Robert J. Haggerty, MD

Interviewed by
James W. Kendig, MD

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Elizabeth R. McAnarney, 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 that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

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ABOUT THE INTERVIEWER

James W. Kendig, MD, FAAP.

Dr. James Willis Kendig received his MD degree from the Jefferson Medical College in 1970. He completed a fellowship in neonatal-perinatal medicine at the Milton Hershey Medical Center of the Penn State University. Between 1982 and 1999, he served on the faculty at the University of Rochester School of Medicine and Dentistry where he had the honor of working with Dr. Haggerty. In 1999, Dr. Kendig returned to Pennsylvania and is now a professor of pediatrics in the Division of Newborn Medicine at the Penn State Children’s Hospital and the Penn State College of Medicine in Hershey.
Interview of Robert J. Haggerty, MD

DR. KENDIG: Good morning. I'm Dr. James Kendig and I have the great privilege this morning of introducing and interviewing Dr. Robert Haggerty for the American Academy of Pediatrics here in Rochester, New York, on September 9, 1998. Good morning, Dr. Haggerty.

DR. HAGGERTY: Good morning.

DR. KENDIG: In a previous interview with Dr. [Robert A.] Hoekelman, you had an opportunity to discuss your family background, your own childhood and your collegiate and medical school education. I thought today it would be appropriate to start our interview with a discussion of your work in Boston, particularly your work with the Family Health Care program.

DR. HAGGERTY: Yes. I'll try to re-trace the development of my own career, although it's always colored by retrospect and probably a little rosier-colored than it really was. And how it got me to what I concede now are my major contributions and perhaps major philosophical underpinnings, namely integration of child health services; the need to partner with various disciplines and organizations; and the need to take a family, community and global role. None of these were preconceived ideas. I want to point out for young people that I got into them as I went along through experience and learning from others, rather than having any overarching goal to begin with.

As I was finishing the chief residency at Boston Children's Hospital, I actually had arranged to have a fellowship with Dr. Alex [Alexander] Nadas, a very charismatic cardiologist. I was going to be a pediatric cardiologist. About in May, before finishing the residency at the end of June, Dr. [Charles] Janeway, who was the chairman of the department, called me in. He said that Dr. Dane Prugh, who was the child psychiatrist at Boston Children's, was leaving, actually to come to Rochester to head the child psychiatry program here, and that he'd obtained a grant from the Commonwealth Fund to develop a home care program. I think Dr. Prugh was interested in using the home care program to educate residents as to family and community aspects of child health. Dr. Janeway said, "Would you like to take it over? You have had a fairly general background." I'd had the two year mixed internship here, two years in the military, and I guess I had complained from time to time that the Boston Children's Hospital was a little super-specialized for training of general pediatricians. So he said, "You've talked about this. Would you take it over?" I said, "Well, I'm committed to Dr. Nadas." But he said, "I'll talk to Dr. Nadas." And I remember I never asked him about salary. As a matter of fact, it's an interesting thing; one never got an answer from Dr. Janeway as to what your annual salary would be. He would hem and haw and say, "Well we'll have to
But then I did ask him, since this was to be a junior faculty position, I said to him, "Is this permanent?" And he laughed and he said, "Nobody's permanent here but Lou [Louis K.] Diamond and me." Two outstanding people. But it was at the time a very small department; there was basically one person in each division. Cardiology maybe had three with Abe [Abraham M.] Rudolph and Julien [I. E.] Hoffman, I think. And they were hospital-employed, not Harvard faculty. So he asked if I would take this over, and part of it was to be the chief of the division of child health. Well, there weren't any Indians in the division; it was a single person division. But Dr. Harold Stuart, who was the chairman of the department of maternal and child health at the Harvard School of Public Health, had been the division chief. It was housed in a three-story wooden building on the corner of Blackfan Circle and Longwood Avenue, across from the hospital. In retrospect quite a firetrap, I suspect. On the third floor, there was a big office, which had been Dr. Stuart's, and I inherited that along with a couch that he used to take an afternoon nap. But the main activity there was a well child clinic run by the City Health Department, I think twice-a-week, and they staffed it with Department of Public Health nurses there.

So I started with a clinical base, if you will, a twice-a-week clinic, and a grant from the Commonwealth Fund to develop something.

DR. KENDIG: Did you have a budget when you started?

DR. HAGGERTY: No. I knew that the total grant for a three-year period was $160,000, and out of that my salary was to come and any other people that I hired. Beyond that, there was no budget. I had a slight delay in starting because just before I was going to finish the chief residency, in June. Dr. Mohsen Ziai, who was to succeed me as chief resident, was Iranian. He came and said that his mother was going to spend the summer with his sister in Paris and he hadn't seen her for several years. He said, "You've been chief resident for a year and summertime's slow. Won't you continue for July and August and I'll be back in September?" And I said, "Well I have to start this program." But he said, "Oh, you can do both." He was a very persuasive person. So, because I was a close friend of his and all, I agreed.

Well, on July 3rd, I think, I got a call from one of the residents that a child came in with bulbar polio, and needed to be put in the tank respirator [iron lung]. I'd had a lot of experience with polio, actually having been sent out by the National Foundation for Infantile Paralysis. And so I went in and helped put this child in a tank respirator. That was the beginning of the last polio epidemic, at least in the Boston area, because it was the year in which the controlled trial of the Salk vaccine was going on. But Boston wasn't a part of
that. We saw over 3,000 patients that summer with possible polio. The 350-
bed hospital was entirely converted to polio patients except for about 15 beds
reserved for trauma. At one time we probably had 30 or 40 patients in tank
respirators. It was a terribly, terribly busy and anxiety-producing summer.
I think I got home about three nights in two months. One of them was to
take 20 cc's of gamma globulin and inject my poor wife, who was pregnant
with our third child, as a preventive. As I said, it was the last gasp. So I had
a delay of a couple of months.

And then in the fall, in addition to just administering this well baby clinic, I
started to think about what I was going to do with this grant. And I thought
I'd better go around and visit some places. In Boston, there was a home care
program run out of Tufts [University] that took calls in the morning from
parents who had a sick child and they would send medical students out to see
the child. It was an emergency room visit basically; but made in the home.
That had been going on for years and years; it was part of what was called
the Boston Dispensary. So that was one model. It didn't appeal to me very
much because there was no follow-up, there was no continuity at all, and it
was not tied to any well child work. I then visited Barbara [M.] Korsch in
New York Hospital, who was doing with George [G.] Reader a program
providing comprehensive care to welfare patients. It was a family program
that provided care for the whole family. That seemed to be more a model
that I liked. I visited Paul Harper at [Johns] Hopkins [Hospital] who was the
chairman of maternal and child health, and he had written a book on what
was involved in preventive pediatrics. [Preventive pediatrics: Child health and
development. New York: Appleton-Century-Crofts, 1962] Again, there was
very little written about this, even though most pediatricians did a lot of well
child work. It was hard to find a text as to what one should provide and Paul
did that. I'm forever grateful for that; it's still a wonderful book. And I
visited Cleveland, where they had a family program for teaching medical
students. First year medical students were assigned a pregnant lady and a
family and they provided more of a social work context.

So out of that, I finally settled on what I called a family health care program.
I thought it was important to take care of the whole family, but I was not
willing to provide only the well child or preventive side. I was enough of a
clinician for sick kids that I wanted the care part. So we called it a Family
Health Care Program. I recruited a public health nurse, Miss [E.] Lenihan,
who had actually worked with Dane Prugh on his controlled trial of an in-
hospital child life program. I think it's one of the few controlled trials
showing that kids got better quicker and had shorter hospitalizations as they
were provided this experience in hospital.

DR. KENDIG: And you had some internists as well?
DR. HAGGERTY: I had an internal medicine [practitioner], an obstetrician, a child psychiatrist, and a social worker. Plus a secretary, and so that's what we used the money for. And we began to recruit families, with the initial plan being to provide this program for our pediatric residents. So, a lot of the families were recruited from the well child clinics there. I was particularly interested in getting the residents involved, and I'd say that they weren't always very enthusiastic about it. I thought one way to involve them was to have them bring patients that they had cared for in the hospital who had ongoing illness, as a child with diabetes or a child with post meningitis or mental retardation or a variety of diseases, including congenital heart disease. And I had an agreement from Dr. Janeway, which in itself was quite remarkable that I could recruit any child from any clinic in the hospital to my clinic. And so I recruited children with cystic fibrosis from Dr. [Harry] Schwachman's clinic, and kids with congenital heart disease from Dr. Nadas. We provided the general care, the preventive care and the acute intermittent care. They continued to receive their specialist care from the specialty clinic.

DR. KENDIG: How did the private pediatricians in the community view all this?

DR. HAGGERTY: Well that's an interesting point. I'll come to it later in Rochester when there was some opposition. I don't remember any opposition in Boston. It was partly because we were selecting patients who were indigent and underserved. This was pre-Medicaid, so there was no basis for payment.

But it's an interesting point because the city well baby clinics that were in my building, which I was responsible for and which were staffed by city public health nurses, were forbidden to provide curative services. You couldn't even write a prescription for penicillin if they had a raging sore throat; you had to send them across the street to the emergency room. That had been the agreement worked out years before, I suspect by the medical society and the public health department, that there was this division between prevention and cure. It's another reason why I put care in our program; I did not want to separate the two. And actually, it was similar to what practicing pediatricians were doing; they provided integrated care. So in some ways I think the practitioners saw me and saw what I was doing as trying to provide training for residents, which would better prepare them for the kind of practice that they did. So rather than opposition, I would say most of the practitioners were really very pleased with this.

A couple of points, I think. Dr. Stuart, who is best known for designing the percentile growth charts, continued to work in the clinic and was a real wonderful mentor to me. He had, for years, followed a group of children in Boston and measured their growth and development. And so I got ensconced in that research. Matter of fact, the first research thing I did there was to
evaluate the 21-year-old follow-up of these kids that he'd followed since birth. Their growth is the growth charts that everybody uses now. I remember seeing these 21-year-old kids come in and looking at his write-up of them at birth. Very frequently he would say, "This flabby, loose-jointed, placid child at birth," and in would walk this floppy, sort of flaccid kid. And then another description of this newborn would be, "This very hyperactive, muscular, energetic kid," and in would walk this muscular, energetic kid. So I became relatively convinced of the persistence of temperament, and even physical characteristics through that. But also two other public health physicians, Dr. Pauline Stitt and Dr. Valadian worked in that clinic. So I began to be exposed to the public health aspects, which were not only prevention but also population-based. All of our patients came from an area of Boston called Mission Hill, in Roxbury, which at that time was a largely Irish immigrant, relatively poor population. But right from the start they began to educate me that you couldn't just wait for patients to come into you, you had to have a system in which you tried to go out and find patients who needed medical care, because the target area was geographically based.

DR. KENDIG: Were home visits involved?

DR. HAGGERTY: Not in the well child program, but as we recruited more and more patients into the family health care program, we did home visiting for the residents. We mainly did home visiting for acute illness. And we had an answering service; they made home visits, but usually I went out with them. It was a little difficult, like pulling teeth, to free them up for that.

The other thing was that I started to do research in this program. I think this was different from some of the other programs around the country. I saw this as a laboratory where we could, in fact, study a lot of things. I think we talked last week about how we were the first to give the live measles vaccine to home dwelling kids; we did a random control trial with Dr. [Samuel] Katz, who had developed the vaccine. We had the patients and he had the vaccine. We did other studies, we did studies with Dr. [John F.] Crigler [Jr.] on normal endocrine development of kids. He was interested in adrenal function development. We studied an influenza vaccine. So we did a fair amount of that kind of research.

The other thing, because I had been chief resident in the hospital, I started out with a fair number of patients that I had cared for who had chronic illness, and fairly rapidly I built up a practice. It was not a planned thing, but people referred patients to me. Doctors in outlying areas would have a child that would be admitted to the hospital, and they didn't want to come in from Westwood, for instance, an hour's trip to see one patient; so they'd call me up and ask if I'd take care of them in the hospital. And if they didn't want them back afterwards for any reason I would take care of them. So I slid into the care of patients with bacterial meningitis, for instance, and
eventually was taking care of most of those children. I got a group of children with juvenile rheumatoid arthritis. I tended to pick up problem cases that there wasn't, at that time, any specialty for. There wasn't anybody doing rheumatoid arthritis; there wasn't anybody really doing bacterial infections in children. Dr. [John F.] Ender's lab and Dr. [Thomas H.] Weller's lab, were focused on viral infections. So at the same time I was attending in the hospital a lot. I would attend two or three months a year on the floors; and I took morning report in the emergency room a lot of the time.

DR. KENDIG: Sounds like a very busy schedule.

DR. HAGGERTY: Well, it was busy. In part it was a desire to maintain and keep my clinical interest. In part it was a little way to earn a little extra money; $4,000, even then, didn't go very far. And in part it was to keep my presence in the hospital. We were one of the first continuity programs, if you will, the predecessor of some of the current continuity programs. It was not easy going. I would say a third of the residents were interested, a third were kind of passive, and a third were very opposed to it; they didn't want to spend their time doing what they considered "not serious" illness.

DR. KENDIG: Was this a required rotation?

DR. HAGGERTY: Well, it was not a rotation; they all were assigned. Initially, we gave them about five families from the well child clinics there, and they provided care for all the children in the family. These are pediatric residents at Boston Children's. But at the same time, the internist and obstetrician faculty members took care of the rest of the family. So I was interested in having the residents learn about the families from these other people, even though the pediatric residents weren't providing that sort of care. But because of the resistance of many of the residents, I thought it was important to be visible in the hospital and to be visible as a doctor who had competence in taking care of all the sick patients that were in the hospital. I think that's still an important issue; I worry sometimes that the continuity clinics around the country seem separate from the in-hospital care. I think to the degree that that happens, they are less successful. So even some of the residents would say, "Well, I don't like this well child work, but if you're doing it it's probably OK." Because I had a certain reputation, I guess, among them. And I always had patients in the hospital who were pretty sick.

DR. KENDIG: How about the involvement of medical students?

DR. HAGGERTY: Well, that came a little later, a year or two after we got going. It had always been the plan to involve medical students. But the question was at what level should we involve them. As I mentioned, I had visited the Cleveland group, which was the first to assign medical students a
family and they did it in the first year. Again, I had this care issue in my
mind, and was unwilling to give up the role of a doctor caring for sick
children, and thought the medical students at first year just couldn't act as a
doctor. So we decided to do it third year. And so the program assigned
medical students a pregnant lady, multigravida, who had had normal first or
other pregnancy. And the medical student took care of the whole family,
under the supervision of the obstetrician, the internist and myself, and, more
importantly, the public health nurse, Miss Lenihan, who provided care for
all the family. We had students do this, and I'm convinced that a bonding
experience occurs between the medical student and the mother through the
pregnancy. That's an experience that makes them much more...

DR. KENDIG: And the student was present for the delivery?

DR. HAGGERTY: And the student was present for the delivery. In fact I
had an agreement from the Dean that they could be called out of anything
they were in if the delivery occurred, because it's the one shot they had.

DR. KENDIG: What did the other departments think of that?

DR. HAGGERTY: Well, surgery in particular was unhappy at first about
it. They thought that this was a little folderol and why did they get called out
of other responsibilities. Particularly the chairman of surgery, at the [Peter
Bent] Brigham [Hospital], objected to it. But the dean and Dr. Janeway were
behind me. And the chairman of obstetrics was behind me. And George
Thorn, chairman of medicine, was supportive. So that's an important part.

About two or three years into the program, we decided to do a random
controlled trial of this clinical education experience. We did this in part
because I really was concerned about the need to evaluate how effective this
was as a teaching exercise, and in part because they started a similar
program at the Massachusetts General Hospital. We didn't get any informed
consent of the medical students, but we randomly assigned about 36 students
to this program, and had a control group, and worked out a series of
evaluation methods. One of these was to evaluate the write-ups of the family
and social history when they were on other services: internal medicine,
surgery, in other hospitals. And that was in itself rather interesting.

One sidelight: there was a woman medical student, who really was very
sensitive and did a super job with us. She had a patient in surgery at the
Mass [Massachusetts] General Hospital, a young man with ulcerative colitis
who was going to have a colectomy. And in her social and family history, she
wrote non-contributory. I went up to her afterwards and I said, "Gee there
must be something here with this serious illness. Does he have a family?"
And she spun out this whole tale. She knew it backwards and forwards; she
had taken a very good family and social history. And I said to her, "Well,
why don't you write it down?" She said, "Oh, if I wrote that on surgery they'd think I was soft in the head." So it impressed me that students are very adaptive to the culture of the moment.

So, at any rate, we did this evaluation and have written it up. There was relatively little difference. One of the concerns of some of the people was that we would actually hurt the students; that their marks would drop because of the investment in this program. Well, that didn't happen. Matter of fact, it was a very small investment. And there was a slight increase in the number who elected to go into the medical specialties; internal medicine, psychiatry, pediatrics; as opposed to surgery which at that time was a very popular selection process. So I think at best we can say it didn't hurt the students, and there are a lot of anecdotes about the students. Years later some of them who went into surgery actually would ask me about their families when they would see me.

The students made home visits. First of all a regular home visit just to assess the home environment, before the mother delivered. Then they made a visit to the newborn baby about a week or ten days after the baby went home. In those days mothers stayed in the hospital seven to ten days, so this was about three weeks or so. And then they went in on acute illness, and saw social problems as well as physical.

Just an example, one New Year's Eve we had a call from this family that was always in trouble. Mother had had a baby and she had psychotic breaks almost every time she had a baby. She called me and said that she was committing suicide. And so my wife and I and a student went out on New Year's Eve to the house and found the father absolutely dead drunk. The mother had taken a bottle of barbiturates. She was fairly comatose, but there were four little kids in the house. And we left the father and we took the mother into Brigham Hospital and had her admitted there. But what to do with four little kids on New Year's Eve? Well, I called the social worker in our program, and she told me about what's called the [New England] Home for Little Wanderers, one of those typical old Boston institutions. We took the children up to that Home for Little Wanderers and they took them in and kept them until the mother got home from the hospital.

Students exposed to that kind of crisis learned something. It's hard to quantitate and all, but it was that kind of experience I think that got me more involved in the social and emotional and behavioral aspects. It was clear that families' emotions were important in their health. Probably the best research that I ever did was the study of streptococcal infections and stress in the family, in which we followed a number of families for a whole year, and cultured them periodically. We were taking care of them so we knew whenever they got sick. We had the mother keep a diary of stressful life events. We were able to show that there was a significant increase in all
respiratory infections, including streptococcal, within a short period after a stressful life event; a father losing his job, the family moving, the kid failing in school. That was published in *Pediatrics*. Actually it was the first paper I ever gave to SPR [Society for Pediatric Research] in Atlantic City. We were doing research in this program and we were increasingly involved in the public health approach through my contact with these people in public health.

DR. KENDIG: What other disciplines were you able to link with?

DR. HAGGERTY: Initially, none. What I recognized was my need for research skills. So I started by taking epidemiology and biostatistics and actually a social anthropology course, all at the Harvard School of Public Health. I got to know some of the people there, including the behavioral scientists. And two of them, a medical anthropologist, Bob Rappaport, and a medical sociologist, Bob Wilson, were running a program at Harvard College with [Talcott Parsons], a very famous sociologist, called medical sociology. It was a post-doctoral program; they had about 18 postdoctoral social scientists, sociologists, psychologists, and anthropologists, and there were three of us physicians who went. We spent all day Friday in seminar and presenting our research and having feedback about it, and that got me very much involved.

I recognized the need for even more training, so I got a fellowship from the Commonwealth Fund again to go to England for a year and study medical sociology. I took epidemiology and biostatistics again at the London School of Hygiene and Tropical Medicine, but I worked with an anthropologist there, Margot Jeffreys, to develop a family function scale and instrument. And when I came home, I then hired a medical anthropologist, John Kosa, who worked with us, and later a medical sociologist, Dr. Leon Robertson. So behavioral scientists were brought in, and we worked in partnership with other disciplines. Certainly, unless I had been able to work with those people, I would have never been able to do the research. But I don't think that's much different than clinicians in medicine working with PhD biochemists, for instance, or neonatology with pulmonary physiologists or whatever. So I think the model of clinicians working with basic scientists is an absolute essential.

I'll mention just a couple of other things about Boston. I don't know quite how it occurred, but Dr. [Lendon] Snedeker, who was an assistant administrator, also worked in this well baby clinic, and he'd been a practitioner before he went into hospital administration. And he had been active in the [American] Public Health Association, and he told me one time, "You know, they're starting these poison centers; there's one in Chicago now. Maybe we ought to have one here in Boston." So I started the Boston Poison Information Center. There were no files of ingredients. We got a
little money to hire a medical student for the summer and he went out to Woolworth's and drug stores and looked at the labels of the most commonly ingested things that kids took, and got the address of the company and wrote off. We had about 600 products that we started with. And I got active in that and the organization of the national program. I was actually president, I think second or third president, of the American Association of Poison Control Centers; so I was getting into toxicology, if you will.

The other thing was the big study that we did, which was to evaluate the effectiveness of family care compared to episodic care. We got a grant from the Commonwealth Fund and later supplemented it with Maternal and Child Health [Bureau] funds, to do a random controlled trial. We recruited families from the emergency room who did not have a doctor and were using the emergency room and other city well baby clinics for preventive services, and randomly assigned them to an intervention group which was our program. They got the family program. Some of them got medical students, some got the internist, obstetrician, pediatrician, providing the care and the others were left to use their usual source. It was a three-year study. Dr. [Joel J.] Alpert was by that time a faculty member and Dr. Margaret [C.] Heagarty was a fellow. It was just at that time that I got offered the chair here at [University of] Rochester, so I left in the middle of that study but went back quite a lot to complete it. Very interesting study in that we were able to show some reduction in hospitalization, increase in preventive services, and cost reduction because we did far less x-rays for kids with asthma, for instance, and didn't prescribe as many medications because we knew these families. So it was one of the first random controlled trials of health services, and it's what got me into the health services area.

DR. KENDIG: And that was published as well?

DR. HAGGERTY: That was published finally in a book form *[Changing the Medical Care System: A Controlled Experiment in Comprehensive Care]*; we published a series of papers along the way. So I think that the contributions of that program were that it got me more and more into integrated services, prevention linked with cure, research on families and research in health services. And I think I came to the attention of Dr. Kerr [L.] White who was then at North Carolina and who initiated the Health Services Research Study Section in the [US] Public Health Service; he got me appointed to that. It really was one of the most wonderful educational experiences, as I think service on all study sections is. It gives you the ability to rub shoulders with many other disciplines. We had economists and historians and health services researchers, various behavioral scientists on this, many very outstanding people, and reviewed grants from all over the country. In addition, I was asked to chair a group that went to Scandinavia to look at health services research there. That ability to move into the health
services research community was another very important aspect and
certainly led to the programs that we developed here at Rochester.

DR. KENDIG: Could you comment a little bit about your work with the
*New England Journal of Medicine*?

DR. HAGGERTY: Yes. Certainly another facet of my career has been
editing. I guess I've always liked that; I was editor of my high school
yearbook and I was editor of a freshman handbook at Cornell. I don't really
know whether that was known to anybody. But Dr. Janeway called me in
one day and said that Dr. [Joseph] Garland, who was the editor of the *New
England Journal* and a pediatrician, had asked him if there was a
pediatrician who would be willing to serve as an associate editor. He was
going to appoint an internist and a pediatrician, and Dr. Joe [Joseph] Stokes
III was the internist at the Mass General Hospital. It was attractive to me for
many reasons. As I said I liked editing. There was a little money involved,
which was always in short supply, I tell you, in Boston. And again, it got me
involved with a very distinguished editorial board of the *New England
Journal*. Maxwell Finland, famous in infectious disease, George Thorn and
others. Joe Stokes and I read all of the manuscripts that came in and
assigned them to one of three groups and frequently sent them out for review
as well. One group we thought was definitely rejection, another group we
thought was definitely acceptance, and then a middle group. It was the
middle group of course that caused the long discussion at the board meetings.

DR. KENDIG: Did you have meetings weekly?

DR. HAGGERTY: Board meetings were monthly. Weekly, Joe Stokes and
I had a long lunch on Friday afternoon with Dr. Garland in which we went
over issues and discussed future things with him. One of the things that I
would tell any young person is try to find yourself a mentor; somebody who
is willing to help you learn the ropes of many things. And my two mentors
were Dr. Janeway, who was absolutely wonderful, but also Dr. Garland. He
was just a marvelous human being, patiently taught us some of the arts of
writing.

He had been a practicing pediatrician until his mid-50s when he went into
congestive heart failure while climbing a tenement in Boston to see a sick
child. He had a patent ductus arteriosus which he never would have repaired,
and he figured he needed a more sedentary life after that. Actually he
continued editing until, I think, close to 80; so he was a long time editor. Out
of those discussions and all with him, we developed a series on social
medicine in the *New England Journal*. I don't know whose idea it was, but I
guess we all contributed. We had an article on the economics of health care,
we had one on compliance, and we had one on public health and clinical
medicine.
DR. HAGGERTY: Yes, well, I guess maybe that was how I came to Dr. Garland's attention, now that you mention it. We had gotten permission through the poison center to publish a monthly article called "Toxic Hazards." I published the first ones myself, but then as time went on it was a good vehicle to get the residents who had taken care of a child to write up a case with me and then we would review the literature on that. Again, there was very little in the literature at that time about how to deal with common poisons. Fred Rosen and I wrote one on boric acid poisoning in a kid who'd had boric acid put on diaper rash, so it was a series of interesting articles of that sort.

The editorial part was certainly very important and led later to the editorial work on Pediatrics. That came after I got here; I was appointed a co-editor of Pediatrics with Dr. [Jerold F.] Lucey. Later I was asked to start this new journal, Pediatrics in Review, in 1978, a continuing education program which I still edit to this day. And then, of course, there was one other editing activity I got involved in after I got here to Rochester. Dr. Morris Green, who had been active in founding the Ambulatory Pediatric Association, and I felt that there was a need for a textbook on this field. I think any field kind of has to either have a journal or a textbook or something to solidify the knowledge. We edited the first volume, I think probably in about '65 or 6, of Ambulatory Pediatrics, and we're just putting the fifth edition to bed right now. So that's continued. Later on we wrote up our community child health experience here in Rochester in a book called Child Health and the Community.

So between editing of journals and editing of books, I have certainly done a fair amount of editing.

DR. HAGGERTY: Well, the first meeting was actually in 1952. I was in the Air Force, and I went to the meeting of the Society for Pediatric Research with another friend of mine in the Air Force. While there, he took me to a room where Katherine Dodd, who had been his teacher at Vanderbilt, and Barbara Korsch and Dick [Richard] Olmstead were talking about the need...
for this kind of a program. This was before I had finished residency. About 1955 or 1956, the organization was formally established and I had at least been involved a bit. I think I was the third president of it. So I became active from the very beginning in that association.

Well then we come to Rochester. As I got back from the sabbatical, I began to get offers of chairmanships around the country. Most of them were not all that attractive for a variety of reasons; either they were areas of the world I didn't want to live in or something. So I was really pretty well convinced I was going to stay at Boston. As a matter of fact, the goal I had there was to create a department of family medicine. We had begun to get fellows from family medicine to train with us. Lynn [P.] Carmichael, after he had his fellowship with us, became chairman of the new department of family medicine. I think had we stayed, we would have done that, and Harvard would probably have trained more of the chairmen of family medicine. I think that might have made a difference so that family medicine might have gone down a more research-oriented path than it has. But since I'd interned here in Rochester and I came from upstate New York, I had a warm spot in my heart for Rochester. So I was at one of the Association of American Medical Colleges meetings giving a talk when I was asked to have breakfast with Dr. [Leonard] Fenninger, who was the director of [Strong Memorial] Hospital, and Dr. [Robert] Berg who was chairman of the search committee for the chairman of pediatrics. Dr. Berg was chairman of preventive medicine.

I was very excited about that, because this was a place I could see coming to. And the more I talked with the people here, the more this seemed to be a real fit for me. So I was very excited about coming here, and came as chair in July of '64. I had what would now be considered a very small dowry, if you will. I think I got five new positions from the dean. But you have to remember there were only 13 people on the full-time faculty in the department at that time, one of whom was the star Gilbert Forbes who remains here and who was a wonderful supporter of me all through those years. I brought with me Dr. Evan Charney who was just finishing his fellowship with me in Boston, to develop a continuity program and family health program here.

The one position we never filled; I had a half-time salary for a child psychiatrist who was to be jointly supported by psychiatry. Dr. Prugh had left just as I came here; he went to Colorado. We were never able to fill that position, which I was very sad about. I think, even to this day, child psychiatry here has not flourished. We got an immunologist, Dr. Robert [H.] Schwartz, who was finishing his immunology program, and a couple of other faculty members, and began.
One of the exciting parts of the job here was that there was to be a new hospital. And, as a matter of fact, in March or maybe April of '64 when I had already agreed to come, the dean called me. He said I had to come right up because they were putting the finishing touches on the plans for the new hospital and I needed to design the pediatric service. So I came up and spent a couple of weeks in the spring of '64. Got here and, of course, then the Vietnam War escalated. We had a fairly large grant from the U.S. Public Health Service for a hospital building that got put on hold. They dug a hole for the basement, but then stopped. We used to kid that it was the world's largest swimming pool. The hospital was never completed until after I left; it opened in the summer of '75, 11 years later. So I never worked in this current hospital.

But our hospital facilities were very inadequate in pediatrics. There had never been a premature nursery. Dr. [William L.] Bradford had carved out a little room across the hall from the infants' ward where we had preemies, but this was before any kind of respiratory therapy and about all we did was keep them warm and feed them. They were just completing an animal research lab, and I think I got 5,000 feet of space there. Stan [Stanford] Friedman was one of the other people I recruited in the area of psycho-neural immunology, as well as adolescent medicine, and he had a laboratory there: a mouse stress laboratory. Aside from that, we didn't have any laboratory space and most of the people worked in other labs.

Our two infectious disease people, Dr. [James B.] Hanshaw and Dr. [Lowell] Glasgow who both went on to be chairs at other places, had their labs in microbiology. Dr. Schwartz, when he came, had his lab in the immunology lab in medicine. So we really had very inadequate space. I remember the first time I met with the faculty I told them that my goal here was to have a balanced department. I guess I was a little sensitive that I may have been known as more of a behavioralist, but I wanted to make sure that people understood I wasn't just interested in that. But we were really hamstrung in terms of the space. I particularly wanted to build neonatology. I mean it was clearly a core part of any pediatric department, and yet we had this terrible little preemie nursery. I started out recruiting with Dr. Mel [Mary Ellen] Avery, I had her up and Nick [Nicholas M.] Nelson and Peter [A. M.] Auld, and several other luminaries in the field of neonatology. And they all sort of laughed at me as if to say, "You mean you want me to work in that space?" And I'd say, "Well, we're going to have a new hospital, you know, and you can design the nursery." It was to be on the obstetric floor where it is now, so it was certainly to be a nice one, although not anywhere near what it is today. But all through that time we really had difficulty developing the hospital-based and laboratory-based services. That's not to say that I wasn't interested in developing a community program, which was going to be my thing. But it certainly led us to look as if that was the major thing we did here because I wasn't able to get some of the other subspecialties developed.
And so we became known as, I think, probably the premier community child health pediatric department. I had brought from England and from this public health experience in Boston the idea of geographically based medicine and the responsibility for a defined population. Right from the start, I said that this department being the only department of pediatrics in the community, the only academic department, should be responsible for the children's health of Monroe County especially, and even for the region. That didn't mean that we were going to provide care for all those, but we needed to understand who wasn't getting care, and assist those who were, including the pediatric services at Highland [Hospital] and St. Mary's [Hospital]. So from the early period we developed random sample household surveys. I was able to recruit Dr. Klaus Roghmann, a sociologist who is still here.

The first summer I was here, I had a grant from the [Rochester] Patient Care Planning Council, Mr. Marion Folsom from Kodak was chair of that. Its purpose was to integrate the pediatric services. All five hospitals in the city had pediatric services. The Rochester General [Hospital] had a pediatric residency program. The others did not, or if they did it was periodic. Genesee [Memorial Hospital] probably occasionally had one. Dr. [Joseph] Stokes [Jr.], this was the father of Joe Stokes III at the Mass General, had just retired as chair at Penn, and he came up and spent most of the summer with me. Together we looked at the needs; he, as a senior person with gray hair, was good in talking to boards of trustees. And we finally patched together a program, which was to close the pediatric services at Highland and St. Mary's. In return they were going to get extended care beds, so they were pleased with that. And to make Genesee and the [Rochester] General integral parts of Strong [Memorial Hospital], and have a single residency program for the three hospitals. A single faculty program in which the chiefs at General and Genesee would be paid for entirely by that hospital, but would be appointed jointly by me and the university and their board of trustees.

DR. KENDIG: That was a very innovative plan in those days.

DR. HAGGERTY: I think so, and therefore it covered all the hospital base. The other part of that was that we would develop the specialty programs in conjunction with strengths in those other hospitals. Genesee Hospital had a very strong gastroenterology medicine group under Dr. [Harry L.] Segal, and so when I recruited a gastroenterologist, first Dr. [Clinton B.] Lillibridge and then Dr. Marilyn [R.] Brown, both were based at the Genesee Hospital. And the Rochester General Hospital had, and I think still has, a strong hemophiliac clinic, and the chairman of medicine was a hematologist there. So we appointed Dr. Jerry Miller, a hematologist, to be the chief there, and developed some of the hematology. So the idea was not to have everything at Strong.
I made a sincere effort to try to show the rest of the faculty an integrated approach, in that I rounded one month every year at the Genesee and one month every year at the General. And, by and large, the rest of the faculty did this. It now has extended, of course, to the house staff even, a third of them having their continuity program at the General Hospital. So integration of hospital services was something that probably was relatively unique around the country.

We also did the development of these community-based surveys. One of the things that was clear is that the inner city here, like every inner city, had a lack of medical care. In the seventh ward, where we ultimately developed a health center, there were two minority physicians, both elderly, and that was all.

DR. KENDIG: And no department of health clinics in those days?

DR. HAGGERTY: Yes, there were well baby clinics. Again, there was a separation. The public health departments around the country had long term agreements with the Monroe County Medical Society that they were not to develop curative systems.

DR. KENDIG: Oh, only well baby care.

DR. HAGGERTY: And you asked earlier about the conflict. In 1965, maybe early '66, Dr. Charney and I went to Washington to see if we could get a grant to develop a Children and Youth Project; it was part of the Great Society [Lyndon B.] Johnson program. Dr. George Silver, who was the Deputy Assistant Secretary of Health, told me, "Well if you've been interested in taking care of families, why don't you go over and see this young woman, Miss Lisbeth Baumberger (who's now Lisbeth Schorr). She's running this new program in the Office of Economic Opportunity." We got over there, and she said, "If you can get a grant in within three weeks, we'll give you three million dollars a year to start a community health center." And we came home and developed the community board, and got the grant in. And then we had two barriers. The first, you asked about opposition. We took this to the Monroe County Medical Society, and I remember Dr. Charney and I presenting this, feeling we were doing this great good for the community, and I almost felt it was pro forma to ask their permission. Well, there was a lot of debate, and it got approved, as I remember, 54 for, to 52 against, by the Medical Society. Very close.

And then the other part was the president of the university was very reluctant to have this as a university project. I think he was concerned that this was a huge financial risk and that if the government pulled out the university would be expected to continue it. He was also politically
conservative and, I think, didn't agree with the Great Society programs. But eventually it was approved and the health center was started in what was the old Baden Street well baby clinic. Dr. Ken [Kenneth] Woodward, who had been a practicing pediatrician, had been running that clinic, so he became the director. And it was a model like the family health program in Boston, in that we took care of the whole family then. We had residents in pediatrics and medical students there, and plans were made very early to build a new building. So probably we took maybe three years before the current [Anthony L.] Jordan Health Center was completed. Dr. Jordan had been one of the minority physicians practicing there, a beloved man. He retired as soon as the community health center came in. He was in his 70s and he'd only hung on because of dedication to the patients.

So the Health Center was started, and from the start there, we also were concerned about evaluation and research. And we had a fairly large budget within the community health center grant to do an evaluation, and that allowed me to do the community surveys that Dr. Roghmann did. In addition we got a program project grant from this health services research study section, to study child health services here, and we were able to hire a number of faculty who were partly research and partly service. Dr. Charney was the chief research physician on the team.

Dr. Charney and I have often referred to this as the Camelot days, because it was a very exciting time. We felt we were on the cusp of something very important. We were able to show that the patients in the community health center had fewer hospital days, better immunizations, again reduced costs. And we were able to recruit Dr. [Philip R.] Nader to develop the school health program, and one of the reasons we built the Jordan Health Center right next to School Six was in order to link the school health and the community health center together. And we got Dr. [Robert] Chamberlain to do some behavioral and community research projects. There were a number of other faculty members who were recruited. And as I said earlier, it looked to the outside world, and I think it looked to many of the faculty here, like we were developing a community behavioral program almost exclusive to the rest. But as I say, it was within this limited hospital base that I intended to develop the hospital subspecialties when I could.

DR. KENDIG: Dr. Haggerty, I'm afraid our time is up for this morning. We will take up again in a future tape, your work from this point on. And I'd like to thank you for sharing these many exciting aspects of your most distinguished career with us this morning. Thank you.

DR. HAGGERTY: Thank you.

END OF TAPE 1, SIDE B
DR. KENDIG: I am Dr. James Kendig. It is September 30, 1998, and I am interviewing Dr. Robert Haggerty for the American Academy of Pediatrics. This is tape number two. Good morning, Dr. Haggerty.

DR. HAGGERTY: Good morning.

DR. KENDIG: Before we continue our chronological discussion of your most distinguished pediatric career, I was wondering if you could elaborate on a few philosophical issues that we had been discussing earlier this morning.

DR. HAGGERTY: Yes. I think the first is viewers of this in the future need to remember that memory is fallible. And I recently had a quote from Dr. [Daniel] Schachter, a psychologist at Harvard, who said, "Every act of memory is an act of imagination." I think, therefore, we are subject to distortion and illusion and our memories are fragile. The other point is that doing a chronological approach to one's life sometimes makes it appear more purposeful, more orderly than I think it actually is.

I've recently been reading a book by Dr. Michael Lewis called [*Altering Fate: Why the Past Does Not Predict the Future*] [New York: Guilford Press, 1998]. He's a psychologist who has done a longitudinal study of children's development. He says, "In this book I will argue that accidents and chance encounters are a part of life. Life is not orderly or predictable, and thus the past does not seal our fate. Instead I will argue for a view of life as complex and emerging, where the task is always adaptation to the present." I think the two points I would take from that are one, that we put an artificial sort of purposefulness and symmetry to our lives when we talk about them in context. We forget the asymmetries. But also that adaptation and change are always possible, and at my age that appeals to me; that your fate is not sealed just because of something that happened in childhood.

There are a couple of things I didn't mention chronologically last time that I think would be helpful in that regard. When I was finishing Cornell Medical School in 1949, my intent was to be an internist or a family physician. I really had not had a terribly exciting experience in pediatrics. I applied to two internal medicine internships, one at Case Western [Reserve University] and one at Columbia [University], and the mixed medical here at Rochester. I was turned down by Columbia; that was my first choice. Had they accepted me, I'm sure that I would have pursued on a straight internal medicine career. As a matter of fact, Dr. David Barr, the chairman of medicine at [Cornell-]New York Hospital, had offered me an assistant residency the following year after finishing my internship in mixed medicine here at Strong. So, it's an example of how chance occurrences: the fact of coming to Rochester, the experience that was so positive on pediatrics here, converted me to a pediatrician.
DR. KENDIG: Well, we're all very pleased that you chose to come to Rochester and select pediatrics.

DR. HAGGERTY: I thought I would also finish a little bit with the contributions that I perceive having made here at Rochester.

DR. KENDIG: During your time as chair.

DR. HAGGERTY: I think that, what we did was to move the department first in size. I think there were 13 faculty when I arrived, and there were 65 full-time faculty when I left. I mentioned in the last tape about the development of the community-based programs. I think what it did was to put on a national visibility basis the fact that pediatric departments could and should take responsibility for organization and evaluation of health services for all the children in their community, not just those who come into the hospital.

DR. KENDIG: A population-based approach.

DR. HAGGERTY: A population-based approach. So that probably, philosophically, was the major contribution. But during that time we started a behavioral pediatric program; we started the adolescent program, both with Dr. Stanford Friedman. We had a health services research program that was a good size here. At the same time, we had the reputation of being a very good place for general pediatric house staff training. Each year we had outstanding applicants, and I think many of them then went on to other places for subspecialty training. We were not terribly strong in most of the subspecialties. But I think we, at that point, were looked upon as one of the top two or three places in the country for an internship and residency in pediatrics. It was a wonderful springboard for most people.

DR. KENDIG: And many of those individuals stayed here in Rochester.

DR. HAGGERTY: And many stayed, but many also went on to other places. The medical school class of, I believe it was '70 or '71, had something like 18 or 20 people that went into pediatrics. These included the current chair of pediatrics at Harvard [Medical School], Phil [Philip] Pizzo, and the current chair of maternal and child health at Johns Hopkins [University], Dr. Bernard Guyer. I think Dr. O.J. Sahler was in that class, and several others. Students were attracted to the department then, as they are now, and then many of them went on to distinguished careers elsewhere.

Well towards the mid-'70s, I think I mentioned that the university wasn't always very friendly towards this community approach. In part I think it was the concern that this was a financial exposure should the external
funding cease. But in part it was also the feeling that this was not academic enough. We were subject to repeated examinations and reviews by committees to see whether we were academic enough. We usually passed with flying colors because we actually were producing lots of papers, and I think the research was good.

DR. KENDIG: Inside reviewers, or outside?

DR. HAGGERTY: Inside reviewers. The process of external reviews was started during that time, and they were always very positive, with the exception that they all decried the lack of a hospital that allowed us to develop a first class neonatal intensive care unit. I think I mentioned that before, but that was in the planning. But I did get a little frustrated at what I perceived as the criticism of the department, internally that is, which externally I think was held in very high regard. I had done a lot of traveling because we were getting the research on our community programs. We were one of the few, I think, in the country that had good evaluation of this. I was asked to give talks in many places, and I felt this was important to spread the word about Rochester, to recruit faculty and house staff.

DR. KENDIG: Yes. Put it on the map.

DR. HAGGERTY: Put it on the map. And I think we did. The price I paid was at home. I was perceived as being away quite a lot. One year the house staff gave me a model airplane, they said, "If you're flying all this time you ought to have your own plane." And another time they gave me a certificate as a visiting professor in the department of pediatrics here at Rochester.

I was getting a bit itchy with the criticism and all. And then some of my key people were recruited to other places. It's always a privilege to have them go. Lowell Glasgow went as chair at [University of] Utah, Dr. [James B.] Hanshaw went as chair at the new school at University of Massachusetts, Dr. Charney went as chief of pediatrics at Sinai [Hospital] in Baltimore and a full professor at Hopkins, Dr. Friedman went as chairman of child psychiatry at [University of] Maryland, and Phil Nader in school health left. So many of the people that I had recruited and were the exciting core of the department were visible and being recruited elsewhere. The thought of starting over and recruiting all those people again, and this feeling that we weren't always appreciated at home, made me susceptible, I guess, to a variety of outside offers.

I began to get offers. I was offered the chair of pediatrics at Case Western Reserve, and I almost took that. I was offered the deanship at the school of public health at the University of Washington and almost took that. And the director of the new Center for Health Services Research at [University of] North Carolina. Our children were in high school, so it wasn't a good time
for them to move; but I was getting susceptible to this, when an alternative arose. I was invited to spend the year of '74-'75 at the Center for Advanced Study in the Behavioral Sciences at Stanford [University]. This was an opportunity to get away from the academic and the administration and think for awhile and see what I wanted to do with my life. And we had only one child in school by that time, in high school. And so we went out there, where I was one of six people of a group that the [Henry J.] Kaiser [Family] Foundation had funded to examine the issue of, "How do you assess quality in health care?" And actually I was on the National Professional Standards Review Organization at that point.

It was while I was there that Dean [Howard] Hiatt, the new dean at the School of Public Health at Harvard, came out and was asking a variety of people for suggestions of faculty. He was looking for a new chair of maternal and child health at Harvard and asked me. I gave him some names, but then I said, "You know I might be available." And I think he saw this as a good move, because he himself had not had training in public health, and the new approach he was bringing to the School of Public Health was much more integration with the medical school. The Maternal and Child Health Department there was a small one, I think four or five faculty, and my initial reaction once I looked at that, I got a little less interested. After all, I had a department of 65 here and house staff and all. And so he engineered a package which was more appealing. He combined the Departments of Behavioral Science, which was about the size of Maternal and Child Health; the Department of Health Services, which was the largest department in the school, a department that trained health services administrators; and the Department of Maternal and Child Health, into a Department of Health Services of which I was to be the chair. He had an endowed Harvard Chair, the Roger I. [Irving] Lee Chair, available. So the offer included this expanded department, the availability of a Harvard chair, returning to Boston which had been one of the most pleasurable periods in our life, and with the mandate to link the School of Public Health with the Medical School and the Department of Pediatrics (I was given a professorship in the Department of Pediatrics at Harvard) and to be considered a division chief by Dr. Avery (she was the Chair at that time) for all of her meetings.

So I embarked with great enthusiasm on this new venture. And things could have worked out had there, again, not been a series of unplanned events. Dr. Hiatt, because he was trying so hard to move the School of Public Health in new directions, angered many of the traditional faculty in the School of Public Health. I think, in retrospect, he was overly critical of them and they were a very distinguished group of people. One, for instance, Dr. Thomas [H.] Weller, a Nobel prize winner, was chairman of the Department of Tropical Public Health, namely infectious diseases. And Dr. Hiatt removed him as chair of the department because he had opposed some of the moves that Dr. Hiatt was making. Well, this led to enormous conflict within the
school. And, at one point, 20 of the 30 tenured faculty petitioned the President to have the dean removed. I didn't join that; I believed in the things that Dr. Hiatt was trying to do, the moving of the School of Public Health, but I didn't believe in the methods that were being used. But at any rate, there was this constant cabal of one group trying to get you to join and another group and so that was crazy politics and unpleasant.

Second point was that within the Department of Health Services, Dean Hiatt had created a number of new programs largely based on the business school, short intensive programs for business leaders, and had recruited faculty from the business school to teach these. Well these were all in my Department of Health Services, and yet I didn't have much control over these courses nor the people that had been recruited. On the other hand I was always being asked to get them promoted, and by and large their scholarship was of a very different kind and the School of Public Health promotions committee were not very sympathetic to it, in part because of their antagonism to the Dean.

DR. KENDIG: I believe you mentioned that when you arrived there, they gave you an honorary Master's Degree.

DR. HAGGERTY: That's right. Well, that's a Harvard tradition. If you have a Harvard named Chair, you have to have a Harvard degree. So they had a special convocation to award me an honorary Master's Degree, because I didn't have a Harvard degree at that point.

And then the third thing, I was developing, what I think is still a very good idea, namely that the School of Public Health needs a teaching community. The equivalent, I said, of a teaching hospital for medical school. A defined population for which it could be an assessor of data, it could be a deliverer of services, it could be an epidemiologic catchment area. We got this started with some [W. K.] Kellogg [Foundation] money, and I recruited the former commissioner of health for Boston City Hospital to head the project. We then applied for a very large grant to the [Robert Wood] Johnson Foundation. One of these fortuitous things, in retrospect, they turned me down on the basis of some of the site visitors feeling that I should be doing this but I should be doing it in the medical school, not the School of Public Health. Had I gotten that grant, I would have felt committed to staying there. So in the third year there, 1978, I was frustrated by all this unhappiness in the faculty and my inability to get enough money to do things. And so I went to President [Derek] Bok and told him that I was resigning. And he said, "Well, I can understand." He was sort of caught in the middle too. He said, "I can understand all the conflicts that you're having there, but you don't have to give up your Roger I. Lee Chair, it's an endowed chair." I said, "Well, but I don't want to hang around and not have anything to do." And he, facetiously I'm sure, I don't think it was honest,
said to me, "Well, half of Harvard faculty who have chairs don't do anything."

LAUGHTER

DR. HAGGERTY: At any rate, I at that point resigned from the School of Public Health, and kept my professorship in the medical school. I actually moved back to the Children's Hospital, where Dr. Avery asked me to try to bring together five or six groups. They weren't all divisions but they were groups that are really a part of what I call general pediatrics. There was the behavioral pediatric with Dr. [T. Berry] Brazelton, the mental retardation unit, the child abuse unit, the outpatient department, a community outreach program and some others. And so I did convene these groups and got them beginning to work together. Again, they were not terribly keen on joining together unless I could find funding for them. That was the glue, and I hadn't been very successful at that.

So I wrote a grant to the Robert Wood Johnson Foundation to develop a fellowship that I called "General Academic Pediatrics," which was to provide fellows for all of these groups as a way of bringing them together. At the same time, I think Dr. [Neil Anthony] Holtzman from Hopkins applied to the Robert Wood Johnson for a somewhat similar grant, so I think they felt there was something positive here. They invited us to some meetings, and ultimately funded what was called the General Pediatric Academic Development Program and asked me to be the national program chair, which I was pleased to do. That was a ten-year project, from '78 to '88. Six schools, including Rochester, had a fellowship program. One hundred eleven fellows went through the program. We've just completed a review of them. Two-thirds of them are in full time academic positions now. So I think it was a reasonable success.

DR. KENDIG: Right. Remarkable achievement.

DR. HAGGERTY: At the same time, Dr. Friedman, who had left here to go to Maryland, had applied to the [William T.] Grant Foundation to develop a behavioral pediatric training program at University of Maryland. And the Grant Foundation had several meetings bringing several of us together to talk about this, and eventually decided to fund 11 programs, a competitive situation, so there were a lot of site visits to be made to select these. I started doing a lot of site visits for the Grant Foundation during that time, '77, '78.

In late '78 the Grant Foundation fired the president. He had angered a lot of the grantees. He was a very bright man who was very confrontational, and accused leading pediatricians of not being totally honest with him and all. I don't think he was correct. But, at any rate, the board summarily fired him. Then a few months later, they asked me to be the president. My wife was not
happy about this; she didn't want to go back to New York; she'd grown up there. And secondly she said, "But they fired the last fellow. Why do you want to go to that when you've got a tenured job here?" But I had done enough with foundations at that point that I had seen what they could do in a creative sort of way of developing new programs. And, in retrospect, it was certainly an appropriate next step in my career. I've often likened it to being a department chairman without the problems. You don't have the real estate of the hospital to manage; you don't have to worry about promotions and appointments, and parking, and all of those things. You can just deal with the intellectual aspect of faculty who come to you for funding.

So I took that position, and I think made a number of improvements. We continued the behavioral pediatric program, much to the consternation of child psychiatry, who opposed this. But I think it's been an important development. I was concerned about the disciplinary boundaries that were existing in universities, where people in one discipline, say psychology, were not working with sociologists or with pediatricians, but all were working on the same kind of problem. To overcome this, we created the consortia; I think we created eight of them. They were all 10 to 15 people and multidisciplined. They met several times a year to review each other's research in its early stages and research that we in the foundation said is going to have to be interdisciplinary and interdepartmental if we're going to fund it. We had one on minority groups, we had one on chronic illness, we had one on injuries, we had one on stress-related illness. So I think those were quite a successful venture.

We created the Faculty Scholars Program, which was modeled on my experience as a [John and Mary R.] Markle fellow, where each school can nominate one person and we would support half of their salary for five years to do research. It was at a time when, in the clinical fields, people were being pushed to do more and more clinical work for their salary, or, if they were in the arts and science faculty, they were being pushed to do more teaching. This, we thought, stabilized their research career. We had annual meetings of all these groups, all these people, and that was a stimulating event. It brought people of different disciplines together; several research projects emerged out of those people coming together at those meetings.

Then, for the 50th anniversary of the foundation in 1988, we created a Commission on Youth and America's Future. Among other people, Hillary Clinton was on it. That commission was looking at the transition of adolescence into adulthood, and made several major recommendations, particularly pertaining to the difficult time that inner city minority kids had in making that transition. They might have been doing OK as adolescents, but unless they got some skills and had some social support networks, they didn't get into the appropriate job market. One of the recommendations was for a national service corps to push that, and that led to Mr. [William
Jefferson] Clinton's program for the Americorps, which still goes on. And actually, he keynoted one of our meetings when he was governor. So, that was a very policy-oriented kind of an approach.

And then there was the collaboration with other foundations. I think when I went there, there was a lot of isolation of foundations; in the sense that if it isn't invented in our house it's not any good. Partly because I was from the outside, I was able to say, "Look, I need to find out what you other folks are doing." So we started meetings with the Robert Wood Johnson, the Foundation for Child Development, the Commonwealth [Fund], the Carnegie [Corporation of New York], [Annie E.] Casey [Foundation], and the Grant Foundation, where the executives got together. And I think that was a useful beginning of collaboration among foundations.

So I found the foundation experience very gratifying. I tried to be user-friendly, which I think I was. I have often said that I don't think people ought to go into foundations early in their career. They need to have experience getting and not getting grants. Dr. David Rogers, who was the founding president of the Robert Wood Johnson Foundation, used to say, "In the foundation world, it is better to give than not to receive." And I think that I was able to be user-friendly. I spent most of my days talking to young faculty members who would come in with their nascent research ideas, and we would try to set up technical assistance to develop them if they were at all promising. And as I say, it really was like being a department chair without the aggravation department chairs have.

Well, you wanted to know about the [American] Academy [of Pediatrics]. And I have to now go back in time. In 1971 or '72, I was on the editorial board of *Pediatrics*, the journal of the American Academy. When the editor, Dr. Clement Smith, retired, and Dr. Jerry [Jerold F.] Lucey and I were asked to co-edit the journal. I was asked to do this in large part to influence the journal to be more helpful to the practitioner. There had gotten to be a feeling that it was turning into a perinatal journal; that it was largely, as they said, "rat kidney and sheep lung."

DR. KENDIG: Right. Fetal medicine.

DR. HAGGERTY: And practitioners found this not as useful. So I was asked to do it. I did a third of the papers. Dr. Lucey sent me all the general pediatric infectious disease and some of the other subspecialty areas. And I handled them, decided with external reviewers, which ones to accept and which ones to not accept, and then just sent the accepted manuscripts to Jerry. So that I think we did make an impact and began to be known as a journal that was much more user-friendly to practitioners.

DR. KENDIG: And members of the Academy, too.
DR. HAGGERTY: And members of the Academy, the majority of whom are practitioners. So I was well wired in there. In the mid-'70s, '76, '77, the whole issue of recertification began to appear and the American Board of Pediatrics devised the program of recertification. There was enormous opposition from the practicing pediatric community, and the academic, too, about having to take a reexamination. The Academy and the American Board worked out the division of labor. The Board would set the examination, and the Academy would do the education for the practitioners, and part of that education was to be a journal. I was asked to edit that, and it naturally fit, I think, with this work I was doing on Pediatrics at the time.

That's how Pediatrics in Review was born. It is a journal that has always been driven by the examination. The American Board develops a whole series of statements that are called content specifications, and they build their examination around those. We take those content specifications and we develop the journal. Never having seen the exam, we don't know what's on it, but we know it's going to be related to those content specifications. And I think that it has been a success.

The Academy members were very hostile to the idea of recertification, however, and at one point in the early '80s the Academy actually voted to totally separate itself from this process. And the final settlement was that, starting in 1988, people who were certified before would have unlimited certification, so that they didn't have to be recertified and the Academy has said that they will not be dropped as members. But the insurance companies and hospitals and all may want to ensure that they do get re-certified. Those certified starting in 1988 would be required to take a re-certifying exam every six years. There was always a hope that more of the practitioners would take the recertification exam. I think by and large that's not happened. On the other hand, there's been almost total acceptance of the recertification process by people since 1988 and the conflict has actually died out.

Pediatrics in Review has been a very successful journal. It's now over 30,000 U.S. subscribers. We're also publishing international issues in six languages, and have another 35,000 circulation there. So that has been a very satisfying experience. And that fits very much with my general pediatrics background because we do try to keep the articles and all pertinent to the practitioner.

Well, this was part of the Academy, and I would be asked to give talks to the Academy chapters. In the early '80s, I think, Drs. Jerry Lucey, Jim [R. James] McKay [Jr.] and I together received the Grulee Award, which is one of the highest awards of the Academy. In 1982 or three, I was asked to give a talk to the California chapter. And in the course of it, I talked about the need for the Academy to keep to its original goal, which is the welfare of all
children. The American Academy of Pediatrics, I think, is the only professional medical organization, which has the recipients of its activity as the reason for existence. Others will say to promote the specialty of X, Y, or Z. But the Academy's was to promote the welfare of all children.

DR. KENDIG: Right. Keeps the emphasis on the children rather than on the pediatrician.

DR. HAGGERTY: On the children, not on the pediatrician. But the beginning of cost escalation and the problems of early managed care were coming in, and the president ran and won in the early '80s on the basis that the Academy ought to pay more attention to pediatricians' needs and pediatricians' income. It had strayed too far, he felt, in the other direction. Well, in my talk in California I took the opposite position, and I said we did that at our peril, because part of our success, particularly in the Washington office, was being seen not as advocates of pediatricians but advocates of children.

DR. KENDIG: Right. Not a union.

DR. HAGGERTY: And not a union. So afterwards, some people in California came up to me and said, "Well, wouldn't you run for president?" I have to say that by and large presidents come up a long process of serving at the local and state...

DR. KENDIG: Up through the ranks.

DR. HAGGERTY: Up through the ranks, and I would never have had the patience for that. But I thought, "Well, this point needs to be made." And so I agreed to run. They said, "We'll deliver California for you, and you'll take New York; those are the two biggest blocks. We think you can win." Well, even people like Dr. Hoekelman said he didn't think I'd win, and Dr. Barbara Korsch bet me a dinner that I wouldn't win. And I think because I was visible to the practitioner through the Pediatrics and Pediatrics in Review, as well as a lot of talking around, I won. I must say I surprised myself.

DR. KENDIG: You collected all your bets.

DR. HAGGERTY: Well, I never collected the dinner from Dr. Korsch as a matter of fact. Dr. Korsch still owes me that. And yet I would only be vice president for a year and a president for a year, so that I knew I couldn't do a lot. I think many of the biggest contributions that executives on the executive board make to the Academy are made while they're on that board. They're usually there for six years and they can start a process and get it going. So I felt I had to do a limited number of things. And I thought the most important thing, aside from reiterating this need of the Academy to be for
children, was to bring the practitioners and the academics together. I had had enough of a foot in both of these camps that I could do it. I was one of the first presidents of the Academy to have been an active academician.

So I set about ways to do this. We created what are called councils, which are groups that come together representing the academic societies in the Academy in adolescent medicine, behavioral pediatrics, all of those groups. And they still exist in their ways of communicating. So I think that was probably one of my greatest contributions.

I also felt that we should do what had been successful in Rochester, namely, research in office practice. I got Evan Charney to start that on a national level, and the PROS, Pediatric Research in Office Settings, is now very well funded externally, very successful. They just won the Pew Primary Care Achievement Award for an organization in research, just last week. So I considered those two Academy successes a good thing.

But things do come up. We were finishing the Baby Doe controversy, which took an awful lot of time. And that was a problem because the federal government set up a hotline that anybody who thought that their baby was not being given full treatment could call, and the troops would descend. I don't know whether you were here in Rochester when it was a pair of Siamese twins, wasn't it?

DR. KENDIG: Yes.

DR. HAGGERTY: That somebody thought weren't being fully, adequately treated, and the group came in and they just disrupted the nursery for days.

DR. KENDIG: Paralyzed the nursery.

DR. HAGGERTY: So the Academy was very much opposed to that. And Dr. [C. Everett] Koop was the Surgeon General, so I had several meetings with him about how to reconcile this issue. It was Dr. Koop who came up with the final wording. The basis for this was a reauthorization of the Child Abuse [Prevention and Treatment] Act and it was going to be written in that it was abusing the child not to provide full treatment. And so Dr. Koop's wording was, "When treatment is futile, it is not necessary to do everything that one can do." And we accepted that, although many of the academicians were opposed to including anything in this child abuse law. And actually the Academy was the only medical society invited to the signing. I was invited to [President Ronald] Reagan's oval office for the signing of it. I think some of the academicians, particularly neonatologists, thought we had sold out. But I think the compromise has worked.

DR. KENDIG: Right. It's worked very well.
DR. HAGGERTY: And at the moment I don't think these exist, these hotlines exist at all.

DR. KENDIG: No.

DR. HAGGERTY: Likewise there is a controversy over aspirin and Reye's syndrome. The aspirin industry was very opposed to our coming out and saying that children should not receive aspirin. We had several very acrimonious meetings with them. But finally, I think, we convinced them on the basis of the data, plus they were beginning to realize that they had a much bigger market for aspirin in the adult prevention of heart disease. So the time in the Academy as president, I think, was a busy time. Nowadays it's a full time job. I was continuing as president of the Grant Foundation all through this. I did give up the editing of *Pediatrics in Review* for two years to Dr. Jim McKay, however, because partly conflict of interest and partly, it was just time consuming.

DR. KENDIG: Too much.

DR. HAGGERTY: I still have frequent flyer miles from my trotting down to Washington frequently to testify. So that was the Academy activities at that time.

Looming at 1990 was my 65th birthday, and you have to begin to think about what are you going to do after retirement. I told the Foundation at that point that I thought in two more years I would like to consider retiring, at 67, and they agreed. I had wanted to move back closer to the children and grandchildren and do some other things. And so I planned in this retirement mainly to keep up *Pediatrics in Review*, and I was going to write a biography of Dr. [Charles A.] Janeway, when a couple of other opportunities came along.

I was asked to become the executive director of the International Pediatric Association [IPA], which I have done for the last six years. And that activity stems all the way back to Dr. Janeway; he was very active in that organization. He got me, in 1959, to have an exhibit on bacterial meningitis at the Montreal International Congress. And I had been on the standing committee of the board of the IPA. And so Professor Ihsan Dogramaci, who had been a long time executive director, was stepping down. I was running for president, actually, and I think part of the solution was if I would take the executive director and not oppose the other person who was running for president, we would both have a role. And I think we did.

I've often said that if the International Pediatric Association didn't exist it would have to be created. It's a membership organization of 143 national
pediatric societies. It brings together pediatricians from every culture. All during the Cold War, Russian, U.S., Chinese pediatricians met amicably in meetings. Dr. Janeway himself wrote a paper once called "Pediatricians for Peace," in which he indicated that this kind of mutual meeting couldn't help but promote understanding. And we largely do this through education. We have a journal; we hold four or five workshops a year around the country.

DR. KENDIG: I understand they have a very elegant office.

DR. HAGGERTY: No. They did, in Paris. Actually, not elegant, but in an elegant place. The Centre International Des L'Enfantes in the Bois de Bologne, but I moved the office here. Not a very elegant office here. The new executive director is moving it back there. But no, the actual office is in the annex, which isn't terribly elegant, but the approach to the chateau is elegant, yes.

Here are two examples of the kind of impact you can have. We had a meeting in Pakistan on pediatric education and found out that while 40 some odd percent of the population are children, the medical schools did not require an examination in child health to graduate. We usually were able to get leading people, so we had the Minister of Health and the Minister of Education there. And we said to them, "This is intolerable, you have to do this." Well, six months later they initiated an examination in child health to graduate. Then we hold yearly meetings in one of the former Soviet Republics on the southern tier, the so-called central Asian republics. All the "stans", Uzbekistan, Tajikistan, Kazakhstan, etc. And they were having diphtheria epidemics in '94, '95. And we had a meeting on immunizable, preventable diseases. [Samuel L.] Katz was there. We asked them, "Why are you having diphtheria; don't you have the vaccine?" And they said, "Oh, yeah, we have the vaccine." "Well why aren't you using it?" And they said, "Well, there are all these contraindications." "What do you mean?" Well, in the old Soviet system, with that rigidity, they had issued something like 50 contraindications to vaccine including diaper rash and cradle cap, which meant you never gave a kid a vaccination. So Dr. Katz said repeatedly, "There are no contraindications to DPT [diphtheria, pertussis, tetanus]," and banged on it enough so I think they went back with that message. These were largely chairmen of departments and leaders. And last year, at the meeting in Azerbaijan, we asked them, and they said, "Well, we've gotten rid of diphtheria." So it's a very satisfying kind of activity in which you can make an impact, which in this country is so hard to see what you do. So that's been a very interesting thing.

The travel got to be too much. Year before last I was 130 days out of the country, and at my age I decided to give it up. September 1st, just this month I've given that up.
The second, small activity, I've been quite active in the New York Academy of Medicine, as a member of the New York Academy. Actually was vice president one year. So when I retired they were just changing the whole mission to one of urban health, hired a new president, and they asked me to take over the editorship of their bulletin, which is 150 years old. It's one of the oldest medical journals in the United States. And it was renamed the Journal of Urban Health: The Bulletin of New York Academy of Medicine. And I think we've begun to turn that around, to get articles on urban health and issues of urban health congruent with that mission. So my retirement has been far busier than I had ever anticipated. I haven't done much with the biography of Dr. Janeway. I hope this year to get back to that.

DR. KENDIG: A few trips to Boston. Use your frequent flyer miles.

DR. HAGGERTY: The other thing I might comment is that I've been just extraordinarily benefited by recognition of the work that I've done. I don't consider myself a self-promoter, particularly, but I've been the recipient of a lot of very nice awards, which I think have recognized the work. I've had several Academy awards, the Grulee Award, the Dale Richmond Award, the [C. Anderson] Aldrich Award, the Job [Lewis] Smith Award, the [Abraham] Jacobi Award. And then the Pew Primary Care Achievement Award, the [Gustav] Leinard Award from the IOM [Institute of Medicine], the [George] Armstrong Award from the Ambulatory Pediatric Association, and just this past year the [John] Howland Award.

DR. KENDIG: All very richly deserved.

DR. HAGGERTY: Well, thank you. I think that, as I've tried to say receiving all these, that they in fact award and pay tribute to the team that we put together, largely at Rochester. I think that the community approach here has been the kind of central theme. And if I had to summarize, as I did in the Howland Award, in retrospect there are three themes in this approach. I go back to my initial comment today that this wasn't planned. One is integrated services, to try to cross disciplinary boundaries, to try to move people beyond the narrow disciplines, either within pediatrics or with more and more the behavioral sciences. Secondly, to move from individual care to family to community, recognizing the context in which kids live; the fact that to practice good pediatrics and to improve child health, you have to work at these three levels: individual, family and community. And the last one, of course, partly as a result of my international role, is that health is a global issue and that we can't live in this country economically or health wise without taking into account the rest of the world.

But, as I say, those are what I look at in retrospect as my life. I had planned to be a family doctor or an internist. I wouldn't have at that point articulated any of those three. So I guess if there's one message to leave with
young people it is that life unfolds in ways you never can really predict. Taking advantage of the opportunities, doing your best, being cooperative and helpful to other people, are all good things that will, in the long run, open doors for you in ways that you never can appreciate, or never can see ahead of time, I think.

DR. KENDIG: Well, Dr. Haggerty, on behalf of the Historical Archives Advisory Committee of the American Academy of Pediatrics, I'd like to thank you for sharing your life's journey with us. I know your work is not yet finished, and I know you have many projects that you continue to work on. In a couple years we'll come back and do a third tape.

DR. HAGGERTY: Well, it is always pleasant to talk about oneself.

DR. KENDIG: Well, thank you very much.

END OF TAPE
Index

A
Alpert, Joel J., 10
Ambulatory Pediatric Association, 12, 31
Ambulatory Pediatrics, 12
American Academy of Pediatrics, 25, 26, 27, 28, 29, 31
American Association of Poison Control Centers, 10
American Board of Pediatrics, 11, 26
Americorps, 25
Annie E. Casey Foundation, 25
Anthony L. Jordan Health Center, 17
aspirin, 29
Association of American Medical Colleges, 13
Auld, Peter A. M., 14
Avery, Mary Ellen, 14, 21, 23

B
Baby Doe, 28
Barr, David, 18
Baumberger, Lisbeth, 16
Berg, Robert, 13
Bok, Derek, 22
Boston, 1, 2, 3, 4, 9, 11, 13, 17, 21, 31
Boston Children’s Hospital, 1, 6
Boston Poison Information Center, 9
Bradford, William L., 14
Brazelton, T. Berry, 23
Brown, Marilyn R., 15

C
Carmichael, Lynn P., 13
Center for Advanced Study in the Behavioral Sciences at Stanford University, 21
Chamberlain, Robert, 17
Charney, Evan, 13, 16, 17, 20, 28
Child Abuse Prevention and Treatment Act, 28
child psychiatry, 1, 13, 20, 24
Children and Youth Project, 16
Clintont, Hillary, 24
Clinton, William Jefferson, 25
Commission on Youth and America’s Future, 24
Commonwealth Fund, 1, 2, 9, 10, 25
community pediatrics, 1, 11, 12, 14, 15, 16, 17, 19, 20, 22, 26, 31
community-based surveys, 16
continuity programs, 6
Crigler, John F., Jr., 5

D
Diamond, Louis K., 2
diphtheria, 30
Dodd, Katherine, 12
Dogramaci, Ihsan, 29

E
Ender, John F., 6
England, 8, 9

F
Faculty Scholars Program, 24
Family Health Care program, 1, 3, 5, 13, 17
Fenninger, Leonard, 13
Finland, Maxwell, 11
Folsom, Marion, 15
Forbes, Gilbert, 13
Foundation for Child Development, 25
Friedman, Stanford, 14, 19, 20, 23

G
Garland, Joseph, 11, 12
General Pediatric Academic Development Program, 23
Genesee Memorial Hospital, 15, 16
Glasgow, Lowell, 14, 20
Great Society program, 16, 17
Green, Morris, 12
Grulee Award, 26, 31
Guyer, Bernard, 19

H
Hanshaw, James B., 14, 20
Harper, Paul, 3
Harvard School of Public Health, 2, 9, 21, 22, 23
Heagarty, Margaret C., 10
Health Services Research Study Section, 10
Henry J. Kaiser Family Foundation, 21
Hiatt, Howard, 21, 22
Highland Hospital, 15
Hoekelman, Robert A., 1, 27
Hoffman, Julien I. E., 2
Holtzman, Neil Anthony, 23
home care, 1, 3, 5, 8
Howland Award, 31

I
International Pediatric Association, 29
internship, 18

J
Janeway, Charles, 1, 4, 7, 11, 29, 30, 31
CURRICULUM VITAE

Robert Johns Haggerty, MD
# TABLE OF CONTENTS

## EDUCATION, TRAINING, AND EXPERIENCE

- Education .................................................................................................................2
- License Certification ............................................................................................2
- Positions Held .....................................................................................................2-3

## PROFESSIONAL MEMBERSHIPS AND ACTIVITIES

- Pediatric Societies ...............................................................................................3-4
- Other Professional Organizations .........................................................................4
- United States Government Advisory Groups .....................................................5
- Editorial Boards ..................................................................................................5
- Other Professional Activities ...............................................................................5-7
- Honors and Awards .............................................................................................7-8
- Name Lectures and Major Visiting Professorships ...........................................8-11

## ORIGINAL ARTICLES ..................................................................................12-20

## BOOKS, BOOK CHAPTERS, AND INTRODUCTIONS ..................................21-26

## ABSTRACTS, EDITORIALS, AND BOOK REVIEWS ....................................27-35
CURRICULUM VITAE

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BIRTHDATE:       BIRTHPLACE:
October 20, 1925       Saranac Lake, New York

CITIZENSHIP:
United States of America

PRESENT POSITIONS:
1978- Editor, Pediatrics in Review

1992- Professor of Pediatrics, Emeritus; University of Rochester School of Medicine & Dentistry
EDUCATION, TRAINING, AND EXPERIENCE:

Education and Degrees:

Cornell University  (BA, 1946)
Cornell University Medical College (MD, 1949)
Harvard University (MA, Hon., 1975)
University of Indiana (DSc, Hon., 1990)

Training and Experience:

1949-1951  Mixed Medical Internship, University of Rochester School of Medicine & Dentistry
1953-1955  Jr. Assistant Resident, Sr. Assistant Resident, Chief Medical Resident, Children's Hospital Medical Center, Boston, Massachusetts
1961-1962  Commonwealth Fund Fellow in Social Pediatrics, St. Mary's Hospital and London School of Hygiene and Tropical Medicine, London, England
1974-1975  Fellow, Center for Advanced Study of Behavioral Sciences, Palo Alto, California

License Certification:

1950          National Board of Medical Examiners
1964        N.Y. State Medical Licensure  #92573-1
1955     American Board of Pediatrics - Certification #5597
1980        Recertification American Board Pediatrics

Positions Held:

1951-1953  Captain, United States Air Force (#A02213940), Maxwell Air Force Base
1954-1964  Harvard Medical School:
                            Assistant Professor of Pediatrics (1962-64)
                            Associate (1958-62)
                            Instructor (1956-58)
                            Assistant (1955-56)
                            Teaching Fellow (1954-55)
1955-1964  Children's Hospital (Boston, MA):
                            Senior Associate in Medicine
                            Medical Director, Family Health Care Program (1955-64)
                            Medical Director, Boston Poison Information Center (1956-64)
                            Attending Pediatrician (1955-1964)
1964-1975  University of Rochester School of Medicine & Dentistry, Rochester, NY:
Pediatrician-in-Chief, Professor and Chairman, Department of Pediatrics; (1964-75)
Pediatrician-in-Chief, Strong Memorial Hospital

1975-1980  **Harvard University:**
Roger Irving Lee Professor of Public Health (Health Services and Pediatrics), Faculty of
Public Health (and Faculty of Medicine - Harvard Medical School)
Chairman, Department of Health Services
Acting Chairman, Department of Behavioral Sciences, Harvard School of Public Health
(1975-78)
Professor of Public Health, Harvard School of Public Health (1978-80)
Clinical Professor of Pediatrics, Harvard Medical School (1978-80)
Member of Faculty, Harvard Graduate School of Education (1977-80)
Senior Associate in Medicine, Children's Hospital Medical Center, Boston
(1975-80)

1978-1988  **The Robert Wood Johnson Foundation:**
Senior Program Consultant & Director, General Pediatrics Academic Development
Program

1980-1992  **William T. Grant Foundation:**
President

1980-1992  **Cornell University Medical College:**
Clinical Professor of Pediatrics

1980-1992  **New York Hospital:**
Attending Pediatrician

**PROFESSIONAL MEMBERSHIPS AND ACTIVITIES:**

**Pediatric Societies:**

1956-    American Academy of Pediatrics, Fellow
Vice-President - President Elect (1983-84)
President (1984-85)
Chairman, Council on Pediatric Research (1986-88)
Member of Board, Center for Child Health Research (1999- )
Member, Major Individual Gift Task Force (2000- )

1958-    Ambulatory Pediatric Association
President (1964)
    Chair, Search Committee for Editor of *Journal of Ambulatory Pediatric Association*, 1998.

1967-1970  Pediatric Residency Review Committee (member)
1958-1994  Society for Research in Child Development
1961-    Society for Pediatric Research (Vice-President, 1970)
1964-    American Pediatric Society

1964-1975  Association of Medical School Pediatric Department Chairmen
Secretary (1966-68)
President-Elect (1968-69)
President (1969-70)
1985-1996 British Paediatric Association - Honorary Member
1996- Royal College of Paediatrics and Child Health - Founder Fellow
1983-1998 International Pediatric Association
Standing Committee (1983-89)
Executive Director (1993-98)
1992- Paraguayan Society of Pediatrics Honorary Member

Other Professional Organizations:

1956-1964 Massachusetts Medical Society
1962- American Public Health Association-Medical Care Section
1962-1964 American Association of Poison Control Centers
President
1964- American Association for the Advancement of Science, Member
Fellow (1990-)
1964- Medical Society of the State of New York
1972- Institute of Medicine, National Academy of Sciences:
Advisory Committee on Quality Assurance, Chairman (1973-77)
Chair, Committee on Mechanisms for Advancing the Quality of Health Care (1974)
Member of Council (1974-77)
Chair, Steering Committee, Assessing Quality in Health Care: an Evaluation (1976)
Chair, Committee, Reliability of Hospital Discharge Abstracts (1976)
Committee on Health Services Research (1979)
Advisory Panel - Infants at Risk for Development Dysfunction (1980)
Chair, Conference on Combining Psychosocial and Drug Therapy, Hypertension,
Depression, and Diabetes (1981)
Health and Behavior - A Research Agenda, Institute of Medicine Steering Committee
(1982)
Member of Committee on the Future of Public Health (1986-1988)
Chair, Committee on Prevention of Mental Illness (1991-1993)
Lienhard Award Selection Committee (1995-1999)
Committee on Building Bridges in the Brain, Behavioral and Clinical Sciences (1999-2001)

1981- New York Academy of Medicine:
Vice President (1988-89)
Trustee (1990-92)
Secretary of the Board of Trustees (1990-92)
Chair, New York State Forum on Child Health Care of the New York Academy of
Medicine (1997-2001)
1989-1994 American Medical Association Member

United States Government Advisory Groups:
1964-1970  Health Services Research Study Section, USPHS, Chairman 1969-70 and 1982-84
1965        White House Conference on Health (member)
1966        Study of Health Services Research in Scandinavia, Chairman
1969        White House Conference on Food, Nutrition and Health, Co-Chairman,
            Panel 2, Infants and Children
1971-1975   National Advisory Health Services Council
1975-78     National Research Council, Commission on Human Resources, Chairman of Health
            Services Committee for a Study of National Needs for Biomedical and Behavior
1972        The Panel on Health Services Research and Development of the President's Science Advisory
            Committee
1985-1987   Board of Consultants to the Commander, Department of the Navy, Naval Medical Command
1986-1987   Office of Technology Assessment Committee on Child Health - Member

Editorial Boards:

1959-1964  New England Journal of Medicine, Associate Editor
1969-1975  Medical Care
1974-1980  Journal of Human Stress, Editorial Board; Co-Editor (1976-88)
1982-1988  Health Policy Quarterly, Executive Editor
1985-86    Vaccine Bulletin, Editorial Board
1978-      Pediatrics-in-Review, Editor-in-Chief
1990-1998  International Child Health: A Digest of Current Information
            Editorial Advisory Board
            Editor-in-Chief

Other Professional Activities:

1960-1970  Pediatric Panel, United States Pharmacopeia
1960-1964  James Jackson Putnam Center of Boston, Board of Trustees
1968-1971  National Board of Medical Examiners, Pediatric Test Committee
1968-1970  National Commission for the Study of Nursing and Nursing Education (Health Advisory
            Panel)
1969-1975  New York State Health Planning Council
1972-1977  Carnegie Council on Children
1972-1977  Committee on National Needs for Biomedical and Behavioral Science Research, Panel on
            Health Services Research
            Chair, National Research Council
            Advisory Committee
1974-1980  Riley Children's Hospital, Research Advisory Committee, Indianapolis, IN
1976-1980  Board of Visitors, Boston University School of Nursing
1977-1981  Advisory Committee, Johns Hopkins Health Services Research Center
1978-1980 The William T. Grant Foundation, Advisory Committee on Behavioral Pediatrics
1978-1979 Member of the Commission on the Future of Academic Psychiatry, Macy Foundation
1981-1985 Metropolitan Life Foundation Advisory Committee
1981-1987 UNICEF, United States Committee Member
1985 Ronald McDonald Annual Award Committee
1982-1988 Visiting Committee, Graduate School of Education, Harvard University
1982-1988 Member, Advisory Committee of the Pediatric Protocol Project, Fund for the City of
  New York
1982-1989 Grant Makers in Health
  Board of Directors (1985-89)
1984-1988 Praxis Biologicals, Inc., Board of Directors
1985-1988 Member of the Corporation of U.S. Committee of UNICEF
1986-1995 MacArthur Foundation, Member Committee on Successful Adolescence
1987-1989 Disney/Metlife Advisory Board Member - Wonders of Life
1987-1989 Chairman, Mayor's Commission on Maternal and Child Health New York City
1988-1993 Member of the Steering Committee for the National Forum on the Future of Children and
  Their Families, National Academy of Sciences
1988-1992 American Health Foundation, Board of Directors
1988-1994 Visiting Committee, School of Public Health, University of Oklahoma
1989-1994 Tufts University, Board of Overseers for the Social Sciences
1989-1994 Children's Health Fund, Advisory Board
1989-1992 Member of the New York State Council on Graduate Medical Education,
  Member of Executive Committee, Chairman of the Subcommittee on Evaluation of 405
  Regulations
1990-1992 Member, Mayoral Child Health Action & Management Council, New York
1990-1991 Chair, Subcommittee on Adolescents & Aids, Governor's Commission
  on AIDS, New York
1990-1994 Board of Overseers, Tufts University School of Social Sciences
1991 Chair, ad hoc Committee on Mandatory Screening of Newborns for HIV- New York State
  AIDS Advisory Council
1991-1992 Member, Advisory Board of Community Medicine, Mt. Sinai Medical Center
1991-1992 Member, Permanent Judicial Commission on Justice for Children
1991-1993 Member of the Advisory Committee of the National Academy of Social Insurance
1991-1993 Member, Senator Jay Rockefeller's Board of the Alliance for Health Care for All
1991-1994 Member, Advisory Board of the Center for Children with Chronic Illness and
  Disability, University of Minnesota
1991-1994 Board of Visitors, University of Oklahoma School of Public Health
1992-1996 Member, Advisory Board, Mt. Hope Family Center, Rochester, NY
  Initiative
1991-1999 Visiting Committee to Department of Maternal and Child Health, Johns Hopkins School of
  School of Public Health
1994-1997 Advisory Committee to the Report on Financing Ambulatory Care Training of Primary Care
  Physicians: Sites, Costs and Options for the Future (funded by Pew Charitable Trusts)
1995- International Medical Faculty Committee, University of Rochester School of Medicine
1995- Member, Board of Trustees (and Vice President), Institute for Research and Reform of
  Education
1995 World Health Organization Consultant to Integrated Child Health Services Program
1995-1998 Advisory Committee, Columbia University School of Nursing
1996- Commonwealth Fund
       Advisory Committee to Healthy Steps Program
       Program Review Committee
1997 University of Michigan, Member of Committee to Review Center for Child Development
1997 Member, Program Review Committee, The Commonwealth Fund
1998- March of Dimes - Child Health Advisory Committee
1998 Consultant to San Diego Children’s Hospital (to develop a research strategic plan)
1998 Consultant, Mott Child Health Center, Flint, Michigan
1999- Advisory Board of Pediatrics International, Japan Pediatric Society
2000 Member, Invitational Colloquium on Interdisciplinary International Primary Care Health and Education of the American Academy of Pediatrics, Washington, DC, April 7-9.
2000- Senior Project Advisor, University of Rochester Ladakh Project
2000- Member, National Advisory Committee to Rochester Clinical Research Curriculum Project (Department of Preventive Medicine Training Grant Program, University of Rochester)
2001- Professional Advisory Committee, Johnson & Johnson Pediatric Institute
2001 Consultant to Kimball House Board of Directors and Riverdale School District for a School Health Program, sponsored by American Academy of Pediatrics Section on Community Pediatrics
2002- Board of Directors, Children’s Futures of Trenton, New Jersey (funded by The Robert Wood Johnson Foundation)
2002- Research Advisory Panel, The Wynne Center of the University of Rochester

Honors and Awards:

1945 Phi Beta Kappa
1948 Alpha Omega Alpha
1962-1967 Markle Scholar in Academic Medicine
1969 The George Armstrong Award, Ambulatory Pediatric Association
1976 Martha May Eliot Award for Services in Maternal and Child Health, American Public Health Association
1980- Who's Who in America
1981 Clifford C. Grulee Award, American Academy of Pediatrics
1981 Dale Richmond Award, Section on Child Development, American Academy of Pediatrics
1983 Annual Recognition Award, American Association of Poison Control Centers
1986 C. Anderson Aldrich Award in Child Development, American Academy of Pediatrics
1987 Job Lewis Smith Award for Community Pediatrics, American Academy of Pediatrics
1987 Alumni of the Year, Cornell University Medical College, Award of Distinction
1989 Joseph St. Geme Award for the Future of Pediatrics, Federation of Pediatric Societies
1989 Gustave Lienhard Award for Contribution to Personal Health Sciences, Institute of Medicine
1994 Primary Care Achievement Award for Education of the Pew Charitable Trust's Center for Health Professions Commission
1982 Who's Who in the East
1982 Who's Who in Science
1982 Who's Who in Health Care
1995 Academy Plaque Award, New York Academy of Medicine (June 20, 1995)
1996  Abraham Jacobi Award, American Academy of Pediatrics
1998  John Howland Award, American Pediatric Society
2001  E.H. Christopherson Award in International Child Health, American Academy of Pediatrics

**Name Lectures and Major Visiting Professorships:**

1967  Copeland Memorial Lecture, Washington Children's Hospital, ACommunity Pediatrics
1968  Silverman Lecture, Syracuse University, ACommunity Pediatrics
1969  Family Health Care Program Annual Lecturer, Harvard Medical School, Boston, MA, "Family Medicine Science or Service"
1970  Mitchell Rubin Visiting Professor, University of Buffalo, Louis W. Sauer Lecture, Evanston, IL
Northwest Pediatric Society Meeting, Hudson, WI, Fall Meeting, Max Scharn Lectureship, "Community Pediatrics"
The First Harry Medovy Lecturer, Winnipeg, Canada, "Social Pediatrics"
Visiting Professor, Postgraduate Ambulatory Pediatrics, Barcelona, Spain
1971  Visiting Professor, Medellin, Columbia, for Pan American Health Organization Course in Social Pediatrics
1972  AOA Lecture, "The Boundaries of Health Care", University of Maryland
1974  Hartman Lecturer, Washington, St. Louis, "Family and Community Pediatrics"
1975  Dedication of College of Medicine and Dentistry of New Jersey, "Primary Care"
Fulton Visiting Professor and Lecturer, Royal Children's Hospital, Melbourne, Australia
Tenth Annual Harold Faber Lecture, ACommunity and Family Medicine in the USA
1977  AOA Visiting Professor, Loyola Medical College
1978  Upsala University, 500th Anniversary Lecturer, "Evaluation of Health Services", "Teaching Children Health Lifestyles"
1979  George Frederick Still Lecture, British Pediatric Association, York, England, "Common Happenings, Stress and Illness and Use of Health Services"
Mackid Lecture, University of Calgary, Alberta, "Stress and Illness, Use of Health Services and Social Supports"
Keynote Address, Montefiore Hospital, Department of Social Medicine Conference on Screening, "A Critical Look at Routine Health Assessment."
1980  Henry P. Goldberg Lecturer, The New York Hospital-Cornell Medical Center, "Stress and Illness"
The First Harle V. Barrett Memorial Lecture, University of Maryland, School of Medicine, "Stress and Coping"
1981
AOA Lecture, Indiana University, "Is There A Future for the Generalist in Academe?"
Keynote Address, Surgeon General's Workshop on Maternal and Infant Health, Brandeis University, "Challenges to Maternal and Child Health Research"
Invited Lecturer, Royal Academy of Medicine, Brussels, Belgium, "Social Stress and Child Health"
Invited Lecturer, Cornell Medical College, ABehavioral Pediatrics

1982
Visiting Lecturer, Colston Symposium, University of Bristol, England, "Epidemiology of Disability and Stress: An Overview"
Invited Lecturer, Northern California Pediatric Society
Visiting Professor, Ohio Medical College, Youngstown

1983
Visiting Professor, University of Utah School of Medicine
Visiting Professor, University of Maryland, Baltimore Hospital for Sick Children, Toronto

1985
John Howland Visiting Professor, The Johns Hopkins School of Medicine and The Johns Hopkins Hospital, "A Time of Passion: What Have We Learned About Child Health Services From the 1960's".
Gallagher Lecturer, "Research in Adolescent Medicine", The Society for Adolescent Medicine
Clausen Visiting Professor and Lecturer, The University of Rochester Medical Center, Department of Pediatrics
Visiting Professor and Eli Friedman Lecturer, Boston City Hospital and Boston University School of Medicine
University of Massachusetts Medical School, 10th Anniversary Day Lecturer
Invited Lecturer, 42nd Annual Brenneman Memorial Lectures, Los Angeles, Pediatric Society

1986
International Congress on Self-Help Groups Buenos Aires, Argentina, "Self-Help Groups in the Care of Children"
Society for Behavioral Pediatrics Lectureship Recipient, "Behavioral Pediatrics: A Time for Research"
The Edmund R. McClusky Memorial Lecture, The Children's Hospital of Pittsburgh, Pennsylvania
Invited Lecturer, Japan Pediatric Society - "The General Pediatrics Academic Development Program"

1987
The John E. Brown Memorial Lectureship, Columbus Children's Hospital
The Blackfan Lecture, Children's Hospital of Boston, "The Academic Generalist: Is There a Role"?

1988
Sixth Jose Albert Lecturer, University of the Philippines, School of Medicine, Dept. of Pediatrics, "Problem Behaviors in Adolescents"
Invited Lecturer, The Sparks Center, University of Alabama at Birmingham, "Handicapped Children: A Social Definition"
Darrow Memorial Lecture. University of Kansas Medical Center.
1989  Gallagher Lecturer, Society for Adolescent Medicine "Youth and America's Future"
      Helmut Schuman Lecturer, Dartmouth-Hitchcock Medical Center, "Youth and America's Future"
      Sydney Rosen Commemorative Lecture, "Behavioral Pediatrics: Can it be Taught? Can it be Practiced?" Hospital for Sick Children, Toronto, Canada
      Robert Crede Visiting Professor, San Francisco General Hospital, "Integrated Health Services"
      Spanish Pediatric Association, Ambulatory Pediatric Section, Santander, Spain, "From Ambulatory Pediatrics to Comprehensive Pediatrics"

1992  Russell Blattner Lecturer, Baylor College of Medicine

1993  The Sidney Gellis Lecture Tufts University - The Boston Floating Hospital, Boston, MA - General Pediatrics Academic Development Program
      Keynote address - Annual Meeting, Wisconsin Chapter, American Academy of Pediatrics "The Role of the Pediatrician in the Community."

      The First Dr. Jimmy Simon Lecture - Bowman Gray School of Medicine, Winston-Salem, "Integrated Child Health Services"

1995  Erasmus University, Rotterdam, Holland, Address given at Farewell Symposium for Prof. Henk Visser, "International Child Health: Every Pediatrician=s Responsibility"
      Keynote address, APrevention of Mental Disorders,± American Hosp. Assoc. Section on Psychiatric and Substance Abuse Services.

1996  Keynote address Annual Meeting of the National Association of Children=s Hospitals and Related Institutions, Scottsdale, Arizona, AGraduate Medical Education: How We Got Where We Are±
      Lowell A. Glasgow Memorial Lecture, Salt Lake City, Utah, AIntegrated Child Health Services±
      Albert Schweitzer Institute Meeting in Nishny Novgorod, Russia, Conference on Reproductive Health
      Second Philippine Ambulatory Pediatric Society Lecture
      Japan Pediatric Society 100th Anniversary, Opening Ceremony

1997  Children=s Mercy Hospital, Kansas City, Missouri, 100th Anniversary Celebration AOpportunities in International Child Health±
      Boston University, 1st Joel J. and Barbara Alpert Visiting Professor, AIntegrated Child Health Services±
Chameides Retirement Program, Hartford, Connecticut, Opportunities in International Child Health

1998

Dedication Address, The Robert Wood Johnson Children’s Hospital, New Brunswick, NJ
Fairfax Hospital, VA, Grand Rounds - Opportunities in International Child Health.

The McLemore Birdsong Lecture on The Future of Pediatrics, University of Virginia Pediatric Conference.

Keynote Address, Medical Foundation of Boston Annual Meeting, Opportunities for Support of Child Health Services Research, December, 1998

1999


2000
Clare Dennison Symposium on the Child, 75th Anniversary Celebration of the University of Rochester School of Medicine. APolicy for Children and Families.


ORIGINAL ARTICLES:


140. Haggerty RJ and Chamberlin R: Dr. Janeway and the Cameroon project: lessons learned from an international project. *Pharos of Alpha Omega Alpha* Autumn 2000;11-16.

BOOKS, BOOK CHAPTERS AND INTRODUCTIONS:


   Haggerty RJ: Green M: The pediatric clinician's job. Ibid., p. 103, Part III.

   Haggerty RJ: When to hospitalize a child. Ibid., p. 138, Part III.

   Haggerty RJ: Social factors and health. Ibid., p. 259, Part V.

   Haggerty RJ: Physically abused children. Ibid., p. 285, Part V.

   Haggerty RJ: Active immunization. Ibid., p. 435, Part VI.

   Haggerty RJ: The management of episodic disorders. Ibid., p. 771, Part VIII.

   Haggerty RJ: Family crisis: The role of the family in health and illness. Ibid., p. 774, Part VIII.

   Haggerty RJ: Childhood accidents. Ibid., p. 813, Part VIII.

   Haggerty RJ: Accidental poisoning. Ibid., p. 817, Part VIII.


   Green M, Haggerty RJ: Child health services and the clinician Ibid., p. 1, Chapter 1.


   Haggerty RJ: Accidental poisoning. Ibid., p. 260, Chapter 36.


   Haggerty RJ: Patient and parent education. Ibid., p. 423, Chapter 50.

   Green M, Haggerty RJ: The clinician's job. Ibid., p. 434, Chapter 52


   Haggerty RJ. Risks and protective factors in childhood illness, Ibid., p. 6-8
   Haggerty RJ. Integrated child health services, Ibid. p. 484-486.
   Haggerty RJ. The increasingly global village, Ibid. p. 544-546.
ABSTRACTS, EDITORIALS, BOOK REVIEWS


68. Demlo LK and Haggerty RJ. Study urges redirection of quality assurance programs. *Hospital Progress*; February 1977, pp. 76-78.


of view.


Commentary.


159. Haggerty RJ. In this issue. *J Urban Health* 1998;75:5. Editor=s note.


