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 which 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, 2002/2003

Howard A. Pearson, MD, FAAP, Chair
David Annunziato, MD, FAAP
Jeffrey P. Baker, MD, FAAP
Lawrence M. Gartner, MD, FAAP
Doris A. Howell, MD, FAAP
James E. Strain, MD, FAAP
ABOUT THE INTERVIEWER

Norman J. Sissman, MD, FAAP

Norman J. Sissman, MD, graduated from Harvard Medical School in 1950 after his undergraduate years at Dartmouth College. Following a rotating internship and two years of active duty in the U.S. Naval Reserve, he was a resident in pediatrics at the Childrens Hospital of Pittsburgh (his hometown), and a Fellow in Pediatric Cardiology under Dr. Helen B. Taussig at Johns Hopkins. He was a member of the faculty of Stanford Medical School, as Director of the Division of Pediatric Cardiology, from 1958 through 1971. He was Professor of Pediatrics and Director of the Division of Pediatric Cardiology at the University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical School from 1975 until his retirement in 2000. Although it might be assumed that he exemplifies a paraphrase of General Douglas MacArthur, "Old pediatricians never die; they just become involved with history!" Dr. Sissman has had a keen interest in historic, economic, political, artistic and social aspects of pediatrics, and medicine in general, throughout his career. He greatly enjoyed meeting and interviewing Dr. Diamond despite their disparate ethical views.
Interview of Eugene F. Diamond, MD

DR. SISSMAN: This is Norman Sissman and I am about to begin an interview with Dr. Eugene Diamond. It is June 27, 2002 at around 11 o'clock in the morning and we are in Dr. Diamond's office. Usually we begin with just some personal background. I noticed that you were born in Chicago.

DR. DIAMOND: Born in Chicago, right.

DR. SISSMAN: And lived all your life here basically.

DR. DIAMOND: Except when I was in the service, yes.

DR. SISSMAN: Did you come from a medical family?

DR. DIAMOND: No, actually my father was an accountant. We were probably what you would call a middle-class family. Then my father died when I was six and we became an impoverished family.

DR. SISSMAN: That was around the beginning of the Depression.

DR. DIAMOND: It was 1932. Yes, right in the middle of the worst part of the Depression. I went to public schools and entered the [US] Navy at 17. And the Navy provided some of my education through the V-12 program. Toward the end of World War II, I was a corpsman and that qualified me for the GI Bill [Servicemen’s Readjustment Act] and so they paid for part of my medical school training.

I started out as an internist in an internal medicine residency and I was called back into the service in the Korean War and I was attached to a Marine Corps battalion. I was called upon to provide some of the dependents’ care for them and that's where my interest in pediatrics began actually. It was not the typical place. So when I came back out of the service in the Korean War, I went into a pediatric residency at the University of Chicago.

DR. SISSMAN: And your service was in the states?

DR. DIAMOND: Mostly, yes. I didn't see any combat but I was out of the country for a while.

DR. SISSMAN: And you were in the V-12 program at Loyola [University of Chicago]?

DR. DIAMOND: No, that was at [University of] Notre Dame. And then I
went to medical school at Loyola; but I had my pediatric training at the University of Chicago.

DR. SISSMAN: How did you get interested in medicine in the first place?

DR. DIAMOND: I think from a kind of an admirable doctor who lived across the street. He always struck me as having a very productive life and being able to help people. Beyond that I suppose as a poor kid I looked up to the fact that he had prestige and some financial comfort. I'm sure those were part of my motivation, but mostly I think I liked the way that he was able to use his life.

DR. SISSMAN: After you came back from the Korean service you had a pediatric residency at Chicago and then opened an office?

DR. DIAMOND: Yes. I went into solo practice. That was in 1955, as soon as I finished my time at the University of Chicago. I have been in solo practice ever since. I have always been fortunate to have associates, people who traded call with me and were very compatible with me in every way. I never did pediatric practice exclusively; I always did academic pediatrics on the side and was part of the faculty at Loyola for about 37 years. I did even spend some time as a part-timer as chairman of the department, which is unusual. At the time, Loyola didn’t have a lot of full-time faculty so part-time faculty actually ran several of the departments.

I enjoyed students immensely. I mean I really enjoyed teaching. My early career at Loyola was spent largely with the junior clerkships. Being chairman, frankly, was a job that was important. It was an administrative job and it always struck me that I had to be dealing with personalities that wanted more space, more money, more recognition. And so I kind of gradually learned to like that less than clinical pediatrics. We built a new medical center over in Maywood [Illinois], which was quite a contrast with our obscure and kind of rundown beginnings.

DR. SISSMAN: When was that?

DR. DIAMOND: That was in 1968.

DR. SISSMAN: You were chairman then?

DR. DIAMOND: I was chairman from 1968 to 1970. At that time we figured that we needed someone who could attract research money to the institution. So we hired David Hsia, if you remember, Hsia, he was a very prominent biochemist. He did a lot of work in neonatal hyperbilirubinemia and phenylketonuria and things like that. So he became chairman and I
became the director of inpatient services. That was, to me, the most challenging job I have ever had in my life. I mean running an inpatient tertiary care service was very, very interesting. That was very stressful, but, I think, very rewarding. You really felt like you were on top of your game when you're doing something like that.

DR. SISSMAN: How long did you do that?

DR. DIAMOND: I was director of inpatient services for about four years. At that time I couldn't really spend as much time away from my practice; it was getting to be too much of a burden to try to do two big things at once. So I cut back on my academic duties. But I was always a salaried part-time person.

DR. SISSMAN: So you did mostly teaching of the students rather than the residents?

DR. DIAMOND: Yes. After I became director of inpatient services then my responsibility was mostly with the residents.

DR. SISSMAN: That included all subspecialty patients or was it just the general pediatric service?

DR. DIAMOND: It was a general pediatric service; we gradually built a subspecialty core. Dr. Hsia was very interested in doing a genetics group. So we had George [F.] Smith who was a geneticist, and we had a couple of PhD geneticists.

DR. SISSMAN: That was pretty farsighted at the time.

DR. DIAMOND: Yes, it was. George Smith was interested mostly in Down's syndrome and other chromosomal disorders.

We started, actually, from scratch. We started with an empty department. Nobody knew we were there practically speaking, and we had to build up a referral base. But that happened actually surprisingly quickly because Loyola made a commitment that they were not going to try to do primary care, although that would have been a way to fill the beds in a hurry; but they were going to stick to being a tertiary care center and a referral center. It cost them a lot of money initially, but it eventually proved to be very wise move because the community wasn't skeptical of us. They knew that we were not going to try to encroach on the local hospital domain, so they began to refer patients.

DR. SISSMAN: There was a lot of competition, though, for academics in Chicago, right?
DR. DIAMOND: Yes. At that time, not only Children's [Hospital] at the University of Chicago but Michael Reese [Hospital] also had a very strong department and the University of Illinois [Medical Center] was building their department along with ours, but we had the prestige of having as our chairman, David Hsia who won the [E.] Mead Johnson Award [for Research in Pediatrics] a couple of times. From the academic standpoint we were known fairly early in our development.

DR. SISSMAN: And all this time you had a private practice. Was it in this area most of the time?

DR. DIAMOND: Yes, my office was down about half a mile. I had a large office there; it was a busy pediatric practice. I was also very much involved in Academy [American Academy of Pediatrics] politics.

DR. SISSMAN: Yes, we will get to that in a minute.

DR. DIAMOND: It was the standard kind of general pediatric practice. You would see 30 or 40 patients a day. A lot of hospital work, a lot of phone calls. It was pretty typical.

DR. SISSMAN: Now do you still have a practice?

DR. DIAMOND: Yes. I have cut back a lot now.

DR. SISSMAN: You mean in the time that you're here?

DR. DIAMOND: Yes. I'm here four half-days a week now. I don't have those wild afternoons anymore like I used to have. It's now slower paced. But I love practice, I love meeting the public basically.

Almost all my practice now is second generation; I even have some third generation patients. So I love to go from room to room and see people, see kids and relate to their mothers and fathers. I think it is a wonderful life really. I don't know what I would do if I gave it up. I have no plans for giving it up. I'm sure eventually I will.

DR. SISSMAN: Do you have any comments about how the circumstances of pediatric practice have changed?

DR. DIAMOND: Oh yes. Things have changed dramatically as a result of managed care. I spend an awful lot of time filling out forms and dealing with HMOs [Health Maintenance Organizations] and that kind of thing. Having to justify having a patient in the hospital and that sort of thing. I think in my present state, which would not have been true my earlier life,
having an all HMO practice would probably be the best thing for me. I mean everybody on capitation. So that all the paperwork would go somewhere else and I could just deal with the patients.

DR. SISSMAN: That's a bit of the hassle now.

DR. DIAMOND: Yes. But now I have quite a mix. With various PPOs [Preferred Provider Organizations] and HMOs and some fee for service, very little, and quite a bit of public aid.

DR. SISSMAN: So you have done some public service all along?

DR. DIAMOND: Yes. I have done public aid since I went into practice. I always felt that ought to be part of my service. In the beginning it was given away; in the beginning there was no formal way to give care to people who couldn't pay. You just had to write it off. And then about 1978, I think it was, we got a grant from Robert Wood Johnson [Foundation] and reopened out of the school health clinic in Robbins [Illinois]; I don't know if you know anything about Robbins. Robbins at that time, by all parameters: mean income, value of housing, rate of unemployment, was the most depressed community in the state. And what we did, Robert Wood Johnson funded us to put clinics in schools, we would take over a classroom in the school district and we would operate out of there.

DR. SISSMAN: We meaning Loyola?

DR. DIAMOND: No, this was my own private thing with a couple of physician assistants and we did a lot of work with nurse practitioners. But this was a community that had never had a physician in its 100-year history. Never had any continuity of care.

DR. SISSMAN: Is it in south Chicago?

DR. DIAMOND: Yes, it's due southwest of here. A very high crime area. They had a wonderful superintendent of schools who actually dealt with Robert Wood Johnson and negotiated the funding. At that time they were doing this all over the country, starting school health clinics.

We were pleasantly surprised that the people actually did appreciate continuity of care. They liked having a doctor to refer to and relate to. They maintained inoculation schedules and things like that. It wasn't all acute-care; it was preventive care.

DR. SISSMAN: And that was on the school premises?

DR. DIAMOND: Yes. It was right in the school. So that if someone had
an appointment to have a DPT injection they could walk down the hall; providing his parents were available, we could give him his well child examination.

DR. SISSMAN: That was quite an undertaking.

DR. DIAMOND: Oh yes. It was a wonderful set up.

DR. SISSMAN: At how many schools did you have a presence?

DR. DIAMOND: There were four schools in the district and we had clinics in two of them.

DR. SISSMAN: Elementary and high school?

DR. DIAMOND: No, just elementary school. Robert Wood Johnson wanted us to use their money as a start up and then we were supposed to be on our own after awhile. But financially it was not really realistic. Nobody except public aid patients used it.

DR. SISSMAN: It was free if you had no insurance?

DR. DIAMOND: Yes. We hardly ever took any money from anybody. Almost everybody was on public aid. I think probably 90 percent of the children in that school were on public aid. So basically it was a public aid practice. The public aid in Illinois is a very bureaucratic operation.

DR. SISSMAN: Not only in Illinois. [Laughter] Everywhere

DR. DIAMOND: So if you did not cross a “t” or dot an “i,” you didn't get paid. The nurse practitioners were making a pretty handsome salary and I was getting a salary from Robert Wood Johnson but eventually we were really a losing operation. And then the school district, their very charismatic superintendent of the schools retired. After the grant ran out, we paid a dollar a year for the clinic, and the schools felt that we should pay them more. For many reasons, it became financially impossible.

DR. SISSMAN: And so the total duration of it was?

DR. DIAMOND: About eleven years.

DR. SISSMAN: And now there is no presence?

DR. DIAMOND: No. Robbins has reverted to its previous status, which is a physician-free zone. I suppose using Chicago public health clinics; maybe they are using the emergency room. It was a wonderful experiment.
It was really tragic to have to discontinue it.

DR. SISSMAN: Do you know if that was true of most of those school projects?

DR. DIAMOND: I think most of the ones that succeeded, and there were some that succeeded, were university-affiliated so that they were a little more successful.

DR. SISSMAN: Got some financial assistance.

DR. DIAMOND: Yes. We thought that maybe the school district might want to capitalize this, but they were kind of in bankruptcy. But for me was a great way to prove that people from poor families very much appreciate good medical care, and the availability of good medical care. The notion always that they were crisis oriented and could always use the emergency room, that wasn't true at all. I mean they were really very loyal patients and very appreciative patients.

DR. SISSMAN: Did their immunization percentages go up?

DR. DIAMOND: Yes. We had at one time about a 90 percent compliance rate, which was as good as or better than almost every school district in the state. Of course it was hard for them to escape us. If they didn't show up we could go down the hall and take them out of the classroom and say, “It's time for your shots.” But that wasn't necessary. I mean, they made an appointment and they showed up. I think that from the standpoint of preventive care it benefited greatly. Achieved much less absenteeism.

DR. SISSMAN: Were you able to deal with learning problems? Were you included in the school’s assessment?

DR. DIAMOND: Yes, we dealt with particularly ADDs [attention deficit disorders], because there were a lot of crack [cocaine] babies in that area. So as far as dyslexia and learning problems, they mostly were handled at the district level. They would have joint psychological services.

DR. SISSMAN: You were never tempted to go into group practice, I take it?

DR. DIAMOND: No. Dr. Hsia wanted very much for me to go full-time and he even arranged for me to get tenure, which was almost unheard of for a part-time person. But in the final analysis, I don't know, I may be a quirky person who didn't feel as though I fit into a group; although I was able to fit into a group informally.

I have always had the good fortune of having an associate. My first associate
was a man who was also trained at the University of Chicago so we were like two peas in a pod. He was a generation older than I, but he had a coronary and he sold his practice to a man who was as different than anybody could be. He was a Ukrainian immigrant. A man who had followed the German army as they were retreating out of the Ukraine. He was just a wonderful man. I mean he was just wonderful in every way. He was just very cooperative, very happy to be able to trade calls. And I remember we had not been associates for very long and I had to have a renal stone removed. It was in the pelvis. In those days they didn't have the soundwave-cruncher. So I had to go into the hospital for about 10 days. He took my practice and afterward he came over to me during convalescence and wanted to give me all the money he had made off my patients during the time I was in the hospital. Of course I didn't accept it; but I never forgot that gesture. He was such a generous man.

DR. SISSMAN: What were you in the hospital for?

DR. DIAMOND: I had a nephrostomy for renal calculus in my pelvis.

DR. SISSMAN: There aren't many graduates who go into solo practice nowadays. Would you still recommend it though?

DR. DIAMOND: No. I have four sons who are doctors and I would not recommend it to any of them. Mostly because they are different personalities. But also because there is much more opportunity for getting coverage and being able to escape the practice, not being on call all the time, you know. So all of my four sons are with groups.

DR. SISSMAN: Are any of them pediatricians?

DR. DIAMOND: One. One is a pediatrician. He works in a Loyola clinic, a three-man group. But groups bring their problems too. Groups bring personality clashes and money clashes. So I've never felt sorry about doing it myself. I've always felt it was the appropriate thing for me to do. But I think that in this generation, a solo practitioner is a fish out of water.

DR. SISSMAN: Has the computer affected your practice at all?

DR. DIAMOND: No, not very much. We don't do billing by computer.

DR. SISSMAN: Or your writing?

DR. DIAMOND: Yes, yes. It has helped there. I do a lot of writing. I love writing.

DR. SISSMAN: So you have adapted to using the computer?
DR. DIAMOND: Yes. I'm not really computer literate, I wouldn't say. But we have a computer and I am on it a lot of the time. I think I'm probably like a lot of other people who feel more comfortable writing in longhand on a yellow piece of scrap paper or something like that.

DR. SISSMAN: Do you still do that?

DR. DIAMOND: I do that, yes.

DR. SISSMAN: The [American] Academy [of Pediatrics] [AAP] sent me some newsletters and things about your early involvement there. Was that early in your career or later?

DR. DIAMOND: I started practice in 1955 and I joined the Academy in 1957. My chairman at Loyola at that time was a man named Joe [Joseph R.] Christian. Joe Christian eventually became chairman at Rush [Medical College], but he was our chairman then. Joe was very interested in the Academy. He encouraged me to become interested in the Academy. He was really in many ways the perfect chairman. He did everything he could to promote the careers of young people in his department. He was very generous in that way.

So he got me involved in the Academy and my first interest was, I was chairman of the Committee on Accident Prevention [AAP Illinois Chapter], which at that time was one of the most unglamorous. But after I got interested, I realized that accidents were killing more than the next ten diseases combined between ages one and ten, and so it's a very important problem. It's a problem that is susceptible to prevention and anticipatory guidance and things like that.

DR. SISSMAN: That was a fairly new idea though at the time.

DR. DIAMOND: Yes it was. From that activity, I got to know the people up in Evanston [Illinois], which is where the Academy offices were then. So I was subsequently appointed to the national Committee on Accident Prevention and my interest there was in automotive injuries, which again was something that nobody had ever thought about as a medical problem. About that time the book, Unsafe at Any Speed, by Ralph Nader was showing that if you design the car a certain way, and if you kept people in the car, they weren’t ejected, because once they were ejected there were going to be seriously injured. Then you did things like protecting against the second collision. He was talking about a certain model of Chevrolet. First you hit something and then you hit the interior of the car. If you padded that and then used restraints, used neck braces to prevent whiplash, it was remarkable what you could do to prevent kids from being hurt in the car,
and adults, too. Of course, as often as not, it was the children who conditioned the adults to wearing their belts and things like that. That was really fascinating.

Then I got interested in poison control. I was on the national poison control committee [Subcommittee on Accidental Poisoning]. That was about the time that poison control centers were being started so that people who were poisoned, the emergency room could call and get instructions. I did those two things probably for six or seven years I guess.

DR. SISSMAN: Was the Academy influential on setting up childproof medicine bottles?

DR. DIAMOND: Yes. Very much so. The one who was most active on that was Jay Arena from Duke [University], who was president of the Academy for a while. But, prior to that, I think he was very active in all kinds of poison control, including childproof containers and using antidotes. So, I think the Academy was central to that, probably with some cooperation with the druggist. I suppose they were also very interested in that. And it kind of brought the pharmacist into a joint, professional relationship with us which they appreciate.

After that, I got interested in sports medicine. I was a chairman of the first Academy sports medicine committee [Committee on Pediatric Aspects of Physical Fitness, Recreation, and Sports].

DR. SISSMAN: Were you involved in sports yourself?

DR. DIAMOND: Yes, I was at Notre Dame. Mostly at track and cross-country. I was captain of my team in high school. And I was the number one half-miler at Notre Dame. But I was interested mostly because my own children were at that time were getting involved in juvenile sports.

What really concerned us, and I think most of the people at the Academy were concerned about this, was the overemphasis on success and the overemphasis on skills. In other words, not letting the children play their own game and have fun and, you know, not be pressured. We had one particular meeting that I will never forget. We met with a man named Creighton [J.] Hale, who was the commissioner of Little League Baseball, nationally. He was a PhD in exercise physiology, a very sophisticated man. But this is all he did with his PhD was to run the Little League nationally. We also met at the same time with a man named Polito who was from Erie, Pennsylvania and was the commissioner of Pop Warner Football.

DR. SISSMAN: This was an AAP committee?
DR. DIAMOND: Yes. We met at the Academy offices.

DR. SISSMAN: Do you remember when that was?

DR. DIAMOND: I think it would have been the early 1970s.

End of side 1.

DR. DIAMOND: In the morning we talked about epiphyseal injuries and changing the rules and all those things, we were very compatible. And then in the afternoon we started to get into the material that made them very testy, which was why do you have adult spectators? It's a terrible thing for a kid to be harassed by his own parents when he is just learning the game. Why don't you let them play by themselves as kids used to play?

DR. SISSMAN: So what was their reaction to that?

DR. DIAMOND: The first thing we said to Creighton Hale was, “Would you ever consider not having a World Series for Little League or not having all-star games or not placing so much stress on winning instead of learning the game? Or competing and relating to your teammates and learning to lose gracefully?” All those things. We have a lot of time to get into competitive sports. I mean you have high school, you have college. It can go on forever with lifetime sports. But why should little kids be treated like they are professional athletes?

Well, of course we were talking about his bread and butter here. His World Series had just been on national television. And the idea that we would just have local neighborhoods playing ball and having a good time just appalled him. And the same way with the fellow from Pop Warner Football. He said, “Well, how would we know whether our kids in Erie, Pennsylvania, could play better than the kids in Monongahela?” or something of that type. I said, “Well, what difference does it make? Who cares? The kids know that they can play at a certain level and you don't have to convince them by that kind of competition.”

Well, that was the last time that they wanted to meet with us. But we kept plugging away at that. I think the Academy did a wonderful job here, also, of trying to take the game back to the kids. And we see the results now where fathers fight at the hockey games and kill one another.

DR. SISSMAN: Right. We still have the problem.

DR. DIAMOND: Yes. Yes. But I think the Academy was the only voice in the country at that time speaking against super organization of sports and against high-pressure competition. Because we were seeing kids in the office
that didn't make the team; although Little League, I must say, was very good about letting every kid play. But a kid that was playing always in right field and only for the last inning of the game, he knows that he's not a good ballplayer and nobody has to tell him anything to the contrary. Why not let the league be stratified so that superstars can play with superstars and so on, down to the kids who are maybe a little bit awkward and just learning the game? So I think the Academy kept going on that point.

DR. SISSMAN: Mainly through publicity.

DR. DIAMOND: Through publicity, yes. And we did have some continuing relationship with the people in Little League because they were very anxious particularly about injury prevention. They wanted to know whether it was safe for a kid to throw a curveball and things like that and we were the only ones who could protect them against suit in that regard, so they were interested in learning from us there. So that would have brought us to probably the 1980s.

DR. SISSMAN: Those are still big problems in kid’s sports.

DR. DIAMOND: Oh, absolutely.

DR. SISSMAN: And I know from my experience with my son, I remember coaches have a dilemma about whether they should play to win or whether they should play to let everybody play.

DR. DIAMOND: Well, with my sons I've found that many people get interested in being coaches and I must say I admire them. They give their time without compensation. But many of them are people who want to live vicariously in either their own son’s or somebody else’s childhood and they forget that this isn't their game anymore.

We had one wonderful coach for some of our kids in football. He was an All-American from Northwestern. And he was coaching because his son was on the team. And he refused to have any kind of an all-star game. He refused to pick a most valuable player. He let everybody play. Never worried about what the score was. And it was just an inspiration to see a man like that who obviously was himself fulfilled. I mean he didn't need to live vicariously. He had had a wonderful athletic career but at the same time it was great for the kids to know that the coach understood the fact that they couldn't execute everything very well.

Now sports medicine, I think, is a specialty for some pediatricians. Some people do it almost exclusively. I think all of us are involved in pre-competition physicals and things like that and you do get a chance to counsel kids.
I did have one child who came in here whose mother was very concerned because he really looked like he was about ready to pass out. I examined him and he was totally dehydrated. I said, “Has he had vomiting?” and she said, “No.” “Has he had diarrhea?” and she said, “No.” “Did anything unusual happen?” Well, they were weighing the football players. So his coach somehow or another had gotten diuretics, I don’t know where, and gave them to the kid. And the kid was absolutely depleted. I mean he was totally dehydrated. Just so that he can weigh under 120 or whatever the cut off weight was and you know it was just obscene really.

We did have a nutrition conference at the Illinois Medical Society once. We studied athletic nutrition. And when you think about they had the kids starve themselves and dehydrated themselves just before a weigh in. Then the kid gets weighed at a certain weight and then the guy on the other team is also doing the same thing. So you have two kids who should weigh 130 who weighed in at 120 and they wind up competing with each other anyway. So the whole thing even from a selfish standpoint is irrelevant.

But I think the Academy has been a positive force in juvenile athletics because we are all seeing kids who are stressed out and brokenhearted because their teammates don't appreciate them, call them out-makers. And of course it's worse when you have the parents there and they say, “You let the team down, you let the neighborhood down, you let the world down by striking out in the last inning.”

About that time I got involved with the Illinois chapter again and became the Illinois chapter chairman, so I didn't do too much at a national level for a while after that. In Illinois, the state chapter chairman had to serve for three consecutive years. So that was a job, which was a complicated job because we had several committees, of course, in the state chapter as well as the national chapter.

DR. SISSMAN: What years were those?


DR. SISSMAN: There was some conflict?

DR. DIAMOND: Yes. They were trying to come up with a plan for child health. In other words, a plan that would be prescribed, written down; every need of children anticipated medically, personnel, facilities, and so on. So we spent most of those three years coming up with that state master plan and every one of the chapters was supposed to come up with a similar plan.

DR. SISSMAN: Including well-child care?
DR. DIAMOND: Yes. It was a comprehensive plan.

DR. SISSMAN: Bureaucratically inspired?

DR. DIAMOND: Yes. I'm sure it was a condition of federal funding. I think there was more of a preoccupation then with a shortage of medical care and how can we best utilize personnel; how can we use physician extenders; how can we somehow or other reach the underprivileged or the uninsured? This was, as you say, largely bureaucratic. But the Academy, I think, got a rather large grant to study this and so we all joined in and I think the material that we produced was good. It brought us into close contact for the first time with the people in public health. You know the kind of health planners. They were of a different ilk. You know, they were a different psychology but they were necessary.

DR. SISSMAN: Not necessarily MDs.

DR. DIAMOND: No. They could have been almost anything. PhDs in sociology and things like that.

But those were a very good three years and it was a chance also to do a lot of planning for CME [continuing medical education]. I gradually got very interested in CME and began to do that at my medical school as well. But pediatricians are hungry for information. I mean they're gluttons for education, so you never had to inspire pediatricians. You know, it wasn't like the surgeons who were missing the operating room if they went into a meeting. Pediatricians were looking for a reason not to go to the office. [Laughs]

DR. SISSMAN: So this was a time for developing not only courses of meetings, but distributional material?

DR. DIAMOND: Yes. Educational material.

We had another committee that I belonged to on the national level which was the emergency and disaster committee [Committee on Disaster and Emergency Care], which actually just existed long enough to produce a manual for emergency care. The man who was chairman was a man named Ralph [H.] Kunstadter, who you may have heard of. He was a fascinating man.

DR. SISSMAN: Where was he from?

DR. DIAMOND: He was from Michael Reese.
DR. SISSMAN: That was in the Illinois chapter?

DR. DIAMOND: Yes. And Ralph was a man who kind of initiated some of the earliest neonatal intensive care units and things like that. He was a wealthy man and a kind of “man for all seasons.” You know, a big game hunter and things like that. He was just a wonderful person to spend a day with, really.

In fact, if I can digress for just a minute to tell you a short story about him. He went hunting for tigers. You could go to his apartment and he had pelts and heads all over the place. He went hunting tigers in India and he was up in a tree because that was the way. You tied a gazelle to the base of the tree and then you waited up there with a light for the tiger to attack the gazelle and then you would shoot the tiger.

DR. SISSMAN: It sounds like an unsporting way to do it. (Laughter)

DR. DIAMOND: Yes. Oh, you would never have gotten past the animal rights people now. But he said he had only been up in the tree for about 20 or 30 minutes when his guide grabbed his chest and moaned and died in a corner up in the tree. (Laughter) So now he’s up in the tree expecting a tiger and he doesn't know what to do next. Anyway that was a digression but that would tell the story.

DR. SISSMAN: That was in the '70s?

DR. DIAMOND: Yes. Well, that committee produced, I think, a very good emergency room manual for pediatrics. Because most emergency rooms were not thinking about kids so much as trauma and sudden acute cardiac episodes and so on.

DR. SISSMAN: I still see that, actually, in some small hospitals where emergency rooms see children but it's not run by anyone has any familiarity with children.

DR. DIAMOND: Yes. That's right.

DR. SISSMAN: Non-emergency things. Fevers.

DR. DIAMOND: And if they are fortunate they have pediatricians on the staff, but often as not they may be dealing with primary care physicians who don't really know much more than the emergency room physicians.

DR. SISSMAN: I am on a child fatality review board in New Jersey and, unfortunately, every couple of months you see a child who fails to survive who should have been referred to a pediatrician.
DR. DIAMOND: Well, I think now that it's probably part of the training of emergency room physicians, who are now, of course, much better trained than they were 20 years ago. It's kind of interesting what has happened to careerism among medical students. We almost consistently at Loyola got about 20 percent of the class in pediatrics. It didn't change much. And most of them stayed with us although some went to Children's [Memorial Hospital] and other Chicago places like that. But, gradually, the medical students seemed to have a different psychological profile. They began to be more interested in what they called “lifestyle specialties,” so that you found students who were interested in dermatology, for example, because there were no emergencies in dermatology. Or they were interested in radiology. They really felt, and they probably were much smarter than we were, that they had to think about their private life and that commitment to neurosurgery or something like that was going to compete with their ability to enjoy themselves. So now, I think, probably the most competitive residency in Chicago is a residency in dermatology. And when we were in school we weren't sure that dermatology was respectable, you know. (Laughter)

DR. SISSMAN: And radiology.

DR. DIAMOND: That's right. It was something sometimes you did when you were older or sicker than a practitioner.

DR. SISSMAN: That's still true with medical students, right?

DR. DIAMOND: Yes.

DR. SISSMAN: Have you got any solutions for that?

DR. DIAMOND: I have always, not always but since I was a member of the admissions committee at the medical school, been a little bit uncomfortable with the process. I think to be realistic it's all numbers. The first part of the admissions process is all numbers. It all MCATs [Medical College Admission Test] and GPAs [grade point average] and I think what we were getting almost exclusively were kind of obsessive-compulsive, overachieving, hard-working, but not necessarily humanitarian types, if you know what I mean. They were scientists. They were physician-scientists, but not physician-humanists, and it is very difficult to evade that process. They do of course show an interest in the person outside work. Is he working in a hospital when he’s a kid? Or what are his extracurricular activities? But I think that the final analysis, what you get is a kind of self-preoccupied, very bright, overachieving type but not necessarily somebody who we would say is the best person to be a physician.
DR. SISSMAN: Do you have any solutions for that?

DR. DIAMOND: Well, you know Lewis Thomas wrote some wonderful things about how to prepare medical students. And he thought we should change the curriculum from a complete emphasis on chemistry and biology and include a lot more philosophy and ethics. He thought we ought to, and I think we eventually haven't as far as I know, require as part of the MCAT that the individual be able to write something. Not only solve problems but express themselves. And I think that was very valuable because what people usually complain about in their physician is not that he doesn't know what he's doing, because most physicians now are so well-trained—five to seven years of training—they know exactly what they're doing. But they don't communicate. “They don't know how to talk to me before the surgery or after the surgery.” They don't know how to relate to what's going on outside of the illness within the family, that kind of thing. So I think we still haven't solved that problem.

DR. SISSMAN: You think you do it by training? I mean having courses on medical history?

DR. DIAMOND: Yes. I think that certainly should be part of training. I think that’s a step in the right direction. But I think, to me, the real solution is getting a certain kind of person in to start the training. And recruiting people into medicine.

DR. SISSMAN: You mean the teachers?

DR. DIAMOND: The teachers and also the students. We used to take about 125 candidates from 6000 applicants and of course they were all applying everywhere so that wasn't a true reflection. But the people on the margins, the people who almost made it; you know the people who were on the waiting lists and things like that. A lot of them were great people, just great people. Dedicated kids. And the many of them, of course, would keep up and take a masters in biochemistry or something and never give up, and finally get in way on down the line.

We had an old anatomy teacher at Loyola, who later became a dean, and he said he would like to start a medical school and take only students who had failed to get in anywhere. He felt that he wouldn't be taking dumb kids, he would be taking the kids who were not quite smart enough and he felt that he could make performers out of them. And I think he's right.

DR. SISSMAN: Of course, I think that it seems to get harder and harder as the extent of scientific knowledge expands. And it's really hard to keep a balance.

DR. DIAMOND: That's right. The body of knowledge is just
overwhelming.

DR. SISSMAN: When I read medical literature now it's like another world from what we learned what we were in school.

DR. DIAMOND: Yes. Well, I think that in the medical school I did most of my teaching at the bedside. Now in the medical school, even in the basic science classes, they don't even go to lectures a good deal of the time. They just go to a computer and they have a canned program and that's the way they learn, which I think again tends to make them more physician technocrats and not necessarily people-oriented. But, as you say, there's no way to avoid it. You have to have a fellow who can somehow absorb the tremendous challenge of what he has to know.

But, I think, that that is partially being solved by sub-specializations so that the individual decides that I'm not going to try to know it all; I'm going to try to know just a very little corner of the world and know it very well. One of my sons is an interventional cardiologist. He's in another world. I mean everything he does is with invasive machines and things like that. But I think he's a good doctor, I mean I think he still likes people.

DR. SISSMAN: The patients still need to be talked to before and after those things.

DR. DIAMOND: Yes. That's right. But when I was at the University of Chicago you can imagine this institution, which was one of the great ivory tower institutions in the world. We had no subspecialists by training except for Douglas Buchanan in the neurology. Everybody else had to take the general pediatric service and then they would do their own thing in their own lab, cardiology and that sort of thing. But there was no such thing as somebody saying, “You're a general pediatrician and you'll see all the patients and we will accept your referrals after that.” And that was a long time ago, but I think there is a certain value in versatility if it’s practical.

DR. SISSMAN: Well I was a pediatric cardiologist myself and so I know some of the problems. But we made rounds and we always took a month of general service.

DR. DIAMOND: That's great. Where did you practice?

DR. SISSMAN: Well, I taught. I was at Stanford [University] for 12 years.

DR. DIAMOND: Oh really.

DR. SISSMAN: And I trained at [Johns] Hopkins [Hospital] with Dr. [Helen B.] Taussig as a matter of fact.
DR. DIAMOND: Oh, yes. [Norman E.] Shumway, was he out at Stanford? He was kind of the nonpareil as far as cardiac surgery was concerned.

DR. SISSMAN: That's right. He came to Stanford out of his resident fellowship. And I always thought of him as sort of the Willie Mays of cardiac professors. He could do anything well the first time. If he had never done an operation before he could do it. That was before he became a transplantation person.

DR. DIAMOND: I remember we had some business at Loyola. Who was the South African fellow who did the first cardiac transplant? [Christiaan Barnard] Well, anyway, he said that I talked to a fellow who was with him at the Groote Schuur [Hospital]. They were trying to find a candidate. This fellow was an internist and he was qualifying candidates. Anyway he said, "If Shumway beats me I will kill you." (Laughter) That's what he said. Really, he learned everything, I’m sure, from Shumway and then kind of cheated him out of the distinction.

DR. SISSMAN: Well, as an aside, Shumway did a lot of the basic animal work that made the path easier.

Well, you also had been very involved with the bioethics committees and so forth. That started about the same time?

DR. DIAMOND: The Committee on Bioethics started in the early ’80s. It was in response to a lot of ferment within the Academy about various issues: abortion, contraceptives for teenagers. There also were a lot of financial issues that brought justice and fairness into play. There were practice issues. So the administration saw a need for a committee first. They appointed a committee that was pretty well balanced between practitioners and also kind of what you would call the professional ethicists. Norm [Norman] Fost was on that committee and Bill [William G.] Bartholome. Bill Bartholome took a course at the Kennedy Institute [of Ethics] and Norm Fost got a master's in ethics. And they had a little bit different approach to ethics then we did, but I think it was a good mix.

DR. SISSMAN: Do you know who initiated that though? Who was the sort of guiding force to setting up the committee?

DR. DIAMOND: It was somebody in the administration. I'm trying to remember who would have been the president at that time. I mean the executive director at that time. I think Bob [Robert G.] Frazier would have been gone by that time.
DR. SISSMAN: Was it [M. Harry] Jennison?

DR. DIAMOND: Yes, Harry Jennison. That's right.

DR. SISSMAN: He was from Palo Alto.

DR. DIAMOND: Is that right? Yes, Jennison was probably the one who started the committee.

The committee very quickly was involved in the Baby Doe and Baby Jane Doe controversy. That happened almost immediately after we were formed. And of course that was suddenly a national issue. But I think that probably if you look at all of the old pediatric surgical books, [William E.] Ladd and [Robert E.] Gross and those old books, if you examine them they say if there is an upper gastrointestinal obstruction you do such and such unless the baby has mongolism, which they called it in those days instead of Down's syndrome, in which case you don't do anything. So it was kind of a dirty little secret that this was going on.

Bill Bartholome was at Hopkins at the time that the original Baby Doe was in the nursery. He was an MD. But his being involved in that case, I think, inspired him in the direction of becoming a full-time ethicist. He didn't practice pediatrics after awhile. And Norm Fost was very bright; and the thing that was admirable about Norm was that he was fully prepared to admit that there were two sides to every question. The one side on which he came down very strongly. But on the other hand he did not want to foreclose discussion of things on which there had already been a policy developed. So I admired him very much.

I can't remember who else was on a committee. Reed Bell was on that committee. The chairman was Bill [William] Weil, he was from Michigan State [University]. So those were the principal issues we discussed in that committee early on. The Academy kind of was on both sides of the Baby Doe issue. There was a tremendous amount of turmoil. Their original position was that they concurred in the actions of individuals who did not provide surgical care for children with duodenal atresia and disabilities.

DR. SISSMAN: So they supported non-intervention.

DR. DIAMOND: Nonintervention, right.

End of side B.

Tape 2, Side A
DR. DIAMOND: So I think eventually the Academy's position became an exemplary one, largely through the influence of Koop, [C.] Everett Koop, who was the chairman of the Section on Surgery at the time. I think he probably was the founder of the surgical section of the Academy. He was, of course, as you know from his public career, a very persuasive, charismatic kind of fellow. A typical surgeon, I guess.

The AMA [American Medical Association] took the position that the decision should be made by the parents. So the Academy, I think, said that if surgery is indicated, what should be done is what is in the best interest of the patient rather than the whim of the parent. That was the Academy's position. But the AMA had, I think, the wrong position. They were going to give to the parents more than parents were entitled to. For example, if a Jehovah’s Witness parent said, “I don't want my child to have his appendix out because he might need blood,” you would go to court and have a temporary guardian appointed to give permission for the appendectomy. And this was a similar situation. There was the element, of course, that the child was going to wind up with other handicaps, but I think the final position that the Academy took was a very good one.

DR. SISSMAN: That was before the Baby Doe case?

DR. DIAMOND: No. That was after the Baby Doe case.

DR. SISSMAN: I remember even Shumway would question whether he should close a patent ductus in a child with Down's syndrome.

DR. DIAMOND: Yes. Yes. That's right. And I think it was before the people like "Not Dead Yet" and the militant handicapped rights people. About that time Section 504 [of the Rehabilitation Act of 1973], I think it was, mandated that every child with a handicap should get an education depending on his level of comprehension, depending on whether he could get to the classroom or not. But the local school boards were suddenly confronted with Section 504, and the necessity of making allowance somehow or other for every child to be educated, even children who were severely mentally retarded and severely handicapped. That was a federal regulation.

DR. SISSMAN: Was [Edward] Kennedy involved with that?

DR. DIAMOND: It probably was during his time. Yes, yes. And of course all the school boards said, “We can't afford to do that because it will detract from the quality of education for normal people.” But there was some federal funding attached and eventually that, of course, has become the standard.
The Baby Jane Doe case came after that and I think the Baby Jane Doe case pointed out that sometimes poor diagnosis is an element in bad decision-making. We have a very large center here for meningomyelocele. David McLone at Children’s Memorial.

DR. SISSMAN: At that time or now?

DR. DIAMOND: Now. And at that time it was there but smaller. But his position on meningomyelocele is that you operate on all of them and you operate on all of them right away unless there meningoencephaloceles. And his outcome was absolutely superb. I mean they are community ambulators. They went to school, with braces usually, but their psychometric scores were better than the control scores. So that was our experience in Chicago with this problem. It was very well handled and Dave McLone was a super surgeon as well as very much a humanitarian. So when the Baby Jane Doe case came out and they decided really on the basis of very bad information.

DR. SISSMAN: What was that?

DR. DIAMOND: That was the case up at Stony Brook [University Hospital]. The child had a lower meningomyelocele. And the first consultant who was saw it, who was not the neurosurgeon, but was the pediatric consultant, gave a prognosis that was very unrealistic, very grim. He said the baby would never be able to talk; he would never be able to stand. In other words, he kind of wrote him off as a hopeless case. As a matter of fact they didn't operate, and if you don't operate early than they get infected and then the outcome is terrible. But this baby survived and survived with problems it need not have had. The neurosurgeon from the beginning said, “I want to operate on this baby,” but he was overruled by the pediatrician, which is very unusual for the academic community, as you know.

DR. SISSMAN: It also shows you the kind of the problems with parental decisions because they are so influenced by what they are told.

DR. DIAMOND: Yes. And that's why I thought the AMA's position that the parents should make the decision was wrong; parents don't make these decisions independently. There's a friend of mine who is an attorney who was on the civil rights commission and he investigated many of these Baby Doe-like situations. And he said the decision made in almost every instance was the decision of the operating surgeon, not the decision of the parents because they were usually referred to a place where they knew nobody and it was kind of an ivory tower. And they were influenced in decision-making by the decision of the surgeon, which was also not to operate. Not to operate for socioeconomic reasons rather than surgical reasons.

So that whole issue, of course, still occupies the stage in pediatrics and
elsewhere. I think Koop kind of dramatized it when he became surgeon general. He was a very talented surgeon so he said in his hands duodenal atresia had about 95 percent positive outcome. So we finally had a meeting sponsored by the bioethics committee in which we gathered together people who were kind of experts on Down's syndrome rather than experts on surgery for newborns. And there was Jerome Lejeune who discovered the 47th chromosome. And George Smith who was in our department and Norm Fost was there.

DR. SISSMAN: This was after Baby Doe?

DR. DIAMOND: Yes. Ira Rosenthal from University of Illinois and the chief surgeon from Children's Memorial, [J. G.] Raffensberger. What we produced was a document that said how should a child with Down's syndrome be managed in general.

DR. SISSMAN: That was just devoted to Down's syndrome?

DR. DIAMOND: Yes. All these people were, particularly Jerome Lejeune was probably the greatest international authority and George Smith was probably the greatest national authority. And the conclusion we came to is that he should be treated like anybody else. We wouldn't of course do dramatic reconstructive surgery on him but if it was an operation with a low mortality then it should be done. And some move should be made to point out to the parents that the community would help them in raising this child in the future. That they wouldn't just insist that you save him and then leave him as a burden on the family. But somehow or another the community, through some social agency, would help them to take this added burden.

DR. SISSMAN: And sometimes financial burden, too.

DR. DIAMOND: Financial burden, too, and then the financial burden of expanding educational opportunity, which was a community wide burden. So I enjoyed that. I think I was on that committee for about four years and I was so interested in the subject and in continuing to be a part of it at the Academy that we applied to form a Section on Bioethics. There’s a certain amount of territorial interest on the part of committees not to have sections competing with the committees. So the bioethics section wasn't formed with the approbation of the bioethics committee, but eventually we did get it through the committee on sections.

DR. SISSMAN: The underlying reason for that was?

DR. DIAMOND: Well, see the bioethics committee used to make position statements. Like they would make a position statement on Baby Doe or a position statement on the care of the handicapped. They felt that policy
should be their domain and that they should be making recommendations to
the Academy hierarchy on policy. We basically didn't disagree with that, but
we felt that the section—just as there is a surgical section and just as there's
a surgical committee—the section should be devoted to educating the
membership. We should be sponsoring meetings at the spring meeting and
at the annual meeting rather than putting out policy statements or edicts.
We were going to educate the population of the membership, which at that
time and even now, I think, is very inadequately educated about bioethical
issues.

DR. SISSMAN: That was the late 1980s?

DR. DIAMOND: Yes. And we felt also that as much as we admired
people like Norm Fost and Bill Bartholome that there really was clinical
ethics that you can only learn by taking care of patients and having a feel for
the family dynamics and things like that with. We didn't feel as though you
could come up with decrees to handle this sort of situation. Norm Fost was
also a clinician, but some of the professional bioethicists are not clinicians. I
have a very good friend, Mark Siegler, who runs the bioethics department at
the University of Chicago. He's a very wonderful bioethicist but I don't
think he's a real down-to-earth, clinically oriented man. But some of the
other people who do ethics are people who are not physicians at all. They are
PhDs in something or other, because nobody has ever described the limits of
bioethics.

What is bioethics? Mostly they are people who were doing ethics in another
context and decided that they had the answers for clinical ethics, which, I
think, is presumptive. But the section now, I think, has taken over that
function and I think it's doing it well. Joe [Joseph R.] Zanga is now the
chairman of the section. And they have a time on the program at the spring
meeting and the annual meeting and they make this available to whoever is
interested. And I think there is a real interest among the rank and file.

DR. SISSMAN: The decisions seem to be getting more complex as we
know more about genetics.

DR. DIAMOND: Yes. That's right. A lot more prenatal decision-
making. Yes. And then of course there is the ability to handle a lot more
problems that would have been uniformly fatal, so you have a decision to
make about therapy which wouldn’t have been necessary in another era
because there wouldn't have been any effective therapy available.

DR. SISSMAN: Many more factors.

DR. DIAMOND: Yes.
DR. SISSMAN: So it sounds like the committee at least had a lot of disagreements as it went along within itself.

DR. DIAMOND: Yes, we kind of broke down into unequal parts, I think, on most things but I think it was basically good-natured. I don't think there was any hostility in that committee to speak of. There may have been at the administrative level because as you remember with both the Baby Doe and Baby Jane Doe cases, there was public scrutiny which went on and on and on for months. It was an issue that doctors had kind of taken for granted and then suddenly they found with public scrutiny that the public was not comfortable with what had become routine management of these cases.

DR. SISSMAN: Were you personally pretty happy with the decisions that were made then and the stands that were taken?

DR. DIAMOND: I think I was happy with the way the Baby Doe case came out. I was not happy subsequently with some of the positions that the Academy took on abortion. I think they pretty much underwrote the abortion on demand position. When I was president of our local chapter we took a kind of bioethics poll. The administration didn't like polls; they thought they were divisive. I don't think they are divisive; I think they bring people together. They let everybody express themselves. One of the questions we asked was the management of Baby Doe type cases and we found out that the practicing pediatrician, in contrast perhaps to the pediatric surgeon, was all in favor of therapy and the pediatric surgeon was not. As far as the issue of abortion, it broke down pretty much into maybe 30 percent were against all abortions, 30 percent were in favor of all abortions and maybe 40 percent were in favor of some restriction on abortion. Rape, incest, the life of the mother, that sort of thing. So there really was a diversity in the Academy that was not being reflected in their public position.

I think that carried over into the issue of whether or not we ought to be pushing contraceptives for unmarried adolescents. The notion was that this was a way to prevent unwanted pregnancies, prevent abortions. I don't think it did that. I find in my own practice, and I think it is generally true, that when the mother comes and says, “I think that Gerty should have the pill,” you find out that Gerty is involved in some very self-destructive behavior. You know, she is being exploited by boys. More often than not she is an unattractive girl who is trying to be socially successful and if you put her on the pill she won't take it anyway; she won't be compliant. And now she's got kind of a tacit approval from her parents to be sexually active and so I think she is more likely to get pregnant. That's my opinion.

That's a very inflammatory issue. But the Academy, I think, initially didn't handle this well. They endorsed all kinds of sex education, including that which pretty much was values clarification, you know: decide what you want.
to do and do it.

I was never comfortable with the notion that adolescents should make decisions independent of parental knowledge or consent. That always bothered me. The Academy was strongly in favor of adolescent privacy; in fact, Bill Bartholome was one of the leading advocates. You know, it was always my opinion that if parents are going to pay for the office visit then they ought to know what's going on. The child does certainly have, given his age I suppose, the ability to make some decisions on his own. But a decision like whether or not I should take the pill, or a decision about whether or not I should have an abortion, is a decision that will have tremendous ramifications. And I certainly want to know what my daughters are being prescribed without having to go through some kind of legal process to find out.

I think now the Academy is coming around to the fact that there are other ways to do it. Abstinence training is another way to do it. And there's more diversity now in the way the Academy is handling ethical issues. As you know, the recent statement they made on homosexual adoption has caused all kinds of ferment and protest.

I think the Academy is better off when they make policy through the chapter chairman's forum [Chapter Forum]. Chapter chairmen are elected by their peers. They know the territory or should know the territory. I knew what people thought when I was state chapter chairman, what the people of Illinois basically thought and wanted. I think I did; at least by the end of my third year I did. The committee, on the other hand, could be kind of insulated. Committees are appointed by the staff. Appointed more often than not to give a certain balance to different points of view rather than to give the rank and file's garden-variety view. So if you're going to make policy I think you ought to make it at the state chapter chairmen's forum, where it can be debated. Where the people are known to and respected by their peers and, I think, come up with decisions that are pretty representative of what the rank and file think. I think when committees make decisions they are limited by the accident of the six or seven people who may be on the committee, who may not be representative at all of membership.

DR. SISSMAN: Even though statements have to be approved by the executive committee.

DR. DIAMOND: Yes. Well, that's right. But it's my impression at least when I was on the bioethics committee, and the other committees, that the executive board is inclined to believe that the people with special expertise on these committees are competent to make decisions. So I don't think they overrule them too often. And that's probably not unjustified, to figure that a group of people trained and interested in a particular subject would know
enough to make a decent statement.

They’re also very concerned about the political implications of statement that are made so the Academy wants a certain image. I think that what they want is—what does it say on their literature? They are interested in all children from the awareness of their conception to the 21st year. They are interested in children in all their dimensions. They’re child advocates, and the child advocates position is, I think, the position the Academy should take. And they should be really insulated against what the political implications of what child advocacy amounts to. The last thing politicians want to do, I think, well in this state, is to go against children. I don't know whether you know much about Illinois, but our governor [George Ryan], is perhaps, even in my long lifetime, the most dishonest politician I've ever run across. And he is going to go to jail eventually, it is just a matter of time. But to popularize himself with the state, he instituted what was called Illinois FIRST, which was a billion and a half dollars worth of pork. Everybody got a swimming pool or got a new village mall. And not exactly unexpectedly, we now have a billion and a half dollars worth of debt that we can't handle in the state. I shouldn't be getting into political issues, but in any event the reason that I brought this up is that one of the lowest priorities is Medicaid funding. So it's children who don't have advocates in general, besides people like the Academy, who get squeezed out in the political process. And I think it's very important for the Academy to remember that. There aren't very many professional child advocates around outside of the Academy of Pediatrics. And I think the AMA in general has lost their interest in child advocacy, because they are in general deferring to specialty organizations to do things for their particular clientele.

DR. SISSMAN: There is something called the Children's Defense Fund, which claims to be a child advocacy organization.

DR. DIAMOND: Yes, right.

DR. SISSMAN: Is this the governor who has put a moratorium on executions?

DR. DIAMOND: Yes. He has put a moratorium on executions, and he has become very popular doing that, of course. And I think it was a courageous thing for him to do. On the other hand, I shouldn't be getting partisan on the tape; but I think he did a certain amount of it to distract from his other problems. The fact that he was under tremendous pressure from his constituency because of some of the things that he did with campaign funds.

DR. SISSMAN: I know that one of the outcomes of the Baby Doe case, including Academy recommendations, was hospital review boards. What do you
think of those in retrospect?

DR. DIAMOND: I think that the conception of a hospital review board was an excellent one. And I think both the bioethics committee and the bioethics section endorsed them. The question was how much power is invested in the board when decisions are being made? In other words is the hospital review committee appellate review; is it a decision-making organization; or is it just an advisory group that doesn't really intervene between a physician and his private patient? I think that they should have some power. I think that they should have the same kind of power that institutional review boards have. For example, when you want to do a study in cardiology at Stanford, the institutional review board would tell you whether you were following the protocol appropriately. And those kinds of institutional review boards always had power. The institutional review boards in the perinatal period, I think, were a very spotty thing. In some places they were very powerful. In other places, they were consigned to a merely advisory role and ignored.

DR. SISSMAN: The concept was to be an advisory group?

DR. DIAMOND: No, the concept, I think, was to be a participating group to bring together expert opinions. In other words, to broaden the base of opinion-making and decision-making. Even getting, of course, parents involved. The members of administration would be involved. If there were a pastoral group in the hospital then they would be involved. So, to diversify the decision-making.

DR. SISSMAN: So you would have laypeople from the community.

DR. DIAMOND: Yes. And I think the concept was good. I think, probably in general, it has been successful. I think in some places it became window dressing. They became, "We have one." The JCAHO [Joint Commission on Accreditation of Healthcare Organizations] came around and said, "Do you have such a board?" "Yes, we do and, yes, they meet regularly." But as far as really having decision-making power, I'm not sure that they actually did. But I think it was a great idea.

DR. SISSMAN: Does Loyola's hospital have such a board?

DR. DIAMOND: Yes.

DR. SISSMAN: Do the neonatologists use it or refer to it?

DR. DIAMOND: Yes, they do in very difficult cases. More often than not they are cases of very low birthweight infants and cases like that. But, I think Loyola's review board has been a good board and an active board and
a respected board. But I have heard of other kinds of boards in other places where they don't have much power.

DR. SISSMAN: From my experience, decisions often have to be made within certain time limits. You can’t wait to ask a board. We had a problem a few years ago. I was in New Jersey at the Robert Wood Johnson Medical School recently where residents are called up in the middle of the night when a 700g infant is delivered. They have to decide right away what to do. Many of them felt kind of overwhelmed by that problem of making a decision.

DR. DIAMOND: Right. I think that is quite true, that the decisions are sometimes urgent decisions that particularly an inexperienced person would feel adrift if he had to make it. And not only make the decisions, but deal with all of the intermingling family consultations that go with it and explanations of why we are withholding or why we are providing care. It's a very complicated business. However, I don't know what your experience is, but the other kinds of institutional review boards that evaluated research protocols were very powerful groups. There was no possibility that you could be a naysayer. There was no possibility that you could proceed with the study if they say the study was not an ethical study. They kind of had the final say. I think particularly among surgeons they don't like people deciding when they can operate or if they should operate. I think they are sometimes less susceptible to this kind of input.

DR. SISSMAN: Our neonatologists always told the residents keep the baby alive. We will make the decision, if one has to be made, the next day.

end of side A.

DR. SISSMAN: Side B of tape number 2 of an interview with Dr. Diamond. We were talking about the necessity for rapid decisions both by residents and families.

DR. DIAMOND: Our chairman of neonatology, who was a very practical fellow, I think he was not somebody who was a ideologue or anything like that, but what he told our residents was that we try to resuscitate everybody. If we are successful then you know that was a viable patient and if we're not that it was a pre-viable patient. This means that there is a whole lot of unsuccessful, frustrating expenditure of energy, time, and money. But I think that it really is a wonderful way to approach the problem.

I remember looking at statistics from around the country when the bioethics section was investigating this question of very low birth weight infants. And the outcome for a 750g baby at—let’s just say for example, this is not my recollection—the University of Alabama, the salvage would be 0 percent. And at the University of Tennessee, the salvage would be 20 percent or
something like that. Well, what does that mean? It doesn't mean that they are more successful than the University of Alabama; it means that the University of Alabama is not trying. They are weighing the baby and saying, “750g, we're not going to do anything for this baby.” So the decisions are often practical ones.

But I think that our record with very low birth weight babies at Loyola is astonishingly good. And we've also had large grants to follow these children up until they get to be school age and beyond. And the outcomes are not bad as far as serious neurological handicap. Now, there is an increase in the number of children who have learning disabilities, not severe ones, not mental retardation; but they do have learning disabilities. They have ADD, they have other minor problems—you might say, minor to a statistician, major to the parents. But the outcomes are not as bad as you would have expected from the projection of anoxia, ischemia, all these things that may compromise central nervous system functioning.

DR. SISSMAN: I just noticed when we had a break that you were the president of your medical school class?

DR. DIAMOND: Yes. We had a very close class. We were a postwar class and we were, I think, very congenial. I think the president was not so much an official as somebody who had the affection of his peers. That's the way I always interpreted it. I liked everybody in the class; I didn't dislike anybody. I didn't feel as though there was anybody that would not be a friend for life. It was an unusual class from that standpoint.

DR. SISSMAN: There were four women, I counted.

DR. DIAMOND: Yes. Now Loyola is about 50 - 50. I don’t know how Stanford is.

DR. SISSMAN: Yes, about that.

DR. DIAMOND: I don't think that's happening without a little bit of affirmative action for women, which is understandable considering what it was in the past. It was almost impossible for a woman to get into class when I was starting to medical school, I'm sure. Unless she had some very rare talents.

DR. SISSMAN: Do you still have reunions?

DR. DIAMOND: We do. We just had our 50th. I think that the morale of an institution is extremely important in determining how the medical students feel about each other. I remember when I was in the service I was on shipboard and I looked at the table of organization and it said that the
captain of the ship has only one duty, that's morale. All other duties are assigned to other people. And the leadership of the medical school should really make a lot of effort not only to upgrade the quality of the teaching but also to establish morale, establish identity with and even an affection for the school.

The University of Chicago had that. It was just remarkable. Everybody felt, "I am at one of the great universities." It was almost incontrovertible. I remember going to lunch—I told this story all the time—I went to lunch and I looked around there was only one empty spot at one of the tables. I sat down and when I looked up I was sitting with three Nobel laureates. Well, that helps in building morale of course. But the Marine Corps was great at building morale. “We are an elitist group.”

It's hard for a place like Loyola, which was for many years very impecunious and struggling to survive, to build morale. I think the people at the top are the ones who should do that. Morale, for me, came from a student health officer who was a fellow named Herb [Herbert] Ratner who was just a fabulous individual. He was part of the original Great Books group at the University of Chicago when [Maynard] Hutchins was there and he wrote the scientific section for the Encyclopædia Britannica. He was a fellow interested in public health and he was absolutely my mentor. He remained my mentor for as long as he lived, which was until fairly recently. He was just a man who taught you how to think. He didn't have any preconceived notions. He hated it if you agreed with him consistently. Then you would not be his friend. He liked to be provoked with disagreement. He was a great Socratic teacher from that standpoint.

DR. SISSMAN: He was at the medical school?

DR. DIAMOND: Yes. He was a student health officer at the medical school. He was also the health officer for a local community so he was a public health guy; he did both of those things. He was responsible for the morale.

I would say otherwise that the quality of teaching is important. I think in teaching, you don't have to be a buddy to the student but you have to have an affection for the students and you have to be able to educate them. For example, I remember at the University of Chicago the person who did the most for making me a good teacher—if I was a good teacher, and I got student awards for being a good teacher—was a man named Douglas Buchanan. Dr. Buchanan was a neurologist. He was a very taciturn Scot but just a fabulous clinician. An unbelievably talented clinician, I mean, you never stopped writing when he was lecturing. Everything he said was a nugget, you know. And that kind of teaching, I think, helps to build morale.
But I think now it seems that the bottom line is everything. How much money are we making? That, I think, is very unfortunate particularly for pediatricians. Joe Zanga was my resident when I was chairman and now Joe is the chairman. Pediatrics departments everywhere, maybe not at ivory towers like Stanford or Johns Hopkins, but everywhere they are underfunded. And it isn't because we are paranoid that we are underfunded. We just don't make money and therefore they always figure that you are not the priority as compared to the cardiac surgeons who are realizing big profits. So we have had a kind of revolving door of chairmen at Loyola and that's because they expect to be able to cost account every department. They expect that every department will be self-sufficient and that's hard to do in pediatrics. Pediatrics is by its nature an outpatient specialty. It's very, very hard to make money off a pediatrics department.

DR. SISSMAN: I get the impression that students aren't as respectful any more of the older, tougher type of instructors.

DR. DIAMOND: Yes, I think that's right. They are, I think, overly impressed with technicians. They are overly impressed with subspecialists. I was on-call in the emergency room and I saw a patient with meningitis in the emergency room. This was a while ago, before Hib vaccine. I was going to send this to Loyola before admitting him to the community hospital because I wanted the students to have the opportunity to take care of this case with my supervision. By the time I got there, they had referred him to about six different subspecialists. The infectious disease man, the neurology man, the surgeon to do a cutdown. I said, “What is this? You know, I have wasted this case. Nobody is learning anything from it except the subspecialists.”

I think even my son is inclined to refer much quicker than I am because that's the way he was trained. He was trained to be a basic pediatrician; whereas when Loyola was just opening we didn't have a nephrologist. So for some reason the first year I was on the inpatient service we have several nephrotics. So I had to take care of the nephrotic with the help of the adult nephrologist. You had to really be multi-talented. I've never changed in my practice in pediatrics. I've always felt fairly self-reliant. Of course, I don't do anything that puts patients at risk. On the other hand I don't feel that I have to refer every patient that comes in with acne, for example, as some people do. They refer everyone to a dermatologist.

So I think that you're probably right that the graybeards in the institution are thought to be unrealistic more than incompetent. But I always remember at the University of Chicago they had a nice old gentleman named Levy, who was a retired ENT man and he was just kind of kept around because he was so bright and such a good teacher. And we had this mystifying case that came in with recurrent meningitis. We knew he had a hole in the dura somewhere, but nobody could find it. Dr. Levy had time on
his hands so he was able to study the x-rays and he found a crack in the labyrinth that nobody else could find. That's why it's so wonderful to have older physicians, not only with wisdom, but also with the time to use that wisdom on the particular case.

DR. SISSMAN: Do you have any advice for the Academy about how to proceed in these times?

DR. DIAMOND: My advice would be to be as democratic as possible. To make all of the processes, processes that allow for broad input and, however you can measure this incident, try to ascertain what the rank-and-file really want. I would recommend that they be as apolitical as possible. It's not always possible because you are dealing with federal agencies and you are dealing with pressure groups that inevitably you have to respond to, but I think that medicine is a profession. It's not a business. The more we can hold onto that, which it's difficult to do, the better off we are.

We are a profession because we profess that we're going to do certain things. We tell the community that and that's the way we're going to be evaluated and measured. That's something that we’re losing now, I think, in medicine, is the professionalism. I know whenever I start talking this way, my younger doctor sons give it the fiddle and, "You're behind the times, Dad." But I think that residuals of that are very important. I think the Academy does a good job of professionalism. I think they do a good job of setting very high standards for particularly things like the Red Book [Report of the Committee on Infectious Diseases] and their other publications that are used broadly. Those are very expert books. They are very well done. Most of their educational materials are very well done.

DR. SISSMAN: Are there any other people in the past that especially influenced you? I know at the Academy you’ve talked about several. You mentioned several names. I noticed Dr. [James E.] Strain was the president when this Baby Doe case was going on.

DR. DIAMOND: Yes. Dr. Strain was from Colorado. I think he probably was an academician. Excuse me. But on the other hand I think he was like a country doctor in the way he opened up the process and allowed things to really get a full discussion before the position was taken. Initially the administration was run by [Einor H.] Christopherson, who was there for a long time. He was kind of the gentle, strictly, I think, an administrator. He was followed by Bob [Robert] Frazier who was a resident with me at University of Chicago, who I think had a wonderful personality. He was an expert at building community and collegiality. I think that's a skill that is born.

Somehow or other a lot of pediatricians become deans of medical schools and
I think it's because they have this kind of an attitude. I remember at one particular national Academy meeting that I went to, Mead Johnson [& Company] had a little gimmick with their exhibit where there was a lady who would draw your caricature. And while she was drawing my caricature she said, “Oh, this is much more fun than when I was drawing the surgeons last week.” And I said, “Well, why is that?” And she said, “Well, all the pediatricians seem to have such kind faces. They seem to be such nice, gentle people in contrast to surgeons who were saying, ‘Get this done I've got to get out of here.’” So I think there is a psychological profile to pediatricians that includes the ability to run a group as a dean is supposed to do.

DR. SISSMAN: Well, they are dealing with children most of the time.

DR. DIAMOND: Yes. That helps.

DR. SISSMAN: Are you doing some writing currently?

DR. DIAMOND: Yes. In fact I was going to give you a copy of my book. I'll let you carry this away with you. I'll inscribe it for you. This is a kind of a compilation of a lot of things I have done in ethics. The writing that I'm doing now is bioethics. Most of the writing I did early in my career was rheumatic diseases. I was 10 years on the staff at LaRabida [Children’s Hospital] sanitarium. And in those days LaRabida sanitarium was almost entirely occupied by kids with rheumatic fever. Now rheumatic fever is practically extinct, of course.

DR. SISSMAN: Those institutions were great places to learn auscultation.

DR. DIAMOND: Oh, yes. Wonderful. I would bring students in there and I could say, “I will give you six mitral stenosis cases to listen to this morning.” But my very good friend Burt [Burton J.] Grossman, who was in my resident class and then became the director of that institution, used to lament to me later in life, “I'm a specialist in an obsolete disease.”

DR. SISSMAN: Well, this is just for the tape. It's *A Catholic Guide to Medical Ethics* by Dr. Diamond, and it was published last year by the Linacre Institute.

DR. DIAMOND: Yes. The Linacre Institute is kind of a think tank, an ethical think tank.

DR. SISSMAN: Good. Thank you very much. I have to ask you a somewhat provocative question. You are very amiable in this interview. When I read your book, *This Curette for Hire*, some of it didn't sound so amiable.

DR. DIAMOND: No. That's true.
DR. SISSMAN: Has that changed with the years? Is your writing persona slightly different than in practice? Or is that an unfair question?

DR. DIAMOND: No, that's a very good question. I remember reading a book a long time ago about a doctor in Brooklyn, called *The Last Angry Man* [by Gerald Green]. Do you remember that? He was angry most of the time and taking on the world most of the time. I think that is probably a weakness of mine. To be maybe too combative. I try to respect the people I disagree with, but on the other hand I was raised in a home where nobody deferred to anybody else. It was a home where we fought and made up and fought and made up again. A home full of boys.

DR. SISSMAN: How many siblings did you have?

DR. DIAMOND: Just three.

DR. SISSMAN: Three?

DR. DIAMOND: Yes. I don't remember *This Curette for Hire* that clearly, but it was a kind of take-on-the-world type book that was my first attempt at writing anything in length. I hope my persona has changed, but on the other hand I think that to succeed and to espouse issues you can't be too diplomatic. Particularly when the issues are foreclosed by the community. You know, I find it very difficult at times to be heard as someone who disagrees with something that is accepted by the popular culture. I just read a wonderful book called *Bias: A CBS Insider Exposes How the Media Distorts the News*, by a man named [Bernard] Goldberg. Have you read that book? It's about the press.

DR. SISSMAN: I've heard of it, but I haven't read it.

DR. DIAMOND: He describes his frustration in not being able to say anything or write anything that was not politically correct or was not part of the conventional wisdom. Eventually he had to quit, because he felt stifled by it. But I can see how that would happen. I think it is very difficult to have access to the media. I think the media are clearly oriented in a certain direction. A liberal direction. In order to be heard, I think sometimes you have to be provocative or sometimes you have to set up an independent facility for yourself as your kind of organ for reaching the public. That's what we try to do at the Linacre Institute.

DR. SISSMAN: So the combativeness when you worked on the ethics committee and subsection, you were able to integrate it?

DR. DIAMOND: I think so. There were some things that I wanted to do
in those committees that, for example, there was I thought a problem then to try to break down some of the protections against sexual molestation of children. The man boy love association where it was said that children could give consent to sexual experiences. So I wanted to write a paper on incest and pedophilia, which would now be a very popular subject obviously. And we invited several psychiatrists in, including Leon Eisenberg who was the psychiatrist, who was superb.

DR. SISSMAN: He was at Harvard [University].

DR. DIAMOND: I guess he was at Harvard then. Well, anyway we asked, “Is this a problem? Is there movement within the community, particularly certain places like John Money and the Kinsey Institute and things like that, to try to portray sex between adults and children as somehow good for the child? As a way for a child to learn his sexuality?” My contraries at the bioethics committee said, “You are loopy. There is no such problem.” But Leon Eisenberg, the psychiatrist, said, “Yes, there is such a problem. There is this kind of sub-rosa, subterranean movement, not to legalize it necessarily, but to popularize it or to make it a lot more acceptable.” So that was one of the things that, I think, led to some of the disagreements because they wanted to suppress that idea. They did suppress it in the bioethics committee, but we eventually publicized it in the bioethics section. Otherwise I think that we had some disagreements about sex education. I think I felt that sex education had every chance to be counterproductive rather than productive.

DR. SISSMAN: But none of those disagreements caused you to think of leaving the group?

DR. DIAMOND: No. Oh, no, no. And some of the people that I met for the first time in those groups have become lifelong friends, like Norm Fost and Reed Bell. I would think I could call them up tomorrow.

I think most of the dissatisfaction in the Academy of Pediatrics comes from people not feeling that their viewpoint is represented at the top. For example, an issue that is almost intrinsically inflammatory is the corporal punishment of children. There are people who say that this is a form of child abuse. There are other people who say that a disciplinary spanking is perhaps more humane than other forms of discipline. And to somehow or other get those poles together is something that would take Solomon. What happened was that they sampled opinion and opinion was basically that people said a disciplinary spanking from well-motivated, loving parents is something that we don't have to condemn. But the Academy published a statement quite the contrary. It said that all forms of spanking were modified child abuse.
DR. SISSMAN: Undesirable.

DR. DIAMOND: Yes. And that has not been my experience either as a parent or as a practitioner. Sometimes a kid who is doing something that endangers him, like putting something in a light socket; if you slapped him on the bottom, his attention span is brief and you've occupied his attention span. Otherwise, if he is four years old and you say, “Go sit in the corner for an hour and a half,” that's not more humane; that's less humane. He forgets immediately why he is there and then he feels as though he is being treated unjustly.

I think that this last issue, the homosexual adoption issue, has polarized the Academy to a certain extent. I don't think too many people have resigned, maybe 25 or something like that. But it has made people think that their voice is not being heard. And that's another thing that I would tell the Academy. That the consensus was not being heard. We talked earlier about making these policy decisions through the state chapter chairman's forum and other modalities that allow for maximum input.

I think the Academy has maybe grown too fast. It was a very neighborly group in the beginning, where everybody knew everybody else. Now it's about 40 or 50,000 people and it's just unwieldy, I'm sure, to try to get these kinds of communications.

DR. SISSMAN: Can we go on just for a few more minutes?

DR. DIAMOND: Sure.

DR. SISSMAN: I noticed that in the book that I read you talked about Birthright of Chicago. Is that still prospering?

DR. DIAMOND: Yes. We are now 22 years old and what we do is we advertise in the Yellow Pages and the newspaper and the ad says, "Pregnant? Need help?" And a woman involved in a crisis pregnancy will call us up. In the beginning it was more older women.

end of Side B.

DR. SISSMAN: This is side A of tape three. We were talking about Birthright.

DR. DIAMOND: Right. It's what is called a crisis pregnancy service. It has a hotline. And women who see our ad or hear about it by word-of-mouth call and we do a free pregnancy test, which is done across the street from us in a laboratory. Then we will provide any service that they want except
abortion; we don't provide abortion. So if they need a medical referral to a
doctor, we have a medical staff that will take public aid or adjust their fee.
We provide housing, clothing, whatever they need. Sometimes they need
legal help. Sometimes there's an abusive husband or something like that and
we have some lawyers that help them out. But it's based on the notion that a
crisis pregnancy can be addressed in a way that meets the woman’s needs.
And we don't lean too much on agencies and officials in the community, but
we try to have it be a woman-to-woman operation. They are all volunteers,
nobody gets paid. Here's a person who has been pregnant, and maybe been
pregnant when it wasn't convenient to be pregnant, and that sort of thing.

DR. SISSMAN: Teenagers are most of them?

DR. DIAMOND: Oh, yes. It's almost entirely teenagers now.

DR. SISSMAN: And it's from all over the city?

DR. DIAMOND: Yes, from all over the city. Mostly the southwest side
because that's where we are. But sometimes what they need more than
anything is assistance in telling their parents. They're always convinced that
the parents will certainly be angry and maybe abusive. Most kids think that
way. Particularly the father. The father usually is very angry, of course, but
he’s usually angry with the guy who got her pregnant more so than his
daughter. And even if he is angry with her and throws her out of the house
or something like that, longitudinally these things heal themselves and he
takes her back grudgingly and they learn to live with a baby born out of
wedlock. Now in this day and age all of the social stigma attached to having
a baby out of wedlock is gone.

Most of our clientele are African-American and two out of three are born out
of wedlock. So there is no problem for the girl in the community to have a
baby out of wedlock. It may interrupt her education and that's a problem.
It may interrupt her career and that's a problem.

I think it's a service that over 20 years has proved to be a very much-needed
service in the community, although it is entirely volunteer. The originator of
the Birthright concept was a housewife from Toronto, Canada, who said, “I
don't want social workers. I don't want professionals. I want somebody who
can talk to somebody at the level of a good friend or a parent or something
like that.”

DR. SISSMAN: Do you help with putting a baby up for adoption also?

DR. DIAMOND: No, we don't. And the reason we don't is, as you know,
if we did that we would do nothing else. People suspect that we do; if you go
through the mail at Birthright, which I don't do anymore because it will
break your heart, there will be two or three letters a week. A picture of a husband and a wife and maybe a dog, or something like that, and they will say, “We have been trying to adopt a baby for ten years and we know we can give a baby a good home. Can you help us?” Well, if we said yes, that's all we would do because the world is full of people desperate to adopt babies. It's really sad. If somebody comes to us and says I want to give my baby in adoption . . . That's a very small minority frankly; most of them want to keep it, even though it's inconvenient.

DR. SISSMAN: Or if she says, “I can’t deal with a child.”

DR. DIAMOND: We would refer them to an agency. It's not that we are unsympathetic; it's just that that's a specialty unto itself. Some people won’t get involved in private adoption and I think some private adoptions are very good. We had a wonderful lawyer in town named Greenfield, who had adopted his own children, and he was so generous in giving his time for private adoptions. He didn't want any money beyond what he was entitled to. He didn't want to exploit them.

But then there are, of course, kind of unscrupulous places where adoption is a business. They will get you a baby from Romania, but it will cost you $50,000 or something like that. That's kind of sad. But the adoption business now is almost all foreign adoption. You know this probably better than I; if you want a Caucasian, intact newborn, it's impossible. In my own family, I have a Vietnamese granddaughter and I have an African-American grandson, and it's wonderful for the family to have that kind of diversity. But there is also this terrible desperation that precedes it. Being childless, and being very anxious not to be childless. But we had to make up our mind at Birthright that we were not going to do this because it is such a societal problem.

DR. SISSMAN: There was an interesting article in the New Yorker, this week as a matter of fact, about the actual experience of going through artificial insemination. It's a very trying, difficult, emotionally wrenching thing to do.

DR. DIAMOND: I went to a meeting, mostly, I'll confess to you, because it was at a nice restaurant [Laughter]. But the topic for the night was a fertility center at which they were doing in vitro fertilization, and they talked about the fact that most of the people who were coming there were unhappy. They were unhappy because they were infertile, but they were also unhappy with being manipulated and timed and put on schedules and so on. But they were talking about the heartbreak of people going through unsuccessful in vitro fertilization; it was just terrible. And now, of course, they were talking about this endocyttoplasmic sperm injection, which, I guess, is more reliable than other methods. They insert a single sperm into the cytoplasm of a single egg and now they found an increased incidence in congenital anomalies from
that procedure. There are so many ways to have your heart broken in that business.

DR. SISSMAN: One of the provocative things that you wrote in your little booklet was that Wade vs. Roe was an abominable decision. I think you said despicable?

DR. DIAMOND: Abominable, yes; maybe I said despicable, too. You know, Roe v. Wade, I think, first of all it made law. In the fifth and the fourteenth amendment they found the right of privacy, which isn't there. It doesn't appear there. You have to interpret it. But beyond that I think it made a decision of making abortion available upon request for the full nine months of pregnancy. Nobody expected that, even the National Association for the Repeal of Abortion Laws [NARAL, now National Abortion Rights Action League] didn't expect that decision.

DR. SISSMAN: I didn't know that that's what it said.

DR. DIAMOND: That is what it says in effect.

DR. SISSMAN: I thought it was up to the point of viability.

DR. DIAMOND: Yes, but after viability the abortion can be done to preserve the health of the mother. And in the text of Roe v. Wade, the health of the mother is defined as including her mental health, and mental health is explicitly stated by Justice [Harry A.] Blackmun as being the desire not to have a baby. So if you ever desire not to have a baby and that constitutes a threat to your mental health, then obviously all abortions are available at all times.

I was very much involved in the public debate on abortion laws. And now I have gotten to know some of the people like Bernard Nathanson, who was a very successful, good obstetrician-gynecologist at New York Medical College. And he opened a clinic in order to prove that abortion could be made available cheaply and efficiently, good practice of medicine. But he left after 40,000 abortions because he said, “I'm convinced that I'm killing babies.” He is now a part of the pro-life team rather than the pro-abortion team. He told of his experiences as part of the original committee of NARAL, which was a group that really wanted the model penal code kind of abortion law. It had to be felonious intercourse, rape or incest; in other words, a threat to the life of the mother, the birth of abnormal child. They didn't want to get into socioeconomic issues, I don't believe. But that is all that abortion is now.

All abortions are socioeconomic abortions, for all intents and purposes. Some are for threat of handicap. But I think that decision was much too sweeping for the time. But one of the problems is, of course, that once
something is found constitutional then it is very difficult to pass a law to change the existing situation.

I will just give you an example, and I hope I am not saying something that you don't want on the tape. In any event, we passed a law giving parents in Illinois the right to notification when their child was having an abortion. Not permission from the parent, but notification that your child is about to have an abortion. It passed both houses. It was vetoed by Governor [James R.] Thompson, who vetoed all abortion bills. It was passed over his veto, so I think it pretty much proved that this was the will of the people. They want to be notified.

DR. SISSMAN: Compulsory notification.

DR. DIAMOND: Yes, compulsory notification, with a judicial bypass. In other words, if a girl were to say, “I can't notify my parents or they will kill me.” If she could convince a judge of that, then there was a judicial bypass. But, anyway, this was passed and it was enjoined almost immediately by the ACLU [American Civil Liberties Union] and finally went to federal court. I had been appointed the guardian ad litem for the class of unborn children. You have to meet certain criteria for that. You have to have adolescent daughters, for example, which I did at the time. So, in other words, you are an interested party. I was the guardian ad litem for the class of unborn children.

I went before a federal justice; Prentice Marshall was considered to be an outstanding justice. They found it to be unconstitutional, but also, in his dicta, he said, “Why aren't you asking Dr. Diamond for cost?” In other words, he asked the ACLU why they weren't asking me to pay them for having brought the litigation in the first place. Well, I had not brought the litigation. It came from the state's attorney, but because I was the guardian, which was a technicality really, he asked them to assess me fees. They assessed me fees of a quarter of a million dollars, and that stuck. I had to find $250,000 to pay for having been the guardian ad litem, which was a technicality for a law that was overwhelmingly passed in the state legislature. They said, “You're being capricious for bringing the suits.” Well, how can I be capricious when I am representing a law that was overwhelmingly passed? But this is the kind treatment that you sometimes get in the courts, that just absolutely boggles your mind. I was in the middle of trying to get kids through college and pay their tuition, and suddenly I get assessed $250,000.

DR. SISSMAN: Did you have any idea when you went into it?

DR. DIAMOND: Absolutely not. There is a public interest law firm that told me, “We need somebody to be the guardian ad litem. Will you be the
guardian ad litem?” I said, “That sounds simple enough. What do I have to do?” They said, “Nothing; we will just use your name.”

DR. SISSMAN: They were not about to help you out?

DR. DIAMOND: Yes, they did help me out when crunch time came. But they would never have gotten me to put myself at risk if they had been frank with me in the beginning. This is what I think.

To a certain extent, this decision should be left in the legislative domain; because judges tend to reflect their particular biases and it's an emotionally laden issue. If you can convince your public representatives of the justice of your law or whatever it is—limitation on abortion or limitation on indications or certain things. I think most people are concerned about the fact that abortions are being done for gender reasons. Babies are being aborted because they are female and they want a male. And that's all over the world of course. That's in general what's happening. So I think, if it were returned to the legislative process, if it were found to be not a constitutional right—and it's on very flimsy grounds as a constitutional right—that it would be handled better. I think that legislatively there would be people who would feel as though, “I can make my point and I can try to convince somebody that it will matter.” Whereas if Justice Prentice Marshall can not only declare that parental notification law to be unconstitutional, but also arbitrarily punish anybody who thinks to the contrary, obviously, we're not getting a fair shake.

DR. SISSMAN: Okay. Well it has been a very good interview from my point of view.

DR. DIAMOND: Well, thank you. I enjoyed it and enjoyed meeting you.

DR. SISSMAN: It's mutual. Is there anything else want to say?

DR. DIAMOND: I want to say that I'm flattered and honored that the Academy thought that I had something that was worth preserving on tape and I've always enjoyed my time in the Academy and appreciate their interest in my opinion.

DR. SISSMAN: Well, thank you very much.
Index

A

A Catholic Guide to Medical Ethics, 34
AAP Illinois Chapter. Committee on Accident Prevention, 9
abortion, 19, 25, 26, 37, 40, 41, 42
abstinence training, 26
academic pediatrics, 2
American Academy of Pediatrics, 4, 9, 10, 11, 12, 13, 14, 19, 20, 21, 23, 24, 25, 26, 27, 33, 34, 36, 37, 42
American Civil Liberties Union, 41
American Medical Association, 21, 22, 27
Arena, Jay, 10

B

Baby Doe, 20, 21, 22, 23, 25, 27, 33
Baby Jane Doe, 20, 21, 22, 25
Barnard, Christiaan, 19
Bartholome, William G., 19, 20, 24, 26
Bell, Reed, 20, 36
Bias: A CBS Insider Exposes How the Media Distorts the News, 35
bioethics, 19, 23, 24, 25, 26, 28, 29, 34, 36
Birthright of Chicago, 37, 38, 39
Blackmun, Harry A., 40
Buchanan, Douglas, 18, 31

C

Chapter Forum, 26, 37
Chicago, Illinois, 1, 3, 6, 16, 22
child advocacy, 27
Children's Memorial Hospital, 22
Children's Memorial Hospital, 16
Christian, Joseph R., 9
Christopherson, Einor H., 33
Committee on Accident Prevention, 9
Committee on Bioethics, 19
Committee on Disaster and Emergency Care, 14
Committee on Pediatric Aspects of Physical Fitness, Recreation, and Sports, 10
continuing medical education, 14
contraceptives, 19, 25
corporal punishment, 36
diuretics, 13
Down's syndrome, 3, 20, 21, 23

D
eisenberg, Leon, 36

E

E. Mead Johnson Award for Research in Pediatrics, 4
Emergency room, 6, 7, 10, 15, 16, 32

F

Fost, Norman, 19, 20, 23, 24, 36
Frazier, Robert, 19, 33

G

GI Bill, 1
Goldberg, Bernard, 35
Greenfield, 39
Grossman, Burton Jr., 34

H

Hale, Creighton, 10, 11
homosexual adoption, 26, 37
hospital review committee, 27, 28
Hsia, David, 2, 3, 4, 7
Hutchins, Maynard, 31

I

Illinois Medical Society, 13

J

Jennison, M. Harry, 20

K

Koop, C. Everett, 21, 22
Korean War, 1
Kunstadter, Ralph H., 14, 15

L

LaRabida Children's Hospital, 34
Lejeune, Jerome, 23
Levy, Dr., 32
Linacre Institute, 34, 35
Little League Baseball, 10, 11, 12
Loyola University of Chicago, 1, 2, 3, 8, 9, 16, 17, 19, 28, 30, 31, 32

M

Marshall, Prentice, 41, 42
Maywood, Illinois, 2
McLone, David, 22
meningomyelocele, 22
Michael Reese Hospital, 4, 14
N
Nader, Ralph, 9
Nathanson, Bernard, 40
National Association for the Repeal of Abortion Laws, 40

P
parental notification, 26, 41
physician-humanists, 16
Polito, 10
Pop Warner Football, 10, 11
public aid, 5, 6, 38

R
Raffensberger, J. G., 23
Ratner, Herbert, 31
rheumatic fever, 34
Robbins, Illinois, 5, 6
Robert Wood Johnson Foundation, 5, 6
Roe v. Wade, 40
Rosenthal, Ira, 23

S
school health, 5
Section 504 of the Rehabilitation Act of 1973, 21
Section on Bioethics, 23
Section on Surgery, 21
sex education, 25, 36
sexual molestation of children, 36
Shumway, Norman E., 19, 21
Siegler, Mark, 24
Smith, George F., 3, 23
solo practice, 2, 8
sports medicine, 10, 12
Stony Brook University Hospital, 22
Strain, James E., 33
Subcommittee on Accidental Poisoning, 10

T
This Curette for Hire, 34, 35
Thomas, Lewis, 17
Thompson, James R., 41

U
U.S. Navy, 1
University of Chicago, 2, 4, 18, 24, 31, 32
University of Illinois Medical Center, 4, 23
University of Notre Dame, 1, 10, 30

V
V-12 program, 1
very low birth weight infants, 29, 30
Eugene F. Diamond, MD

Education
University of Notre Dame  
Loyola University (MD)  
University of Chicago (Pediatric Training)

Pediatric Practice
1955 – Present

Professor of Pediatrics
Loyola University Stritch School of Medicine

Visiting Professor
Rush Medical College

Acting Chairman
Department of Pediatrics  
1967 – 1969  
Loyola University Stritch School of Medicine

Member
American Board of Pediatrics  
American Academy of Pediatrics  
Midwest Society for Pediatric Research  
American College of Chest Physicians  
Alpha Omega Alpha

Chairman
Committee on Nutrition, Illinois Medical Society  
Joint Committee on Physical Fitness, American Academy of Pediatrics  
President, World Federation of Doctors Who Respect Life (U.S. Section)  

Past Offices
President, Catholic Physician’s Guild  
President, Calumet Branch of Chicago Medical Society  
Vice President, Chicago Medical Society  
President, St. Francis Hospital Staff  
President, National Federation of Catholic Physicians Guild 1979-1980  
President, Illinois Family Institute 1990-1995

American Academy of Pediatrics Activities
Illinois Chapter  
Secretary, Illinois Chapter 1971-1974  
President, Illinois Chapter 1977-1980

National AAP Committees
Accident Prevention 1965-1971
Disaster and Emergency 1967-1973
Chairman, Sports Medicine 1967-1973
Bioethics 1980-1985

AAP Section Activities
Executive Committee, Section on Bioethics 1988-1994
Chairman, Section on Bioethics 1988-1992

Illinois Chapter Committees
Chairman, Accident Prevention 1960-1965
Chairman, Committee on Adolescence 1985-1990

Awards
Student Award, Outstanding Clinical Faculty Teacher, Loyola University Medical School, 1960
Man of the Year, Sertoma, 1970
Pediatrician of the Year, Illinois Chapter, American Academy of Pediatrics, 1980
George Award in Clinical Pediatrics, 1981
AAP Memorial and Endowment Research Award, 1979
Guardian of Life Award, AUL Legal Defense Fund, 1986
Summerhill Award, Birthright International, 1995
Physicians Resource Council, Focus on the Family, 1988
Fellow, Institute for Bioethics & Human Dignity, Trinity University

Married, 7 Sons, 6 Daughters

Books
1. This Curette for Hire, ACTA Press, 1977.

Articles


50. EEG findings in juvenile peptic ulcer, Transactions: Midwest Society for Pediatric Research, November 1969.
57. Abortion, no, Medical Insight, 2:36, 1972.
63. Screening for asymptomatic bacteruria in the delivery room, Transactions: Midwest Society for Pediatric Research, November 1972.
64. A physician views the hospital code, Hospital Progress, 53:56, 1972.
82. Care of acute poisonings, Emergency Medical Services, 3:36, 1974.
89. Redefining the issues in fetal experimentation, JAMA, 236:281, 1976.
91. Quinlan decision misinterpreted by critics, Hospital Progress, 57:6, 1976.
98. Children and sports, Pediatric Dig, January 1978.
100. Children in sports, Clinical Medicine, 84:11, 1978.
102. In vitro fertilization, a moratorium is in order, Hospital Progress, 60:66, 1979.
113. A.M.A. guideline on defective newborns raises ethical, legal questions, Hospital Progress, 62:8, 1981.
122. Protecting the handicapped newborn, National Right to Life News, 10:8, 1983.
125. Infant Doe and HHS. In Press.
156. It’s time to give up on the AMA, *Seminarians for Life*, 2:1, 1990.