and training of Child Care Health Consultants (CCHC). CCHC make a significant difference in the quality of specific early education programs. My work with Dan Huber produced a DVD set to help professionals serve as health consultants. Pediatricians and nurses lack training of pediatricians
about how to consult with child care programs. While their professional education provides them with skills to communicate effectively one-on-one with families, in order for them to work with a program they must possess some organizational development strategies to use that differ from a one-on-one relationship. The care plan for an individual child, e.g., a child with a chronic illness like asthma, can often be more effective if it includes the observations of the teachers and caregivers who see the child and family every day. Collaboration strategies among teachers/caregivers, health professionals, and families within the limitations of HIPAA [Health Insurance Portability and Privacy Act] privacy restraints are key to successfully management of children with special care needs.

We’ve developed other administrative tools for early educators that enable them to do things we’re asking them to do. For example, all child care programs in every state are required to assure that enrolled children are completely immunized on admission and remain up to date with their vaccines during their attendance. Some states also require that early education programs assure that children receive the AAP’s schedule of preventive health services. This requires early educators to create and manage health records, as well as knowing how to assess the up-to-date status for vaccines and other services for an individual child. Few early educators have the ability to decode and apply the complex immunization schedules that exist today whether a child is a “right start” child who has received all vaccines properly since birth or a “late start” child whose immunizations are off schedule for a multiplicity of reasons. Simple dose counting for vaccines does not work because the schedules for vaccines are too complicated. Our first tool was an Immunization Dose Counter [IDC] that looked and functioned like a slide rule. ECELS created it with the consultation of CDC [US Centers for Disease Control] immunization expert. The IDC could assess the number of doses of vaccine required by the child depending on the age of the child and whether he started on time or started late. As I recall, we produced 8-10 updates of the IDC during its lifespan. The IDC was widely distributed in Pennsylvania and across the country.

Once vaccine schedules and preventive care health record management became even more complex, it was necessary for us to develop more sophisticated approaches that early educators could use. We collaborated with Stu [Stuart T.] Weinberg, MD FAAP, an informatics-trained pediatrician and software developer who was an academic working at Children’s Hospital of Pittsburg to develop WellCareTracker™ (WCT), initially as a PC application and subsequently as an Internet app. WCT
enables early educator subscribers using any computer anywhere to enter
data securely on the immunizations and screenings that a child has had.
Subscribers pay only the annual cost to maintain the data on a “cloud
server,” about $1/child/year plus a one-time registration fee of $25 making
this a very affordable administrative tool for budget-strapped early
educators! Algorithms built into the software and regularly updated by Dr.
Weinberg assess the child’s up-to-date status for preventive care and
immunizations. Educators can print out reports for themselves or parents
advising them of clinical action required now because a child is overdue or
due for within the next 3 months. WellCareTracker™ gives early educators
the administrative tools to provide aggregate reports necessary during
licensing inspections and/or for specific quality improvement strategies.
There are very few alternatives to WellCareTracker™. Most alternative
tools require that the person who is using it has an understanding of the
schedules. This service is available nationally.

Recently, in a throw-back to HAT – Health Advocacy Training Project, my
first educational program for early educators that ran from 1973 to 1976, I
developed an on-line course on Health and Safety for Early Education and
Child Care. This 15-session online course targets early education directors
and others anywhere in the world via the Web to become child care health
advocates. Educators who complete the course receive 3 hours of credit from
Northampton Community College in Bethlehem, Pennsylvania to whom PA
AAP ECELS has licensed the course. Data shows that child care health
advocacy works, and that it works best when the advocates have been
effectively educated about what they are supposed to be doing. Early
education programs or the lead teachers who are generally not health
professionals need not do everything. However, they should delegate tasks
and see to it that these tasks get done. Our online course in Health and
Safety in Early Education and Child Care is currently (2015) in its eighth
year of offering this course and is offered 2 times each year.

Once again, this curriculum is a tool that, similar to book writing, requires
regular updating. Thus, there is an endless opportunity for me to keep busy
and out of trouble.

DR. GLASSY: Right.

You’re still active in the Pennsylvania chapter. Is it just in your role at ECELS or
do you do other Pennsylvania chapter work?
DR. ARONSON: As a past president and Pediatric Advisor to ECELS, I continue to contribute to the leadership of the chapter. I attend the semi-annual PA AAP Leadership Meetings when I’m around and available. PA AAP is run very, very competently by the current elected president and Suzanne Yunghans, the executive director, as is ECELS by its director. The ECELS director is a 20-year veteran of ECELS who does a masterful job of managing the funding, reporting and documenting requirements for getting money from the state and from other private and public sources. ECELS remains funded by grants and state funding. The amount and directives of the funding sources varies from time to time. Our ECELS goal remains to have a child care health advocate in every early education program and to have every program linked with a health professional, even if it’s only a telephone number to call and ask questions. Progress towards the goal is slow, almost Sisyphus-like. However, looking retrospectively, we have made progress.

Federal and state program early education program priorities often change. At present, the federal government appears to be emphasizing the need for health and safety in early education and is providing financial incentives to states make sure children are safe, healthy and ready to learn. This provides a wonderful opportunity to develop and promulgate observation tools to help quality improvement staff measure performance to know where there's a need for help. The systems model teaches us that once standards exist, performance can be measured against the standards, making it possible to identify interventions that may be effective, implement them, and follow-up to see whether or not the implementation has actually occurred. As I noted earlier, there is a lot of similarity between strategic planning, and problem-oriented approach to patient care. It’s like Plato said, “There is one truth, and we keep rediscovering it.” The systems model has proven itself in many different arenas of life.

DR. GLASSY: We’ve talked long today about all your experiences and how they’ve influenced the work you’ve done. We’ve talked long about the huge body of influence you’ve created, the innovative tools you’ve created, your innovative models with collaboration, and your work within the Academy at a seminal time. Are there any other areas you want to highlight for this oral history?

DR. ARONSON: Well, it comes back to family.

DR. GLASSY: There we go. Thank you.
DR. ARONSON: I’m 74 years old now, about to be 75. This oral history has provided me with an invaluable opportunity to reflect on my life’s work. It has made me realize that family is, and has been my first priority in life. Family is really the reason that I do everything that I have done. We (Jerry and me) want to be able to make sure that our family is well cared for and loved, and that we’ve provided them with opportunities to do in their lives what they find meaningful. We want our legacy to be one of giving back and sharing with family, community, with children. We want those that follow us to look around, decide what their strengths are, select among the opportunities available and in which they have interested, and then go for it.

We want our children, grandchildren, and those to follow us to create big, audacious, hairy goals—one of the terms the Academy taught me—as guides to their future. You can do much more than you think possible while getting pleasure from doing something good for others. My Dad called this the enlightened selfishness principle. Make yourself happy and satisfied by doing something good for somebody else. If we all practice the enlightened selfishness principle in our daily lives, the world can be a better place for everyone!

DR. GLASSY: That’s great. Thank you so much for everything you do and for this wonderful day spent in your home. Thank you.

DR. ARONSON: Thank you.
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Curriculum Vitae
Date: October 2015

Susan S. Aronson, MD, FAAP

Home (preferred mailing) Address: 605 Moreno Road
Penn Valley, Pennsylvania  19072-1618
Phone: 610/664-3923; FAX: 610/664-3924; Mobile 484/432-1691
E-mail: saronson@aap.net

Employer Address: PA Chapter of the American Academy of Pediatrics
Early Childhood Education Linkage System-Healthy Child Care Pennsylvania
Rose Tree Corporate Center II, Suite 3007
1400 North Providence Road
Media, PA  19063
Phone: 484/446-3003.  FAX: 484/446-3255

Education: 1958-62 B.A. University of Rochester (General Science)
1961-65 M.D.  Case-Western Reserve University

Post-Graduate Training and Fellowship Appointments:
1965-67 Resident in Pediatrics.  Albert Einstein College of Medicine,
Bronx Municipal Hospital Center, Bronx, New York
1971-72 Fellow in Comprehensive Care (considered a residency).
Children's Hospital of the District of Columbia, Washington, DC
1972 Faculty Institute on Medical Care Teaching.  University of
Michigan, School of Public Health, Ann Arbor, Michigan

Faculty Appointments:
1972-1973 Instructor in Pediatrics and Community and Preventive
Medicine.  The Medical College of Pennsylvania
1973-78 Assistant Professor.  Department of Community and Preventive
Medicine.  The Medical College of Pennsylvania
1973-80 Assistant Professor.  Department of Pediatrics.  The Medical
College of Pennsylvania
1978-80 Associate Professor.  Department of Community and Preventive
Medicine.  The Medical College of Pennsylvania
1980-87 Clinical Associate Professor.  Department of Community and
Preventive Medicine.  The Medical College of Pennsylvania
1987-93 Clinical Professor.  Department of Pediatrics.  Hahnemann
University
1993-95 Clinical Professor.  Department of Pediatrics.  University of
Pennsylvania
1995-98 Clinical Professor.  Department of Pediatrics.  MCP•Hahnemann
School of Medicine
2000 Clinical Professor.  Department of Pediatrics.  University of

Hospital and Administrative Appointments:
1967-70 Pediatric Attending.  Department of Pediatrics.  Fairfax County
Hospital  (Fairfax, Virginia)
1967-70  Pediatric Attending. Department of Pediatrics, Alexandria Hospital (Alexandria, Virginia)
1980-92  Pediatric Attending. Department of Pediatrics. Delaware County Memorial Hospital
1988-92  Pediatric Attending. Department of Pediatrics, Hahnemann University Hospital
1992-95  Pediatric Attending. The Children's Hospital of Philadelphia
1995-98  Pediatric Attending. St. Christopher's Hospital for Children
1998  Attending. Parkview Hospital
1999  Voluntary Faculty. The Children’s Hospital of Philadelphia

Specialty Certification:
1972  American Board of Pediatrics
1983  American Board of Pediatrics, Voluntary Recertification

Licensure:  Pennsylvania

Awards, Honors and Membership in Honorary Societies:
1962  Phi Beta Kappa
1965  Student Research Prize
1980  Award of Merit. Pennsylvania Public Health Association
1983  Citation As A Child Passenger Safety Advocate. American Academy of Pediatrics
1984  Governor's Highway Safety Award For Occupant Restraint Program
1985  Citation as a Child Advocate. Delaware Valley Association for the Education of Young Children
1985  Award for Excellence in Early Childhood Development. Delaware Valley Association for the Education of Young Children
1986  Award of the Pennsylvania Association of Child Care Agencies
1986  Recognition of the Ministerio de Salud de Peru and special guest status awarded by the Municipalidad d Piura for pediatric care provided as a member of the Interplast Program in Piura, Peru
1988  PA Pediatrician of the Year Award
1988  Citation for Outstanding Service, American Academy of Pediatrics
1991  U.S. Public Health Service Unit Commendation (for service on the National Head Start Health Coordinators’ Task Force 1988-90)
1994  Flashes of Brilliance - Gold Award for 1994, Brochures Category
1998  John C. MacQueen Lecture Award. Association of Maternal and Child Health Programs
1999  Women of Achievement Award. Girl Scouts of America
2003  Clifford Grulee Award of the American Academy of Pediatrics
2004  Leadership Award, University of Colorado Health Sciences Center School of Nursing, for service as Co-Chair, Steering Committee, Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care. 2nd Edition
2004  Job Lewis Smith Award of the American Academy of Pediatrics
2007  DVAEYC Champion for Young Children
       (Delaware Valley Association for the Education of Young Children)
Memberships in Professional and Scientific Societies:

National Societies:
American Academy of Pediatrics, member since 1972 (Life Member since 2000, after serving 6 years on the Board of Directors, and District Chairman for Mid-Atlantic Region state chapters and pediatrician members.)
Consultant to the Infant and Preschool Committee, later Early Childhood, Adoption and Dependent Care Committee of the AAP, 1976-96
Member of the Ad Hoc Committee on Child Passenger Safety of the Accident and Poison Prevention Committee, 1979-83
Member of the Communication and Public Information Committee, 1979-81
Member of the Public Information Committee of the National Campaign for the building fund, 1983-85
District III, Mid-Atlantic Region, Representative to the Chapter Chairmen's Committee, 1983-86
Liaison to the Child Care Action Campaign for the American Academy of Pediatrics, 1984 to 1990
Vice-Chairman, Chapter Chairmen's Committee, 1985-86
Member of the Ad Hoc Committee to revise the Constitution and Bylaws of the American Academy of Pediatrics, 1986
Member, Central Steering Committee of the AAP/APHA national standards for health and safety in out-of-home settings for children, 1987-92
District III, Mid-Atlantic Region, Representative to the National Nominating Committee, American Academy of Pediatrics, 1988-91
Liaison Representative of the AAP to the Head Start 25th Anniversary Silver Ribbon Panel, to set national goals for the future of Head Start, 1989
Alternate District Chairperson, District III, 1990-94
District Chairperson, District III and member of the Board of Directors, 1994 to 2000
Co-Chair of the Central Steering Committee for the second edition of the National Standards for Health and Safety in Out-of-Home Child Care, a joint project of the American Academy of Pediatrics, American Public Health Association and the Maternal and Child Health Bureau of HHS, 1997 to 2002
Member of the Steering Committee for the Child Care Special Interest Group of the Section on Community Pediatrics; then member of the Executive Committee of the Section on Early Education and Child Care (SOEECC); then advisor to the SOEECC, 2000 to 2013, then advisor to the Council on Early Childhood to present
Liaison for the American Academy of Pediatrics to the National Resource Center for Health and Safety in Child Care, 2001 to present
National Association for the Education of Young Children – Life Member
National Association for Family Day Care National Resource Panel, 1989-92
The Children's Foundation
Board of Directors, 1989-91
Child Care Action Campaign
Board of Directors, 1984-98
American Society for Testing and Materials
F-15 Committee, 1989-97

State Societies:
Pennsylvania Chapter of the American Academy of Pediatrics
Chairman of the Infant and Preschool Committee, 1973-82
Project Director of the Pennsylvania Speak Up For Children Program, 1979-80
Member of the Executive Committee, 1980-82  
Alternate Chapter Chairman, 1982-84  
President, 1984-88  
Pennsylvania Medical Society 1972-2006  

Local Societies:  
Philadelphia County Medical Society (until 1/99)  
Montgomery County Medical Society (1999-2006)  
Delaware Valley Association for the Education of Young Children (1977 to present)  
Day Care Association of Southeastern Pennsylvania  
Association of Day Care Centers of Greater Philadelphia  
Secretary, 1972-73  

National Committees:  
Administration for Children, Youth and Families, U.S. DHHS  
Day Care Advisory Group, 1980-81  
French-American Child Care Study Team.  
Member of a 14 member national team to determine how French approaches to  
child care and maternal and child health can inform U.S. policy, 1989  
Administration for Children and Families, U.S. DHHS  
Advisory Committee to Secretary Shalala on Services for Families with Infants  
and Toddlers, 1994  
Advisor to the National Training Institute for Child Care Health Consultants  
University of North Carolina, Chapel Hill. 2000 to present.  
Advisor and Liaison for the American Academy of Pediatrics to the National Resource  
Center for Health and Safety in Child Care at the University of Colorado Health  
Sciences Center. 2000 to present  
Member of the National Accreditation Criteria Panel, 2002-06  
National Association for the Education of Young Children  
Advisor to the Executive Committee of the Section on Early Education and Child Care of  
The American Academy of Pediatrics, 2006 to present.  

State Committees:  
Committee on Regulations for Group Care of Infants for the Commonwealth of PA  
Chairman, Subcommittee on Health of Infants.  1972-74  
Pennsylvania Child Care Advisory Committee.  
Advisor to the Secretary of the Pennsylvania Department of Public Welfare,  
1973-77  
EPSDT Subcommittee, 1976-77  
Chairman, Nutrition Subcommittee, 1976-77.  
Delaware County Citizens Advisory Council on Fire, and Burn Prevention  
Pediatric Consultant, 1981-86  
Day Care Policy Advisory Committee of the PA Department of Public Welfare  
Pediatric Advisor, 1987-89  
PA Department of Health Advisory Board, advisory to the Secretary of Health  
Member of the Board, 1989-94  
PA Governor's Advisory Council for Young Children  
Pediatric Advisor, 1989-90  
PA Partnerships for Children  
Member of the Board and Co-Chair. Child Health Committee, 1991-92  
PA Governor's Commission for Children and Families  
PA Department of Public Welfare, Child Care Advisory Committee, 2000 to date  
(Advisory to the Deputy Secretary for Children, Youth and Families)
Local Committees/Boards:
Delaware Valley Regional Poison Control Program, Board of Directors, 1988-90

Editorial Positions:
1978-81 Child and Family Research Review Panel for the Administration for Children, Youth and Families of the U.S. Department of Health and Human Services
   Consultant and Reviewer
1979-80 Select Panel for the Promotion of Child Health. U.S. Department of Health and Human Services
   Chapter author and Consultant. 1979-80
1980-83 Day Care and Early Education magazine of the Day Care Council of America
   Health Editor
1986-89 Young Children, Journal of the National Association for the Education of Young Children
   Reviewer and Consulting Editor
1982 - Exchange, a magazine for early childhood program administrators with national distribution. Solicit and edit articles by other health professionals.
1983 American Medical Association
   Consultant on a book on child care
1984- Pediatrics
   Reviewer
1987-90 American Red Cross.
   Author and Editor for the Child Care Course - First Aid, Preventing Injuries, Preventing Infections, Caring for Ill Children
1988-94 Pediatric News
   Board of Editorial Advisors
1994-95 Archives of Pediatrics and Adolescent Medicine.
   Reviewer
2002- Injury Prevention
   Reviewer
2006- Parents
   Board of Advisors
2006- Journal of Developmental & Behavioral Pediatrics
   Reviewer

Academic Committees
1993-95 Resident and Medical Student Advisor, CHOP, University of Pennsylvania
1995-98 Medical Student Advisor, MCP-Hahnemann School of Medicine

Major Teaching and Clinical Responsibilities at the University of Pennsylvania and at MCP-Hahnemann School of Medicine
1. Primary Pediatrician with oversight of medical students and residents working in the Primary Care Unit at CHOP (past)
2. Primary Pediatrician with oversight of medical students working in St. Christopher’s Primary Pediatric Practice at the Center City location (past)
3. Pediatric Pathway medical student advisor. St. Christopher’s Hospital for Children (past)
4. Seminar faculty leader for the seminar on advocacy for second year pediatric residents at CHOP. (past)
Mentor for residents and other pediatricians who are working on datasets to prepare scholarly papers for publication. (e.g. mentored Kristen Copeland, MD at Cincinnati Children’s Hospital for her research grant about physical activity in early care and education programs)

**Lectures by Invitation:** (from available records for past 10 years)

- **9/01** “Using National Standards for Health and Safety in Child Care” Healthy Child Care America Annual Meeting, Maternal and Child Health Bureau and Administration for Children and Families, Washington, DC
- **10/01** “Using Risk Watch® to Teach Children Injury Prevention” PA Association of Child Care Agencies, Monroeville, PA
- **10/01** “Breastfeeding and Child Care” American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA
- **11/01** “Health and Safety Performance Standards” and “Medication Administration” National Association for the Education of Young Children Annual Meeting, Annaheim, CA
- **9/02** “Measuring Process versus Outcomes Related to the Work of Child Care Health Consultants” Healthy Child Care America Annual Meeting, Maternal and Child Health Bureau and Administration for Children and Families, Washington, DC
- **11/02** “When a Child is Sick” American Public Health Association Annual Meeting, Philadelphia, PA
- **11/02** “Using the National Health and Safety Standards” National Association for the Education of Young Children Annual Meeting, New York, New York
- **12/02** “How Child Care Health Consultation Impacts the Quality of Care” Regional Conference for Child Care Health Consultants, Princeton, NJ.
- **3/17-18/04** Albert Einstein Medical Center, Pediatric Dept Noon Conferences: “Improving health and safety in early education and child care settings” Philadelphia, PA
- **9/23/04** Organizer and moderator for audio conference, “Let’s Talk: Quality Active Play”, a statewide CME activity for the PA Chapter of the American Academy of Pediatrics
- **9/29/04** Managing Health Records; Observing for Health and Safety in Early Education and Child Care. PA Association of Child Care Agencies, Harrisburg, PA.
- **10/10/04** 2004 Job Lewis Smith Acceptance Address, American Academy of Pediatrics National Conference and Exhibition, San Francisco, CA
- **11/11/04** “Update on Health and Safety in Early Education, Using the National Standards” National Association for the Education of Young Children Annual Meeting, Annaheim, CA
- **2004-2013** Workshops about health and safety topics for early education professionals at the annual state-sponsored Early Childhood Summit Conference at Penn State University
- **3/17/05** “Learning the Language and Understanding the Field of Early Education and Child Care” Plenary Session Presentation. AAP Conference for Child Care Advocates, Orlando, FL
- **3/17/05** “Child Care Health Consultation Resources & Implementing Model Child Care Health Policies” Workshop Session Presentation. AAP Conference for Child Care Advocates, Orlando, FL
- **3/17/05** “Mentoring Others and Making Learning Contracts” Workshop Session Presentation. AAP Conference for Child Care Advocates, Orlando, FL
- **5/6/05** “Preventing Obesity in Early Childhood” Workshop Session, Annual Conference, Delaware Valley Association for the Education of Young Children, Philadelphia, PA
- **6/9/05** “Update on Health and Safety in Early Education and Child Care” Audio conference, PA Department of Health, Maternal and Child Health
- **9/14/05** “Giving Advice on Health and Safety in Early Education and Child Care” Grand Rounds, Riley Children’s Hospital, Indianapolis, IN
- **9/14/05** “Child Care Health Consultation” Keynote Address, Annual Conference for Child Care Health Consultants, Indiana Department of Health, Indianapolis, IN
Organizing Roles in Scientific Meetings:

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Bibliography:

Research Publications, peer reviewed (print or other media):


Scientific Publications, peer reviewed:

Aronson, S. "Child Care: Opportunities for the Pediatrician to Make a Difference" Pediatric Update 19:1-10 Transcript and audiotape. 1998
Shope T and Aronson S. "Improving the Health and Safety of Children in Nonparental Early Education and Child Care" Pediatrics in Review 26:86-94, 2005

Editorials, Reviews, Commentaries, including participation in committee reports (print or other media):
Committee on Early Childhood, Adoption and Dependent Care, (Susan Aronson, MD, consultant) "The Pediatrician's Role in Promoting the Health of a Patient in Day Care" Pediatrics 74:157, 158, 1984.

Committee on Early Childhood, Adoption, and Dependent Care of the American Academy of Pediatrics. (Susan Aronson, statement author and consultant to the committee) "The Pediatrician's Role in Promoting the Health of Patients in Early Childhood Education and/or Child Care Programs" Pediatrics 92:489-492, 1993.


**Editor**

Osterholm, M., Aronson, S., Klein, J., and Pickering, L., guest editors of "Infectious Diseases in Child Day Care: Management and Prevention" Reviews of Infectious Diseases Vol 8, No 4, July/Aug, 1986


Aronson, Susan S. *Health Link Online*, a newsletter disseminated by the Early Childhood Education Linkage System, a program of the PA Chapter of the American Academy of Pediatrics, established 1989. Newsletter was initially published monthly in hard copy, then every other month, and then online, quarterly since 1997.

**Chapters in Books**


Aronson, S. "Child Care and Early Education Programs" in Primary Pediatric Care, 4th edition, Part Six – Psychosocial Issues in Child Health Care, Section Two – The
Books:

See also books with role as editor, but also authored: Healthy Young Children, Managing Infectious Diseases in Child Care and Schools, Model Child Care Health Policies

Papers/Chapters in Federal Publications:


College Curriculum

Aronson, S. Curriculum for 3 credit hour, 15 session (college) course for directors and lead teachers to function in their programs as Child Care Health Advocates; taught on campus in 2007 and then online 1-3 terms per year by Northampton Community College instructors with guest faculty support from S. Aronson since 2007. Curriculum updated 2009, 2012, 2014.

Child Care Health Advocate Course, 3 credit hour, 15 sessions taught on campus and online at Northampton Community College 1-3 terms per year since 2004. In addition to writing the syllabus, readings and assessment tools, provide guest faculty participation on student discussion board and in live interactive online sessions with the students during the course.

Devices & Internet Applications:

Weinberg, S, Aronson, S & Aronson, J. WellCareTracker™, an Internet Application to identify gaps in preventive health services from entry of dates of service into an Internet Application with built-in logic rules to test the dates against currently recommended schedules. As of 11/05, used by 320 child care centers in 5 states. www.wellcaretracker.org.
Alternative Media:

**Electronic Media:**
Aronson, S. “Caring for Children with Special Needs in Child Care” Statewide Teleconference chaired and organized with the Family Focused Early Intervention System and the PA Department of Education, 5/24/95
Aronson, S., chairperson for the joint project of the American Academy of Pediatrics and the National Association for the Education of Young Children to produce a 6 part video series: “Caring for Our Children” funded by a grant from AT&T.
Aronson, S., Executive Producer. “Health and Safety Consultation in Child Care” a 5 part video series on national resources and the role of the child care health consultant, how to observe in child care, the child care culture, how to use adult learning principles to teach child care providers, and how to make collaborative improvement plans with child care providers (Updated as a DVD interactive educational media set)
Aronson, S. Webmaster and Content Manager. Website of ECELS-Healthy Child Care Pennsylvania, found at [www.ecels-healthychildcarepa.org](http://www.ecels-healthychildcarepa.org)

**Magazine Articles and Columns in Journals/Magazines:**
Aronson, S. Health Advocacy a need, a concept, a model" Children Today January/February, 1975.
Aronson, S. "Commentary on the Hepatitis Outbreaks Reported in Day Care Centers" Child Care Information Exchange September, 1980.
Aronson, S. "Infection and Day Care" Child Care Information Exchange 30:10-14, 1983.
Aronson, S. "Teaching Children to be Safe" Child Care Information Exchange 32:26-29, 1983.
Aronson, S. "Injuries in Child Care" Young Children 38;19,20, 1983.
Aronson, S. "To Worry or Not About Infectious Diseases in Day Care" Child Care Action News Vol 1, No. 5, Sept/Oct, 1984.
Aronson, S. "Health and Safety in Day Care" Ecumenical Child Care Newsletter IV:2 March/April, 1986.