Preface

About the Interviewer

Interview of Morris Green, MD

Index of Interview

Curriculum Vita, Morris Green, MD
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, 2000/2001

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ABOUT THE INTERVIEWER

Joseph "Jerry" Rauh, MD

Dr. Joseph "Jerry" Rauh is a graduate of Cincinnati's Walnut Hills High School, Harvard College, and the University of Cincinnati College of Medicine (1955). After an internship at Boston City Hospital and two years in the US Public Health Service, he completed his pediatric residency at Cincinnati Children's Hospital Medical Center. In 1960 he joined a pediatric practice in Cincinnati and also started the Adolescent Clinic under the mentorship of Dr. Robert Lyon. In 1971, with support from his pediatric chairman, Dr. Edward Pratt, he went full time the Department of Pediatrics and Children's Hospital.

Dr. Rauh retired as the director of adolescent medicine in 1997; he still works part time and devotes time to the national board of Planned Parenthood as well as the Alan Guttmacher Institute. He was a charter member and president of the Society for Adolescent Medicine for whom he has done several oral/video histories.

Dr. Rauh had never met Dr. Green before the interview. He especially enjoyed Dr. Green's engaging, warm, empathic response to questions, which is so reflected in his distinguished career.
Interview of Morris Green, MD

DR. RAUH: I am interviewing Dr. Morris Green on Thursday, October 15, 1998, in his library office at Riley Hospital for Children. Dr. Green, I’d like to start out asking you some questions and get you to talk a little bit about your family.

DR. GREEN: Well, let’s start with my parents, who were immigrants to this country, from Lithuania. They were relatively very young when they came here, in their late teens. They came to Indianapolis because they had family here who preceded them, and who could help them adapt to this new culture and new opportunities. They were married shortly after they came to this country.

My parents were very impressed by the opportunities in the United States, always spoke very highly about the tremendous opportunities this country presented. I think they always felt that they would succeed in one way or another and were very confident about the future, though they had not much in the way of material resources at that time. I think that they had the feeling that there were opportunities and you could make the most of your opportunities, and proceed. They wanted to have their own business at that time, and they were also comfortable in working very hard. They wanted to work in some area in which they would have some close relationship with people around them, in this case the neighborhood in which they opened a grocery store, a mom and pop store at that time. It was a fairly stable neighborhood as I look back on it. I don’t remember anyone getting divorced in our neighborhood, nor do I remember any family violence. I’m sure there was . . . must have been some. It was a rather tranquil time. There were a large number of children around so I had a lot of friends there. I had uncles and aunts here in Indianapolis, and cousins, so again we had a feeling of great stability.

DR. RAUH: Tell me a little bit about how many siblings you had, where you fell into the order of sibs, and maybe a little more about your childhood.

DR. GREEN: I was one of six children. I was the third from the oldest. The most significant event in my childhood, one I don’t remember consciously, was the fact that my oldest brother died around six years of age. He had some type of croup; I don’t know if it was diphtheria at that time or something else. He was seen by what was then a pediatrician, but he was not helped and so he died.

DR. RAUH: How old were you?
DR. GREEN: I must have been a newborn, a young baby. My mother was never really able to talk about this much; they obviously were very sad about it. My dad was, too, so it never really got discussed very much. However, I think that that experience in my family, and probably my mother’s reaction to it when I was a very young child, has had a considerable influence on me without my knowing about it. I’ve also been interested in learning about the death of children and grieving and related matters. I don’t know where that came, that interest, but I think it’s certainly related in some way to that experience.

DR. RAUH: Any other illnesses, either yourself as a child or among cousins?

DR. GREEN: No, they were just the usual. At that time many, many infectious illnesses, scarlet fever and measles and all the other diseases which we don’t see much in this country now, were prevalent. I know my parents were, I’m sure, anxious about all that sort of thing. I now appreciate why they were particularly. They had a lot of respect for physicians at that point. I think the physicians that we consulted were adequate for those days but today they would not be; they didn’t have any antibiotics and the other things. But I’m sure that having lost a child, a very precious child, modified the way they looked upon us somewhat. I never felt overprotected or things of this nature. I felt very protected, but I think they were letting us be pretty independent and so on, confident and things like that. But that’s the event I think that was very important.

DR. RAUH: Did you have doctors in your family?

DR. GREEN: Not at that time. We had one cousin who was a doctor, but that was the only doctor in our family at that point. I don’t know where I got my interest in medicine. I think that, again, it may have been related to that early experience with the death of my brother. And my parents’ respect towards doctors.

DR. RAUH: Later on a brother became a doctor?

DR. GREEN: He went into ENT [ear, nose and throat].

DR. RAUH: I see.

DR. GREEN: He was two years my junior. And that may have been perhaps because of my influence.

DR. RAUH: Where did you go to elementary school?
DR. GREEN: Here in the city. It was one of the public schools at that time. The neighborhood has changed a lot since then, but I thought it was a group of very dedicated, very competent teachers. I really enjoyed it very much. I looked forward to school a lot; I really liked it. I was encouraged by the teachers. So again it was a much more stable era.

DR. RAUH: Did you help your parents in the mom-and-pop store?

DR. GREEN: Yes I did, yes I did, a lot. It gave me more time with them, and so on and so on. It was hard work; I’ll say that. You got to know people and to work with some customers and so on. In those days, if you operated a neighborhood grocery store, you were a person in the neighborhood whom everybody knew. My parents tried to be very helpful to families. If they fell on hard times, they gave them credit, much of which was probably never repaid exactly. But they were concerned about the families in the neighborhood.

It was much more personal than what I see today, walking into a big supermarket. You know, they’re pleasant but it’s not very personal. It was different at that point; very family-oriented, very neighbor-oriented. It was a sort of a community in a way. And there was much more support of people around you than I think there often is now, at least in a big city. People’s families, babies, illnesses, jobs, deaths were important. It was a much more cohesive area than I think it is today. I think that gave me a feeling of trust in things, faith that things will be OK and people will help you. It may not be very realistic today, but that’s where I come from.

DR. RAUH: Did you go to public high school?

DR. GREEN: Yes. I went to a very good school here, Shortridge High School. It was a tremendous school, excellent teachers, very academic, and I loved it. I loved every part of it I think. And I felt well prepared. I became very interested in literature.

DR. RAUH: Got a pretty liberal education.

DR. GREEN: Yes, I think it was an excellent school. There are not many schools like that in the inner city anymore within the metropolitan area; there are some in the suburbs, I think. But I think that I was very fortunate to have the teachers I had. And the opportunities.

DR. RAUH: Then you went on to the Indiana University as an undergraduate.
DR. GREEN: Yes. I was a pre-med, but I majored in chemistry. And again, it was a much smaller university at that time than it is now. Again, I think I had a very good education, competent teachers.

DR. RAUH: When did you decide to go to medical school?

DR. GREEN: Well I think I became interested in medicine in high school, exactly why I don’t know. So, when I was ready to go to college I was pretty sure I was going to want to be in medicine at that time.

DR. RAUH: Who was your doctor as a child?

DR. GREEN: Well there weren’t any pediatricians around at that time, in Indianapolis, so it was one of the family doctors around the neighborhood.

DR. RAUH: Did you have any particular illnesses that stand out?

DR. GREEN: No. I didn’t at that time.

DR. RAUH: What memories do you have of medical school, particularly in regard to pediatrics?

DR. GREEN: Well, the atmosphere in medical school was affected by the fact that we were at war. Shortly after I entered medical school, World War II started. So, most of my medical school was kind of a hurried-up affair. Instead of having four years or so, ours was probably about three years; we went year round. We were in the ASTP [Army Specialized Training Program]; medical students were inducted into that. A lot of the clinical teachers had gone into the army.

It was a little different experience than it is now. I thought the first year or two were not as open and supportive as they are now. Sometimes the faculty was not very kind to the medical students. We only had one woman in the class at that time, and she had a fairly rough time of it with some of the faculty. But we had a lot of content to cover, a lot of reading to do, and it was a hurdle to overcome in the first two years.

The clinical years were much better, I thought. They were intriguing, interesting. We didn’t have many full-time clinical faculty at that time, but I think the ones we had were, as I look back now, superb; particularly the Chairman of Pediatrics, Dr. [Lyman T.] Meiks, who was trained at [Johns Hopkins University]. He was a consummate clinician, one of the best I’ve ever seen, particularly in physical diagnosis. He had very high expectations and he made personal rounds six days a week. You were expected to really know your patients. He gave excellent clinical lectures that I found very
fascinating. So in terms of models, I think that he was excellent. We also had lectures by practitioners, pediatricians in the community at that point, which I found also very interesting. So I think we had a good clinical experience at that time. Also it was at that time the clerkships were being developed, so we did a fair amount of work on the wards in our senior year. It was kind of new at that point. I found that very intriguing. I enjoyed all the rotations actually; but primarily I was interested in pediatrics. I had been interested in pediatrics even before I entered medical school.

DR. RAUH: Were you working part-time at that time?

DR. GREEN: No, I wasn’t working. Fortunately I didn’t have to, being sort of in the Army reserve at that time, so I did not work in addition.

DR. RAUH: And then you went on for an internship. Where did you go?

DR. GREEN: I interned at the [Indiana University] Medical Center; it was a nine-month internship at that time because of the war. Then I went to the [Army] Medical Corps after that, for two years.

DR. RAUH: And where were you stationed?

DR. GREEN: I was stationed in many parts of the country, shipped around from one general hospital to another for the first few months of my service period, and then I was sent to Japan, and I spent 17 or 18 months in Japan.

DR. RAUH: Was the war over by then?

DR. GREEN: Yes. It was over just a few weeks before I finished my internship. I remember very much the dropping of the atomic bomb.

So I think for awhile they didn’t quite know what to do with all the army officers they had in the Medical Corps. I was sent to Japan anyway; at that time there was an epidemic of typhus in Tokyo, and the country was bombed out in many places. So we were assigned to public health work supervising DDT administration and vaccinations against smallpox among the Japanese citizens, things like that.

Then I was sent to the port of re-entry for Japanese soldiers from Manchuria where cholera had been present. I was assigned to a bacteriological laboratory that performed cultures on these folks being repatriated and being held on the ships out in the harbor. That lasted a couple to three months. Then I was sent to Sendai, and there I was assigned to the central offices, doing largely administrative work.
Fortunately I didn’t have to do that very long. It was very boring. Then I was sent to the northern tip of Honshu, a province called Aomori, and I was assigned to the military government there as a medical officer. And I was there for the rest of my Army career.

DR. RAUH: Did you have contact with children professionally?

DR. GREEN: No. I, of course, was always interested in that, but I had no direct medical situations where I was working with children. I worked with a public health officer there, a wonderful man. Things were so difficult for the people, we had so few resources, and a lot of the city had been bombed out. I remember in the big railroad station there, seeing so many orphaned children walking around at night and in the afternoon. It was very upsetting; I’ll never forget that.

DR. RAUH: Children who were orphaned?

DR. GREEN: Yes, or abandoned or whatever. That’s probably all changed now, I think, but that was always very troublesome to me. And they were very pretty children, very nice children.

They had a medical school, but the facilities were abysmally inadequate; but the medical students really worked hard and tried hard. I can tell you, coming back here to this country, I could never see anybody criticizing this country. I always appreciate the opportunities I had in this country. Of course, my parents were that way too. They always emphasized what a wonderful country this was, with many opportunities, and they were not hypercritical at all. They felt it was wonderful. Through their past experiences, I know why. So I’ve always had a great appreciation for whatever opportunities I have had. I always tried to look for the positives, and not tear things down.

I’ve been very interested as a pediatrician in focusing on people’s strengths, not just the negative aspects of sickness and so on. Particularly in pediatrics, you have an opportunity to do that. I’ve thought about how you can help instill this in other people in pediatrics and medicine. I’ve been intrigued by how you do that. But anyway, as I think back here and talk about this I can see that one of the reasons for this attitude is a mindset of which you really aren’t aware. You just sort of do it. And so I think a lot of our past comes with us. Good or bad. And I’ve been fortunate that most of it’s been very good, and so little of it has been bad.

DR. RAUH: Then you were in the Army…

DR. GREEN: Two years.
DR. RAUH: Two years. And went in, from that experience, into a pediatric residency.

DR. GREEN: It's not an observation novel with me, but luck can be important. Actually, the then-president of Indiana University, Herman B Wells, wrote an autobiography, and his title was *Being Lucky: Reminiscences and Reflections* [Bloomington: Indiana University Press, 1980]. Here is a man with tremendous abilities and skills, yet he describes a lot of it as luck, because he was a very generous guy. I think that a lot of things in my life have been luck, being at the right place at the right time and so on. When I was in the army overseas, there were many other young doctors from many other schools. Some of them spoke a lot about the University of Illinois; they thought it was a very good program for students. They mentioned a young man named Julius Richmond, and it sounded like a place that might be interesting to me. So when I got out of the Army, I wrote to them. I was discharged at a somewhat atypical time, October, where most of the residencies had already been filled. I wrote about my experiences in Japan, what I saw the students there trying to do against considerable adversity. I wrote that I would be determined to really make the best of my opportunities. This must have hit a chord with them I guess, because they found a job for me there.

DR. RAUH: What was Julius Richmond’s responsibility there?

DR. GREEN: There weren’t many full-time people at that time. Dr. [Henry C.] Poncher was the head of it, a very brilliant man; but Julie was in charge of the teaching, making rounds, and helping in research. He was also very interested, as you know, in the psychological aspects of pediatrics. He worked with the psychiatrists there. He was very interested in the new curriculum, and making it what we like to see today. He was far ahead of his time, very far ahead of his time. I knew that right away. I knew he was a very special man intuitively, and very congruent with what I had hoped to find sometime. I was very fortunate; I’ve known him for 50 years and we’re still great friends. I’m tremendously dedicated and in debt to him.

DR. RAUH: Did you enjoy the bread and butter aspects of pediatrics?

DR. GREEN: Yes, I did. I really liked it. I still consider myself basically a clinician; I think that’s a very challenging thing to do. It’s not the bottom of the totem pole; it’s right in there. So I was very interested, and I still am. I also recognized that just the residency, even at that time, did not prepare me adequately for what I thought the challenges were in pediatrics and what the problems were and how to manage them clinically. I had thought a lot at that time about how to prevent them. So I sort of felt unfinished by the residency at that time, though it’s one of the better ones. It was probably representative of the situation at that point, and so I felt
why even go in practice? I could do ordinary stuff, but I didn’t think I was fully prepared at that time. So I read a lot about broader aspects of pediatrics and child health.

I thought about being a child psychiatrist. Child psychiatry was pretty strong in Chicago at that point, at least the analytical part of it was, and I met some of the young child psychiatrists. I really admired them a great deal; I still do. But I decided I didn’t really want to do that; I wanted to be a pediatrician. That was a hard choice to make, in a way: should I go into psychiatry or should I stay in pediatrics? There weren’t many guidelines at that point, you know. But usually if people went into psychiatry, then they left pediatrics, with few exceptions.

DR. RAUH: So you were thinking about the possibility of two pathways. Is that what led you to go on with your training?

DR. GREEN: Well, that was again by luck, which has played a big part in my life. Milton [J. E.] Senn then became the chairman of pediatrics at Yale University. He was the director of the Yale Child Study Center that included child psychiatry and other disciplines. He was sort of a successor to [Arnold L.] Gesell, except he was much broader than Gesell. It had been a very distinguished department, and so it was really a big challenge to him. He was looking for people to help him do the teaching and so on. He had met Julie Richmond and they admired each other, and Julie recommended me as an assistant professor there. So I was invited to meet with Dr. Senn and he offered me a job. That was a tremendous, wonderful opportunity for me.

DR. RAUH: In a way this was like a combined residency, wasn’t it?

DR. GREEN: It was, absolutely. I never had a formal fellowship, but I had a fellowship in a way.

Some people at Yale at that time didn’t like Milton Senn very well. They put him down because he wasn’t Grover [F.] Powers, who was really a tremendous person in that day; he was from Indiana, actually. Grover Powers was highly admired, and there’s nobody who can really succeed someone like that; whoever came in after him really had a challenge. I knew, right away, that this was a very special opportunity. I got to make clinical rounds and do teaching. Also I’d already read the articles that Senn had written independently, before I knew about him. He had written many things; including a couple of classic articles. So I felt, "Gee, this is a man who has done some things that I’d like to do." He preceded me; he was a real pioneer and I knew that. Whenever I had an opportunity to be with him or listen to him, I was all ears and really filled with admiration.
There weren’t many people at that time like him. Dan [Daniel C.] Darrow was there, a brilliant investigator. Although Milton Senn had tremendous ability and knowledge, it wasn’t appreciated. He wasn’t at that point involved in biomedical research. He had trained that way with [Alexis F.] Hartmann in St. Louis [Washington University], but so many people didn’t appreciate his great ability. He was one of the most mature people I’ve ever met. I’ve learned a lot about maturity from him, just observing and listening to him and trying to emulate him in some way. He was very kind to me.

That was a tremendous growth experience for me, like meeting Julie Richmond. Meeting Milton Senn was a major crossroads for me. There were other people there that I admire, like Al [Albert J.] Solnit and Sally Provence, who were a great influence in my career. I was there five years, and I wasn’t particularly planning to leave or anything like that; I didn’t have my future worked out like that. If I had stayed I would become director of ambulatory care there. Milton Senn thought that was an emerging area. He thought that would be very important in terms of clinical care, teaching, and research, and he thought I was the person that could do that.

DR. RAUH: Did the patients there come through a pediatric door or a psychiatric door, or is it hard to even say?

DR. GREEN: Pediatric mostly. There was also child psychiatry across the street, but they were fairly small, in terms of patients. They were more classical psychiatric patients, whereas in pediatrics there were a lot of emotional problems which could have been pediatric or psychiatric or both. They would come in the pediatric door.

Al Solnit worked in the ambulatory care clinic, but he would take patients like the one I saw here this morning -- two children with hyperactivity. The mother of the child I saw keeps calling the doctor worried about this and that. Her own mother criticizes this mother frequently and this young woman keeps talking to the pediatrician for support. You have to know something about the mother as well as the child. In New Haven they would be concerned about the family as well as the child, whereas classical pediatrics would just look at the child, fix him, and that’s it. So I thought it was a tremendous place at that point.

I guess when I talk here I generally take a very rosy view of things, maybe too much sometimes. I try not to see the negative aspects of it. Not exactly deny it -- having been a chairman for 20 some years you darn well know that there are negatives. [Laughs] I have people like my secretary and my wife to help keep me realistic.
DR. RAUH: Maybe just to digress on your personal life, were you married at that time?

DR. GREEN: No. That’s another lucky break I had. My wife was a pediatric head nurse at the Yale-New Haven Hospital. I met her there; one of the great things to happen in my life. A tremendous influence on my life. I met her and we got married there in New Haven; and we had two children there.

That’s when I was offered a job back here [Indiana University]. I didn’t expect to come back here. I didn’t plan that far ahead. They were going to open up a new ambulatory care center here and so Dr. Meiks, who had been my predecessor, asked me if I would come back for a job, and I did. My wife was originally from Boston and New Haven; she was a graduate of the Yale [University] School of Nursing at that time. She’s been tremendously supportive to me here in what I do. She also is a pediatric nurse, and very, very interested in children.

DR. RAUH: Did she continue working as a pediatric nurse when you first came back to Indianapolis?

DR. GREEN: Well, not immediately because our children were quite young. We had six of them very quickly, one set of twins. She really wanted to be with the children, and I wanted her to be with the children, too. But when the children grew up and were leaving home, she came home one night and told me she had signed up for a refresher course in nursing. She had been out of it for 15 years or more, I don’t remember exactly, so I was kind of surprised. But also, thinking about it, I really admired her for doing that. I think that was hard to do, because things had changed. So she took a refresher course, and then she worked until about five years ago when she retired.

But that’s how I met her there. I was going to say that’s the greatest thing that happened in New Haven.

DR. RAUH: Ok, why don’t we stop now. This is a good break point.

PAUSE IN TAPE; END OF SIDE A

DR. RAUH: Tape number two with my interview with Dr. Green. Dr. Green, you came back to Indianapolis and Riley Hospital for Children in 1957 and you’ve been here ever since.

DR. GREEN: Correct.
DR. RAUH: Would you talk a little bit about your first responsibilities here and how you saw that evolve in regard to your career?

DR. GREEN: Well, at that time the number of faculty was very small; maybe three or four, if you can believe that. The number of residents was also very small, five or six. So it was kind of a critical situation in terms of resources, in terms of people. Which, of course, is the main driving force of any institution. I saw that the number one challenge was to recruit excellent faculty, because if you don’t have them nothing else matters much. It was important to attract dynamic, bright interested residents, and to try to bring an integration of the staff here which exist; the nurses, social workers, and psychologists; to integrate our work with other departments with which we were loosely joined, like surgery and orthopedics and ENT and all the others, to create a cohesive whole out of the various individual parts. Kind of stitch things that were here together. Some of them were really strong, but it was not as well developed as we needed to be in that era. So that was my number one immediate task, the one on which I spent a huge amount of time.

It’s much easier to attract people now in 1998 because of our facilities and faculty and all the other things that have happened since that time. But then it was quite a challenge.

We also had an antiquated physical facility with open wards. We segregated boys and girls and we had no adolescent unit here at all. We had no intensive care as such. Our newborn service was not what it should have been in terms of the facilities and organization and so on. So we certainly needed to develop a physical plant, so to speak, that met the needs of the times. That was highly important.

At that time, pediatrics did not have high status on this campus. Those of us in pediatrics thought we were doing a good job and laudable work in many ways in view of our numbers. But we were regarded among other departments, particularly medicine at that time, as just kind of a small activity here. Medicine has changed a lot, internal medicine now relates to us differently than it did then. We can talk as equals now with them; then they were always nice to us but it was like to a junior partner. We were not regarded as having any tremendous potential for increasing the stature of this university medical center and so on. I didn’t feel defeated by that or actually very worried about it. I probably had a high amount of denial.

DR. RAUH: What were you denying?

DR. GREEN: That this may not be possible to pull off.

DR. RAUH: I see.
DR. GREEN: Looking back on it, I don't think I'm overstating it. I see what we have here today, so many, many years later and at that time it was hard to envision. I had a pretty good idea of what it could be like, not only the physical things. I thought we had great potential here. I think it was a sleeping giant, to use that phrase, and that some leadership, some vision and so on would carry the day. So I never really got despondent over it all. Maybe I should have, but I didn't. I thought we'd just do it.

DR. RAUH: Let's go to the ambulatory responsibility you had, and take that forward.

DR. GREEN: OK. Well, I'm pleased you raised that. It's close to my heart, of course. In those days, the Ambulatory Pediatric Association was just beginning. Now it's very large and very active. But then it wasn't even included in academic pediatric meetings. It was an also-ran. Behavioral pediatrics is in the same situation as ambulatory care was back then. So my blueprint for behavioral pediatrics would be somewhat similar to that, but it hasn't been completely implemented yet.

At any rate, I thought that there were good opportunities in ambulatory care which were unexplored. I'd thought that we could offer a diagnostic consultation service to physicians throughout the state of Indiana -- pediatricians and family physicians or general practitioners as they were more commonly called then. They could refer patients here, no matter what the problem, and we would try to deliver an integrated evaluation of this child in one day. Then by the next day, or sometimes that day, a letter would go out to the doctor, one page usually, indicating what we thought was wrong with the child, what we ought to do, and what are the plans; one, two, three. This was new at that time. Doctors are very busy, they don't have time to read a five page report. They don't need to. They want to know what’s wrong, what are you going to do about it, and what they should do about it.

We did that; we dictated some five to seven certified letters that afternoon, which were then typed by my secretary, Mary Ann Underwood. That’s before we had computers and word processors. We didn’t have an electric typewriter. I don’t know how that was all done, but it was. It had a tremendous impact on the state of Indiana in terms of referrals. It was something that they didn’t have to worry about. If they had this problem they didn’t have to sweat it out, just send the patient here where they’d be seen by senior people. We were adding facilities then, and we tried to integrate both surgery and medicine with pediatrics. The parents would report to their doctor that they were treated very well. They liked the atmosphere, and they got their questions answered. Whether they had money or not didn’t make any difference; we treated everyone the same.
DR. RAUH: Did you follow-up those patients?

DR. GREEN: Yes, I’ll tell you how we did that. We’re not doing this today, for many reasons, not all of which are under our control. We’d have this teaching conference every day, five days a week, and we could obtain additional evaluations such as x-rays or EEG [electroencephalogram] or EKG [electrocardiogram] or consultations with subspecialists that same day, e.g., with a dermatologist or neurologist. We even got some people out of the OR [operating room] in between cases to, e.g., a neurosurgery resident to look at a child who has this large head who might even have a brain tumor.

Creating this willingness to see children the same day to save the family a long return trip was a major effort on my part and a tribute to the spirit of the Pediatric Diagnostic Clinic. In the past, appointments to the outpatient clinic were all at one o’clock or eight o’clock. So you came in at eight o’clock with your child, after a long trip here from southern Indiana with two or three little children who are hungry and tired. You might have to wait up to four hours. The assumption was that the children were there at the convenience of the doctors. I’m exaggerating slightly. So you’d come in at 8 then you’d wait three hours; nobody got too concerned about it. Well, we quickly changed all that with appointments. Our goal was to reduce waiting to 15 minutes or so. These folks often came a long way on the bus, and were hungry and confused in the big city.

Physicians were sometimes were hesitant to refer you an inpatient, because they were afraid that they may not get them back, but they would send you an ambulatory patient. I think that we got a reputation for being interested and looking upon the practitioner as a colleague equal to us. We felt it was a privilege to see this child and we owed the physician a letter immediately. That was, not surprisingly, highly successful. In the past, doctors would send a patient here and they’d never hear about them. A patient could die and they never heard what happened to them. We changed that, and that also led to referral of inpatients where the same philosophy prevailed. That was very effective.

Follow-up, in those days, was easier. If we thought the child needed to be followed-up here for reasons beyond what his doctor at home could do, it could be done. For example, if it was a psychological problem, it’s pretty hard to solve one of those in one visit.

DR. RAUH: Right. Rarely is it solved in one shot.

DR. GREEN: You just can’t do it. A child overweight or with abdominal pain or depression or whatever. But now some of them are
difficult; you only get approval for a certain number of visits. But we could
do pretty much what we wanted to do, within reason. We weren't worried
about being paid from outpatients; we didn’t charge for it if they didn’t
have any money. We saw them anyway.

We would then decide who was going to follow a patient. If we saw a child,
one of the questions was does he need follow-up or not? If he did, we would
write a letter to the doctor and it was all set. If he had questions, we’ll see
him again. Sometimes they were followed in one of these special clinics like
a seizure clinic. If it were an ordinary seizure, we could do it ourselves, but
if it were something more complicated a neurologist would do it better. Or
if it were a psychiatric problem, Jim [James] Simmons, who was our child
psychiatrist then, and I would decide whether the child should be followed
in child psychiatry or in pediatrics, if we could do the job well, and our
residents would have a chance to learn something about it. Jim and I
would talk awhile and decide, "Well, it’s really a psychiatric problem and
it would be better if we referred him there."

So we assigned these patients to one of our residents after they presented
them to me. The resident would give them an appointment, and we’d keep
a simple list. We had a three by five card on every patient. We’d put the
date on it, say we saw the child here in October, "Have him back December
10th to see Dr. Jones." My secretary would put it in a little file. And on
December 10th we would pull those cards out and she’d send for the charts.
I’d have them stacked on my desk, and I’d flip through them quickly to see
what happened to this child. It also helped me learn a lot about the
outcome I saw and also what the referral specialist had done about it. That
was a very important learning experience for me. I learned an awful lot of
neurology. I learned a lot about other specialties, like genetics. It was very
important for me.

Also I could tell the residents who were really interested and effective with
their patients. Some had many failures, reflecting that he conveyed a
message to the people, "I’m not too interested in you; I don’t care. I’m
talking to you but I’m not listening; I’m thinking about something else."
Of course that comes through very quickly. Also, if a patient came back
and the resident had seen him and he didn’t think things were going well,
or he wasn’t sure, he could call me and I’d go down and see the patient
with him. Or if I knew ahead of time that this was something I can teach
more about in terms of interviewing, then I would put it in my book and I
would go and join them. So the residents were really having a continuity
experience, not in well babies at that time, but in patients that are seen
because they had problems. We kept a good check on them in a simple
way.
I would send a note if I thought the doctor should know about a change in treatment, a new or different anticonvulsant, another x-ray or whatever; I thought the doctor should know about it, particularly drugs. If the patient would call the doctor up two o’clock in the morning, he would know what’s going on. That was done very well. We don’t do that as much anymore. The residents don’t always have anyone to really mentor them right away. That’s a big loss, I think. It could be done, but it isn’t being done. Particularly in the psychological parts, I think that that is not being taught as well as it needs to be.

DR. RAUH: This is really one-stop teen care. While you were developing your ambulatory facility and this concept of teaching care which you just described, were you also working to develop developmental and behavioral pediatrics?

DR. GREEN: Yes. I was trying to, I didn’t think about it in this way then, so I do not wish to imply that.

DR. RAUH: Right, but as you look back on it now.

DR. GREEN: My idea then was to use the clinical experiences, to generalize from them, and to develop a picture of certain types of children we’re seeing and how to recognize, diagnose, prevent and treat specific problems. Example: Increasingly I’m seeing a lot of children under the age of three who are out of control; I’m just besieged by them. These children are very frustrating to doctors; who have only ten or fifteen minutes to spend with them. So we get a lot of that, I think more in the last ten years than before. It probably reflects the social situations, economic situations, more one-parent families, more mothers working outside the home, less support systems available to people, less grandmothers around, in one context, and more grandmothers in another context. So it’s a different world, and that’s reflected in what we see here.

Well, if I’m seeing these patients and I have a certain approach to how I manage them, I have an obligation to identify what I see, describe the symptoms, talk about the risk factors that led to this, identify the strengths that some people have that prevent that kind of problem, help me manage it, and then transfer this into what can pediatricians do in terms of anticipatory guidance to prevent it. If you identify a family at risk, like divorce, or death, or other risks, then you know what it might lead to, and you can alert the family to that. I call this a matter of authoritative parental presence, like command presence in the Army. I don’t like to use the word command because it sounds like it’s militaristic and I’m opposed to that in families, but at least the children respect you and try to please the parent. They know what parents want and they try to meet those expectations. They trust a parent. I see good parents when I walk around
here, who are really great with their children. They’re not austere but they’re in control; they have presence.

A little child touches the book over there, and she’d just give a little glance, and not say a word and he’d put it back. Another child would take it and throw it. Some children are very nice to parents, others aren’t. One we had here a couple days ago, a boy, suddenly said to his mother, who was sitting here, depressed, "You stupid idiot. You’re lying." She just sat there, embarrassed and didn’t know what to do; kind of crestfallen, as if it happens all the time. He doesn’t respect her, and she doesn’t understand why. Anyway, I think we had an opportunity here to make clinical discoveries in this clinical laboratory. And then you try to put some theory into it and so on.

One of the first papers based on that approach was the vulnerable child syndrome. That’s exactly how we described it. I was seeing all these mothers who could not control their kids, who worried about them a lot, who wouldn’t sleep at night. The symptoms were quite dramatic. The fact that they got sent here meant that they were not routine problems. I was trying to figure out why is this mother so overprotective. It was different than, say, a mother who’s born in a foreign country and who had never been here. Of course, they tend to be overprotective of their kids for many reasons. It wasn’t that kind of benign overprotectiveness. It was pathologic. Well, what I learned was that at one time this parent was told or thought the child was going to die. He was very sick, or in the intensive care unit, or whatever, and the doctor may have told them, "I think we’re going to lose this child." She became convinced that the child was going to die. Well, the child didn’t die, he recovered. And she’d hear comments like this from the doctors, "You know if he got here two minutes later he would have been dead. I didn’t think we could save him but by some miracle he was saved." Sort of patting themselves on the back so to speak, but it's harmful to parents. So she became convinced that God had given her child back to her alone and that it was very tenuous. She believed this child was very vulnerable to become suddenly ill and die or an accident or something bad could happen. It was a secret, she didn’t tell her husband or anybody. She didn't tell her doctors, because she was embarrassed. She thought she was the only mother who thought that way. She couldn’t sleep at night; she had to check the child four times a night to be sure he was still breathing. She would actually wake him up, just be sure he's alive.

That’s how we described it. We had 25 cases when we described it. We called it the vulnerable child syndrome, and it seemed to arise because of the child's illness or somebody in the family who died prematurely, or a mother’s life itself was threatened during her pregnancy. We still see that. It's fairly common and could be prevented, I think.
So I’m excited by clinical experiences such as these, but it’s trying to string the patients together, trying to make something out of it not yet described. This clinic offered a special opportunity to do that. I think that’s very exciting, and I really like that opportunity to translate basic child development science knowledge into clinical practice of pediatrics. My view is that the clinician does not have to memorize all this cookbook style. If you know child development, etc., you can pretty much figure out the answer to a clinical problem.

DR. RAUH: I agree with you; I think much of it is intuitive.

DR. GREEN: Yes, it is. You’re taking it right off my paper. Yesterday I was writing that part of it; the importance of the interview, the importance of direct observation. When I see these patients, I am really listening, hearing, seeing, feeling, and some of the residents say, "How’d you know that; how’d you know that?" Well, it’s pretty easy, actually, because the patient or parent will give you the message. You’ll see it if you’re looking for it.

DR. RAUH: Yes, and I think if I could just say that residents need a setting for that where they are not distracted by being up all night and worrying about the hemoglobin or sodium level of this or that patient, etc., etc. This is an area of training that’s not being done very well at all today. It’s always taken special skills that you clearly have in spades, and I guess we grope for ways to bring it back, to maintain it.

DR. GREEN: That type of excellent patient care is very fragile. I may be very happy the way things are at this time, but it could easily disappear.

DR. RAUH: Talk about what you were doing this morning before I got here, with the group of community pediatricians and a resident.

DR. GREEN: Well, we had a meeting sponsored by the Maternal Child Health Bureau [MCHB], I think it was seven years ago. Woodie Kessel from MCHB was there along with five pediatricians and child psychiatrists. The agenda was to bring pediatrics and psychiatry together, so to speak, profitably and productively? I’ve been very lucky in a way; every place I’ve been we’ve had a good relationship with child psychiatry. That was true when I was with Julie Richmond in Illinois, when I was in New Haven. While I have been here, we have been very close and I didn’t see a conflict. The reason why some may see a conflict right now is that the behavioral people may see the benefit -- the necessity -- for sub-boards like other pediatric subspecialists and this is opposed by a few child psychiatrists. I do not see behavioral pediatrics as a threat to child psychiatrists. It could actually help them. The meeting sponsored by MCHB was to develop a workable arrangement that would bring the two
disciplines together. Personally, I never thought they were apart because my experience had been very positive.

Anyway, when I was at New Haven, Al Solnit organized a group which would meet, I think once a week, attended by pediatric practitioners, most of whom didn’t have any special training in this area. The idea was then to discuss their patients.

DR. RAUH: Present a patient.

DR. GREEN: Yes. It’s like morning report. I come and present a case to you and the gist of that was to look at what you think is going on with this family.

I chaired this group sponsored by the MCHB, and we recommended the formation of COR [Collaborative Office Rounds' Groups to consist of seven to eight practitioners and a behavioral pediatrician and a child psychiatrist as co-moderators. Anyway, I decided to have a group like that here.

The inclusion of a child psychiatrist is mandated. It could be started by psychiatry too, but pediatricians initiate most of them. My psychologist here is fantastic, she comes. She knows what pediatricians need to know and she can inform them without being patronizing. So we meet, originally twice a month, but I started a separate group here of people who meet here in this room one Wednesday a month. This second group consists of pediatricians who work in public clinics.

The pediatricians I met this morning are in private suburban-type practices. They just report on patients from their practices and we talk about it, what we think is going on and what we think they ought to do. Now we had two cases this morning. One was a two-year-old who was hyperactive, just shy of ADHD [attention deficit, hyperactivity disorder]. The psychiatrist co-moderator is very interested in hyperactivity, so we had a nice discussion about whether or not the child has ADHD.

In the second case this morning I suggested some clarifying questions that I would ask to get information and to give a message to the mother that rather than just thinking of this small area we should really think larger, here. This mother has called this practitioner a lot about little things; the baby is having breath-holding spells and this and that, sometimes three times a day and three or four times a week. She is really worried about this baby and wondering what she should do. The baby is healthy. The doctor was uncertain about what to do. She was maybe a little irritated about being called all the time, for no good reason, she wondered about Munchausen syndrome, but it didn't quite sound like that.
She didn’t know what to do and she wanted to help. You don’t get angry at this mother, but you also feel very frustrated. I indicated to her, I thought that sometimes you have to reframe the question. The woman comes in thinking there’s something wrong with this child, that’s a problem. She’s gotten the pediatrician to work within her parameters, and it doesn’t work. She doesn’t know it doesn’t work, she just thinks we need a few more tests or something and it will work. And you’re trying to be nice to her because you’re a nice person and she is a nice person. We’ve got to do something about this; this isn’t going to work out. Either she’ll quit coming to you or you’ll miss an opportunity. We’ve got to reframe the question. If a resident asks me a question, sort of a narrow question, I’d probably answer, "Well, that’s fine. I think we ought to see this in the greater context; let’s look at the larger question.” And when you answer your bigger question, you’ll answer the little question, hopefully. And I said, "Here is what I would do, I think. You have to do it without accusing her, without being too obvious about it." She had mentioned that every time she saw this woman, she had brought another adult with her, a friend, a neighbor; but she’s just always had a woman with her when she brought the baby in. Occasionally the grandmother, her mother, came and the grandmother is very controlling, trying to tell the doctor what to do, and saying, "You ought to do this; you ought to do that,” and also belittling the mother. So here’s a woman who’s very dependent on this mother for babysitting and she’s beaten down by the mother who is very skilled at making her feel small because she’s trying to do the same thing to the doctor. Here’s a woman who is so insecure that she brings a friend or somebody with her. Every time I see that, I point out to residents that usually if somebody drives you to see the doctor, and it’s not really essential, they’ll sit out here and they say, "I won’t go in, you can.” So I said you have to kind of look upon this woman as dependent on the mother but very angry at the mother; however, she can’t face that particularly, and she’s going to have to work that out. This mother herself might need psychiatric help.

DR. RAUH: It sounds that way to me.

DR. GREEN: So you have to change the subject by saying some mothers tell me this and so on.

I think the pediatricians that come to these sessions are among the best in town, among the best; they’re very good. They’re interested in learning more about behavioral issues.

DR. RAUH: Do you discuss these cases over time?

DR. GREEN: Yes, usually the next time we meet we’ll hear what happened to them. It’s not perfect, we ought to do it more frequently.
It's hands-on learning, which, to me, is always the most effective. Then you try it and see if it works. So I think that’s a good way; I’ve tried to help the people who rotate through my section. That’s how I handle it, based on actual cases.

DR. RAUH: Yeah. I think this tape’s going to run out in a couple of minutes. Why don’t, let’s just stop it and we’ll get a new one in here.

END OF SIDE B

DR. RAUH: Tape number three, Dr. Rauh's interview with Dr. Green.

Once you became chairman of the pediatric department here, did you keep up your clinical teaching along with being department chairman?

DR. GREEN: With some difficulty, because of the commitments on your time that you don’t control at times; particularly executive committee meetings and things of this nature.

DR. RAUH: More traveling, I’m sure.

DR. GREEN: A lot of traveling. And trying to balance what I do here, which is important, with what is more important which is my family; I hope I did that OK. Most of the time I did, I think. I was very lucky to have a wife that was very good about that. She occasionally would coach me to spend more time with the boys or something like that. Without saying I’m neglectful, just, "The boys would like to have you go to a ball game with them," something like that.

DR. RAUH: Speaking of your family, I’ve found I learned more in in pediatrics from my children than any other children. Did you have that experience?

DR. GREEN: Oh yes. I think I’d be a less competent pediatrician if I didn’t have any children. I don’t want to say people who don’t have children can’t be good pediatricians, they can and many are. Particularly with children who may not be having a lot of medical problems at the time or children who are going through developmental stages, various questions about their friends; it’s another reality tester in what they’re thinking and so on. Yes, I think that I learned a lot from them about things. They didn’t directly tell me or teach me, but I learned.

DR. RAUH: Is that true when they were teenagers too?
DR. GREEN: Yes, I think so, very much so, and particularly the girls, four of the six are girls. They're a little different in their approach to the world and how they see themselves than say my generation and my wife's generation, and I think in a positive way. I think they are much more articulate, they are much more willing to speak up when they think they have something to say.

DR. RAUH: You have six children.

DR. GREEN: Yes.

DR. RAUH: And from what you told me before, most of them are involved in some type of child care, if you will, professionally. Could you talk a little bit about that?

DR. GREEN: About the children?

DR. RAUH: Yes. I think one is a physician.

DR. GREEN: Yes, Alan, my second oldest child.

DR. RAUH: What does he do?

DR. GREEN: He’s a child psychiatrist and is also a forensic psychiatrist; he just added that on. He works in the Los Angeles area. He's in charge of the service at one of the state mental health hospitals there, the unit for children who have, as I understand it, pretty big problems. They've been in various other state hospitals where they didn’t make much progress, so the state decided to centralize them. They come there for diagnosis and management, and then they’re put out to follow through on that. He also is involved in having fellows in child psychiatry who rotate through the service. He also may be starting a clinic at Cedars-Sinai Medical Center for children ages zero to three. This is not definite, this is just proposed. He took a year and learned forensic psychiatry, because of all the problems that come with children of divorce and violence and all sorts of things like that. He was interested in that; the problems are really challenging, obviously. He’s most interested in children who are probably five to ten years of age. Right now that’s his unit.

Carolyn, my oldest daughter, went to Cornell and she wanted to go into child psychology. None of my daughters wanted to be physicians; I don’t know why exactly. They weren’t opposed to that; they admire physicians. I think they weren’t sure that was compatible with a kind of a rounded life they’d like to have. They could see me as a bad example, I guess, working long hours, and I’m not sure they thought that was what they wanted to do. Well, anyway, she entered the graduate program in child psychology at the
University of Virginia, which I think is a very good clinical program. And she graduated from there, and then she took an internship at the Washington National Children’s Center, in the child psychiatry unit. Then she worked at one of the group home places in Washington DC that sees young children, for a year or so. She has two children, one is ten and one is eight years old now, time goes so fast, so she did not want a full-time job. So she works when they’re in school, by appointment, and she sees a lot of families who have school or behavioral problems. And she does very, very well. Pediatricians send her problems sometimes; she works with a psychiatrist group there too. If they need psychological testing, she’ll do that. She’s really, I think, a superb mother. My wife and I are very impressed with how she manages her children; she’s just a natural at it.

DR. RAUH: Who’s the next one?

DR. GREEN: My oldest is David. He’s a computer scientist. He was always very good at everything, mathematics, astronomy, English literature, writing. He had a hard time deciding what to do. He went to Harvard as an undergraduate; he wasn’t terribly enthused about the place because he didn’t really get to see many top professors. And the preppy things didn’t interest him too much. It was hard for him to decide what to do. He decided on computers, and he’s been working in the space program and satellites ever since. He seems to be very happy with what he does.

DR. RAUH: And who is the next one?

DR. GREEN: The next one is Susan. Susan was a newborn intensive care nurse, a very warm person, very oriented toward babies and mothers. She married a pediatrician, and they now live in Vista, California. She has three children, six and three and three months, so she’s pretty busy with them and that’s what she's doing right now. She is the most outgoing of our children. It’s interesting how siblings vary and are somewhat different.

DR. RAUH: Did you help train her husband?

DR. GREEN: No, he trained out there. I’m very happy with him, he’s a very positive person and wonderful father.

DR. RAUH: And then your last one?

DR. GREEN: The last two, twins. One of them is Marcia, she’s the oldest of the two twins by a few minutes. At first, she was going to become a marine biologist, went to the University of Miami for that, and then she decided she didn’t really want to do that. She got interested in television, movies. She transferred to the New York University Tisch School of the Arts, and she graduated from there and she worked in New York City for
awhile. But the place to do that kind of work is out in California, in Los Angeles, and so she went out there. And she worked for a succession of shows, television shows, very successful as an associate producer. After a while she got tired of that, so she went to law school and she just graduated.

The other twin, Sylvia, is still in that business, writing for television. She loves that sort of thing. So they’re all six doing something different. And they remain very close.

DR. RAUH: So you have two sons and four girls?

DR. GREEN: Yes.

DR. RAUH: Tell me, when I came in today to start this interview you said you were being quizzed by a newspaper reporter about whether it’s harder to bring up girls or boys, having had a fair amount of experience. Not just with your own children, but with your very long and large clinical pediatric experience. Do you want to tell me how you’re going to answer that question?

DR. GREEN: I hadn’t thought about it actually until now. I like to be cooperative, particularly with local journalists, because they’re well meaning. If it’s something to be sensationalized, you know, I’d say, "I’m sorry, but I can’t do it."

DR. RAUH: Is it a newspaper reporter?

DR. GREEN: Yes.

DR. RAUH: That’s easier than TV, don’t you think, where you have to say it in 30 to 90 seconds?

DR. GREEN: Also they edit it, and it doesn’t come out the way you say it.

DR. RAUH: Yes, exactly.

DR. GREEN: They’re always wanting something sensational, something provocative, which I don’t like.

In answer to the reporter's question, I will likely say that it depends on the temperament of the child. I don’t think that it is particularly gender-specific. And it depends on the parents’ own life experiences and how your siblings came out. I don’t know of any evidence that it’s harder to raise one or the other. There are different worries and considerations you know, with girls. It’s a little different than boys, but I don’t know what my wife
would say to that. I’ve never heard her say that the girls are more difficult than the boys.

DR. RAUH: Let’s turn our attention to the American Academy of Pediatrics [AAP] for a moment. What stands out in your mind over the decades of work, commitment and accomplishment you’ve had with the AAP as it’s evolved to today?

DR. GREEN: Well I have many responses to that. I think it’s been a very positive experience for me personally, a positive growth experience. You can never have enough growth experiences. Some people put their own fence around themselves but don’t realize their potential of growth; I see it in the residents all the time. I have to emphasize that with them, "Don’t sell yourself short." I don’t mean in terms of academic achievement or something like that. I’m talking about what kind of a person you want to be, what kind of a professional you want to be; don’t limit yourself. Don’t decide at 25, in the case of the residents, that you’re going to be limited to what you can do. You don’t know what the opportunities are out there. You also have to make your own opportunities. There are opportunities left and right if you just recognize them and have faith that you can do it, and think this is important. When you’re all through with your life and career and look back over what you’ve accomplished, what you’ve influenced, those are the things that will be very meaningful to you. Not just the car you have, the house you have. It’s, have you made a difference? I wrote a paper once and did a talk on this, on "making a difference." And I think that each of us probably would like to have made a difference, a worthwhile difference, with our lives. That is, have you touched somebody or improved their life, made something better?

That’s a pretty high aspiration, it covers many things, discoveries or clinical care, friendship or whatever. One of my best friends is going through a difficult time. I work very closely with him. He has prostate cancer and he’s had tests, he’s had a lot of pain. He called me today; I keep in touch with him every day. He made a difference. I worked closely with him, I really saw what a great difference he made. He may not think so, and the people around him may not know that, but I know it.

You have to do that. I don’t think all the time about how I want to make a difference. I’m just thinking retrospectively about that, what is the motivating factor. Well, if you’re going to make a difference, you do rely on your own self, intuitively or whatever. A lot of people have, but you can also have people help you with what you want to do.

When I was in high school, I heard [Edwin] Land, who discovered Polaroid, speak at a convocation. I don’t remember his whole talk, but I
remember he said that in research you have to think of the questions, and then you have to find somebody who will help you answer the questions. Having somebody to help you find the answers, that was a very cogent statement. He gave a great talk to a young group of high school students including me.

Well, I'm getting around to the Academy. If you’re just in one little small area, like Indianapolis or Cincinnati or wherever, particularly if you’re in a smaller town, or not in an academic environment all the time where you can’t help but be influenced by a lot of people in a vibrant place. How can you grow on your own? How do you see beyond what you see right in front of you? Well, personally, I’ve been able to see more, my vision’s been larger, because of people I’ve met through the Academy committees. I’ve made a great many good friends. You’re there, listen to them, see how they think, call them on the phone sometimes. You can’t avoid being in contact with so many bright, energetic, good people.

That is, you can’t come away from that without being very constructively influenced. It's not painful, it's enjoyable, and you get such tremendous personal benefits. I ascribe a lot of that to the Academy. Other things do it too -- organizations like the Ambulatory Pediatric Association, which I’ve been heavily involved with over the years. That’s had somewhat the same influence on young people coming into it. It's important for young people, especially those who otherwise might be somewhat isolated, people that haven’t had the chance to have excellent mentors. I’ve had some terrific mentors that have really expanded my view of things. If I hadn’t known Milton Senn or Julie Richmond, would I see the things I see now? No, I don’t think so. They’re magnifiers, they show me how to look through this glass, let me see it better. I was telling Julie once that it’s interesting to look at where we are right now and five years later to look back and think about it. You think you’re on a mountain and back in the past you thought you were at the top of the mountain. Five years later, you see much more of the valley; it just happens. That's fascinating. I’m writing another paper now, trying to get my experiences and ideas down in black and white and looking at each of the words is difficult. Is this really what I mean? Is this clear? Does this make sense? That really helps me understand it.

DR. RAUH: What’s the theme of the paper?

DR. GREEN: It’s about parental presence, how you create it, how you develop it and so on. I think it’s very important in influencing health supervision and anticipatory guidance. I feel very strongly that health supervision is chiefly focused on developmental surveillance of children, which is laudable, but we’ve got to extend that to parents. I think when the doctor sees the children, he also has the opportunity for developmental surveillance of the parents. Are they developing as parents as they might;
how can we help them do that? In a very brief period of time, how we can be very influential. How can we do that, in what way? Not just talking to them in 10 or 15 minutes; how can we evaluate their ability to be effective parents? Do we have forms to fill out? Just thinking about that subject, seeing these patients, has helped me, I think, become a better clinician. If that helps me, could this help somebody else do that who hasn't had the privilege of seeing all these patients? It is a privilege to see them, and to have the time to see them and to have the time to think about them.

Well, the Academy has introduced me to a lot of people. It’s made me aware of some challenges, a lot of unsolved problems with children, policy problems, that I might not even have been aware of before. To me, it’s very exciting. I just feel I see a bigger view than I did before. I see this and I feel very strongly about this last point. I think that I didn’t appreciate this at first, but as I got to know how the pediatricians in this state were so constructively influenced by their service on an Academy committee, I began to appreciate it more.

DR. RAUH: Yes, I’m sure you have.

DR. GREEN: They may not be an expert in whatever, but they got involved. For example, say somebody got involved on an adolescent committee or section, and met some of the leaders in adolescent medicine, and participated in discussions; that would have a very profound influence on him or her, a profound growth experience. They may have had a somewhat restricted view of pediatrics, but when they serve on a national committee they reach out to others and most of them change. So I think it’s a growth experience.

This is apart from the influence the Academy has on public policy, their journals, and the CME [continuing medical education] courses. That's all very powerful. The Academy has high credibility in Congress when they speak.

DR. RAUH: No question about that.

DR. GREEN: They’re talking about good stuff, they’re not talking about “me”. And I think we must not lose that, I don’t think we will. So does that answer your question? It was a very complex question.

DR. RAUH: Yes, I know it is.

DR. GREEN: I think that if it hadn’t been discovered it should be discovered. If you join it, you will get better. Some organizations don’t influence you very much. You feel after while, "What am I doing with this, is this important or not?” And I’ve belonged to some of those
organizations, but usually I drop out after awhile because I don’t think they’re good investments in time. I never dropped out of the Academy.

DR. RAUH: How many years has it been, since you gave up the chairmanship?

DR. GREEN: Twelve years.

DR. RAUH: Twelve years ago and you’re still working full-time. Still enjoying it tremendously. I think that’s a real tribute to your whole life, and a wonderful example of how you’ve been a role model for the more senior pediatricians.

DR. GREEN: I think I’ve learned that too. I’m now 76 years old. Well; at age 50 or so I would have thought that I would be ancient at 76 and wouldn’t be vital and energized. I didn’t know how I would feel, didn’t really think about it much. I think that I’ve been very lucky in terms of my health being maintained; that’s critical. But I don’t know, I just like what I do. My secretary tells me, "Slow down; what are you doing that for? There’s another day tomorrow." But there’s so many things I really enjoy here. As I say I think I have the best job in the world. There are a lot of good jobs, but I have something to do with children and families, I get to read, I get to write, get to see young people. I can make a change if I want to, I can make a difference.

DR. RAUH: What do you like to read, what areas do you like to read in besides pediatrics?

DR. GREEN: I like to read biographies, principally, history. Non-fiction kinds of things. I don’t read fiction much. My wife’s interested in literature, English literature and so on, and you know sometimes I see a book she has and I read those, but I think it’s mostly histories and non-fiction things.

DR. RAUH: One of the things I’ve been asked to ask you about is what they call gazing into the future. Where do you think pediatrics will go in the next ten years? Is that something you feel you can respond to?

DR. GREEN: Well, I can explain what I’d like to see happen. It may not happen in ten years. It’s hard to predict a time, you know. You can tell when a building will probably be finished, that’s pretty concrete. The question you asked is more philosophic, and conceptual. It’s a little more difficult to answer and predict in terms of time, so many things influence it. I would like to see them work more in the area of psychological and emotional development, particularly in young children. But also teenagers, in a way that starts back then. I’d like to have them have pediatrics be
really concerned about how a child’s developing psychologically, emotionally, developmentally. What the aspirations of children are, do they feel they can’t develop, do they have opportunities? We’ve done a lot better than we did starting out in pediatrics in this field, and I don’t know what they’re going to say yet in the new report on pediatric education. I hope it will emphasize it a lot more. I was on the last task force and I wrote the section about the bio-psycho-social aspects and the need for more training there. That has improved some, but I think we have a long way to go. Probably it’s influenced by whether pediatricians will be paid for this activity. I don’t think we’ve made our case yet to the public or legislators or to opinion leaders or to corporate presidents, people like that. They’re the ones that I think will determine that. That’s a big challenge. I would like, of course, to see the assurance that all children will have access to good care. I think the Academy’s been working on that now, and has worked on it a lot. That will be a nice bit of progress, and I think continuing research in all aspects of pediatrics will pay off. The Academy will be one of the leaders there.

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

DR. GREEN: I think in terms of their physical health, generally -- like infectious disease, things like that, life or death situations -- I think so -- except for accidents. So I think they’re probably better off there. Whether they’re better off psychologically, I don’t know. I see so many children who are not doing very well. I think we can combat prejudice which has always been a problem; I’m concerned about that. The minority children that very early on decide they don’t have a future and they act that way. How are we going to turn that around? Terrible, big problem.

The question is what can the private pediatrician do in his office, with the problems he has? Well, he can’t do it all alone. He has to develop key resources, or help develop them. I think pediatrics will increasingly join with other forces, organizations, people, to improve things for children generally. If we don’t do that, if we don’t see the broad context of what we’re doing, we’ll limit ourselves, and that’s not in the best interests of children. We’ll put a fence around ourselves. It’s pretty hard to go from being comfortable, sitting here in this hospital, smug, self-satisfied, feeling that if any child comes to this hospital we’ll take good care of him or her. I think we can. That’s not too difficult, given the resources, we can do that. So I’m not too concerned about that, but I never focused on that alone when I was chairman of the pediatric department. That’s what I wanted to explore when I was acting commissioner of the Indiana State Department of Health. I took that opportunity, because I saw quickly that one can be the chairman of pediatrics and build a big hospital department and have a lot of people doing excellent work, and that’s wonderful. But what about
the rest of it? Is the chairman of pediatrics limited to just the traditional role which has been determined for a children’s hospital? Pediatrics and children's hospitals will, I believe, assume a larger role in the future in mental health education, family health, and become more involved with population as well as individual child health. That’s what the Academy wants to do with community health, and what should be in our master plan -- identifying with others the needs of children in our state, for example. Now they say research labs, of course, that's good. I can't oppose that obviously; we need some other things, you know, like that. But that’s pretty concrete, and it’s important. My view is just, can we have more influence on the health of children?

DR. RAUH: In the broader sense.

DR. GREEN: Yes. We're doing well here with children, we can influence care elsewhere. While we can complain about what we don't have, limits and this and that; we ought to think, "Well, we are pretty damn lucky here." We are. My parents felt that way, I think. As I look back on them, they could have had many reasons to say, "Well, I came from a foreign country; I don’t know English very well; I don’t have the education yet to really do all these things we’d like to do." They had the brainpower but they didn’t have the sophisticated education at that time and they had to work very hard just to raise their children. I think they hoped that we would do better. They didn’t ever say that specifically but they felt it was worthwhile investing in education as most immigrant parents felt at that time. "If we do this, maybe our children can help achieve what we were not permitted to do." They weren’t you know, envious of us or anything like that but they were just proud of what we could do, and really felt good about it. I always felt an obligation to them in that sense. I think if we could have more impact on children, we can influence the future in a broad way. I don’t see the ones that are really bad off. They can’t get to us, they’re not referred and don’t have access, or whatever, so we don’t see a lot of the really bad ones.

DR. RAUH: If we could reach them more in public policy ways, as we’re trying to do; I think the Academy is a good example of a success there. Of course it’s not doing it alone. But it is the lead organization, probably in the world, as a pediatric organization. We can accomplish an awful lot.

DR. GREEN: Well, I think so. I think there are a lot of bright people in the Academy -- both practitioners and academicians. I have a high regard for practitioners of pediatrics based on my long experience here. I know a great many of those in Indiana very well and I think they’re doing a very good job. There's a lot of brainpower there; a lot of drive, and we need to capture that in the interest of children. And I think the Academy’s
doing that. If you get these people involved in projects, they will make important contributions.

I’ve seen the Academy become a remarkably strong and effective organization. That’s why I encourage our residents to join the Academy, get involved so they will continue to grow and advance. To be an active member, you just have to be a person interested in children. And that takes real leadership that brings young people along, shows them the way, gets them enthused. Pediatricians can be very powerful motivators for families, parents and children. They have great positive influence, if they use it. Who else do families have access to that have the scientific, clinical background, that broad understanding and judgement to really be a mentor -- thoughtful and wise? I think pediatricians could be, and many of them are, extremely influential. And I emphasize to residents.

I saw a 13-year-old a couple days ago and he was very anxious. He becomes very angry at times; eg, he slashed woodwork in his bedroom. He has very few friends; he worries a lot about things; he’s not doing as well in school as he could. He’s also said to be hyperactive and on a tremendous dose of Ritalin, but it's not helping. He spends four hours a night doing homework with his mother. Well, that boy and the family need somebody that understands what’s going on, and the judgment to help them make needed changes. It’s already late in the child's development. And you have to motivate them. Well, my interview with this child was a challenge, because I wanted the boy to identify with me in the sense of here’s a doctor that understands what’s healthy for 13-year-old boys and who likes him and would like to know him better. I like him, in a sense he likes me. I’m going to try to have him identify with what I, as a pediatrician, think is healthy for adolescents his age and act as a coach for him. Helping children identify with the pediatrician and what the pediatrician believes is healthy for children is a powerful therapeutic tool that can make an important difference.

I have come to appreciate the importance of the pediatrician serving as a model for a broad variety of persons whose interests, understanding, and skills are important to children. I just mentioned the importance of gaining the adolescent patient's identification with the pediatrician's expertise as to what is best for the health of infants, children, and adolescents. Not only is the acquisition of such an ability critical in relation to individual patients but also in influencing positively the clinical care provided by other professionals, the quality of community child care services, the contributions of teachers and schools, and the dedication of legislators to the best interests of children and families. Because of their exemplary personal commitment to children, expert knowledge, wide clinical experience, and practiced judgement, pediatricians have unparalleled
opportunities to serve both as clinicians and highly effective advocates for children, individually and collectively.

END OF TAPE
Index

A
ambulatory care, 9, 10, 12
Ambulatory Pediatric Association, 12, 25
American Academy of Pediatrics, 24, 25, 26, 27, 28, 29, 30
anticipatory guidance, 15, 25
Army Medical Corps, 4, 5, 6, 7
Army Specialized Training Program, 4

B
behavioral pediatrics, 12, 15, 17, 18, 19, 22

C
child psychiatry, 8, 9, 14, 17, 18, 21, 22
Collaborative Office Rounds, 18

D
Darrow, Daniel C., 9
developmental pediatrics, 15, 20, 25

G
Gesell, Arnold L., 8
Green, Alan, 21
Green, Carolyn, 21
Green, David, 22
Green, Marcia, 22
Green, Susan, 22
Green, Sylvia, 23

I
Indiana State Department of Health, 28
Indiana University, 3, 5, 7, 10
Indianapolis, 1, 4, 10, 25

J
Japan, 5, 7

K
Kessel, Woodie, 17

L
Land, Edwin, 24
Lithuania, 1

M
Manchuria, 5
Maternal Child Health Bureau, 17, 18
Meiks, Lyman T., 4, 10

P
Pediatric Diagnostic Clinic, 13
Poncher, Henry C., 7
Powers, Grover F., 8
Provence, Sally, 9
public health, 5, 6

R
Richmond, Julius, 7, 8, 9, 17, 25
Riley Hospital for Children, 1, 10

S
Senn, Milton J. E., 8, 9, 25
Shortridge High School, 3
Simmons, James, 14
Solnit, Albert J., 9, 18

T
Tokyo, 5

U
Underwood, Mary Ann, 12
University of Illinois, 7

V
vulnerable child syndrome, 16

W
Wells, Herman B., 7
World War II, 4

Y
Yale Child Study Center, 8
Yale University, 8, 10
Yale-New Haven Hospital, 10

32
Curriculum Vitae

MORRIS GREEN, MD

BIRTH DATE: May 27, 1922

BIRTH PLACE: Indianapolis, Indiana

MARITAL STATUS: Married - Janice Gorton Green

CHILDREN: David, Alan, Carolyn, Susan, Marcia, and Sylvia

ADDRESS: Indiana University
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UNDERGRADUATE EDUCATION: Indiana University, Bloomington, IN

MEDICAL EDUCATION: Indiana University School of Medicine
Indianapolis, IN

DEGREES: AB, 1942; MD, 1944

INTERNSHIP: Indiana University Medical Center
Indianapolis, Indiana
January 1945 - October 1945

MILITARY SERVICE: Captain, Medical Corps, US Army
October 1945 - September 1947

RESIDENCY: Department of Pediatrics
University of Illinois
Research and Education Hospitals
September 1947 - September 1949

BOARD CERTIFICATION: American Board of Pediatrics, June 1951
Recertified, June 6, 1980

ACADEMIC/PROFESSIONAL POSITIONS:
Instructor in Pediatrics, University of Illinois College of Medicine, Chicago, September 1949 - September 1952

Assistant Professor of Pediatrics, Yale University School of Medicine, September 1952 - July 1957

Associate Professor of Pediatrics, Indiana University School of Medicine, July 1957 - June 1963

Professor of Pediatrics, Indiana University School of Medicine, July 1963-

Chairman, Department of Pediatrics, Indiana University School of Medicine, July 1967 - November 1987

Physician-in-Chief, James Whitcomb Riley Hospital for Children, Indiana University School of Medicine, July 1967 - November 1987

Director, Section on Behavioral/Developmental Pediatrics, 1985 -

State Health Commissioner, Indiana State Board of Health, February 1990 - November 1990

HONORARY SOCIETIES:

Phi Beta Kappa
Alpha Omega Alpha, President, Indiana Chapter, 1980 - 1981
Sigma Xi

AWARDS:

Raymond B. Allen Instructorship Award, University of Illinois College of Medicine, 1951

The Francis Gilman Blake Instructorship Award, Yale University School of Medicine, 1955

The George Armstrong Award of the Ambulatory Pediatric Association, 1971

Irving Rosenbaum Community Pediatrics Award, Indiana Chapter, American Academy of Pediatrics, 1981

The C. Anderson Aldrich Award in Child Development, The American Academy of Pediatrics, 1982

The Irving S. Cutter Award, Phi Rho Sigma Medical Society, 1984
The Ross Award for Pediatric Education of the American Academy of Pediatrics, October 1985

The Glenn W. Irwin Distinguished Faculty Service Award, Indiana University School of Medicine, 1987

The Simon Wile Award of the American Academy of Child and Adolescent Psychiatry, 1989

The Joseph St. Geme Award of the Federation of Pediatric Organizations, 1992

The Abraham Jacobi Award of the American Medical Association and the American Academy of Pediatrics, 1990

Distinguished Service Award, American Academy of Pediatric Dentistry, 1995

Lifetime Achievement Award, Ambulatory Pediatric Association, 1996

ORGANIZATIONS:

American Pediatric Society
Society for Pediatric Research
American Federation for Clinical Research
American Academy of Pediatrics
  Member, Ross Education Award Committee, 1988-91
  Past Chairman, Council on Child and Adolescent Health, 1989-95
  Member, Task Force on the Future of Pediatric Practice, 1989-90
  Past Chairman, Committee on the Psychosocial Aspects of Child and Family Health
  Past Chairman, Section on Child Development
  Past Member, Scientific Program Committee
  Past Member, Committee on Hospital Care of Children
Indiana Chapter, Past-Secretary: Member of the Executive Committee; Past-Chairman, Committee on the Handicapped Child; Chairman, Committee on Promotion of Pediatrics
  Past Alternate Chairman, District V
  Past Member, National Nominating Committee
  Member, Section on Community Pediatrics
  Member, Section on Adolescence; Past-Chairman, Section Nominating Committee
  Past Member, Task Force on the Effectiveness of Preventive Health Care
Member, Work Group, AAP Task Force on Coding for Mental Health Disorders in Children
Association of Medical School Pediatric Department Chairmen, 1967-87
National Association of Children's Hospitals and Related Institutions
Past Member, Board of Directors
Past Member, Council on Pediatric Health Care and Delivery
Society for Research in Child Development
The American Orthopsychiatric Association
Midwestern Society for Pediatric Research
Past Chairman, National Clinical Advisory Committee, the National Foundation
American Medical Association
Fellow, American Association for the Advancement of Science
Past Member, Pediatric Test Committee, National Board of Medical Examiners, 1975-79; Member, Panel, Standards Project, 1982;
Supplementary Reviewer, FLEX 2 Examination
Past Member, Residency Review Committee for Pediatrics, 1979-84
Accreditation Council for Graduate Medical Education Appeals Panel
Member for Pediatrics, 1987-93
Past Member, Task Force on Pediatric Education
Study Group for Pediatric Education; Vice Chairman, 1980-81;
Chairman, 1981-4
Study Group for Pediatric Education and The Needs of Handicapped Children, 1979-82
Institute of Medicine, National Academy of Sciences
Chairman, Committee for Study on Health Consequences of Bereavement, 1983-84
Member, Panel on Mental Health of Children, 1985-
Member, Membership Committee, 1986-89
Member, Steering Committee, Study on Research on Child and Adolescent Mental Health Disorder, 1988-89
Society for Behavioral and Developmental Pediatrics
National Center for Clinical Infant Programs. Past Member, Board of Directors; Committee on Communications
Chairman, Task Force on Growth and Development Program for Recertification, American Board of Pediatrics, American Academy of Pediatrics, 1985-86

PUBLIC SERVICE:
Planning Consultant: Health Services for the Poor in Marion County.
Marion County Health & Hospital Corporation, 9/91 -
Past State Health Commissioner, Indiana State Board of Health

Past Member, Advisory Committee for the National Program to Consolidate Health Services for High Risk Young People. The Robert Wood Johnson Foundation

Past Member, Technical Advisory Committee, P.L. 94-142, Harvard University Division of Health Policy Research and Education

Past Member, Bristol-Myers Nutrition Grant Selection Committee

Chairman, Health Forums, 1970 White House Conference on Children

Former Pediatric Consultant, Project HEAD START

Past Member, Task Force on Prevention, Joint Commission on Mental Health in Children, Inc.

Past Member, Board of Directors, Marion County Chapter, National Foundation

Pat Member, Board of Directors, United Cerebral Palsy, Indiana

Past Chairman, Governor's Advisory Committee on Child Mental Health, Indiana. State Department of Mental Health

Chairman, State of Indiana Preventive Health and Handicap Services Coordination Study Commission, 1987-89

Past Member, Indiana State Commission for the Handicapped

Chairman, Block Grant Advisory Council, Indiana State Board of Health, 1987

Past Member, Indiana Task Force, White House Conference on Children and Youth

Advisory Committee to the State of Indiana Department of Public Welfare, Division of Services for Crippled Children

Past Member, State of Indiana Sickle Cell Advisory Committee

Past Member, Indiana Breast Feeding Promotion Advisory Council, 1987-88, Indiana State Board of Health
Past Member, State of Indiana Developmental Disabilities Advisory Council

Cluster Leader, Child Health and Safety, Indiana Federation on Children and Youth

Member, Task Force on the Prevention of Handicapping Conditions. Indiana State Board of Health Chairman, Child Health Committee, 1984-86

Panelist, NIH Consensus Development Conference on Defined Diets and Childhood Hyperactivity, January 13-15, 1982

Regional Interviewer, Yale Medical School

Member, National Advisory Committee, The Ounce of Prevention Fund, Chicago, IL, 1982-

Past Member, Pediatric Task Force, St. Vincent Hospital and Health Care Center

Past Member, Advisory Board on Child Developmental Toys, Mattel, Inc.

Member, Selection Committee, William T. Grant Foundation Faculty Scholars Program in Mental Health of Children, 1983-90

National Advisory Committee, American Association for Gifted Children Advisory Committee on Community-Based Comprehensive Service Systems, National Maternal and Child Health Resource Center, 1987-88

Member, Planning Committee, National Conference on Primary Health Services for Children, Bureau of Maternal and Child Health and Resources Department, HHS

Member, Riley Memorial Association Board of Governors, 1990 -

Consultant to Marion County Health and Hospital Corporation on Planning of Health Services to the Poor and Uninsured

EDITORIAL BOARDS:

Past Member, Editorial Board of PEDIATRICS
Past Editor, Newsletter of the Ambulatory Pediatric Association
Past Member, Editorial Board, CURRENT PROBLEMS IN PEDIATRICS
Past Member, Editorial Board, JOURNAL OF DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS
Past Member, Editorial Board, PEDIATRICS UPDATE
Editorial Board, CONTEMPORARY PEDIATRICS
Past Member, Editorial Board, SOCIAL WORK IN HEALTH CARE
Past Member, Editorial Board, PEDIATRICS IN REVIEW
Contributing Editor, Childcraft and World Book Publications, Field Enterprises, Inc.
Past National Advisor in Pediatrics to Children Today, published by the Office of Child Development
Advisory Board, Pediatric Projects, Inc.
Advisory Board, Current Diagnosis 7 and 8
Past Member, Advisory Board, Behavioral Developmental Series, Ross Laboratories
Editorial Board, Caring for Your Baby and Young Child, Birth to Age 5, American Academy of Pediatrics, New York, Bantam Books

UNIVERSITY COMMITTEES:

Chairman, Committee on the Future of the Medical School, 1988-89
Chairman, Committee Planning 20th Anniversary Celebration, Indiana University-Purdue University, Indianapolis, 1989-90
Past Member, Executive Committee, Medical School; University Hospitals
Chairman, Selection Committee, Camp Riley for Handicapped Children
Past Member, Ambulatory Care Strategic Planning Committees, I.U. Hospitals
Past Chairman, Riley Master Program Planning Committee
Past Member, Education Committee, School of Medicine
Past Member, Committee on Senior Electives, School of Medicine
Past Member, IUPUI Faculty Council
Search and Screen Committees:
Past Chairman, Committee for Dean, Indiana University School of Medicine
Past Chairman, Committee for Chairperson, Department of Obstetrics and Gynecology
Past Chairman, Committee for Chairperson, Department of Medical Genetics
Past Chairman, Committee for Chairperson, Department of Psychiatry
Past Member, Consultative Committee on the Search for a New Indiana University Vice-President (Indianapolis), 1986
Past Chairman, Committee for Chairperson, Department of Family Medicine, 1988
Chairman, Committee for Dean, Indiana University School of Nursing
Chairman, Beering Lecturer Selection Committee, 1987
Member, Advisory Committee for Fine Arts Medicine Program
Member, Ethics & Research Committee, 1990 -
Past Member, Executive Committee, Diabetes Training Center
Past Member, Presidential Inaugural Advisory Committee,
Indiana University

PAPERS:

77. Green M. Interview techniques that get results. Contemp Pediatr 1984;1:52. (Oct)
78. Green M: When the toddler is out of control. Contemp Pediatr 1984;1:86. (Dec)
100. Green M: Dealing with the competitive parent. Contemp Pediatr 1987;4:98. (July)
143. Green M: Coping with the "helpless" parent. Contemp Pediatr 1997;14:75-88. (Nov)

PUBLICATIONS:
BOOKS:


BOOK REVIEWS:


COMMENTARIES:

4. Green M: The ties that bind. Commentary to accompany videofilm. Prepared by Health Sciences Communication Center, Case Western Reserve University, Cleveland, OH.