PREFACE

Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

This volume is the written record of one oral history interview. The reader is reminded that this is a verbatim transcript of spoken rather than written prose. It is intended to supplement other available sources of information about the individuals, organizations, institutions, and events that are discussed. The use of face-to-face interviews provides a unique opportunity to capture a firsthand, eyewitness account of events in an interactive session. Its importance lies less in the recitation of facts, names, and dates than in the interpretation of these by the speaker.

Historical Archives Advisory Committee, 1996/97

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ABOUT THE INTERVIEWER

James E. Strain, MD, FAAP

Dr. James Strain graduated from Medical School at the University of Colorado following his undergraduate education at Phillips University in Enid, Oklahoma. After completing a rotating internship at Minneapolis General Hospital and a pediatric residency at Denver Children's Hospital he entered the private practice of pediatrics in Denver in 1950. He served on the pediatric clinical faculty at the University of Colorado and was appointed Clinical Professor in 1969. He was elected Chairman of the Colorado Chapter of the American Academy of Pediatrics in 1967, became Chairman of District VIII in 1975, and was elected Vice President of the American Academy of Pediatrics in 1981. He served as president in 1982-83 when the care of disabled newborns was an issue. He returned to the private practice of pediatrics in Denver following his tenure as president. In 1986 he was called to assume the position of Executive Director of the American Academy of Pediatrics where he served until his retirement in 1993. Since then he has continued to be involved in Academy activities, including serving as the Academy representative to the National Advisory Commission on Childhood Vaccines. Dr. Strain considered it a privilege to interview Dr. Kendig, a very special colleague and friend with whom he served on the Academy's Executive Board for more than four years.
DR. STRAIN: This is an interview with Dr. Ed Kendig, conducted by Dr. James Strain, and this is on the 26th of October, 1996. The location is the Boston Marriott Copley Hotel. This is tape number one, side one.

PAUSE

DR. STRAIN: I’ve already said beforehand that this is an interview with Dr. Kendig on the 26th of October, 1996, and we’re in the small room, the Connecticut Room, in the Marriott Copley in Boston. So Ed, it’s a real pleasure to talk with you and get some of your thoughts about your career and your background. And let’s just start with your family, where you were born, your brothers and sisters.

DR. KENDIG: Well I was born in a little town in Virginia, Victoria, located in Lunenburg county, which claimed 3,000 inhabitants but I doubt very much if there were more than 2,000. I was an only child. My father was a physician and he and his brother, another physician, had moved to Lunenburg County to practice medicine and they married sisters who were already living in Lunenburg County.

My mother’s family was well established in that county; they had been there for many years. Her father was the clerk of the court for something like 55 or 56 years. He was also a large landowner. I was the only child. It’s interesting that my father married the older sister first. My father was the younger brother. And his older brother married the younger sister later. And they had two children, and one of them is still living. Her name is Frances Steinheimer. Her husband is an ex-dean of the Washington & Lee University Law School. She was earlier married to a surgeon, William Pugh, and they had two children (twins). William died about 20 years earlier of lung cancer.

So I was reared in a small town, and I had the advantage of being in a family of some influence in that area. I went to summer camp in North Carolina, but I did not go to prep school, and summer camp was the reason. It was run by people from Hampden-Sydney College. I became so enamored of Hampden-Sydney that when it came time to go to college my father had all kinds of ideas as to where I should go to school, but my idea was to go to Hampden-Sydney. And it was a great choice for me. It was a small Presbyterian school in Virginia, six months older than the Declaration of Independence, tenth oldest in the United States, and just a delightful place. I was able to play college baseball and later on played some pro ball. I was editor of the college newspaper, and when I finished I had received what was called the Gammon Cup for character, scholarship and athletics; so it was a great time. And I went to the University of Virginia after that.
DR. STRAIN: That was a small school, was that right, small enrollment? The college?

DR. KENDIG: I don’t remember the number that enrolled.

DR. STRAIN: But it was small, it was not a large school.

DR. KENDIG: It was a small school.

DR. STRAIN: And then you went to the University of Virginia for medical school?

DR. KENDIG: Medical school. And it’s interesting, I’m not sure how much of these personal things you want in here, but . . .

DR. STRAIN: Well, whatever you want.

DR. KENDIG: I went to the University of Virginia to Medical School. My father died at age 52, he was a very young man and was a very interesting person. About ten years before he died, he decided he had had enough general practice and thought he was cut out for surgery. So, remember this is 1920, he tooted off to Chicago and took his family with him. I don’t know how long we stayed; it may not have been more than a year, because in those days training was different. When he came back, he and his brother built a nice beautiful brick hospital in Victoria, Virginia, two or three thousand people, remember. He was in the American College of Surgeons; there was no board at that time. He died in ’34. He was also a state senator, and he was on the Board of Visitors at the Medical College of Virginia while I went to the other school, the University of Virginia.

DR. STRAIN: Well, when did you decide you wanted to be a doctor?

DR. KENDIG: Oh, I guess sometime along about the time that I was seeing all that he [my father] was doing.

DR. STRAIN: I see.

DR. KENDIG: But, I still had some doubts even when I went to Hampden-Sydney and my father thought it very important that I know something other than medicine. And so I have both a BA and a BS; I got them both the same year. I went to summer school one summer, and so I have a good background in English as well as in medicine.
DR. STRAIN: Now you were at the University of Virginia for four years?

DR. KENDIG: Four years. Then I went off to a hectic rotating internship. Back in those days, this is back in 1936, practically everybody in any specialty always wanted a rotating internship. My father of course had died by this time, he died during my second year in medical school, but I was thinking about him when I went back to the Medical College of Virginia as a rotating intern. I spent a year down there. And by the way, here’s an interesting thing. In three months on OB-GYN [obstetrics and gynecology], I had 75 deliveries and 12 by forceps. One of my friends recently said, "My residents who come up here don’t have that much training." [laughs]

Anyway, I started out to be a surgeon, but it took me about two weeks to find out that that wasn’t what I wanted to do. So after about that time I started looking around, and then when I went into pediatrics I said, “Boy this is it, and I really like it.” But, in those days—again, you have to put these things into context, this is back in 1936, ’37—there were not very many real good pediatric residencies, certainly not many in the Southeast. The one at the Medical College of Virginia was not very good, nor did I like the one at University of Virginia. And so I was moaning around one day, and one of the residents on neurosurgery said, “Oh I know where you can go.” He said, “There’s a Doctor [J. Buren] Sidbury in Wilmington, North Carolina.” He was a member of the American Pediatric Society, at that time there were 100 members, and he was the only one who was a non-academic. And he ran the Babies Hospital at Wrightsville Beach, North Carolina. [My colleague told me,] “I know for a fact, because I heard just the other day, he does not have a resident for this year, and I’ll get you an interview with him.” And Dr. Sidbury accepted me as a resident.

I went down there and stayed up to six months, perhaps till the first of the year. And I learned more in six months than any other time in my training. It was just great. He had a great many patients; I remember all sorts of things, all procedures. When I was at Johns Hopkins [Hospital] a little later on, they said, “Gee, where did you learn all this IV [intravenous] stuff?” Well, I learned it all at Babies Hospital in Wrightsville Beach, North Carolina. And the next few years I was at Johns Hopkins for an internship and at Bellevue [Hospital], to complete my training. I can’t give you the exact times because I went to Bellevue and then to Hopkins and then back to Bellevue, but it totaled about four years when I finished. And at that time, I came back into Richmond to practice pediatrics.

DR. STRAIN: I see. After your residency, then, you decided you wanted to go into general pediatric practice.
DR. KENDIG: Oh yes, I was in general pediatrics.

DR. STRAIN: And then following that, you had the diagnosis of…

DR. KENDIG: Tuberculosis.

DR. STRAIN: Tuberculosis. Can you tell us a little bit about that? That was an interesting story. I read about that.

DR. KENDIG: Well, actually I had a little lesion when I left Bellevue, but it didn’t amount to anything. I took off a few months and I went to Arizona just to be sure; that’s one of the reasons I didn’t start until the fall in Richmond. Well they said, “You’re fine.” I was in the medical corps reserve. And so when the war came along, naturally they called me up. But in the meanwhile, you see, I was married. I went to Richmond in the fall of 1940, and I lived at the Chesterfield Apartments, which was a very nice address for single young men and women. And I met my wife there. She had been to the Columbia Graduate School of Business, and had gone to Duke earlier. She had come to Richmond to be Executive Assistant to the Commissioner of Banking. We met, and in six months we were married.

And so, it was almost two years exactly from the time that I came to Richmond that I was called up for military service. And I was all ready to go, had my uniforms, and went over to Petersburg to have my physical examination, but unfortunately they took an x-ray. Or fortunately, perhaps. And after an x-ray, they said, “You have active tuberculosis.” Then they put me in the hospital at the Medical College of Virginia. Then they said, “No, the army doesn’t need you, and we’ll send you up to Trudeau Sanatorium at Saranac Lake, New York.”

Now if you don’t know about Saranac, it’s a beautiful area, a land of rolling hills and lakes and nearby mountains. It was just a great place to be although I didn’t think that was where I wanted to be at that particular time. And I was stuck in that area. When I was admitted there were about 200 patients and if memory serves me correctly, I can’t get figures on this, between 20 and 25 doctors were patients there at that time and many more nurses. It was an occupational disease at that time. So I went up there and [laughs] when I went in it was late October. And cool of course, but not like it is here in Boston today, a nice, almost summery day. It wasn’t like that at Saranac Lake. And after about two weeks there, it started snowing.
Well I first ought to point out that a new patient is kept for a week in the admissions cottage for diagnosis. Management makes a decision as to therapy. Well they had all kinds of cottages and there was an infirmary for those whose disease was life threatening. They had two infirmaries as a matter of fact. A lot of people were very ill. And then they had some that really weren’t very sick at all, and these were placed in “up” cottages. They were the ambulatory cottages. And then there were the “down” cottages with bed rest, and I was put on the bed rest. And so they put me in this cottage, with three others, and it had a porch. And patients were supposed to stay on the porch. There were four bedrooms and a great big center room, which served as a dining room. The only time patients were supposed to go indoors was for meals or to go to the bathroom.

Well, they put me on the porch. It was getting cool by that time and there were electric blankets, the very first electric blankets, very primitive, a parka and gloves and a little radio beside the bed, and of course no television at that time. That was in the distant future. And you were not supposed to do anything. They didn’t want you to read either, just sit, but they didn’t argue too much about the reading or anything like that. I was out there and about two weeks later it snowed. My goodness, it snowed. And it was cold. Of course, that was not for a person who came from Virginia. And so I paid the tray boy fifty cents to move my bed back inside. Every day thereafter the doctors came by and said, “You need to be out in this weather, nice weather, you have to be on the porch. That’s good old fresh air.” I said, “Boy, I’ve been in the cold with that fresh air.” And we kept the window partially open the rest of the time. I stayed inside every day. They came by and tried without success to get me to move to the porch.

Along with my bed rest, which was supposed to be complete absence of care, it was decided that I should have artificial pneumothorax. Well, as you know, this is a measured injection of air into the pleural space, finally collapsing the lung, and the idea was that if the lung was collapsed it would have a better chance to heal. Well, my lung didn’t collapse. When they realized that I had adhesions, probably from an earlier inflammation, arrangements were made for me to go into Saranac Hospital, which was three or four miles from the Sanitorium. I was put into a taxi one morning and I went into the hospital where, under local anesthesia, Ed Wells freed the adhesions and I spent the afternoon in a glorious haze. I was floating along and the next morning I awakened and I was just fine. They put me in a taxi and sent me back to the Sanitorium. I stopped to get an x-ray as directed earlier and I went back to bed. Thirty, forty minutes later, two doctors come rushing into the room saying, “Are you all right, all right?” And I said, “Yes, I’m fine.” They said, “Well, your lung collapsed, and it looks like the size of a handkerchief at the present time. You’re going to
need care and we thought that maybe something horrible had happened to you.”
But I was all right.

And after about three or four months, I moved over to what they called the
Doctor’s Cottage. That wasn’t the name of it; I can’t remember the name, but
it housed about twelve doctors. All had been on bed rest and now were on an
ambulatory program. The patients walk for 15 minutes in the morning, 15
minutes in the afternoon. Then the next week up to 30 minutes. Third week
one goes to 45 minutes. After four weeks the patient is up for an hour, and then
the only restriction was two hours bed rest after lunch each day. And of course
be in bed early at night, but the patient could go to town for a meal. A taxi ran
constantly. Two men, one named Chris, drove taxis in to town and back
constantly. An up patient could go in for dinner, or go in for an occasional
picnic on the lake or whatever. Before that, the patient couldn’t go anywhere,
or do anything; it’s sort of like being in jail.

So finally after about a year they decided I was able to be discharged.
Meanwhile just as the year was ending I had a letter from Dr. Wilbur Davison
who was the Dean at Duke University School of Medicine at that time. He had
been appointed Secretary of the National Research Council. He asked me to
come down to be his assistant, and I was all ready to go, and I said, “Boy this is
great.” And the people up there put that one to rest in a hurry. They said,
“You’ll get in that hot weather and you’ll activate the tuberculosis.” Well I
didn’t bother to tell them that Baltimore was just as bad and so I went on back
to Baltimore like I intended to do in the first place, to learn something about
children’s chest disease. I stayed there a year, and then I went on back to
Richmond. And I began the Child Chest Clinic at that time.

DR. STRAIN: Now, were you in practice at the time of your diagnosis with
TB?

DR. KENDIG: Yeah, I was in practice two years.

DR. STRAIN: And you were married.

DR. KENDIG: Yes. I had had a child.

DR. STRAIN: I see. And then it was after that you went into the Trudeau
Sanitorium.

DR. KENDIG: Mm-hmm, after I was married and had a child, and I had
been married not quite two years when I went up to Trudeau.
DR. STRAIN: And then was your decision to go into pulmonary or take a fellowship or whatever it was at that time at Hopkins, was that the result of your own illness?

DR. KENDIG: Oh sure, it came from my illness, and that’s when I decided to go back and do that. And then I came back to Richmond in 1944, late ’44. All these things began in the fall in Richmond.

When I came back to Richmond, I was on the faculty at the medical school then, and I initiated what we called the Child Chest Clinic at the Medical College. And I ran it for 50 years, ’44 to ’94. And, actually, I was actively engaged in academics as well as private practice from that point on. And I did that pretty steadily for about 30 years. I had been doing all these other things at that time, something you can’t do today. Nobody would ever be able to do that sort of thing today. But they let me do this, and in 1972 they decided to put in an outreach program. It wasn’t really an outreach program; it was part of the regular teaching program they used at St. Mary’s Hospital in Richmond. So they appointed me to go there to do that. I had been a professor of pediatrics down there since 1958, and this was 1972. And I went to St. Mary's and I stayed there for about 16, 17 years. Then I stayed on after that at St. Mary’s as a consultant, until just recently when I’ve gone over to the Medical Society of Virginia offices. I edit the Virginia Medical Quarterly, but I’ve actually been doing that on a part-time basis for about, oh, 14 years now.

DR. STRAIN: Now when you first went back and organized the chest clinic, you were part-time at the University of Virginia? Or was this the Medical College of Virginia?

DR. KENDIG: The Medical College.

DR. STRAIN: Of Virginia, Richmond. And you had a private practice as well.

DR. KENDIG: That’s right.

DR. STRAIN: Was that about half-and-half? How did you balance that?

DR. KENDIG: You couldn’t do it now I don’t think, but they were very kind about it and they let me do it. Actually to be perfectly honest, I don’t think anybody else was very interested in children’s chest diseases. Because, you see, children’s chest disease at that time really amounted to only two things. Practically all of it was tuberculosis and the other thing was cystic fibrosis. And you know at that time they didn’t have that many cases of cystic fibrosis, so
that was really just coming along. So it was really tuberculosis. Tuberculosis
was a forerunner of pulmonary disease in children.

DR. STRAIN: That’s what you saw at the clinic.

DR. KENDIG: Yeah.

DR. STRAIN: Now, your practice was general pediatrics. You saw all kinds of
conditions including well child care.

DR. KENDIG: Oh yeah, oh yes, some of my earlier publications were on
some aspect of hematology, and various other things; but I did everything at
that time.

DR. STRAIN: What did you see as the changes in general pediatrics? You were
there from about ’58 to ’72, when you were doing part-time general pediatrics?

DR. KENDIG: I was in part time general pediatrics from 1944 to 1972.

DR. STRAIN: I see. Did you see any change in the general practice?

DR. KENDIG: Oh yes, there’ve been changes in a lot of different ways.
Let me go back even further than 1944. When I went to Richmond in 1940 I
was the 12th pediatrician in town--there must be 150 to 200 there now--and the
other 11 weren’t doing so well. People were not accustomed, not educated to
have pediatricians, so you just didn’t see too many children. I was the first
person in town, in 1948, to have someone in my office other than myself. I
brought an associate in in 1948, a young man by the name of Albert [Merritt]
Edmonds, and he came to me from Johns Hopkins. From that time we built up
to about four and stayed at about that level. But we were the first ones to have
anybody else. Everybody else was solo. And nobody seemed to be terribly
busy. So it was a gradual period of education, and I suspect that it was pretty
much the same thing throughout the country, maybe a little bit different in some
parts of the country than others, but not much. It was a gradual education of
people until pediatrics became a major specialty. But really it took at least 20
years after that perhaps.

DR. STRAIN: Did you see more well children or more sick children?

DR. KENDIG: More well children. By the time I was back in 1944, the
obstetricians began to refer patients, but not all obstetricians referred
newborns, even then. But there were several of them in town who referred
them immediately, and I had a big practice of patients referred from the time of the newborn period, and then my practice became pretty large.

Well, I did know how I managed my teaching job. It was sort of like this. Thursday, I didn’t hit the office at all. Even when I was practicing alone the only thing I did on a Thursday was to spend the day at the Medical College. If I had emergencies I took care of them at the Medical College, but otherwise I did not see patients. When I got somebody with me, I did the same thing. I just gave that one day, that’s the day I ran the Child Chest Clinic in the afternoon. I usually had a couple of other lectures or rounds earlier in the day, so I had a pretty full day right from the beginning. Even when I was a part-timer. Of course, I spent other time at the Medical College. It just wasn’t always structured in the same way.

From that point on the subspecialties began to come in on a national basis. Of course we were already there. I really don’t know those dates. I was on the Residency Review Committee [RRC] and I can remember there was cardiology, and allergy, and just a very few subspecialties that came through for a long period of time. And pulmonology was very late, very late. And so most of the time it was just a matter of building in that way. And, as a matter of fact, that’s how I got around to the book [Disorders of the Respiratory Tract in Children]. It was in 1960, middle of the 1960s that I conceived the idea that there wasn’t anything on pulmonary diseases in children, and saw there were no books on that. And so I talked to people at [W. B.] Saunders [Company], and [to] a man named Bob Rowan, who has recently died, and was at that time medical editor. He later became executive vice president; he was very helpful. They hit on the idea immediately, saying, “Gee, this is great.” So I worked on that from about ’65 to ’67, and the first edition was published in ’67 with 29 contributors. The fifth edition was started, oh, six, seven years ago, 1990. And that was ’90, ’91. And that had to have almost 100 contributors. Perhaps not that many, but pretty close to it.

DR. STRAIN: Early on, how did you find the names of the people that were interested in pulmonology? Did you have meetings, or was it part of the Academy?

DR. KENDIG: Yes, there were meetings, primarily with people who were interested in childhood tuberculosis. And others who were interested in cystic fibrosis had meetings. And that’s where we began to get the names of people who were interested at that time. And they had programs, and at that time I was pretty active in the group. The major problem I had with the first edition was that at that time there was practically nobody who knew anything about the pathogenesis of pulmonary pathology. Practically nobody. About half a dozen in this country, including [Charles] Davenport Cook and Mary Ellen Avery.
Maybe I’m exaggerating, maybe more than that, but I didn’t know that many
anyway. And Mary Ellen Avery helped me out with that one. She said that
she’d write that chapter, but she said, “There’s a young man here in my
department, Victor Chernick, that I will ask to help me with it. I’m pushed right
now, but I’ll get the chapter in.” And she got Vic to do it. That’s how I got Vic
to be an associate editor and then co-editor and then for the fifth edition he was
the editor and I was the consulting editor. And for the sixth edition, which is
now in process, he and Tom [Thomas] Boat in Cincinnati are the editors, and I
am the consulting editor, and that edition will be out in the spring. The sixth
edition.

DR. STRAIN: Well that’s certainly a well-known publication. It must be a
landmark…

DR. KENDIG: It was the only book on pediatric pulmonary pathology in
North America for 25 years. And there’s been one out since that time, and
there’s another one that was in process, and I don’t know whatever happened
to it, but it hasn’t come out yet that I know of.

DR. STRAIN: Can we go back to your general pediatric practice for just a
minute? Did you make house calls?

DR. KENDIG: Oh yes.

DR. STRAIN: Did you?

DR. KENDIG: Up until, oh I can’t remember. One of my memories is
looking out and seeing some snow falling, about 6:00 or so in the afternoon, I’m
still in the office, and they hand me a list of house calls, seven house calls to
make. Oh yes, I made house calls. The charges in my office when I first
started were $3.00 for an office visit, $5.00, no, $4.00 for a house call, and
$10.00 for a night house call. As time passed, we all agree, the house calls
became less and less common and people became much more adjusted to the
idea of not having house calls. But I made some house calls up to the day I
stopped private practice in 1972, and from that point on I was a consultant.

I have enjoyed all this. When I got out of private practice, I really did miss the
patients. I really did. To me that was the most fun of all, to see the children
growing up with the families and everything. I go into St. Mary’s Hospital
almost every day, and I would say at least three or four times a week I run into
somebody from a family I took care of. Maybe four or five times a week, I run
into somebody in a family who says, “Oh Dr. Kendig, I’m so glad to see you,
and so-and-so and so forth.” It’s a real thrill, it really is.
DR. STRAIN: Oh that is real satisfying. I think for anybody in practice it’s exciting knowing the second generations.

DR. KENDIG: There’s nothing like it. Nothing like it. Nothing like it. It’s wonderful.

DR. STRAIN: One of the things I wondered about, you know, we’ve had the trend recently of family practitioners referring patients into the subspecialists in pediatrics if they had a special problem. And I wondered in that period of time between ’44 and ’72 when you were in general pediatric practice, of course you did have the chest clinic, but I’m wondering did you get very many referrals of patients for special conditions?

DR. KENDIG: It was hard for me to figure out exactly how many of them were directly referred. But by the time I finished practice, at least 25% of my work, probably 25 to 30% of my work, came from outside Richmond.

DR. STRAIN: And they were pulmonary diseases?

DR. KENDIG: Well, no, now remember, this was just general pediatrics.

DR. STRAIN: So there were general pediatric problems…

DR. KENDIG: Yeah, general pediatric problems. Yes, pulmonary problems were probably most prominent or most common, of course. But actually…

DR. STRAIN: It’s all general referrals.

DR. KENDIG: Yeah, I think. I don’t think there was a great problem about referred patients. One of the things my uncle taught me when I started out was when a patient comes in from out of town to see you, a sick patient who needs to be hospitalized, what you need to do is after you evaluate the patient, don’t wait until tomorrow, [is to] call the referring doctor. Tell him what it’s all about, and then, if anything changes the next day, call again. But if it doesn’t change, give him a ring within two days and summarize what’s going on. And then when the patient gets ready to go home, call him again. Don’t wait for the note to get there, because the dictated note may not get off for about two weeks, but you call him and tell him. And I tell you right now, I still think that I had by far the biggest out of town practice. And it was probably because of that

DR. STRAIN: Well, I think we need to teach our subspecialists to do that more. I think that’s one of the real problems in general pediatrics.
DR. KENDIG:  And this idea of putting it in writing, nowadays of course they probably are using faxes, they probably are not going to send it out much faster, because they don’t dictate it. They ought to do something immediately. He [my uncle] says, “I’m a family practitioner and when I send somebody into the hospital, and I don’t hear from the doctor in a couple days, the family doesn’t understand that.” They said, “Dr. Kendig why don’t you know?”

DR. STRAIN:  Exactly. Ed, I wanted to talk to you a little bit about pediatric education, because you’ve had some comparisons that I think are important. You had your training at North Carolina and Bellevue and Hopkins, general pediatrics, and later pulmonology or at least chest disease. And then, more recently, you’ve been involved in the teaching program at Richmond. What changes have you seen in the education of pediatric residents over the years? How is it different now than it was when you were in training?

DR. KENDIG:  Well I think it’s almost an obvious one. First when we started off it was a general approach, but it was a general approach to hospitalized patients. At Johns Hopkins, at Bellevue, everywhere, the patients who came in to the clinic were usually sick. They did have well baby clinics and there were clinics for children with minor problems, but a lot of them were quite sick. Now it was hard to tell about that, but the patients you were taught to take care of as a house officer were sick patients. Sick patients in the main. And patients who had relatively serious ailments. And you didn’t have as much outpatient clinic work as we finally end up doing if we are in the practice of pediatrics.

The feeling I think, I’m going to come back to this in a minute, but, at that time, you were supposed to learn everything. I’ll start off by saying that there were not as many subspecialists around. But the subspecialists in the hospitals, most places, were very interested in one area, and if that person was your attending, you saw a lot of that particular illness. If another was, you saw a lot of that particular type of disease. And so forth. But it was a matter of taking care of hospitalized patients, and not nearly as much outpatient as the private practice of pediatrics at that time.

DR. STRAIN:  What do you think of the new regulations, or at least recommendations that are coming out of the RRC in regard to ambulatory training. Do you think that’s a step forward in terms of residency training programs?

DR. KENDIG:  Yes, but I have a little bit of concern about that too. And the reason, I want to be sure that they do see enough sick patients. Because one of the keys to a good pediatrician is that he or she recognizes a sick
person. If you don’t recognize serious illness, you’re going to drop the ball at the wrong time. And it’s one of the criticisms that I’ve had of the family practice programs. In family practice programs, residents are at the hospital for a very short period of time, and practically all of their training is outpatient and patients with relatively minor things. And I figure if they make a diagnosis, and they usually do in time, they don’t really know how to manage them. And I feel that if pediatrics swings too far, to all outpatient care, so that you don’t get enough inpatients, if you don’t see enough of the sick patients, you may turn out pediatricians who don’t recognize a serious disease when it occurs. And I don’t think that’s one of the things that people thought much about.

DR. STRAIN: What do you think of the trend in pediatrics, of pediatricians in practice being in the office say 90% of the time, and stepping back when a patient goes into the hospital and turning the case over to a subspecialist, for example? And that’s happening around the country more and more as you know.

DR. KENDIG: I think it’s a very poor idea. It may be a practical idea, but I would hate to do that if I were in private practice. I believe in following them all the way.

DR. STRAIN: Did you have much training or education in behavioral problems in your residency program, the so-called new morbidity, which at that time may not have been thought about?

DR. KENDIG: I can’t say we didn’t have any. Dr. Leo Kanner was at Hopkins, and we had a few sessions with him along the way, and at Bellevue we had the Bakwins. Ruth and Harry Bakwin were interested and they were very good. We just didn’t have as much of it as we have now. And I think we need more of it. Harry thought we did at that time. I think it’s very important that we know a lot more about these things.

DR. STRAIN: Where do you think pediatrics is going? Do you think we’re going to continue to train a large number of general pediatricians, fewer subspecialists, or is it going to drift into the area of subspecialties?

DR. KENDIG: At the present time, with the tendency of promotion of family medicine, my guess is that we’re going to slide more toward the subspecialists. I’m not sure I think that’s right, because I think that the pediatrician is the doctor who ought to follow children through their formative years. I worry about the approach to family practice. I think they just get a little smattering of everything as they go through, and I don’t believe they know enough to be able to accomplish the complete care of a child the way the pediatrician does.
DR. STRAIN: I was going to ask you a question about that, Ed, because 50% of the children in this country--particularly older children, school age children--are cared for by family practitioners. Do you have any thoughts about the difference in care provided by a pediatrician versus a family physician?

DR. KENDIG: I don’t think child health care is as well organized by the family practitioner. I don’t think the mothers take the patients as regularly. And I’m not sure whether their development is monitored as carefully as it is by the pediatrician. To me, the care that a pediatrician gives a child is not limited to immunizations. It’s not limited to the illnesses, but it is the monitoring of all things. It’s the monitoring of his behavior, all the things that are associated with a growing child. And I don’t think that the family practitioner understands that or does that. I don’t think the training for a family practitioner is the same and it isn’t enough of pediatrics. I know some good family practitioners, and there are good ones. This is not any disrespect of any one of them. I think they do a great job, but they cover a lot of ground and medicine is so complex now, everything about it is so voluminous that it is impossible to know everything. And when you start from the cradle to the grave, you’ve covered a lot of ground. And I don’t see how anybody can know that much and can manage that much. And I don’t think they do as well as we do in pediatrics.

DR. STRAIN: What do you think about the movement to incorporate either physicians’ assistants or pediatric nurse practitioners into a practice to enhance or expand the pediatricians’ ability to care for more people?

DR. KENDIG: What we’re doing with that is that we are eliminating a number of pediatricians.

END OF SIDE OF TAPE

DR. STRAIN: We were talking about the nurse practitioners and whether you see a role for them.

DR. KENDIG: Oh, to me, it’s almost simplistic. You put the nurse practitioners in, you knock some pediatricians out. And the other thing that bothers me about it is the amount of supervision they get. Now I think that the average nurse practitioner is perfectly capable of looking at a child that’s got a rash or someone who’s got acute pharyngitis or taking a throat culture or arranging a few things like that, just routine stuff, sure. The key to a good practitioner of pediatrics is the ability to detect, to discern what’s present in a sick child. To recognize a sick child. And all these other things anybody can do. But I wonder about whether or not they don’t miss a certain number of
things that would be apparent, even obvious, to a pediatrician. Now, the answer
to that on the one hand is that pediatricians, or the ones who promote this, will
say, “Well, we check all these things.” They don’t check all this, because they
can’t. They wait to have the nurse practitioner ask them, if the nurse
practitioner is not sure about the situation. But that again comes back to the
individual, which one is going to ask for help. Some people are going to ask,
some are not going to ask. And a certain number of people are going to miss a
lot of things as they go through.

So I think you’ve got two problems with the nurse practitioner. One is that
they’re putting pediatricians out of work. They’re reducing the amount of work
that pediatricians have to do, no question. And the second thing is, certain ones
are not going to recognize the sick child, and they’re not going to ask for help at
the time. Because the idea of having them in your office is you are not to go
around and check everything she does, or he does. He or she is supposed to
take care of part of the work so it will keep you from having to do all the work.
But in so doing, if you don’t check on it, that’s where the problem lies. Am I
making it clear?

DR. STRAIN: Yes. One of the things that’s come up, and I think it was
discussed this morning at our past presidents’ breakfast was the question of outcome,
and the insurance companies not wanting to pay for something that doesn’t have a
demonstratable outcome. Do you have any ideas about how the outcome of pediatric
care, both preventive care and illness care, can be measured so that we can at least
make a good case for pediatric care being the ideal care for children? You see what I
mean?

DR. KENDIG: Yes I do. I see what you mean, but I haven’t given any
thought to the fact about how we could remedy this. I didn’t think that we’re
going to be able to do it anyway. Now I don’t know . . .

DR. STRAIN: We’ve thought a lot about that and nobody’s come up with any
real good solutions, and I just wondered if you’d thought much about that.

DR. KENDIG: No, I don’t know. It’s hard to do. But those are the
problems, I think. They are major problems that go back to the same story
about the family practitioner. There are some good family practitioners, I’m
not critical of them. But they don’t have the training. I guess in most of them,
two years and a half of a three year program is on an outpatient basis. And the
other, maybe six months in a hospital. And you just cannot recognize the sick
patient. You’ve got to be able to recognize somebody who’s sick. That’s the
reason I don’t want us in pediatrics to drift entirely to the ambulatory basis of
training. It’s right that we should do more in ambulatory training than we have
been doing in the past. My Lord, when I started practicing, I had no idea how to start a practice. It was flying by the seat of my pants. I just started by putting up my little shingle and said, “Here I am.” Not a pediatrician in town had any laboratory work in their office.

DR. STRAIN: Not even cultures.


DR. STRAIN: Not a lot of antibiotics.

DR. KENDIG: There were no antibiotics when I started, you see. I started with no antibiotics. So I saw all of it; I have really had the best in medicine. The very best. When I was in medical school, it was all diagnosis, because you couldn’t do very much about anybody. And then after I got started in practice, we still had no antibiotics but we had a lot of other things in pediatrics we could do, immunizations and other things. [laughs] I think one of the reasons they gave me the Child Chest Clinic was because they didn’t think anything was going to happen in tuberculosis. [laughs] And fortunately at that time the drugs came. It’s an interesting thing.

DR. STRAIN: We’re training about, as I understand it, about 3,000 pediatricians a year. Are we training too many?

DR. KENDIG: Probably.

DR. STRAIN: We have in the Academy, 53,000 pediatricians, and that’s only 75% of the board certified pediatricians. So we’ve got 70,000 pediatricians in this country.

DR. KENDIG: Yeah, I think we probably are, Jim, because I see pediatricians going to mighty small places. One of the things that’s saving us is women in medicine. And I’m strong for them. I think that women have improved medicine. They are good doctors, and I think they’re especially good in pediatrics. But they also have saved us in another sense, they don’t want to work all the time. I don’t blame them, but they don’t want to work like I worked when I started out. I was impressed with a man who’s a pediatrician, who must be 60 years old now. He has an office in a building near St. Mary’s Hospital. And I asked him the other day how many days he’s working, and he said four. And I said, “How about the others (all women) in the office?” He said, “Well, one of them is working three days, another one is working three days, and I’m not sure whether the other one is working three days or four days.” In other words, they’ve got five people, three women and one man, and
a nurse practitioner. Nobody’s working all the time, but they work three or four days. So, if you go back and look at it that way, maybe we aren’t training too many pediatricians. Because we may have a lot of them in name, but as far as putting in full time in pediatrics, they’re not. And it may take two of them to be able to do that. Do you remember there was a study done back in the 1960s? They said there would be too many physicians or too many pediatricians, I can’t remember which one it was now. But they didn’t know what was happening in medicine, because I’ve just gone through a study of women in medicine, and the number that are entering medical school now is something like 40%. It’s a little over 40% as a matter of fact. And the number graduating is around 40%.

DR. STRAIN: Women are a higher percentage even in pediatrics.

DR. KENDIG: Oh yes. And in those in pediatric residencies, it’s about 60/40, the other way around. It’s 60% women, 40% male.

DR. STRAIN: How many women were in your medical school class?

DR. KENDIG: We finished with three.

DR. STRAIN: Big change.

DR. KENDIG: Big change, yeah. Big change. And now, as I said 60% of all the graduates in pediatrics. But in medical school, I should have written down those figures because I was just looking at them because I was doing an editorial on it, [laughs] on the changes, and women in medicine. They have never had a president of Medical Society of Virginia who was a woman, and in my editorial I said, “There’s never been a woman president of the Medical Society of Virginia; isn’t it about time?” And I think that’s a bad situation. I think women in medicine have been great. I really do think that they have been very stimulating and they have presented qualities that we’ve needed. But they do have that one additional factor, though, that it does help you add more doctors, because they don’t work as many hours. And I don’t blame them.

DR. STRAIN: Do you have any thoughts about the HMO [Health Maintenance Organization] movement? Good or bad?

DR. KENDIG: Oh, it's a disaster.

DR. STRAIN: In what way?

DR. KENDIG: All we've done is we have taken medicine, which has cost a good bit of the GNP, gross national product, and we want to reduce the cost.
And they have reduced it some, but in the main what they have done is shifted the financial return to the investors. Investors in for-profit HMOs like Columbia/HCA don’t buy Columbia/HCA because they want to help somebody who’s sick. They buy Columbia/HCA stock so they can make money. There’s no way that you can practice health care and start looking at the bottom line too much. You start looking at the bottom line too much, somebody’s going to be hurt. And I think a lot of people are being hurt now.

I think an obvious example is the idea of sending the mother home after delivery within the first 24 hours. Of course many of them could go home then, but you’re taking a chance that a certain number of babies are going to develop jaundice that may be serious. A certain number of them are going to develop a cardiac murmur that you couldn’t hear for the first 24 hours but that would knock you down about three days later. What I think some of the pediatricians have done is to try to see the babies within a certain number of days after they go out.

In my early days of practice, one of the obstetricians who referred more work to me than anybody else was a man who was the Chairman of OB/GYN at the medical college. Back in those days he had a huge practice. He had two other people with him. Huge practice. But he had a good nurse. And when the mother went home, two days later that nurse was at the door to see how that mother was getting along. It wasn’t because of the baby; he was looking out for the mother. If you’ve got the time, if the mothers have got to get home, I think that if I were in practice today that’s what I’d do; because the mother might not be able to get in the office in three days with a baby. But if they didn’t do that I’d have a nurse sit right there, looking at that baby to be sure the baby was getting along all right and it wasn’t the same color as an orange, or was eating reasonably well, or didn’t look sick. I think that’s an important area.

But of course, I think now they’re loosening up on that. But you see it’s such a small percentage of patients that develop these complications that you can’t prove anything. They say one-tenth of one percent of such and such a thing. Well, what the heck, if you’re a doctor, you don’t look at percentages, you look at the patient. You look at this one patient. That is the one that you’re worried about; you’re not worried about percentages. Isn’t that true?

DR. STRAIN: Mm-hm. I think that’s right. I think we’ve all been concerned about the 24-hour discharge.

DR. KENDIG: Well that’s just one thing.

DR. STRAIN: Across the board too.
DR. KENDIG: We got off on that one point, but I think that it’s widespread. If you look at it from the surgical standpoint, someone who needs an operation can’t go to the hospital. And somebody is sitting in their office several hundred miles away who’s never seen the patient, who by the way is not a doctor, or even a nurse in many instances, making decisions as to whether that patient can even be in the hospital. Or if they’re in the hospital, how long they can stay, no matter what complications occur. Just because they have a certain type of illness they can stay only a certain number of days. That’s wrong. You can’t do that. You can’t practice medicine; you can’t practice it well; you can’t give good health care in a situation like that. Those things bother me.

DR. STRAIN: Well Ed, you’re an expert in tuberculosis, beginning with your own disease. And probably you can give us more information about the natural history of the disease, with the introduction of antibiotics, and bring us up to date on what you think about tuberculosis then and now, and in the future years. What have been the developments you’ve seen?

DR. KENDIG: Well, I suppose, at the time when I was starting probably more than half the population of the United States was tuberculin positive. It was a very widespread disease. But at that time, we took better care of the patients than we do now, except for the antibiotics. Now, let’s put it this way. First, the health department always had a tuberculosis division. Let’s go back to Virginia. In Virginia, one physician was in charge of tuberculosis in the whole state. He had several other people who were involved in tuberculosis, and we had two, three sanatoria in Virginia with several hundred patients. We had a number of clinics throughout the state at all times.

When a patient was found to have tuberculosis, he or she was put in the sanatorium. There were two or three reasons for that. There are two obvious reasons; first, we got the patient who had a positive sputum off the streets. He wasn’t going to give it to somebody else. And the second reason is that we put everyone on rest as much as we possibly could. There was no question about it. We also had nurses who were trained in the epidemiology of tuberculosis. They found the patients and they found a case and all the contacts and they got all of those things accomplished.

So you had clinics, and there was somebody who was in charge who knew what he was doing. You had sanatoria and in general the patient was much better taken care of except for one thing. We didn’t have antimicrobial agents. Then when the antimicrobial agents came in, to begin with, it was just great. We started off with streptomycin and para-aminosalicylic acid and then later on
added isoniazid and all the various other drugs. With the drugs, we became over-confident. I guess that would be the word. We were so sure everything was taken care of. Trudeau Sanatorium, that I talked about earlier, had closed in the 1950’s. The sanatoria in Virginia closed. At the time I had tuberculosis in the 1940’s there were 400 sanatoria throughout this country. By the 1950’s, I can’t give you the number, but it dropped down to a minimal number, and then very shortly thereafter they were practically all closed. But that’s all right. As long as you had someplace that you could put these people who were infectious, and couldn’t continue to spread it. We don’t have tuberculosis clinics, and people are treated at home. They’re not treated very well, and they pass it on to everybody else. What has happened is a recurrence of tuberculosis. Let me go back again for a second.

In 1900, the tuberculosis mortality in the United States was 200 per 100,000 population. By 1940, it had dropped below 50. And in 1980, the mortality from tuberculosis was less than one per 100,000 population. Less than one. But we still had plenty of it, and were passing it around. And all these other things have come along. One is the homeless, those people that were dumped on the streets, put out of the various mental sanatoria, and others are homeless for other reasons. That is part of it. The ones with HIV [human immunodeficiency virus]. And by the way, it is my understanding that the person who has HIV infection is no more likely to acquire tuberculosis than any other individual, even though he is immunologically deprived. But once he gets it, it goes just like wildfire. As time passes a little bit more of the disease is knocked out by the antimicrobial agent until finally it’s all knocked out and it’s controlled. But the trouble is if it’s not knocked out, you are left with these drug resistant organisms. So you’ve got HIV, you’ve got the homeless, you’ve got all these people coming from various countries in which there is a very high incidence of tuberculosis. They may screen them very carefully coming into the country. They don’t have tuberculosis at that time, but within the year, many of them have tuberculosis, and that’s where they come from. Then you’ve got the fact that the health departments don’t do what they’ve done before. And the doctors don’t know much about it. And that of course is a major part of it because, after all, pulmonary doctors haven’t seen much tuberculosis for a long time. It’s relatively low on the list. There are some other reasons too, but these are the predominant ones.

DR. STRAIN: What’s your thought about routine TB skin testing?

DR. KENDIG: [laughs] That’s a sore spot. I’m one of the very few who still thinks that you ought to do routine testing. I think a private practitioner ought to do one at about a year of age, ought to do another one at preschool, ought to do another one in early adolescence. I don’t think that you can
possibly lose in doing that. I think you really would be able to pick up a lot of tuberculosis that way. Most of the young people who have come along think the only way that is productive is to find a case of tuberculosis in an adult and then try to check the contacts, and work from that standpoint. Of course, that is going to be the most productive, because that’s going to be the only way you’re going to find it. I’ve noticed that the ones who are doing tuberculin testing at home by now are beginning to call me at rather frequent intervals to say, “I’ve got a child over here who’s got this; what do I do about this one now?” It’s coming back. It’s here.

I was at a CDC [Centers for Disease Control] conference about three years ago. There were about 100 people there from medical schools and hospitals and so forth. Everybody. And I mean, they divided it, as I recall, in four sections. Different things about tuberculin testing and so forth and so on. Well, in the section I was, there were some good people. Don’t misunderstand me, good people. They disagreed with my opinion about tuberculin testing. They were all floating away from all this idea of tuberculosis. I said, “I want to ask one question. I have had experience in private practice for 30 years. I have been in academics for more time than that, because I have been overlapping on this. But I’ve been in private practice, and I’ve been with this. How many in this room (there must have been, oh, 25 people) how many in this room have practiced pediatrics in private practice for as much as a year?” Not a soul. So you were dealing with people who were in the laboratory or people who were in the health departments or people at CDC. And I know they know a lot about all these things, but they are not practical. As I say, that’s a sore spot with me. [laughs] They all look at me like I’m something out of the ark.

DR. STRAIN: [laughs] Now Ed, I wanted to ask you about some of the people that influenced you in medicine. You mentioned Dr. Bakwin. How about the people that you knew in the previous generation? Can you tell us about them, and any personal accounts of your interchange with them?

DR. KENDIG: Well, you mean from the standpoint of when I started in medicine?

DR. STRAIN: Yes, because you had as your mentors Bakwin and others like that. They undoubtedly influenced you.

DR. KENDIG: Dr. Sidbury taught me more practical pediatrics than anybody I ever knew in the same period of time.

DR. STRAIN: He was at Wilmington.
DR. KENDIG: Wilmington, North Carolina. You know his son, Jim, don’t you?

DR. STRAIN: No, I don’t think so.

DR. KENDIG: Well, Jim ran the metabolic unit at Duke for years, and then he went to NIH [National Institutes of Health]. Now he’s retired. He’s retired and he was a little boy when I was in training. [laughs] But he was great and practical.

I guess Harry Bakwin was the one that taught me the most at Bellevue. He was a very provocative teacher. He wanted to give you something to think about. He’d give you something, and he would argue the other side vehemently. It made you think. The other, the Chairman at Bellevue when I was there, was Charles Hendee Smith. Charles Hendee Smith was old. He was in his sixties of course at that time, and gray hair. Handsome man. And when Charles Hendee Smith says it’s so, it’s so. There’s nothing to discuss. There was nothing provocative about it. I mean, he just said, “That’s it.” When I was at Bellevue, that was that way. Then I went down to Hopkins. Did you know Dr. [Edwards A.] Park?

DR. STRAIN: Mm-hm, yes.

DR. KENDIG: Oh, what a wonderful person. So gentle and he would just get up and make rounds. I went down there and made grand rounds the first time, with 18 to 20 other residents. Then Dr. Park would say, “uh.” Dr. Park would “uh-uh-uh” all the time. He was not a good speaker. But he was good in rounds. We all listened to Dr. Park. And all of a sudden he just pulled it all together. Just beautiful, just beautiful, but I looked at those extremes, Dr. Smith and Dr. Park, saying, “Now wait just a minute; is that right?” Dr. Park pulled it all together. Two ways of doing it. Interesting thing. But they both influenced me a great deal.

DR. STRAIN: Well, Dr. Bakwin’s wife was also a physician.

DR. KENDIG: Oh yes, and a wonderful person.

DR. STRAIN: Now were they on the full time faculty at Bellevue?

DR. KENDIG: Yeah.

DR. STRAIN: I see. And then they had an unusually interesting art exhibit, as I remember. Had you ever been to their house?
DR. KENDIG: Oh yes. They were very nice to the house staff. I mean, they had the house staff out to all kinds of functions. They also had a home out at Ossining [New York], where the prison is. They had a beautiful estate out there. And they used to have the house staff there. And that’s not where they had the big art exhibit. It was in the house on East, I can’t remember, 71st Street, I believe. I started to say 72nd, but I believe it was 71st Street. I believe it was 132 E. 71st Street, but it was about there. And they had all kinds of art work. They had Cezannes, Monets…

DR. STRAIN: They had a lot of impressionists.

DR. KENDIG: It was some years ago, just after Harry had died, the Virginia Museum of Fine Arts, which is in Richmond, a remarkable museum with a very fine reputation nationally, was doing personal exhibits. And I got the Bakwins to put their [collection] down there, and it was quite a show. They bought those paintings way back in the early years. They went over and stayed for months in Europe at various clinics. That’s when they were doing a lot of their psychiatric training, I guess. And they actually met these artists, and talked to them and saw many of them. That’s how they started, and they bought those paintings when they were not very expensive. They later on became a wonderful, a beautiful exhibit.

DR. STRAIN: Now they were musicians too, were they not?

DR. KENDIG: He was, I didn’t know that she was. I don’t think she was.

DR. STRAIN: Well it may not be, I may have…

DR. KENDIG: Oh yes, you were invited to the home to hear the chamber music, and have dinner. We had a very pleasant evening. Harry played bass viol, as I recall. Don’t hold me to that. But that was part of the house staff visit. I don’t think we were ever overcome with the prospect of listening to the chamber music, but the rest of the evening we thought was all right. [laughs] But Harry was a great teacher, because he was so provocative. And I was never sure whether he just led you into the thinking on the other side at first so he could nail you, but he really made you think.

DR. STRAIN: Now was it largely psychiatric or behavioral pediatrics?

DR. KENDIG: Primarily behavioral.

DR. STRAIN: Yes.
DR. KENDIG: They call it child psychiatry, but it’s more behavioral than psychiatry.

DR. STRAIN: But he did make rounds on inpatients?

DR. KENDIG: Oh, yes, he made rounds on other things. He did a lot of work in tetany in the newborn and things of that type. He was particularly interested in the laboratory aspects of medicine, and the clinical applications. He was not a laboratory man as such, because he was very strong on clinical approach. When I went to Baltimore, I realized that he was much more attuned to the laboratory approach to medicine than anybody else at Bellevue.

DR. STRAIN: Any other pioneers that you remember, that you came in contact with, other than Dr. Park, Dr. Smith, Dr. Bakwin?

DR. KENDIG: I think of the other people that I had, the only other one was the one I mentioned earlier, who was not in pediatrics, was Dr. Hudnall Ware, who was the obstetrician. He embodied what anybody wanted to do in medicine. That is, he was so conscientious and he did such a great job with his patients. He was primarily a clinician, but he was head of the department, and he was quite prominent nationally in obstetrics.

DR. STRAIN: And he was at the University of Virginia?

DR. KENDIG: No, he was at the Medical College.

DR. STRAIN: Medical College of Virginia.

DR. KENDIG: Yeah, everybody gets that mixed up. The University of Virginia is in Charlottesville, and that’s where I went to school, but the Medical College of Virginia is in Richmond, that’s part of Virginia Commonwealth University.

DR. STRAIN: I see.

DR. KENDIG: In those days, it was just plain Medical College of Virginia, not part of any other institution.

DR. STRAIN: If you were asked what are the major advances that have occurred in pediatrics, since you went into practice and since you became interested in chest disease, what do you consider the major changes, major advances in pediatrics in the last 50 years?
DR. KENDIG: Well, I think a lot of those are pretty easy. The antibiotics and the antimicrobials and corticosteroids, I think those things have made the biggest difference in management of patients and what we can accomplish. And, of course, the other technical advances that have come along such as the things that we can do in heart disease or in pulmonary disease. The surgical aspects of all of those things are major advances. If we exclude all surgical things, then there’s no question about the fact that the two major things that have happened are antibiotics, and corticosteroids. They made all the difference in the world.

DR. STRAIN: And probably immunizations.

DR. KENDIG: Well, immunizations, yes. Oh, absolutely. That was not very smart of me to overlook that. Immunization, I think, would be up in the forefront. I think that one of the pediatricians who has done the most to advance things like that is Saul Krugman. Saul Krugman did an amazing job in working with the measles vaccine, and with hepatitis vaccine. He was a remarkable fellow.

DR. STRAIN: We were able to interview him by the way.

DR. KENDIG: You got him?

DR. STRAIN: Yeah, we got a lot of it. OK. Ed, we talked a little bit about your book, and I know you’ve written a number of articles and publications, editorials, and you’ve served on editorial boards, and I suppose you consider the book your most important contribution to pediatric literature. Or do you have other thoughts about that?

DR. KENDIG: No, I think it’s bound to be, Jim. It happened at a time there was certainly nothing else like it. It was the only one in North America for 25 years. I don’t know what the sales were compared with the other books. In fact, I don’t think I ever inquired; but with the fourth edition I know that 45% were overseas. As a consequence thereof, I have really been able to lecture all over the world. And it certainly wasn’t because of any great knowledge on my part, it was just because of the book. And people knew my name and they said, “He’s bound to know something.” [laughs] So I was invited, I guess.

We’ve been almost everywhere. As a matter of fact, that’s helped Emily and me with our travel. What [would] we do, if I was invited to the Philippines, I would spend three or four days at the Philippines giving some lectures, then we would manage to take another week to go to Japan or something like that. One
time we went to Taiwan and other times various other places. But the fact that
the book came out has certainly made the greatest difference to me. As far as
other publications are concerned, most of them have been on some form of
pulmonary disease. Publications have been in almost everything. I’ve had four
articles in the *New England Journal of Medicine*, probably about 12 in
*Pediatrics*, same number in *Journal of Pediatrics*, and roughly that many in the
*American Review of Tuberculosis* or *Chest*, or something like that. It’s pretty
evenly divided, except for those four.

DR. STRAIN: Would you say most of your publications and original papers have
been about chest disease?

DR. KENDIG: Yes.

DR. STRAIN: You’ve served on editorial boards. Which of the publications,
journals, have you been involved in as far as the editorial review is concerned?

DR. KENDIG: It’s hard to say. The interesting thing is, I enjoy the
editorial board of my little *Virginia Medical Quarterly* more than anything else
that I’ve ever been on, primarily because we have such good discussions.

DR. STRAIN: Now you’re the editor of that quarterly.

DR. KENDIG: Yeah. What we do now is we meet four times a year. And
we talk about what we do with this little periodical. It’s not to be compared with
the other journals, but it provides a little bit of news, a little bit of business, a
little bit of other things about medicine in general, and something in the way of
science. For example, we just had one on telemedicine. One issue devoted to
sleep disorders. The one before that was neuro-critical care. And these things
are decided by the board, and that’s what I was getting around to. We bring up
what subjects we’d like to publish, because remember we’re dealing with a
general population of medical people. You can’t give them something in
pediatrics all the time. We can’t give them everything in neurosurgery every
time. Something like that gives us a general picture of everything else, and it
has more appeal to a general population of physicians than if we tried to put in
something more definitive.

DR. STRAIN: You have been editor of that journal for quite a while.

DR. KENDIG: This is the 14th year, but it started out as a monthly. But
doing a monthly for a state medical journal is too much. Too much. As a matter
of fact, a lot of people think four times a year is too much. The number of
journals that you get is probably around 15, and I said, ‘Gee whiz, what am I
doing with all these things?” One of the things that’s come up at the medical society meetings, they ask, “Does anybody read this?” I said, “If you’re talking about somebody that will sit down and read it through, more people sit down and read this straight through, than read the New England Journal of Medicine straight through.” And the reason is, they can read the whole thing in a half-hour or so, maybe an hour at most. What they do with the New England Journal is they’ll sit down and read two or three articles that are very good, but that’s all they’ll read. The same thing is going to be with Pediatrics; the same thing in anything else. I said, “There’s no comparison; they’re so much better.” But at the same time, you’re dealing with a general population, and they’re going to say, “I see your journal every now and then. It’s a real good journal; I certainly enjoy it.” But it’s fun, and I’ve enjoyed it more than any of the rest. The one that you and I are on, the advisory committee of the, I can’t remember the name of the journal now, but we are on it. I’m off at the present time, but what is the name of the journal?

DR. STRAIN: Pediatrics in Review, that one?

DR. KENDIG: I think maybe that’s what it is. But anyway, they all have something different. Everything’s a little bit different. I enjoy the ones that get up a discussion, what you’re going to do, and everybody’s not biased. You get a lot of people and it’s an interesting thing. Of the dozen or so members of my board, guess how many are pediatricians? Seven.


END OF TAPE ONE, SIDE TWO

DR. STRAIN: This is side number one of the second tape. [I want to] get your thoughts about HMO’s, because we didn’t discuss that as much as I’d like. Why don’t you tell me more about your experience with HMO’s?

DR. KENDIG: I go into St. Mary’s hospital I’d say almost daily. St. Mary’s is a very good general hospital. It has almost everything. It’s probably where the Medical College likes to do most of their teaching, other than downtown. Pediatrics is the major outreach program. The thing that bothers me about the HMO’s and everything else is that everything is reduction of caregivers. Now this is a good hospital. I’ll go to other hospitals and I’ll find the same thing is true. On a wing or on a ward we might have three RN’s, three LPN’s, three aides, now I’m just picking the numbers out of a hat. As time has passed, we’ll now have one RN, and two LPN’s, and three aides. Or maybe have an extra one, four aides. In other words, not only have they reduced the number of nurses on the floor, but they have reduced the quality of the nurses
on the floor because they reduced their training. You have fewer that have good nursing training. And you just can’t tell me that these people can give the care.

I’ll give you a good story. Emily was a patient at Hopkins. Hopkins is the number one hospital in the country. It has been named as number one the last four, five years, or something like that. And she had a knee replacement. She was getting along fine, had a great doctor, Lee Riley, a wonderful orthopedic surgeon. He did a great job. I don’t remember now whether she had a catheter to begin with, but she didn’t have one after the operation. She wasn’t voiding much, but they had an IV fluid running in. She was given antibiotics, so she had the IV fluid running along, but she began to get very uncomfortable and had pain in the abdomen. They couldn’t figure out what in the world caused the pain in the abdomen. Well, of course you know what happened. They had two or three consultants, had a gastrointestinal consultant, finally one of the surgeons came up to me and says, “I think an x-ray will tell you what is wrong down here.” She had retention. And the first time that they did the catheterization she had something like 2,000 cc removed, and that didn’t take care of all of it by any means. They were worried about whether or not she was going to get complete bladder function back again. But she came back all right, so, this is the story.

Dr. Riley says, “Mrs. Kendig, I can sympathize with you. There’s absolutely no excuse for it. But,” he said, “I want to tell you a story about my father who was about 90, and he was here in Johns Hopkins Hospital. He just couldn’t get a nurse to come so he dialed 911. [laughs] And he said that the 911 was answered promptly, and everybody came pouring in, and he said, ‘Son, I’m sorry I did that. I hope I didn’t embarrass you too much, but I tell you, I just couldn’t wait any longer.’”

Well, I won’t say that’s quite the way it is now, but it illustrates exactly the point that I’m making. And that is the fact that there is not enough help on the floor. I don’t mean that it isn’t adequate for taking care of the vast majority of instances. But if you’re sick, if you’re good and sick in the hospital, you need something more than just the general flow of care. If I’m put in the hospital right now, I want to get what they now call sitters. They don’t do a darn thing but just sit right over there, have a white uniform and sit in the corner. But anything you need, they’ll take care of or they’ll call somebody who can come and take care of you. But you need somebody like that. And this is how I advise a lot of my friends who are in the hospital now who are really sick, get a sitter. It costs only half as much, and they can get somebody in a hurry.
They just don’t have enough personnel to take care of minor things or many things on the floor. Sometimes these things are not mild, like the 2,000 cc of retention. And these things can happen, and so I worry about the fact that they’re trying to cut down too much, and I picked nursing because that is one of the most obvious ones. This is not only St. Mary’s, I’ve just used Johns Hopkins Hospital, I can give you the Medical College of Virginia, I can give you any other place that I’ve been, and I’ve been to a lot of them along the way. It’s a big difference in the care. Another thing that bothers me, I’m worried about our care in this sense. Nobody practices alone now. Most of people don’t practice in groups of three or four, but you go to a group of 10 or 15. Or if you happen to be caught in a group of four, you don’t limit your work to four, you divide your calls with another group, which may be four or eight. So you take your calls one evening, let’s say a maximum of once a week. That bothers me. Patients don’t get the care I would like if somebody is not around any more than that. Maybe I’m wrong about that, but to be on call once a week, or once every ten days, means that the other nine nights or the other nine days the people are going to have a hard time reaching you.

DR. STRAIN: Well I think that’s true of the staff model of the HMO, you know.

DR. KENDIG: That’s right; that’s what I’m talking about.

DR. STRAIN: Call nights are about every 14th night or so, and there is another trend that you may have in Virginia or if you don’t have, you probably will have, is physician groups, pediatric groups, signing out to the hospital emergency room at 5:00 at night and on weekends.

DR. KENDIG: Yes, I’ve seen that. I heard about one, but not in Richmond, but this is hearsay. An obstetrician was talking to a woman in labor. They said she was going to be delivered within the hour, so he looked at his watch and said it’s five o’clock and I’m leaving, but the other man’s going to take care of you, he’ll deliver you, it’s five o’clock. [laughs] So I guess we’re not completely without fault. As far as the incomes of physicians are concerned, I have a little difficulty in evaluating that. I heard them talk this morning about the fact that five years ago pediatricians were started off at $130,000. Anybody that made $130,000 in Richmond did very well. It depends on what part of the country you’re in. Then it dropped to 80, he said. I guess I’m different about that because I really didn’t expect to make a lot of money in pediatrics. I think it was something I liked to do, and I certainly wanted to get along reasonably well, but if you want to make a lot of money in medicine, be a neurosurgeon, be a radiologist. Radiologists make a lot of money. And, I’d certainly like to make a reasonable living but I can’t get worried about the incomes at the moment. Maybe I will later on.
DR. STRAIN: OK. You mentioned a minute ago, and I wanted to follow up on this a little bit, that you had been lecturing in many countries, probably the result of your recognition as the editor of the book. But for whatever reason, you’ve been all over the world with your lectures, and I wondered if you had any experiences on any of your trips that you’d like to share with us that were of interest or would be of interest to people in international pediatrics. You’ve been in a lot of countries, done a lot of things.

DR. KENDIG: Not all of which I can respond to. [laughing] No, they’re all different, but you’re right, there’s no question about the fact that I got that because of the book. That’s the only way they would know my name. As I said, the book has a large overseas sale, but I don’t know anything. I probably have been more in the Latin American countries than anywhere else. Part of it was in Puerto Rico. I’ve probably been in Puerto Rico eight or ten times. I love the Latin Americans, I really do. I think they’re the nicest people in the world. I think they have the greatest feeling and everything else. I’ve thoroughly enjoyed them.

Their idea of time and things like that are not always the same as mine. I remember one time I was in Santo Domingo; we went there to the Central Dominican University East or something like that. It was a university in Santo Domingo. And they had us staying at this lovely place in a resort up there [Casa del Campo] and it couldn’t have been nicer, just very fancy. And they said, “Now we’ll pick you up at 9:00 in the morning, I mean, 8:00 in the morning, right by that gate.” I was there five days. Each morning I arrived at the gate at 8:00, each day they arrived to pick me up at 9:00. Regularly. Didn’t miss a day. [laughs]

Another time we were in Santo Domingo and Emily and I were sitting down by the swimming pool. Emily said, “Who are those men up there on top of the building?” Well it developed, there were four men on the corners, and they had rifles. [laughs] She found out a day or two later. She wanted to go downtown, and they wouldn’t let her go, unless they sent a group, or a couple of people with her.

DR. STRAIN: And you’ve been all over South America too.

DR. KENDIG: Oh yeah. Went down to Mar del Plata in Argentina, which is right at the very tip, just right across from the Falkland Islands. As a matter of fact, I was there giving a talk one month before the Falkland Islands broke loose. Before they went, before the British and Argentina had their little battle. But do you remember [Angel Eduardo] Cedrato?
DR. STRAIN: Oh yeah.

DR. KENDIG: Cedrato took us for a ride and pointed to the navy. I saw one ship down there. I didn’t think they were going to do very well against the British. [laughs] But it’s a beautiful part of the world.

DR. STRAIN: Now you gave your lectures in English? Was there a language problem?

DR. KENDIG: All English.

DR. STRAIN: And they all understood.

DR. KENDIG: Most of the times you can give it in English entirely. A lot of the times, they had simultaneous translation. In either Venezuela or Santo Domingo, I put my slide up and I’d whip off a paragraph and stop. A man translated a paragraph. Then I’d say another paragraph, slide, and he’d translate again. That is not fun. It would bore me to tears if I were watching a person do it, so I didn’t like that at all. But in the main, it’s a simultaneous translation. Because most of those people didn’t know English that well, it was practically always a simultaneous translation. They had those little headphones on.

DR. STRAIN: Now you did some lecturing in the Far East, too, didn’t you? In the Pacific Rim countries?

DR. KENDIG: Yeah, I’ve been in Japan several times, in Tokyo a couple times, and one year they had a symposium in Kyoto. I’ve been to Japan about five times I guess, but that year we started off in Tokyo and my friend, Dr. Niitu, who lives up at Sendai which is in Northern Japan, had invited me there to give a talk at Tohoku University. They don’t speak much English in Japan, and you have a hard time getting around. And we were instructed to take the bullet train up there. So he sent this young man to pick us up. And he got us on the train, and we were whipping along at a rapid rate up to Tohoku. All of a sudden the train came to an abrupt stop. There we sat. He was in the seat up front. We sat about 20 minutes or so. So I got up and went over there and asked Dr. Horikawa, “What has happened?” He said, “It stopped.” [laughs] Well we knew it stopped but that’s all we got out of him. We stayed there about an hour, and then went on. They were having a cocktail party for us. We got there, and some of the ladies said, “Did the earthquake bother you much?” [laughs] They had had an earthquake, and so they had to go and check the tracks beforehand so they could see if they could get in and out.
Another story about Dr. Niitu. We know him well; he’s a delightful person. We’ve been in his home and I’ve seen him throughout the world. One time we were in South America, I believe this was in Buenos Aires. We were having one of those big cocktail parties that day. And here comes Dr. Niitu. “Oh Dr. Niitu, I’m glad to see you.” And we talked to him, and Emily asked what inflation had done to the pearl market in Japan. He said, “Yes, my son did get into medical school and he’s doing very well.” [laughs]

DR. STRAIN: The language problem.

DR. KENDIG: We didn’t always communicate as well as we might.

DR. STRAIN: Now you were in India too, were you not, at the time of the International Pediatric Association meeting?

DR. KENDIG: Yeah. I didn’t do much there; I just gave a couple of talks.

DR. STRAIN: And Western Europe? You’ve given talks in Western Europe?

DR. KENDIG: Yeah. And we’ve also been in Thailand, to Bangkok a couple of times. Gee, that’s the biggest change I’ve ever seen in a city. The first time I went to Bangkok, we stayed at a hotel called, gee I can’t remember, well it means “elephant” in English [Rama Hotel]. We arrived at 11:00 at night. We got in there, dead dog-tired. When we got in there, anxious to get to the room, the man says, “Oh, you didn’t get here on time, we’ve given your room away.” He said, “We’ll put you in another hotel down the street, just about a block, and you can come back up here tomorrow, I think we’ll have a room by tomorrow.” So we went down there, we got in the room. It wasn’t the fanciest place I ever saw, but it wasn’t too bad. We got in there, and Emily looked up on the wall, it says, “All female guests must leave by 11:00 pm.” Emily says, “Lock that door!” [laughs] But the traffic at that time, you could just go on to all the places without any trouble at all. And I was back there, oh, I guess about six years later.

DR. STRAIN: It’s awful.

DR. KENDIG: You take an hour to get anywhere, I’d never seen anything like the crowd of people in Bangkok.

DR. STRAIN: Yes, you can’t get anywhere there without spending all kinds of time.

DR. KENDIG: “Lock that door,” she says. [laughs]
DR. STRAIN: Now I wanted to ask you about your honors, Ed, because I…

DR. KENDIG: My what?

DR. STRAIN: Your honors. You’ve received a lot of them in your career in pediatrics. What’s the most significant one, from your point of view?

PAUSE IN TAPE

DR. KENDIG: Is this about the endowed professorship? It’s what pediatricians should be, and if you happen to be picked for something like that, I think that certainly is a significant one. The second one I guess is the International Pediatric Association medal for service to pediatrics internationally [Medal of the International Pediatric Association], I guess it’s probably that. A third would be the Jacobi Award.

DR. STRAIN: Now I want you to tell me a little bit about that endowed professorship, that to me was a tremendous honor. I need to know more about that.

DR. KENDIG: Well, to say I was pleased is understating it. Certainly I was overwhelmed by it. It was great. And this young man, Barry [V.] Kirkpatrick, who succeeded me running the program out at St. Mary’s for MCV, is a neonatologist. He’s on the Committee on Fetus and Newborn for the Academy. I think he’s finishing up in another year or two. He initiated the neonatology program at MCV, and ran it for 13 years, built it up to about seven, eight people in the department. And then he decided that he wanted to take care of his growing family, and so he took this job up there with me. Anyway, he was the one who thought of the endowed professorship, and he asked me if I would have any objections. And I said, “Oh Lord, I’d be happy. But I’ll tell you this; I’m not going to ask my family to give a lot of money. In the first place, I don’t think anybody in the family has got a lot of money to give you, and in the second place, that’s not the way I think you ought to get it. If you think you can get it, that’s fine. Of course, I’d be most complimented.” So he said, “Well I’ll tell you now, when we start this thing, when it goes public, it’s going to take about two years or better to do it, because it takes a little time to get the money.” And so they put it out, and in four months they had the money. They didn’t need as much money as we do now. Now I think it is five to six hundred thousand dollars.

DR. STRAIN: That’s right; that’s the average.
DR. KENDIG: At the time that they did that, I know it wasn’t that much. It wasn’t that much because it went up considerably just a few months after it was completed. And of course I was very pleased about it, and Mary Ellen Avery came down to give the little talk at the time it was announced. All of which pleased me a great deal.

DR. STRAIN: Oh my, yes. That’s a Chair now…

DR. KENDIG: It’s a professorship, not a Chair. Chairs run a couple million.

DR. STRAIN: So this is a professorship.

DR. KENDIG: This is the Edwin Lawrence Kendig Jr. Distinguished Professorship in Pediatric Pulmonary Medicine.

DR. STRAIN: At the Medical College.

DR. KENDIG: Pediatric Pulmonary Center.

DR. STRAIN: At the Medical College of Virginia.

DR. KENDIG: That’s right. Not where I went to school.

DR. STRAIN: I think that’s a tremendous honor when you have your previous students get together and really raise that kind of money.

DR. KENDIG: Students and patients and friends, I know. And the interesting thing, he just told me a few things about it, I think they had one contribution from the State Lung Association, which I think was for forty or fifty thousand dollars. And next they had about three at $15,000, and everything else was less than that.

DR. STRAIN: A lot of people involved.

DR. KENDIG: Yeah, I was right pleased.

DR. STRAIN: I should say. I think that’s a real honor. Now I wanted to talk a little bit about the medical organizations that you’ve been involved with. Let’s start with the RRC. You have been on the RRC in the past. Do you want to tell us anything about that, anything that came up during your service that was something you remember?
DR. KENDIG: No, the things that I remember most about the RRC were: one, it was a very hard working organization. And two, I remember two or three people on there that stuck in my memory, and one of them was Owen [M.] Rennert and another one was from University of Indiana.

DR. STRAIN: [Morris] Green?

DR. KENDIG: Yeah. They were the ones that I particularly recall. There were a lot of others, but I remember them particularly. Morris was a good solid person, solid thinker, didn’t make any waves particularly but let you know exactly how he felt about everything. Owen Rennert is bright.

DR. STRAIN: He was at that time I think at the University of Oklahoma, wasn’t he? Then he went to Georgetown.

DR. KENDIG: Yeah, he’s at Georgetown now. I’ve seen him a few times since then. As a matter of fact I invited him down to Richmond at one time to talk. I enjoyed the RRC about as much as any of the organizations I have been involved with. I thought they handled problems well and they had good discussions; it was fair in its approach.

DR. STRAIN: We are talking about the RRC.

DR. KENDIG: It reminded me of the policy of admitting students to the medical school. They come in for an interview. They are interviewed by two people. One is a faculty member, and one is a fourth year student. Now that bothered me a little. I didn’t mind having a fourth year student up there to visit with one of the prospective students, but I said, “Look, a fourth year student doesn’t know enough to be able to tell whether this person should be in, and this is half of the interview process.” The Dean of Admissions says, “Now, come on, don’t worry about that.” He says, “You’ve got a whole group of people who make this decision.” I said, “Look, I learned on the RRC that that’s not the way it works. Because what happens is the person who does the spade work is the person who has the most influence in what is going to happen. And this young man is going to have just as much influence as the faculty member, and a lot more than anybody else in there. And that’s not right.” And this is the only thing that I had some questions about. The RRC, it’s the same kind of question…

DR. STRAIN: You’ve learned that.

DR. KENDIG: Yes, sir, that really taught me, that was the thing…
DR. STRAIN: Where the influence was.

DR. KENDIG: That’s right. The person who does the work, the person who does the spade work, is the person who has the most influence.

DR. STRAIN: Yes, and it was the person that might be reviewing a program.

DR. KENDIG: Exactly, that’s what it was at the RRC, and in that case, it was a person that was reviewing an applicant. But it amounts to the same thing, the person who does the spade work is going to have the most influence.

DR. STRAIN: Sure they will. It’s a natural thing, that’s true.

DR. KENDIG: But the RRC was a great committee, I thought.

DR. STRAIN: You enjoyed that. What about the American Board [of Pediatrics]? Now you were an examiner; did you ever serve on the board of the ABP?

DR. KENDIG: No, I never was on the board. I was an official examiner for twelve years, and for at least six or eight after that I was called back at least once a year to fill in as examiner. I enjoyed it thoroughly. I was very sorry they gave up the oral exams because I think that the oral examinations gave them information about applicants that they would not have otherwise.

DR. STRAIN: Yes, I think you’re right.

DR. KENDIG: I think that oral exams are a very good idea. Very effective.

DR. STRAIN: What do you think of the recertification program at the ABP?

DR. KENDIG: I’m singularly unenthusiastic. I don’t know. It’s probably all right, but I don’t have much interest. I am not impressed by the need for recertification. Now, I think the persons who are in favor of it could say, “Now look, somebody can practice and never could read a book, read a paper, or have any follow-up as far as his training is concerned and keep his information up to date. And may turn out to be very poor.” But I’m not so sure that that’s going to make that much difference. And I don’t believe there are going to be that many of them. The same persons who don’t do that are not going to take the recertification examination anyway. So they’re never going to find it. I just can’t get very excited about it.
DR. STRAIN: Of course right now, since ’88 of May, it’s a time-limited certification.

DR. KENDIG: Yes.

DR. STRAIN: So you’re decertified after seven years.

DR. KENDIG: It doesn’t keep them from practicing though.

DR. STRAIN: No. It might make a difference in hospital or staff appointments. We’ll have to see how that works out.

DR. KENDIG: Well, tell me, do you like the recertifications?

DR. STRAIN: Well, I think it gets people to read, and I guess from that point of view it may have a value. I understand that the pass rate is about 99%, so you know, it’s a matter of studying and attending meetings. Nobody’s going to flunk.

DR. KENDIG: No, I think it’s pretty much pro forma.

DR. STRAIN: I wanted to talk to you about the IPA, International Pediatric Association. You were on the standing committee for a number of years.

DR. KENDIG: Nine years.

DR. STRAIN: Nine years.

DR. KENDIG: And I was a consultant for six years.

DR. STRAIN: During that time?

DR. KENDIG: I was six years as a member of the standing committee. Then I was six years as a consultant. Then I came back for three more years on the standing committee.

DR. STRAIN: Tell me what you thought about that organization, how it operated. You were kind of on the inside.

DR. KENDIG: It was a one-man organization for many, many years because Ihsan Dogramaci ran it like a fiefdom. He ran it, and anybody else who had any other ideas didn’t get very far. Actually he really was a rather remarkable fellow and in the main he ran a very good program. I thought the organization was very good. After all, you have to look at things this way.
Ihsan is a remarkable person. He’s a czar; he’s going to run it. With his own money and his wife’s money, he built a university. I mean, built it, the whole university. It’s there.

DR. STRAIN: It was in Turkey.

DR. KENDIG: In Ankara, yes. That’s right. One time I spent a week in Ankara at one of those meetings. Have you ever been to Ankara?

DR. STRAIN: No.

DR. KENDIG: Well, it isn’t like Istanbul, I can tell you because it’s way inland, and we were there in the fall. As a matter of fact it was at Thanksgiving time, and we were on the 13th floor of the hotel for that week. They had a 13th floor by the way. And below our floor, you could see the level of the smog. It looked like a little layer of land right beneath you, the smog was so thick over the whole place in that area. They had a system in place where if your license plate number was even you couldn’t use your car on one day, then the next day you couldn’t use your car if your license plate number was odd.

One night he had had a cocktail party at the capitol. He had people from every embassy in the world there, except the American embassy. The American ambassador was out of town, but then nobody else bothered to come. I think that’s an example of what the American Embassy does in most of these places over there. But it showed us that Dr. Dogramaci has the recognition of all the nations right at the highest level.

One time we went into Kuala Lumpur, and we had happened to come in on the same plane with him. We were up in tourist class I think, and he was in first class, but we were on the same plane. And we got off, and we rode into town in the limousines with the little flags flying. Every place that Ihsan went, he dealt at the highest level. So I’ve wandered off a bit in trying to talk about him, because he is a remarkable person. I mean, he is an autocrat, no question about that. But he is a remarkable person, and I think he’s done a lot of good. He’s been a force for good, in many ways.

Any time you crossed him, and you wanted to get somebody else as president, and he didn’t want that person to be president, your man didn’t win. I supported Norm [Norman] Kretchmer on a couple of occasions. In fact I made a speech for Norm at one time. And I thought we were really on a roll that time. Politics in the United States is nothing compared to international politics. And our politics in medicine is non-existent, embarrassing as that is. I mean they have it all worked out. They know exactly who is going to do what, and that’s the
way Ihsan worked. And it’s very simple what happened. They were beginning to push too hard. I believe Norm Kretchmer was about ready to run again, his third time. And that’s when, that’s when we were talking to Bob [Robert J.] Haggerty about running. And Norm said, “If he’s going to run I won’t bother.” But he said, ”I wanted somebody from over here to win.” And I did a lot of work for Bob, and we had him in a pretty good position. I thought Bob was going to win the election. And I think Ihsan thought so too. So that’s when he came over to see Bob, and he said, “Bob, how would you like to be the Executive Director?” Because he wanted to have his old friend as president.

DR. STRAIN:  [Gavin C.] Arneil?

DR. KENDIG:  Yeah, he wanted Gavin to be the president. Gavin Arneil to be the president. And, Gavin’s here, you saw him, didn’t you?

DR. STRAIN:  No, I haven’t seen him, but I heard he’s here.

DR. KENDIG:  Yeah, Ihsan wanted him to be the president, and he knew it probably might be Gavin’s last shot at it if he wanted it. So he figured it out. He gave the executive directorship to Bob. [laughs] But Bob’s found out it is not as easy as it looked, because whenever they ran short of money, in the past, old Ihsan just shelled it out. But over here Bob’s got to raise it. Bob’s done a good job, and he will do a good job. He’s an excellent man; I can’t think of a person who would do a better job in that position, but at the same time he doesn’t have that one little thing, money.

DR. STRAIN:  Money. Do you see a role for the IPA in international health? Where do you think that organization is going in terms of its effectiveness in improving child health?

DR. KENDIG:  Well, I’m sort of losing touch with it at the moment. I haven’t been part of it, but I think Bob has the right idea. I think his approach is to have somebody from the Academy connected with it, to try to promote working very closely with the American Academy of Pediatrics. And if he can work it out so that the Academy has a good bit of influence and is able to help them financially, I think it’s the only way it’s going to work out very well.

Sometimes I had a hard time trying to figure out what the IPA was trying to do. I think the major thing that they do, the best thing that they do, is the thing that the Academy does the worst, and that is the international pediatric conferences. I think the one we had out there in Hawaii was a total loss.

DR. STRAIN:  In Hawaii.
DR. KENDIG: Yes. That was a total loss. That was the worst one I’ve been to, and I’ve been to every one since 1956. But these others, in the main, serve as a good education center, education program, for the doctors in many of these countries who couldn’t come over here to stay for a length of time. They can go to a lot of sessions to hear papers presented, and go to things there. I think a lot of them learned a great deal by going. I really believe that the International Congresses of Pediatrics are very helpful for those people. Now they’re not helpful for you; they’re not helpful for me; they’re not helpful for anybody from the United States, because a lot of them are just rehashes. But at the same time, for the people over there, I think they learn a great deal. And for that reason, if for no other reason, I think the IPA does a good job. Because we don’t handle international conferences very well.

FADES OUT; PAUSE IN TAPE

DR. STRAIN: Were you disappointed with the conference the Academy sponsored in Hawaii?

DR. KENDIG: Yes. In the first place, it should never have been held in Hawaii. It couldn’t have been held in a worse place. It was the hardest place for them to reach; it was too expensive; it was at the wrong time of year; it was too everything. If it could have been anywhere else they would have been better off. Others that I’ve been to have been very good and I think that the doctors themselves have learned, not the Americans, but the others have learned.

DR. STRAIN: What about these conferences that are held in developing countries? You’ve been involved in some of those, are they worthwhile?

DR. KENDIG: I’m not sure. Because as far as the conferences are concerned, it seems to me that most of them evolve into a discussion by members of the board, the committee, international committee or board. Rarely is somebody who is not associated with it at all put on the program. And I am not sure that it’s not just a lot of discussion without anything ever coming from it. Now I may be wrong about that; it may be that I’m just not in on that. But I think that’s of limited value.

DR. STRAIN: Is there any relationship between the IPA and the WHO [World Health Organization]?

END OF TAPE TWO, SIDE A
DR. STRAIN: …Continuation of the interview with Dr. Kendig.

DR. KENDIG: Well, Jim [James] Grant [Director General of UNICEF [United Nations Children's Fund]] was of course a very close friend of Ihsan Dogramaci. I think that the close association and the financial help and the interest stem largely from that. And I don’t know whether that has continued since Jim’s death, and the fact that Ihsan is longer involved with the IPA. I will stop right there and say I’m not so sure how much Ihsan is involved. At the same time, he’s not officially involved, and Jim Grant is not living, I don’t know whether their approach is the same or not. And the WHO still, I think, has some interest in regional meetings. It’s really hard to evaluate if a conference like those held in developing countries really helps anybody, unless it helps the people who are locally working in that area. Because as far as I can tell, there was no significant outlay of money, or anything like that, no financial help from the IPA.

DR. STRAIN: I think that Mr. Grant had an interest in hydration for gastrointestinal disorders, and they were pushing that through WHO as well as UNICEF.

DR. KENDIG: I think things like that have been very helpful, that came from them, you know. It didn’t come from UNICEF. That came from WHO, it came from, oh, what is the man’s name, it begins with an “M” [Merson]. But it’s his idea. And I remember the first time I heard him on that subject and of course, as you know, it’s completely foreign to anything that we were taught in medical school. When you start vomiting, you don’t give them anything else, you have to give them IV fluids. But of course they couldn’t give them IV’s, but he certainly showed good results by pouring the fluid in.

DR. STRAIN: Enough is retained that it’s saved a lot of children.

DR. KENDIG: Enough is retained, and there’s no question about the fact that it’s been very effective.

DR. STRAIN: But that came from the WHO, you say.

DR. KENDIG: Yeah.

DR. STRAIN: It was supported, though, by the IPA, and UNICEF.

DR. KENDIG: Yeah, it came from WHO. I heard Dr. Merson present that original program, what I think was the original presentation on the subject of what he had done, and I just couldn’t believe that all this had happened. But he
did a great job that is very impressive. It’s been a great contribution, but you know, one of the interesting things about that is that WHO has never understood why that the American pediatricians haven’t embraced it.

DR. STRAIN: I think it’s happening more and more, but everybody jumped on the IV bandwagon right away.

DR. KENDIG: It’s too easy to do the IV, and furthermore you know the IV is getting in. Over there they don’t know that, but they hope it’s going to do all right.

DR. STRAIN: Yes. But I think more and more pediatricians are using it. Well, Ed, I wanted to talk a little bit now about the Academy and your role in the Academy and that goes back quite a ways to your involvement at the Virginia level, the chapter level. And I want you to tell me a little bit about how you got started with the Academy activities. Start with the chapter first and how you progressed through the hierarchy.

DR. KENDIG: Well, I was one of perhaps a dozen pediatricians in Richmond when we first decided to have a Virginia Pediatric Society. And then from that point on it sort of evolved into a combination of an Academy chapter and the Virginia Pediatric Society, and it still works that way. Anybody who is a pediatrician can join it, but they have a different type of membership. One is called an Academy member and the other one is a Society member, in the Virginia Pediatric Society. Well, anyhow, about a dozen of us started it.

I was not the president to begin with. In fact I don’t recall now exactly who was the president. It may have been Mac [McLemore] Birdsong, I’m not sure. I think I was about the second, third or fourth, something like that. And at that time it was a very popular meeting. We packed the house; we really did. Everybody went; it was big. There were parties every night and everybody went to the meetings, and the meetings went all day long. We had good guest speakers, Sidney Gellis and all of that type.

I was president of the local pediatric society, of course, in Richmond, and then later on I was president of the state chapter. I ran for the alternate district chairman. I can’t remember which one I ran for first, whatever it was, and I didn’t win. I can’t remember what it was, but Jay [M.] Arena beat me twice, for whatever we ran for. I can’t remember whether it was for the alternate, but it wasn’t for the district chair. And then I came on the Academy as a district chairman. And obviously served on the board for six years, and became Vice President, then President. I’ve thoroughly enjoyed all of it. I really enjoyed not only the work, but I enjoyed the people and they were just days that I liked.
DR. STRAIN: Did you serve on any of the national Academy committees or councils?

DR. KENDIG: Yeah I was on the Committee on Medical Education for six years.

DR. STRAIN: Was that before you went on the board?

DR. KENDIG: Mm-hm.

DR. STRAIN: Was there a pulmonary section?

DR. KENDIG: Oh yes, as a matter of fact. Actually, I was the one that started the pulmonary section [Section on Diseases of Chest]. I was pushing for it so hard, I didn’t think I had the stature to be the person to head it. Edith [M.] Lincoln was the first chairman, and she should have been. She was very outstanding. I was the second chairman of the thing. But Edith Lincoln was quite a person.

DR. STRAIN: But you were in on the formation of the section.

DR. KENDIG: The trouble with all these things is that you sound so egotistical, but it was my idea. I started the thing. Harry Bakwin said, “You’re the only one I’ve heard yelling about this thing and you’re the one who’s going to talk about it,” because Harry was on the board at that time. And he said, “Are you sure we’ve got enough pediatricians interested in pulmonology?” I said, “Yes, absolutely.” He says, “Well, tuberculosis maybe, but I’m not sure about the rest of it.” But he pushed it and then it came through. And Edith Lincoln was the first president of that.

In those days, the American Thoracic Society paid no attention to children at all, but they had what they called a Committee on Respiratory Diseases in Children. I’m not sure whether it was a committee on pediatric tuberculosis or children’s tuberculosis or children’s chest disease. There were probably 15, 20 people on that committee at that time. I think Edith was the first one of those, and I was the second, and Margaret Smith was the third, or something like that. But that committee, you know, has really done much better than the Academy’s.

DR. STRAIN: Oh really? More than the Academy sections?

DR. KENDIG: Oh, yes. Yes, much better. Most of the people in pediatric lung disease now try to present their material there because they have a full
day. They call it the pediatric forum or something like that, and they have really pushed it. And, of course, we at the Academy have got so many different sections it really is not nearly as prominent as it has been.

DR. STRAIN: Now Ed, you were the last president to be elected without a competitor.

DR. KENDIG: [laughs] Thank goodness, I probably wouldn’t have been elected if they had gotten another candidate.

DR. STRAIN: I was going to ask you, do you think that’s good or bad, to have two candidates? Because the year following your election, there were two candidates.

DR. KENDIG: I’m mildly prejudiced, but I think one candidate is the way to do it! [laughs] Well, I’ll tell you why I think that’s the way to do it. Suppose you and I are running for president, you and I. Take somebody who is practicing in Nevada, and he hasn’t been to a pediatric meeting in the last five years. What does he know about it? He doesn’t know who he’s voting for. Flips a coin. He says, “I like the name Strain better than that other name, I’ll vote for him,” or whatever. But you know that’s the way it goes, and I see these guys all the time voting for people [when] they haven’t got the vaguest idea of one over the other one. And my own feeling is that you’ve got a good committee that is doing the nominating

DR. STRAIN: Nominating Committee.

DR. KENDIG: It’s a good nominating committee; that is one [representative] from each one of the districts, of course. Each person from those districts can tell you who has got all the material. I was on the nominating committee; I was chairman of the nominating committee for three years. And from the material that was presented to me, I was sure which one I thought was a better person. I didn’t think there was any question. I wasn’t doing it out of a hat. I think the members of the committee do it that way. Because they presented us with all the material, and each person knew about the persons who come up in his district, and you can pick the person. And that’s the reason I think you can make a better decision, whereas with the other thing, a lot of people are voting who really don’t know who they’re voting for. Now, the only thing that might be argued against it is the fact that these same people nominate both candidates, so they’re not going to let it get off too far. They really essentially do the same thing. They pick two, and they think that either one could be a good president, so that would be a counter argument against what I’ve just presented. So it may be just as well. I wouldn’t argue one way or the other, but my own feeling would be just to let somebody select the person
who’s probably going to do the best job. The nominating committee is in a much better position to do that than just someone who lives in Chuckatuk, Virginia, because they don’t know. But it’s interesting I think.

DR. STRAIN: We only have about 40% of our members who vote.

DR. KENDIG: That’s the point I make.

DR. STRAIN: Got any ideas how that can be improved?

DR. KENDIG: No. Can’t be improved. Can’t be improved because they don’t know, and the other 60% says, “Gee I don’t know who they are,” and just does not bother with it. I think you ought to go back to having the nominating committee do it. But, I don’t think you’ll ever do it because I think if you ever suggested that, people would say, “Oh, you’re getting away from the democratic process.” And I can understand their feeling about it. Yeah, I’m glad I came the other way, I never would have been elected otherwise! [laughs]

DR. STRAIN: What was the most significant thing that really happened in the Academy during your tenure as president? Can you remember any one or two or three things that you feel you accomplished?

DR. KENDIG: Not very much, I guess. It was the Year of the Child, you remember, which we promoted a great deal. I thought it was an excellent idea. The other thing that I pushed during that period of time was communication. And I was interested in hearing something about communication in the last few days when Bob [Robert E.] Hannemann got up and talked about the difference in the way he was going to promote communication. It was interesting because the communication he’s talking about is not the same communication that we were talking about at that time. We didn’t have all those things he talked about today.

When I came along, there wasn’t a schism, but there certainly wasn’t great cooperation between the APS [American Pediatric Society] and the SPR [Society for Pediatric Research] and the Academy. And I would like to think that one of the things that we did during that period of time was to draw the research societies and the Academy closer together. I hope the reason we were able to do that was because I was involved in all the others and I tried to improve the relationship. And I’d like to think that we did that during that period of time. So the communication that we were dealing with is not the same communication that Bob Hannemann is talking about now. But nevertheless, [it] is very important as far as communication is concerned. I remember my
presidential address, and the reason I remember what it was is because I was looking over some reprints the other day. But, it was on communication.

DR. STRAIN: I wanted to ask you about the Academy’s Washington activities. Are we doing too much, not enough, about right, in terms of our support? We’ve got 16 people in Washington, five lobbyists and the rest are support people. How do you think we’re doing in Washington and the legislative arena?

DR. KENDIG: I think we’re doing pretty well. I can’t think of anybody that does a better job than Jackie Noyes. I think she’s a fine person herself, and she has done a good job as far as the office is concerned. Sometimes I’m not as gung ho about each one of them, about all of them that come through the office up there, but I’ve never found anybody that I didn’t think was adequate. And I think some of them are better than others. But she’s outstanding. She’s a good, bright person.

Now, you’re bringing me to a subject that is against the general thinking. And that’s one of the things that has bothered me, is the fact that one of the tendencies for the Academy in the past years has been the promotion of the practicing pediatrician. And you say, “What could be wrong with working for the practicing pediatrician?” Well, I’ll tell you. At the time that I was president, the motto of the Academy was the promotion of the health and welfare of children. It didn’t mention pediatricians. You don’t have to spell it out and say look out for the practicing pediatrician, because I think when you start doing that, then you put yourself on the same level of the AMA [American Medical Association]. And at the time that I was president, I had the same amount of influence in [Senator] Ted [Edward] Kennedy’s office, for example, as the AMA did. Probably even more, because I was for the health and welfare of children. The AMA is promoting the doctors. Anybody that starts promoting themselves too much loses a little bit in that. But, at the same time, you do it subtly. You do it subtly; you don’t out and out say I work for the pediatricians. But when you deal for the welfare of children, health and welfare of children, who are you promoting? The pediatricians. And I haven’t been able to convince anybody at the pediatric office. But I think I would like less emphasis on the practice of the pediatrician and more on the health and welfare of children. And now I’ve gone around the corner to come back to answer your question about what happens in Washington.

Now the second point is, I think I can be a big help in your relationship with the AMA. Maybe beginning even this year, but certainly a year hence if I’m still living. Because the new president today, the president-elect of the AMA, is Percy Wootton, who is a cardiologist in Richmond. As a matter of fact he’s Emily’s cardiologist. But he’s an old friend. Much younger of course. As a
matter of fact, [laughs] Joe [Joseph Robert] Zanga was talking to him. I told him what to do, the things he talked to Percy about, to get prepared because the AMA had just taken credit for a lot of things the Academy had been doing. Joe was just devastated. I said, “Call Percy and tell him about the situation.” I said, “I’ll tell Percy.” So, he wrote me and I gave it to Percy. And Percy said, “Well, I think this is a good point. But I can’t do anything about it this year, but next year I’ll see what I can do about it.” And Joe talked to Percy too, and he said, “Dr. Kendig is my mentor. He’s told me about all these things, he’s helped me in this pediatrics business,” and Percy said, “Well he’s my mentor too.” And I didn’t think I’d gotten to that stage, but, at the same time, he is a friend. I believe I can help the Academy in certain ways. I may not be able to, but I believe he will be more receptive to things that come from the Academy. The AMA has never been one of my favorite organizations. I remember when I was president of the Academy I went to two meetings and I made a promise to myself that I was never going back again if I could keep from it. I guess it’s just not my cup of tea.

DR. STRAIN: This is the House of Delegates that you’re talking about at the AMA. It’s different than the Academy.

DR. KENDIG: Oh, boy, it’s really different.

DR. STRAIN: And as you point out, they are a 501(c)(6) organization and make no bones about promoting the physician. I think they do try to take on public health ventures as well, but it’s mainly speaking for physicians.

DR. KENDIG: I think the organization is OK. I don’t have any objections to the AMA. I think it does a very good job at what it does. But it is different from the American Academy of Pediatrics, and I think for the number of members we have we exert a great deal more influence in comparison to the numbers than they do. I think the reason is because we do it in a different way, and that’s just a point I’m making, to get back to the health and welfare of children. It’s not so flagrant. It’s more subtle, the approach is more subtle, and I think it’s much better. But I think the AMA is going to help us.

DR. STRAIN: And I wanted to talk to you a little bit about South America. You brought up Latin America. You mentioned how you enjoyed the Latin Americans. You were appointed after your presidency to be a liaison person between the Academy and Latin America. And you’ve gone through a transition there; I think it’s been difficult. We’re still kind of struggling about what our relationship should be. Do you have any thoughts about that?
DR. KENDIG: No, I really don’t have any, because I think in some ways they take advantage of the Academy. And I don’t think they mean to do it, but they think the Academy is a source of great income and that we’re able to do all these things. So they ask for many things. They ask for many favors that I think probably are really not warranted. One of the things that has hurt us with the Latin Americans is ALAPE [Association Latino Americana de Pediatrica]. It’s an organization of all the Latin American states. They have a couple of people who ran it who were anti-American, or who certainly were not very interested in America or the United States. The pediatricians felt that they were getting more out of ALAPE and more of them drifted toward that organization than drifted toward the Academy. And the second thing is that it was much easier for them to get into ALAPE, just as long as they said, “I’m a pediatrician, in Latin America.” Whereas in the United States we expected them to pass the boards that put them in certain categories. And I’m not even sure at the moment exactly what our categories are, but I don’t think that they can be listed in the Academy. I don’t think we still list them unless they pass the boards, is that right?

DR. STRAIN: That’s right. For full membership anyway.

DR. KENDIG: That’s right. And I think that’s probably right that you have to do that. But there ought to be members who can belong to the local chapter. You can put some modification on their designation.

DR. STRAIN: Associate member?

DR. KENDIG: Yes, that would indicate a different kind of member and still have them so they could come to the meetings. I think also that we ought to make some effort to let them come to the meetings at a lesser cost than for the regular members. They don’t have as good an income as we do in the United States. And I think that would be helpful from that standpoint. What they always end up wanting to do is for us to send a number of speakers down there, and the speakers that they want to pick out. And it’s not a completely satisfactory approach. What you ought to do is to have the people who are now pushing for membership--there is this man who’s down at the University of Texas in El Paso, I don’t remember his name.

DR. STRAIN: Gilbert [A.] Handal?

DR. KENDIG: Yes. And then the one in Mexico who is a recent president of ALAPE [Dr. Camarena]. He is a charming person. Either he or his wife is quite well to do. But he can’t speak three words of English, and he is not a very good representative from that standpoint. The best way to have him come is to
be sure he brings his wife too, because she went to school in the United States and she speaks English well. And she’s very attractive, and she can come and do that part of it. But have Handal come and present. What they present might be helpful. I started to say that might be helpful, but they’ve done this on two or three occasions and nothing has happened as far as I know. Nothing positive has happened.

The other way to do it would be very costly, and that would be to have two or maybe three people from the Academy go to each country. They might not want to do it all on one trip because that would probably be back breaking and money breaking too. But to go down for a Society meeting. You’d be surprised at the crowd you’d get out, because they would be interested in having this person come down. He could talk on a subject for a half an hour or so, and then for 20 to 30 minutes talk about what they could do for the Academy and what the Academy could do for them. If they got that interest from the Academy, then I think you would get them back again doing what they ought to be doing so they would learn something. What you’re really trying to do is to improve the care of children throughout the world, and this is a place you can do it. And they have never much caught on to the IPA. I’ll take that back, in a sense, because they’re very political in the IPA. Cedrato is very political in there, and a couple of the others, but the Academy could do that very well I think.

DR. STRAIN: It’s been a real problem. We feel we have a responsibility to provide education to pediatricians in general in Latin America, and we haven’t been able to do that very well.

DR. KENDIG: No. I think, we distribute the Red Book [Report of the Committee on Infectious Diseases] don’t we now?

DR. STRAIN: Yes.

DR. KENDIG: Yeah.

DR. STRAIN: That’s the one book we do.

DR. KENDIG: Are we publishing Pediatrics down there now? Or, is there a translation of Pediatrics in Spanish?

DR. STRAIN: Pediatrics is translated into Spanish by a publisher in Spain. The Red Book is also translated.

DR. KENDIG: Yeah, the Red Book is. But now, how about Ballabriga? What is he doing now, in Spain?
DR. STRAIN: I can’t answer that.

DR. KENDIG: Because for a while he was translating *Pediatrics* into Spanish. I was through Barcelona about three months ago and we called him. I didn’t want to call him beforehand because we weren’t sure where we were going to be and, by the time we got there, it was Sunday afternoon. I said, “No I’m not going to bother him.” I was just going to call him and tell him hello. And I talked to him; he’s such a nice person. He’s very influential over there. I’m not sure about his health, and what he’s doing about the translation. But if he got somebody to translate it, and if you could make some arrangements so the translation could be passed on to somebody in Latin America, that would save a lot of the cost.

DR. STRAIN: Yes. I know translations aren’t easy. There are different dialects apparently.

DR. KENDIG: But I would think that the Spanish there would be an acceptable translation in Latin America.

DR. STRAIN: Yes.

DR. KENDIG: I’m just so fond of the Latin Americans. They’re just such nice people. But, you have to really put yourself out to try to make it work.

DR. STRAIN: We were dealing with the elite for a number of years, and really not reaching the general pediatrician in Latin America. And we tried to develop a program where we were reaching them, and I think sending our material down there has been good.

DR. KENDIG: Oh, the material is good.

DR. STRAIN: We just haven’t been able to reach the average pediatrician. It’s an elite group.

DR. KENDIG: I don’t believe you’re going to be able to reach them. It is my understanding that in at least one or two or maybe several of those organizations, they had two or three people that were running it, and they took care of everything and the other 97% got nothing.

DR. STRAIN: That’s what we found.
DR. KENDIG: Yeah. I fear that’s what you’re going to run into most of the time down there. I really believe that if you really want to sell it, and I don’t know how much money or time it would take, but [you need] to have somebody go down and spend a half-day at one place. Maybe one or two talks, with the right people down there. One for the crowd, one for the people who are running it. I think that you would lay the groundwork for something that would be very helpful to them. I don’t think you’re going to do it otherwise. Because there are two reasons that I’ve pointed out; one is financial and the second is politics. Politics the world over. [laughs]

DR. STRAIN: That’s right. Ed, I want to talk a little bit about the future. You’ve mentioned the future of pediatrics. From your perspective, tell me what you think the future of pediatrics is in this country.

DR. KENDIG: I have difficulty in answering primarily because I think it is intertwined with another question, and that is the future of medicine in this country. Because I’m not sure what’s going to happen with the trend toward managed health care and what that entails as far as the pediatrician is concerned. You don’t really have a choice. If the government, for example, should suddenly decide that family practitioners could do all the things that pediatricians do and we only need a few pediatricians who are subspecialists in a particular field, then pediatrics as a profession would be completely wiped out. I’m overstating it a little bit you see, but the point is, it would be essentially wiped out. So I can’t tell you about the future. On the other hand, all things being equal, if we’re trying to compete against the rest of the world I think pediatrics has the opportunity of being even greater than it is at the present time, for the same reasons that we have just mentioned a while ago. We’ve got the tools now. We’ve always had the personnel to do it. What we’re really dependent on is government.

DR. STRAIN: Would you advise a medical student to go into pediatrics? Would you urge them to select pediatrics as a career? Now?

DR. KENDIG: I think it depends on the person. If I were in medicine, or were going into medicine, I would go into pediatrics. Now, yes, but to me the person that goes into pediatrics is different than the person who goes into other branches of medicine. In spite of all the conversation I hear about incomes, as I said, I didn’t go into pediatrics for the income. I knew I wasn’t going to make a great amount of money. But I was doing what I wanted to do. I thought I could help others. Yeah, I would be happier myself, but I wasn’t doing it for the money. And I think the person who goes into medicine or goes into pediatrics for financial return is in the wrong profession. And I think that’s one of the things that you have to worry about. What always worries me is when
pediatricians start talking about the fact that they need to make $150,000 a year or whatever it is that they want to make, because I don’t think that’s why you get into pediatrics. There are a lot of branches of medicine you can go into if you want to make money. A person who wants to make money is not my idea of the ideal pediatrician. Now, having said that, sure I’d go into pediatrics. I like pediatrics, I like children, I like all things about it. For me, it couldn’t have been nicer. I love the work, and I love everything about it. I don’t know whether I answered your question.

DR. STRAIN: Yes, you did. Let’s talk about children for a minute. Do you think children are better off now than they were 50 years ago?

DR. KENDIG: In what way?

DR. STRAIN: I was thinking in every way: education, health, social conditions. What are some of the things that you see that are better now than they were 50 years ago, and what do you see as some of the things that aren’t as good?

DR. KENDIG: Well, education is better, except [laughs] they can’t read now. But the opportunities for education are better. And the medical care is better, and the opportunities, I guess, are better. On the other hand, there are things that are so obvious that I almost hate to say them, for example, the drug scene and things about education. As I said, people can’t read very well and don’t seem to be taking education seriously. I think that is not as good obviously.

DR. STRAIN: What about families?

DR. KENDIG: Families?

DR. STRAIN: Now compared to 30, 40 years.

DR. KENDIG: Oh, families I don’t think are good right now. I was interested in talking about the presidential race. And they said that [Robert] Dole was making a great mistake in saying that you have to have two members of the family go to work to be able to make enough for the child to go to school and make a goal of their financial status. And actually what happened was that a lot of the women wanted to get out of the house. They’re tired of the house anyway, and they would really like to go out. And so they didn’t mind the fact that they had to give it up.

I object to the idea of latchkey children. I feel like somebody ought to be home to take care of the children when they come in, and that children need
somebody who is there to take care of them, whether it’s the mother or the father--however you can arrange it--not someone who is constantly away from home. But I don’t think that enough of that’s being done at the present time. I’m also very worried about drugs, and I don’t think that we’re doing anything that’s right about management of the drugs. I noticed that the Clinton administration has reduced the number of positions in the interdiction of drugs by about 75%.

Well, drugs are worse; there are a lot of latchkey children; they’re doing very poorly in school. Yes, we’re worse off, I think, than we were 50 years ago. Much worse off.

DR. STRAIN: What about adolescent pregnancy?

DR. KENDIG: That’s one of the areas that I think they’re approaching in the wrong way. Most of the adolescent pregnancies are coming because from the boys’ standpoint it’s the macho thing to do, to get the girl pregnant. From the girl’s standpoint, in the vast majority of cases, it’s a way to get on welfare. It’s the way their mother did or the way their grandmother did and they’d like to keep on doing it that same thing way. They can get it all from government handouts, and they’d like to do it that way. I’m also on an advisory board of health for the city of Richmond. Thirty years ago, I was chairman of the Board of Health and the state wanted to take over the Health Department in Richmond. And the city manager in Richmond talked to me and he said it was going to save us $700,000 a year. And I said, “Well Lord’s sakes, they’ve got a good health department, go with it.” He said it was fine for awhile. But the health commissioner of Virginia retired and then things began to go a little bit off and they didn’t pay as much attention to it.

END OF TAPE TWO SIDE B

DR. STRAIN: [This is] the interview with Dr. Edwin Kendig, by James E. Strain on the date of the 26th of October, 1996. The location is the Marriott Copley in Boston. Continuing on tape three. We were talking about the health department.

DR. KENDIG: Oh, about the immunizations. I mean, it costs them nothing. They set up clinics where they don’t have to ride automobiles to get there. At the immunization level, I did a study. I had some figures from Cuba, six years ago, and figures in Richmond, Virginia. The immunization record in Cuba was at least 10% better than it was in Richmond and in Richmond they were getting it free. Now, that’s ridiculous. Now, we’ve got to be able to stimulate these people to get their children immunized, and I’m afraid that is one of our problems. We haven’t been able to take the ones who are third generation
welfare, as an example, and get them off welfare and to work a little bit. They just must get out of the old routine. Because when things are available, they don’t take advantage of it. And I think the immunizations and the adolescent pregnancy and all those things are just examples of the same sort of thing.

I don’t mean I’m against welfare. For Lord’s sakes, certain people need all the help they can get, and certain others need some help; but we need to try to educate people to get their children immunized. Now, speaking of education, the idea of thinking, as [President William] Clinton says, that everybody should be able to go to college is the most ridiculous statement that I’ve heard in the last 20 years. [laughs] Some of those people that can’t read past the third grade certainly are not going to be able to do very much in college.

DR. STRAIN: Well, Ed, is there anything you would like to say in general about your career, about past history, about what you see the future of pediatrics, the future of children, anything you’d like to say in conclusion?

DR. KENDIG: I’m not sure that I have done what you’d like for me to do, but I have enjoyed this interview. I will say this. I have enjoyed medicine. I’m just thankful every day that I had sense enough to be in medicine, and even more so that I’m in pediatrics. I don’t think that I would have had the same interest, I don’t think I would have had the same pleasure in being in any other branch of medicine. I continue to be surprised at the number of people who still want to be in medicine, with the changes that we are having at the present time. One of these reasons is they haven’t seen what it was like before so they can’t tell the difference. They’re not measuring what we’re doing now against what we did then, but they are measuring what we’re doing now.

I think the Academy has done a beautiful job. I’m really very proud of the Academy. I still say that I think that we ought to promote the health and welfare of children and stop worrying about us as individuals.

I don’t really think that I have anything else to add. I’m a happy pediatrician. [laughs]

DR STRAIN: Thank you very much. That concludes the interview with Dr. Edwin Kendig with our thanks. This is Dr. James Strain signing off.

END OF TAPE
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Edwin Lawrence Kendig, Jr., MD
Physician, Author, Editor

Professor of Pediatrics, VCU/MCV (1958-present)
Director of Pediatrics, St. Mary’s Hospital (MCV teaching program), 16 years (1972-1988)
Pioneer in the study of pulmonary disease in children
Initiated and directed the first children’s chest clinic in Virginia (MCV 50 years, 1944-1994)
Editor of the first, and for 25 years the only, textbook in North America devoted to diseases of the chest in children. *Disorders of the Respiratory Tract in Children*. Except for the 4th edition, figures for distribution are unavailable; however, 45% of the sales of the 4th edition were outside the US
Editor of the Virginia Medical Quarterly (formerly Virginia Medical Monthly) From 1982-1998
Author or co-author of more than 200 scientific articles and editorials, four in the *New England Journal of Medicine.*
Co-editor (with C.F. Ferguson) of *Pediatric Otolaryngology*
Contributing editor to seven other textbooks, one for 13 editions
Editorial Boards: *Pediatrics; Pediatric Pulmonology; University of Virginia AlumNews; Center for Mind and Human Interaction; Advisory Board, Annals of Pediatrics*
Guest Lecturer in the United States and Abroad

**Born:** Victoria, Virginia
November 12, 1911

**Parents:** Edwin Lawrence Kendig, MD
Mary McGuire Yates

**Married To:** Emily Virginia Parker

**Children:** Anne Randolph Young (Mrs. R.F.)
Mary Emily Corbin Rankin (Mrs. T.T.)

**Church Affiliation:** Grace and Holy Trinity (Episcopal) Church

**Education:**
Hampden-Sydney College: B.A., 1932 Magna cum Laude
B.S., 1933 Magna cum Laude
D. Sc., (Hon.) 1971

University of Virginia: M.D., 1936
**Hospital Training:**

Medical College of Virginia, Richmond, VA  
Bellevue Hospital, New York, NY  
John Hopkins Hospital, Baltimore, MD  
Babies Hospital, Wilmington, NC

**Honors:**

Recipient Gammon Cup (Hampden-Sydney College)  
Certificate of Recognition, Virginia State Health Commissioner  
Resolution of Recognition, Medical Society of Virginia  
Award of Recognition, Virginia Chapter of American Academy of Pediatrics and Virginia Pediatric Society  
Award for Contribution to Medicine, Louise Obici Memorial Hospital  
William P. Buffum Oration, Brown University, Providence, RI  
Abraham Finkelstein Lecturer, University of Maryland, Baltimore, MD  
Derwin Cooper Lecturer, Duke University, Durham, NC  
Dr. Renato Maria Guerrero Lecturer, Santo Tomas University, Manila  
Ruth and Harry Bakwin Lecturer, NYU-Bellevue, New York City, NY  
Bon Secours Award, St. Mary’s Hospital  
Outstanding Alumnus Award, University of Virginia School of Medicine  
Abraham Jacobi Award, American Medical Association and American Academy of Pediatrics  
International Pediatric Association Medal  
Keating Award, Hampden-Sydney College  
Honorary Professor, University of Santo Domingo  
Edwin Lawrence Kendig, Jr., M.D., Distinguished Professorship in Pediatric Pulmonary Medicine, Medical College of Virginia, Virginia/ Commonwealth University (established by University in 1991)  
Laureate Member, Virginia Cultural Laureate Society

**Honor Societies:**

Phi Beta Kappa  
Alpha Omega Alpha  
Omicron Delta Kappa  
Raven Society  
Epsilon Chi Epsilon  
Tau Kappa Alpha  
Sigma Upsilon
**Extracurricular Activities (College):**

Editor of *Hampden-Sydney Tiger* (College Newspaper)
Varsity Baseball (Hampden-Sydney College)

**Clubs and Social Organizations:**

Member of Commonwealth Club, Richmond, VA
Country Club of Virginia, Richmond, VA
Richmond Hundred, Richmond, VA
Farmington Country Club, Charlottesville, VA
Kappa Sigma
Society of the Cincinnati
Soixante Plus

**Other Activities:**

Former Member, Board of Visitors, University of Virginia (11 years)
Former Chairman, Richmond City Board of Health (member 10 years)
Former Director, Metropolitan National Bank
Member, Virginia Steering Committee, 1960 White House Conference
Board of Directors, Virginia Medical Service
Former Member, Board of Directors, Maymont Foundation, Inc.
Former Chairman, Medical Affairs Committee of the University of Virginia
  Board of Visitors (8 years)
Director Emeritus, Dominion National Bank
Board of Directors, Children’s Hospital, Richmond, Virginia
Board of Directors, Sheltering Arms Hospital, Richmond, Virginia
Former Member, Advisory Board, Center for the Study of the Mind and Human
  Interaction, University of Virginia School of Medicine
Board of Directors, Bon Secours-St. Mary’s Health Care Foundation, Richmond, Virginia
Member, Board of Directors, University of Virginia Medical School Foundation
Advisory Board, Richmond City Health Department
VCU Search Committee -- Vice President for Health Sciences, 1989
MCV/SMH Liaison Committee

**Positions (Medical):**

Instructor in Pediatrics, Johns Hopkins University School of Medicine, 1944
Professor of Pediatrics, Medical College of Virginia, Health Sciences Division,
  Virginia Commonwealth University
Director, Child Chest Clinic, Medical College of Virginia Hospitals
Director Emeritus, Department of Pediatrics and Coordinator of Hospital
  Affiliations, St. Mary’s Hospital of Richmond, Virginia
Former Chief of Staff, St. Mary’s Hospital of Richmond, Virginia
Memberships and Offices:

Past President, Richmond Pediatric Society
Past President, Virginia Pediatric Society
Former State Chairman and President, Virginia Chapter, American Academy of Pediatrics
Member, American Pediatric Society
Former Member, Committee on Medical Education, American Academy of Pediatrics
Founding Member, Section on Diseases of the Chest, American Academy of Pediatrics and Former Chairman of Committee Governing Section
Former Chairman, Committee on Respiratory Diseases in Childhood, American Thoracic Society
Past President, Richmond Academy of Medicine
Former Chairman, Board of Trustees, Richmond Academy of Medicine
Former Member, Medical Alumni Board of University of Virginia
Former District Chairman, American Academy of Pediatrics
Past President, American Academy of Pediatrics
Former Chairman, Medical Advisory Committee, University of Virginia
Former President, Virginia State Board of Medicine
Standing Committee, International Pediatric Association (9 years)
Member, Pediatric Residency Review Committee (6 years)
Scientific Program Committee, XVIII International Pediatric Congress
Consultant, Standing Committee, International Pediatric Association (6 years)
Consultant, AAP Red Book Committee, 1986
Steering Committee, One Hundred Twenty-fifth Anniversary, MCV Hospitals, 1986
Official Advocate, Executive Board of the American Academy of Pediatrics for Latin American Members, 1988-present
Consultant, Provisional Committee on International Child Health, American Academy of Pediatrics

Other Medical Activities:

Former Official Examiner, American Board of Pediatrics
Former Member, Editorial Board, Pediatrics
Editor; Virginia Medical
Editorial Board, Pediatric Pulmonology
Advisory Board, Pediatric Annals
Editorial Board, University of Virginia AlumNews

Publications (Books):


**Listings:**

*Who’s Who in America*
*Directory of Medical Specialists*
*Who’s Who in the World*

**Book Reviews:**


**Audio-Tapes:**

Letters to the Editor:


Other Publications:


**Other Publications (Editorials):**

156. And these we have lost. *Va Med Q*. 1996;123:209.

**Guest Speaker, Visiting Professor, Etc.**
(1978 - Present)

State University of New York at Buffalo,
Visiting Professor. Buffalo, NY. January, 1978  Guest Lecturer

Pediatric Section, Puerto Rico Medical Society,
San Juan, Puerto Rico. February, 1978  Guest Lecturer

Blackstone Family Practice Center,
Blackstone, VA. February 1978  Guest Lecturer

Conference on Pediatric Lung Diseases,
Harrisburg, PA. March 1978  Guest Lecturer

Chesterfield Family Practice Center,
Richmond, VA. May 1978  Guest Lecturer

William P. Buffum Oration, Brown University,
Providence, RI. May 1978  Guest Lecturer

Medical College of Virginia Postgraduate Conference,
Sutton Day Lectures, Williamsburg, VA. May 1978  Faculty

Hospital for Sick Children, Toronto, Canada.
May 1978  Guest Lecturer

AAP Continuing Medical Education Course,
Sea Island, GA. June 1978  Guest Lecturer

Mountain Pediatric Society, Asheville, NC.
June 1978  Guest Lecturer

Chesterfield Family Practice Center,
Richmond, VA. July 1978  Guest Lecturer

International Conference on Sarcoidosis,
Cardiff, Wales. September 1978  Guest Lecturer

Institute on Advances in the Health Sciences Relating
To Children and Youth, Charlottesville, VA.
November 1978

Jacksonville Branch, Florida Pediatric Society, Jacksonville, FL. December 1978

Mayo Clinic, Rochester, MN

Medical College of Virginia Continuing Education Course, Williamsburg, VA

Washington State Medical Association, Seattle, WA

Pittsburgh Pediatric Society, Pittsburgh, PA

Mount Sinai Hospital, New York, NY

University of Virginia Pediatric Conference, Charlottesville, VA

Virginia Academy of Family Physicians, Roanoke, VA

National Institutes of Health, Consensus Development Conference on Febrile Seizures, Bethesda, MD

Josiah Macy Conference on Present and Future of Academic Pediatrics, New Orleans, LA

International Pediatric Congress, New Delhi, India

Symposium on Respiratory Disease in Children, Children's Hospital, Washington, D.C.

Supercourse Pulmonary Disease, New Orleans, LA

MCV Springfest, Williamsburg, VA

Argentine Pediatric Society, Mar Del Plata, Argentina

Guest Speaker

Guest Speaker

Visiting Professor

Guest Speaker

Keynote Speaker

Guest Speaker

Visiting Professor

Guest Speaker

Guest Speaker

Chairman

Invited Participant

Participant

Guest Speaker

Guest Speaker

Participant

Guest Speaker
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<td>Blackstone Family Practice Center, Blackstone, VA</td>
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<td>Southern Maryland Lung Association, Bethesda, MD</td>
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<td>Symposium: Advances in Pediatrics, Kyoto, Japan</td>
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<td>International Pediatric Congress, Manila, Philippines</td>
<td>Organizer, Moderator, Speaker (Symposium)</td>
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<td>Philippine Pediatric Society, Manila, Philippines</td>
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<td>Dr. Renato Maria Guerrero Lecturer, Santo Tomas University, Manila, Philippines</td>
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<tr>
<td>North Shore University Hospital, Cornell University, Manhasset, NY</td>
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<tr>
<td>Brown University, Providence, RI</td>
<td>Visiting Professor</td>
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<tr>
<td>First Brazilian Congress of Pediatric Pneumology, Rio de Janeiro, Brazil</td>
<td>Guest Speaker</td>
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<tr>
<td>Duke University, Durham, NC</td>
<td>Derwin Cooper Lecturer</td>
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<tr>
<td>X Venezuelan Congress on Pulmonary Diseases</td>
<td>Guest Speaker</td>
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<td>International Pediatric Association, CONAPE, Mexico City, Mexico</td>
<td>Invited Speaker</td>
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Thailand Pediatric Society, Bangkok, Thailand  
Guest Speaker

5th Asian Pediatric Congress, Kuala Lumpur, Malaysia  
Guest Moderator

5th Asian Pre-Congress Symposium, Kuala Lumpur, Malaysia  
Guest

18th International Pediatric Congress, Honolulu, HI (1986)  
Moderator and Lecturer (Symposium)

New York University--Bellevue Hospital, New York, NY (1986)  
Ruth and Harry Bakwin Memorial Lecturer

Pan American Pediatric Congress, Caracas, Venezuela (1987)  
Guest Lecturer

International Pediatric Association Standing Committee Meeting, Helsinki, Finland (1987)  
Consultant

University of Wisconsin, Madison, WI  
Guest Lecturer

The Children's Memorial Hospital, Chicago, IL (April 1989)  
Visiting Professor

Royal Free Hospital, London, England (July 1989)  
Guest Lecturer

Invited Lecturer

International Pediatric Congress, Paris, France (July 1989)  
Moderator and Consultant

V Panamerican Congress of Diseases of the Chest, San Juan, Puerto Rico (April 1990)  
Invited Lecturer

Pediatric Grand Rounds -- Fairfax Hospital, Fairfax, VA (October 1990)  
Guest Speaker

Panamerican Pediatric Congress, Asuncion, Paraguay (October 1991)  
Guest Speaker
Southeastern Tuberculosis Controllers Conference,
Ft. McGruder, Williamsburg, VA (November 14, 1991)  Invited Speaker

XX World Congress of Pediatrics,
Rio De Janeiro, Brazil (September 1992)  Invited Speaker