Richard C. “Mort” Wasserman, MD

Interviewed by
Thomas McInerny, MD

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PREFACE

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

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

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Thomas McInerny, MD

Thomas McInerny, MD, was a primary care pediatrician in private practice in Rochester, NY for 40 years and was Professor and Associate Chair for Clinical Affairs in the Department of Pediatrics at the University of Rochester Medical Center. He is a graduate of Dartmouth College and Harvard Medical School and did his pediatric residency training at Cincinnati Children’s Hospital and Boston Children’s Hospital. He has held many elected and appointed positions in the AAP since 1987 including President of Chapter I, District II, Member and chair of the Pediatric Research in the Office Setting Steering Committee, Member and Chair of the Chapter Forum Committee, Member and Chair of the Committee on Child Health Financing, and the Steering Committee on Quality Improvement and Management. He also was a member of the Task Force on Mental Health which developed the AAP Mental Health Toolkit.

He is Editor-in-Chief of the *AAP Textbook of Pediatric Care* and *Pediatric Care Online* and is a co-author of over 30 peer reviewed articles.

He was a member of the American Pediatric Society, the Academic Pediatric Association and a Certified Physician Executive and Fellow of the American College of Physician Executives. In October 2011, he was elected as President-elect of the AAP and took office as President in October 2012. His term as President finished in December of 2013.

Dr. McInerny worked closely with Dr. Wasserman when he was a member and chair of the PROS Steering Committee and Dr. Wasserman was the PROS Director. They have co-authored several publications from PROS research findings and have remained good friends over the past 25 years.
Interview of Richard C. “Mort” Wasserman, MD

DR. McINERNY: Well, Mort, this should be a lot of fun. The first thing I noticed is that we were both born in New York City, just a few years and a couple of days apart. Where in New York City were you born?

DR. WASSERMAN: I was born on the Upper East Side in a hospital that no longer exists. It was called Park East Hospital. I’ve checked it out; it’s long gone. It has been converted to co-op apartments, I’m sure now. My parents were living in the Catskills in Mountaindale, New York. I was the second of 2 children. As may have been the custom, my mom went in to New York City to have the baby, closer to her mother. That’s how I came to be born on the Upper East Side.

DR. McINERNY: What were your parents’ names and occupations?

DR. WASSERMAN: My father, Abe Wasserman, was a math teacher, both high school and then junior college after he retired from high school teaching. My mother was Lenore, her maiden name was Stern, so Lenore Stern. She was a kindergarten teacher. So, I’m the child of 2 public school teachers.

DR. McINERNY: Fantastic, very good. Mort, you said you had 2 siblings.

DR. WASSERMAN: One sibling. I’m the youngest of 2. I have an older sister, Lee, who is 3 years older than I and who lives currently in Silver City, New Mexico.

DR. McINERNY: And your wife?

DR. WASSERMAN: My wife is Abby Foulk, Abigail Foulk, and she grew up in Philadelphia. She is the youngest of 3 sisters of one of my best college friends.

DR. McINERNY: Is that how you met?

DR. WASSERMAN: That’s how we met.

DR. McINERNY: And your wife’s occupation?

DR. WASSERMAN: She is no longer working full time. When she was working, she was an elementary school librarian. But she’s also a metalsmith and a community activist around topics like composting and waste disposal, doing good for the community.
DR. McINERNY: Good for her. And your children?

DR. WASSERMAN: I have 2 children, a daughter, Nora Wasserman, who lives in Evanston, Illinois, married to Chris Ody, and they have 2 little boys, Abe and Nat. And then my son, Ben Wasserman, who is married to Richa Gawande, and they live in Arlington, Massachusetts.

DR. McINERNY: So you have 2 grandchildren?

DR. WASSERMAN: Two grandsons, yes.

DR. McINERNY: What are some of the things that you remember about your early childhood that you thought might be of note and interest?

DR. WASSERMAN: Well, I think one thing is it was a rural area, the Catskill region of New York State, but every summer it was invaded really by tens of thousands of people from New York City. It was the Jewish resort area known informally as the “Borscht Belt.” It had a lot of big hotels, but in addition to the big hotels, it had 100 or 200 small hotels, and many collections of cottages that were called bungalow colonies. So, we had a rural upbringing for 10 months a year, and then it was very urban influenced for those 2 months of a year. It was the kind of situation where you were thrown in with all kinds of different people. There was no way to be isolated as some sort of elite; it was everybody in there together.

DR. McINERNY: Including some famous entertainers.

DR. WASSERMAN: Yes, many famous entertainers, right.

DR. McINERNY: You went to high school where?

DR. WASSERMAN: High school was Fallsburgh [now Fallsburg] Central High School, which was a collection of, I believe, 6 small communities that had centralized. It was in Fallsburgh [now Fallsburg], New York, which is in Sullivan County in New York State. My graduating class was 100, and that was the biggest class that ever graduated from the school, as far as I can remember. I was a good student. I played sports because in that size high school, anybody who’s not physically challenged can play a varsity sport. I played soccer and was on the swim team. It was a very pleasant kind of an upbringing.

DR. McINERNY: It sounds ideal, at least for 10 months out of the year.
DR. WASSERMAN: Yes, right. I guess one thing that happened though, my mom died when I was 15. She had Hodgkin’s disease. That was an initial experience with illness, which I didn’t think would have any influence on career decisions, but probably did.

DR. McINERNY: Maybe, yes. So, then you went to Williams?

DR. WASSERMAN: Williams College. I chose Williams College because there was a guy I really admired from my little town of 1,200 who had gone there, and he was very cool. I looked at a bunch of schools, but chose Williams College without any thought really of the fact that it was an all-male school. It didn’t even occur to me that that might matter. I applied early decision and got in in November of my senior year and subsequently got my first B in high school, because I finally relaxed.

DR. McINERNY: And then at Williams what was your major?

DR. WASSERMAN: I didn’t know what I wanted to major in the first winter. Williams has a winter study program, which was novel at the time, with a one-month course, ungraded, in anything between the 2 semesters. I took a course in Plato. I was hooked by philosophy, and for a while I was a philosophy major, but then switched over to religion major. I took no science courses in my first 3 years at Williams.

DR. McINERNY: When did you decide that you wanted to go to medical school?

DR. WASSERMAN: The summer between junior and senior years I had an experience that opened the possibility of medicine as a career. I was whittling on a weekend afternoon and managed to drive the carving knife into my upper left thigh. This was in Vermont, and it was not far from Dartmouth [College]. After I gazed into the wound, passed out, revived, I was taken to Mary Hitchcock Memorial Hospital and I was sewed up by an intern who, in his nice bedside manner, was telling me about himself. He had been a graduate student in English before deciding to go to medical school.

I think it was the combination of being helped, and hearing from someone who hadn’t really thought he might want to go to medical school and had been able to go to medical school, that first put the idea into my mind. So, I spoke to my many friends who had been pre-med and kind of washed out of it or ones who were still pre-med, and then I spoke to the pre-med advisor who asked me about my science career at Williams. When I told him I hadn’t taken any science he suggested I take biology during senior year and
see how that went, and if it went well then he’d advise me further. So, it went fine.

I had the advantage of having sowed -- I don’t think “wild oats” is the right expression -- but having done a little exploring in the first 3 years of college. So, I settled down, and I did well in biology, and he had me take 2 semesters of inorganic chemistry at Dartmouth summer school, and then I returned to Williams. I had a 7-year deal at Williams, 4 years of scholarship and 3 years of post-graduate fellowship, and so I got to apply the first year back at Williams taking all of my pre-med classes, all the ones I hadn’t taken. I did that, applied to medical school, and it seemed I wouldn’t get in. I was on 3 waiting lists, and then I got into Jefferson Medical College [Thomas Jefferson University, now Sidney Kimmel Medical College] in the early summer, and so I went off to Jefferson, to Philadelphia.

DR. McINERNY: How was Jefferson?

DR. WASSERMAN: I hated Jefferson until it got to the clinical years. It was very much like a high school to me. I had never taken short-answer exams in college, even science classes were little essays on how to synthesize this compound or how to extract that substance. That may be an exaggeration, but Jefferson was very obsessed with the national board exams, now known as the USMLE I guess. They wanted the scores to be really high, and so we were taught to the exams and took national board-style exams for everything. I was really not particularly pleased with that style of learning. But then the clinical years at Jefferson were great, because there were a lot of great clinical teachers.

DR. McINERNY: When did you decide you wanted to get into pediatrics?

DR. WASSERMAN: I decided on pediatrics after I took a pediatrics rotation and realized it was the place I had felt most comfortable. It wasn’t so much that I liked children. I didn’t particularly care for many of the other specialties, and I liked the whole focus on normality and normal growth and development. That really appealed to me. And I liked chatting with parents. Of course, if one doesn’t like chatting with parents, one shouldn’t go into pediatrics, no matter how much one loves children.

I really wanted to get out of an urban area, and I interviewed at a bunch of places but only applied to 2 residencies in pediatrics, the University of Vermont [UVM] and Dartmouth. I had done an elective at UVM and put it first and got chosen, and that’s where I started my residency. I did 2 years of residency at UVM, then known as the Medical Center Hospital of Vermont, under Dr. Jim [R. James] McKay [Jr.], who was a big influence on me.
because of his patient-centeredness, and the fact that he was quite a prominent pediatrician. He had been President of the American Academy of Pediatrics, and he was the co-editor of the *Nelson’s Textbook of Pediatrics*, and he was an associate editor of *Pediatrics*. Jerry [Jerold F.] Lucey, the editor of *Pediatrics*, had just started as editor then, and we had a great, very small clinical faculty.

But after 2 years my wife, Abby, wanted to go to grad school, so we picked a city, which was Boston, and she got a Master’s degree in early childhood development. I went looking for a residency program, and I ended up at Boston Children’s [Children’s Hospital Boston] in what was then called the ambulatory program under Mel [Melvin D.] Levine. At the time, I thought I might want to be a developmental behavioral pediatrician, but I quickly figured out that I didn’t. It just didn’t seem to be the right thing for me. But while at Boston Children’s I encountered not only Mel Levine, but Bob [Robert J.] Haggerty, who at the time was Chair of Maternal and Child Health at Harvard School of Public Health.

I should mention one formative experience for me in Vermont. On call in neonatology, we were allowed to sleep in Jerry Lucey’s office — on his office couch, which was right next to the NICU [neonatal intensive care unit]. I went in and I was just looking around for something to read, and there was a book called *Child Health and the Community*, which was by Haggerty and Klaus Roghmann, and I started to read through it. I thought, this is the kind of stuff that really interests me, because it’s very much the application of epidemiology and social science to the understanding of clinical care.

During residency, I became impressed with how foolish much of what we were doing in the management of children was, like being required to do a lumbar puncture on a smiling child who just had a febrile seizure and now was afebrile, but was under the magic age at which nuchal rigidity was a good way to rule out meningitis, and it was an era when there was plenty of meningitis. We would have to hold these screaming, helpless toddlers down for spinal taps that were really totally unnecessary. So, that was my first inkling that I might want to study something, because I thought, ‘Gosh, there’s got to be a way to prove that this is not a great idea.’

DR. McINERNY: So you were one of the thousands of pediatricians that were mentored by Bob Haggerty.

DR. WASSERMAN: Definitely, Bob Haggerty was important. When I was at Boston Children’s we all were required to take a course on research methods, and I encountered there some other influences: Don [Donald M.] Berwick, who was an attending in the primary care clinic where I worked;
and Michael Weitzman, who was also an attending in the primary care clinic; and lots of other people. I did a year in the ambulatory residency and was on call in the emergency room exclusively. I was relieved of having to be on call in the NICU, which was a big thing in Vermont. Back then you would spend as many as 6 months in NICU because the residency review committees hadn’t figured out that that might not be the best education for a pediatrician.

I had lots of great experience in a big, inner-city emergency room in my third year, and I also got a chance to do a half day a week as a school physician in Brookline High School, and I did developmental behavioral testing at the Brookline Early Education Project. I worked at various behavioral clinics.

But the most important thing was I did 2 full days a week of primary care. I had my own patients, which was great experience and unusual for a pediatric resident at the time. Then I went on to be the ambulatory chief resident for a year, which was some more primary care and a lot of supervision in the emergency room, and a lot of dealing with hassles as a chief resident does, such as people that aren’t working up to snuff. But the other thing was organizing the regular morning lectures for people in the emergency department who were in a primary care rotation. I got to call up and invite all kinds of people to come and talk on individual subjects and got to listen to the talks, too. So, I got a pretty good general pediatric education between UVM and Boston Children’s, with really a focus on primary care.

DR. McINERNY: So then you migrated back to UVM?

DR. WASSERMAN: No, no, then I went to Seattle. I was trying to figure out what to do. I was pretty sure at that point that I wanted to do academic pediatrics, whatever that was, but needed more training. Abby and I wanted to try a different part of the country, and so I applied to the Robert Wood Johnson Clinical Scholars Program. I actually interviewed at 2 places, UNC [University of North Carolina] and Seattle, but we ended up going out to Seattle. The Seattle Clinical Scholars Program was not a pediatric program, so the other fellows were mostly internists — there was one pediatrician, and a neurologist, and 2 obstetricians, and we all took a pretty rigorous curriculum in research. Most of us got an MPH as part of that, and we were all required to do a research project. That was a real formative experience.

I was mentored by Tom [Thomas S.] Inui, who has had a very prominent career in internal medicine. We had been required to write a research idea to get into the clinical scholars program, and mine was on trying to understand why people brought their children to the emergency room with what I would consider minimal illnesses. So, I did a lot of reading on
explanatory models and different distinction between illness and disease. When I got to Seattle, Tom Inui had been doing research on doctor-patient interactions in internal medicine, and so I formulated a research project on doctor-patient interactions in the pediatric setting. I did a study of 40 some well-child visits at the 2-week checkup, which was in those days the first checkup. Infants spent a long time in the hospital, maybe up to 5 or 6 days. I videotaped these and developed a system for analyzing them, had the parents interviewed before and after the visits, and tried to understand what aspects of communication were most effective in talking to parents. That was my first truly independent research project.

DR. McINERNY: How long did it take you to complete your MPH?

DR. WASSERMAN: The whole program was 2 years. It took me another year to write up the results and submit them for publication. The name of the article, published in *Pediatrics*, was “Pediatric Clinicians' Support for Parents Makes a Difference.”

DR. McINERNY: So then you moved to Burlington.

DR. WASSERMAN: No, then I moved back to Boston, because it had one of the only jobs that were advertised.

DR. McINERNY: Oh, that’s right, instructor in pediatrics.

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DR. WASSERMAN: There was no job in Vermont, and then there was an opening in Boston, so I got hired back at Boston Children’s where I was an instructor in pediatrics and got to meet a lot of other people whom I got to supervise and who later went on to be well known. My boss, Lewis First, was a medical student when I was there.

I spent a year there, but when I went back I made it clear to them that if a job opened up in Vermont that I was going to go interview for it, because Abby and I really wanted to return to the Burlington area. A job did open up, and we did return. I was hired by Jim McKay, although he was just retiring as chair, and [Carol] Lee Phillips took over. But I was hired with the stipulation that I would have time set aside for research, and nobody had ever had that as a Vermont general pediatrician before. So, I had 2 full days a week of clinical care, plus an evening a week on call, and every fourth weekend on call. But I had some time set aside during the day to pursue research, and that’s how I actually got started on research.

DR. McINERNY: So you were probably one of the pioneers of general academic pediatric research.
DR. WASSERMAN: We were the first group that actually called ourselves general academic pediatric researchers. There had certainly been people before us, like people at Rochester, the people Bob Haggerty trained, Jim [James M.] Perrin, Evan Charney, Jim’s wife, Ellen [C.] Perrin, and others. But we were the first who thought of ourselves as having had research fellowships, and we had the training, and we moved forth.

DR. McINERNY: And so, remind me again, your percent clinical and percent research?

DR. WASSERMAN: I was 2 full days a week clinical, plus an evening on call, so 2 and a half, a weekday evening, 2 full days of clinical, and so really I had 40% protected time for research.

DR. McINERNY: And what sort of research were you doing?

DR. WASSERMAN: Well, I was casting around. One of the challenges for me was I really wanted to continue to pursue research in communication, but I had no infrastructure to do it, because in Seattle there were video-taping facilities set up and audio-taping and microphones and everything. There was nothing like that at UVM, and of course that kind of stuff takes money. I was really pretty green about how to get that sort of stuff funded and hadn’t negotiated for it, which is now what I would tell someone negotiating for a job. If you want to pursue this, you have to negotiate for what you need to pursue your passion.

So, I put communications research on hold, and I did some injury prevention research mainly in bicycle helmets and was really casting around for where to go next. I was on the tenure track, and so I had a stipulation that I had to publish or I would perish. That was when the opportunity with the Academy appeared. I don’t know if you want me to talk about that now, or we could put that aside for a second, and we could go through some other things.

DR. McINERNY: I thought maybe we would talk about some of your awards of note over the years. And then your APA [Academic Pediatric Association] activities.

DR. WASSERMAN: All right.

DR. McINERNY: And then other activities and other organizations, and then we can really get into the PROS [Pediatric Research in Office Settings] story.
DR. WASSERMAN: OK, yes. So we’ll put aside the PROS story for now, but just to say that for me it started in 1985, so that’s only 2 years after I had come to Vermont.

I guess the awards that I have had are all associated with PROS, and in fact I always felt that it was PROS that needed to get the award, and I would be honored if PROS got the award. There was an award from the Pew Charitable Trusts for primary care research that PROS got I think in 1998, and I got to put that on my CV. Then we got what was then the Ambulatory Pediatric Association -- now known as the Academic Pediatric Association -- Research Award in, I believe, 2005. I’ve been honored to be a visiting professor at a whole bunch of places, which I wouldn’t even bother to name, except those are great experiences.

DR. McINERNY: Including, most recently, Rochester.

DR. WASSERMAN: And that was in some ways the capstone. The Paul Beaven Memorial Lecture, where I gave lectures at Rochester General Hospital and Golisano Children’s Hospital on the “futures” of pediatric primary care, and got to speak to a lot of the people who were part of my formative experiences in the PROS network. Getting those visiting professorships is a very gratifying thing.

The Ambulatory Pediatric Association evolved into the Academic Pediatric Association. By the way, I was one of the people who really felt we needed to change the name, because ambulatory was kind of strange and outdated, and actually inappropriate now for the current APA. I was involved in the APA as the Region I Co-Chair and then Chair, that’s the New England region. That was exciting, because you got to hold an annual meeting and invite the leading notables from New England medical schools to give talks, and young researchers would practice their presentations for what are now the PAS [Pediatric Academic Societies] meetings. That was excellent, and I did that for several years. Subsequent to that I ran for the APA board and was chair of memberships and actually helped the APA to finally get to 2000 members by the year 2000. That was my slogan, “2000 by 2000.”

DR. McINERNY: I remember that.

DR. WASSERMAN: Later on I took over and helped to establish a Practice-Based Research Network Special Interest Group within the APA, which then evolved into a Pediatric Clinical Research Network Special Interest Group. We got away from focusing just on primary care research, because there was other really exciting clinical research network work being done. By that time the emergency medicine community had established the Pediatric Emergency
Care Applied Research Network, PECARN, as it’s known. The hospitalists had started a research network, Pediatric Research in Inpatient Settings (PRIS). Both of those networks have been very successful, and they also fall under the APA umbrella. In its wisdom, the APA captured the emergency medicine people and now the hospital medicine people, and so that’s the big tent for the APA. So, I had overseen that special interest group and just gave that up last month. Those are my major APA activities.

DR. McINERNY: Any other activities with other organizations now, either at UVM or around the country?

DR. WASSERMAN: There’s one more theme in what I’ve done that is worth exploring. Many of us who are general academic pediatric researchers were intrigued with the quality improvement movement. As I mentioned, Don Berwick had been a preceptor of mine and was very influential. With a few others, he had started what grew into what was called the Institute for Healthcare Improvement, a very successful and probably the most successful national quality improvement group. There were a number of us who had been doing research in general pediatric areas, Charlie [Charles] Homer, Peter [A.] Margolis, Carole Lannon, Jim [James W.] Stout, and some people from non-primary care areas like Jeffrey [D.] Horbar, who was a colleague of mine at Vermont. We were all very taken with and intrigued with quality improvement.

Jeffrey, under the leadership of Jerry Lucey, had gotten involved in what’s known as the Vermont Oxford Network, which is a premier pediatric quality improvement network that does both research and quality improvement. That group had actually gotten a grant from the Packard Foundation, and a bunch of us thought we might also want to put together a national network, and so that ended up with some funding from the Packard Foundation in the creation of what was called the NICHQ, National Initiative for Children’s Healthcare Quality (now National Institute for Children’s Health Quality). That was started. And, as part of starting that, myself, Jeffrey Horbar, and some other people, Paula Duncan and Wendy Davis, were interested in doing something about quality improvement in Vermont. We put together a proposal to Lewis First, my chair, and then to the dean of the medical school to set up a Vermont Child Health Improvement Program (VCHIP), which would work with this new NICHQ group to do quality improvement in Vermont. And we sort of did a leveraged situation where we told the Packard Foundation if they gave us the money the dean would match it, and then we told the dean that if he gave us a certain amount of money the Packard Foundation would match it. They both came through, so we got the Vermont Child Health Improvement Program and hired my colleague, Judy Shaw, who holds a doctorate in education, and who has grown that
organization considerably. So, I served on the NICHQ board for, I don’t
know, 6 or 7 years and have worked and still work in quality improvement
efforts in Vermont with VCHIP, as it’s known.

DR. McINERNY:   Premier, a premier organization.

DR. WASSERMAN: Very good, and there were people from other states
who were interested in what Judy Shaw and the rest of us were doing in
Vermont and wanted to start up some more organizations in their states, and
so that turned into the National Improvement Partnership Network, NIPN,
which is a national network of regional quality improvement networks. I’m
very proud of that, because whereas research is the effort to generate new
knowledge, quality improvement is the idea of taking what is already known
to be proven, or mostly proven, and implementing it. Berwick has said the
gap between what we know and what we don’t know is exceeded by the gap
between what we know and what we actually do. In VCHIP we work with
primary care practices and clinics and with specialty services as well in
Vermont to improve care. We’ve written up some of it as research, but I
must say most of the energy goes into doing the work, which is very
gratifying.

DR. McINERNY:   Yes, I believe you had, what, 90 to 100 pediatricians in
VCHIP?

DR. WASSERMAN: Oh, yes. I mean, all the pediatricians in Vermont and
all the family physicians who care for children in large numbers are part of
the VCHIP organization.

DR. McINERNY:   And the results have been very impressive.

DR. WASSERMAN: Yes, I mean, there are concrete improvements in
preventive services, asthma care, a variety of different things, newborn care.
So, that’s been fun.

DR. McINERNY:   All right, well now let’s delve into the PROS history and
why you would do that when it was certainly innovative, to say the least, and
somewhat risky to get into that line of research.

DR. WASSERMAN: Right. So, you know, Tom, from your own experiences
in Rochester that in the 1960s and 1970s Bob Haggerty, as the chair of
pediatrics at the University of Rochester, had with his faculty -- most notably
probably Evan Charney, but others I’m sure -- begun to do research with
primary care practices. And there was a strong tradition of individual
community practitioners doing research on their own. There was Burtis [B.]
Breese, Jr., and Frank Disney at Elmwood Pediatric Group. Much of what we know about streptococcal infections is still traceable to the studies they did in the 1950s and 1960s. But in Rochester you certainly had what could have been called a practice-based research network, it just never named itself a practice-based research network.

So, this is the back story to PROS, that Bob Haggerty thought this was a good thing. I think he thought it was a good thing for pediatricians themselves, in their professional development. It maintained their curiosity and allowed them to contribute to developing new knowledge. The other thing is that there were huge gaps in what was known about how children should be cared for in general settings and primary care settings. There weren’t a lot of Frank Disneys and Burtis Breeses out there. There was T. Berry Brazelton doing developmental behavioral stuff, and Bill [William B.] Carey doing stuff on temperament, and a handful of other pediatricians doing work in otitis and various other things. But there really weren’t many, and those folks were not going to be in a position to necessarily continue. So, it was nice to have a network of pediatricians with some institutional support.

Bob Haggerty had this in his mind all along. He became President of the AAP in 1985. Before that he’d had some interactions with a family medicine group called ASPN. ASPN was short for the Ambulatory Sentinel Practice Network, and it was a group of independent family physicians who were doing research in their offices and clinics. Bob, as I recall, went to ASPN meetings, and he thought this would be a good idea for pediatrics, too. In 1983 he actually got Barbara Starfield, who was on a sabbatical out in Stanford I believe, to write up a prospectus for what a primary care pediatric research group might look like. She did that, and I have her original report tucked away here. But one of the interesting things to mention about that report is it actually mentioned electronic communication. It mentioned billing data, and it mentioned electronic health data as something that should be a foundation of such a network. Now, that didn’t come to pass for another 20 or 25 years, but Barbara Starfield was thinking about it.

So, when Bob became president of the Academy, my impression is that every president of the Academy gets at least one harebrained scheme to try out, which then the staff at the Academy either endure, or actually try to implement. Bob’s idea was to look into the idea of a pediatric research network, and so he created the Task Force on Collaborative Research. At the time a local Vermont pediatrician, Dick [Richard] Narkewicz, was chair of the Advisory Committee to the Board on Research, [ACBOR]. Every board member at the Academy rotates through chairing these boards which oversee various academy activities. Dick was someone I knew from having
been a resident in Vermont, and also because I had tried to rope his practice into a research study as a young faculty member there, so he knew I was interested in practice-based research. One morning in the newborn nursery he asked me if I might be interested in serving on this task force. I asked him what it was about, and he said it was setting up a research network. I asked him who was going to be on it, and he said Bob Haggerty was overseeing it, and Evan Charney was going to be part of it. He was going to chair the task force, and Bob [Robert] Pantell would be part of it, and David Bergman, and Barbara Starfield, and a bunch of people from family medicine. I said, “Yes, of course I want to be on this task force.” So I was on the initial Task Force on Collaborative Research.

Just to trace it so far, Bob Haggerty’s idea, inspired by what he had done in Rochester, and then reinforced by this ASPN network, which was national, not regional but national, very ambitious, led to the Task Force on Collaborative Research. So, that task force met a couple of times. I have to pull out the reports from my briefcase here. Tom, you can see this.

DR. McINERNY: These are some real historical documents.

DR. WASSERMAN: And I’m going to give these to the Pediatric History Center.

DR. McINERNY: Oh, good. That’s great.

DR. WASSERMAN: Yes, this was the first meeting, and then there was a second meeting.

DR. McINERNY: In 1985, November 11, 1985, so we’re talking now over 30 years ago.

DR. WASSERMAN: Right, and then there’s the second one on July of 1985. Meanwhile Bob Haggerty’s been elected to the presidency, or I guess he was a president-elect. I’m just saying. Who else was there? Larry [Lawrence F.] Nazarian was there. Evan Charney is the chair. A pediatrician, Bob [Robert] Black, from California, Gretchen Fleming, who at the time was head of the Department of Research at the Academy. So this is the second agenda. But the punch line is that the Academy Board of Directors decided to go for it.

DR. McINERNY: The Board of Directors bought it.
DR. WASSERMAN: So thus it was established, and its initial name was the Collaborative Research Practice Network, or CRPN. So, one of the first and most important things that PROS did was change the name.

How did PROS get put together? Well, there was fabulous use made of the Academy’s chapter infrastructure, and a call went out to every chapter president to recruit pediatricians from each state who might be interested in overseeing chapter-level activities. I believe you were the victim from New York, Chapter 1, right?

DR. McINERNY: Yes.

DR. WASSERMAN: We had about, I think, 25 chapters that responded, and I responded as the person from Vermont. So, my initial position in this new network was as the Vermont Chapter Coordinator, as we were called, and I was also placed on the steering committee. The steering committee had myself, David Bergman, Bob Pantell. I’ve got those minutes, too, probably from the first meeting. We had a first Chapter Coordinators meeting in probably 1986. PROS was founded in 1986.

DR. McINERNY: Thirty years ago.

DR. WASSERMAN: Thirty years ago. As I said, a vote was taken to change the name, and each Chapter Coordinator recruited practices in his or her chapter. So you recruited practices in the Rochester area, upstate New York, and you were very successful. There were a bunch. I managed to rope a bunch of people into it from Vermont.

The steering committee members were given the task of coming up with a first research study for the network. Well, the way I was taught to do research was you come up with a question, and then you figure out how are you going to answer the question, and PROS was a different approach, which is you come up with a mechanism for answering questions, and then you figure out what questions you can answer using that mechanism. So, our task was to figure out what we could study in a group of maybe 100 or so practices initially that would be worth studying and contribute new knowledge, and each of the people on the steering committee were assigned a topic.

Kathy [Katherine K.] Christoffel, from what was then called Children’s Memorial [Hospital] in Chicago, Northwestern’s Children’s Hospital, thought up an idea on injury prevention, because she was an injury person. We all got various assignments. Bob Pantell had an idea about the management of febrile infants. I was given the topic area of screening, a very
broad area, and then each of us brought back the ideas to the steering committee, and the steering committee selected an idea. My idea was chosen, which was initially going to be on sensory screening, vision and hearing screening, just an observational study of how much it was done in preschoolers and what happens following up the patients. My idea was chosen not because it was the most compelling, but because it was deemed the easiest, because if you want to start something -- don’t start with the hardest thing.

So, the next step was, and we were still developing our methods here, for me to present my idea to the assembled group of Chapter Coordinators. I presented and they completely tore me to shreds in typical PROS network fashion, mostly kindly. Modified my study so it was just about vision, and really that was a better thing to focus on since we knew then that preschool vision screening could prevent permanent unilateral blindness, namely amblyopia. We also had a pretty good idea it wasn’t being done according to Academy recommendations and guidelines. Then Evan Charney, who was chairing the PROS Steering Committee, and I went out shopping for money to do this study, because the Academy was supporting the infrastructure for PROS, but that really was not much support. They really weren’t devoting new staff to PROS. So, we went and shopped the idea around to the Robert Wood Johnson Foundation, various places, and Evan and Bob Haggerty found a partner in Woodie Kessel. Woodie Kessel, formally Samuel Woodrow Kessel, was the head of research at the US Maternal and Child Health Bureau in the Health Resources and Services Administration. Woodie had been in the Clinical Scholars Program back in the day, and Woodie was very creative. This study was something of a departure for the Bureau of Maternal and Child Health, which really focused more on traditional MCH issues.

We wrote a grant and got, I don’t know, $75,000 or $80,000 to do this study. And believe me, the study was going to cost more than that, and this was my first wake-up call with the Academy, because I said we got this money in, and then how much is it going to cost, and I told the Academy leadership what it would cost. We didn’t have the salaries of the Academy personnel or of myself covered at all. This was all AAP volunteerism. This $75,000 or $80,000 would cover just the expenses of mailing and printing up cards and stuff. The study was a classic card study. A pediatrician could carry a card around in his or her pocket, and as a kid came in for a vision screening note the kid’s age, and whether the screening was done, and whether it was pass or fail, and then we got the ability to follow them up. This was all done without, I believe, getting informed consent. So, there was a lot of stuff that would never fly today, and the Academy was not terribly pleased with the notion that we would do this without enough to just cover the staff at the
Academy. But this is the first example in what turned out to be a long series of interesting discussions that PROS had with the Academy.

Anyway, we started the study, and we put out a recruitment, and we got 100 practices to participate, and that was the first PROS study on preschool vision screening, the first one that got publication. Meantime we were writing grants. We were looking for other study ideas that had accumulated, Bob Pantell’s most notably, the one on febrile infants. But the PROS didn’t really have a staff at that point. Evan Charney in his parting from being the PROS Steering Committee Chair -- because you’re not allowed to be a steering committee chair at the AAP for more than 4 years -- made some recommendations. One was that the Academy should hire some PROS staff, and the second was that there should be a position of a PROS Director who would be a pediatrician. That was certainly not Gretchen Fleming’s vision. She was head of the Department of Research. She thought there should be a pediatrician who was an advisor, but it should really be run directly from the Academy by the research department. But Evan prevailed, and so an advertisement was put out for a PROS Director, and that was in the spring of 1990. I have a copy of that ad somewhere here. But it was put out, and basically nobody else applied but myself.

DR. McINERNY: I remember a little bit of this history, and what struck me is that PROS was certainly untried and a lot of possible funders were wary of this as a sort of a -- what kind of an animal is PROS? Without a track record, you know, it’s a little bit like publishing your book. If you haven’t published somewhere else before, you’re not going to get funded.

DR. WASSERMAN: It was an experiment.

DR. MCINERNY: Yes.

DR. WASSERMAN: Here’s the job description. It said 50% time. That was certainly not what I got. Basic function, to direct the Pediatric Research in Office Settings, PROS, program, a program in which a network of pediatricians in practice collaborate in research. Then there’s a list of duties and responsibilities, and education requirements, a medical degree with board certification in pediatrics, training in epidemiology desirable, experience in directing several clinical research projects. Anyway, but literally I was the only person who applied for this job.

DR. McINERNY: A good thing you did.

DR. WASSERMAN: And so I got the job. Just as a lesson to people thinking about careers, you just never know what’s going to turn up. It was
a total accident that I was on this task force. If Dick Narkewicz had been practicing in Manchester, New Hampshire, I don’t think I would have been on the task force, and if someone else had applied for the job who was more senior, because at that time I was an assistant professor at Vermont, someone with more experience might have gotten it. But nobody else did, and so we started out.

The idea was that PROS should have its own employees, so there was an advertisement put out for someone to direct the Division of Primary Care Research at the AAP. That was a new division. There were multiple people for that job. The person who ended up with that job was Eric Slora, PhD in psychology, who came to work at the Academy in, I believe, April of 1990, so before I did. So, there was myself and Eric, and I believe we had a fragment of an administrative assistant who quickly retired from the academy, and we found some other people. So, that was the beginnings of the PROS staff, Eric Slora and a part-time administrative assistant.

The way the relationship worked out between Eric and myself was that I was Mr. Outside and he was Mr. Inside. I related to the outside world, so I spoke to the pediatric community, and I dealt with investigators, and I dealt with funding agencies, and Eric made the whole thing work at the Academy, which meant hiring people and overseeing them.

As I said, we started from nothing. We were doing one study, the vision screening study, and putting together other ideas for studies. Our vision for the network, and it certainly came in part from me, was that this was not going to work if it was Mort Wasserman’s research network. Why would anyone want to bring really cool ideas to someone else’s research network? So, the vision that we had was that this was going to be like a public utility, and we were a laboratory for primary care, large-scale primary care pediatric research. You wouldn’t want us for a small-scale study, but if you wanted a big study, we were the place to go. We tried to let it be known in the academic community, and this has always been a challenge, by the way, that we’re looking for ideas to implement in PROS. We fortunately attracted some really innovative people. One, Bob Pantell, had always wanted to do his study of febrile infants in our network, so that was one study that was under development. A second one was from Marcia Herman-Giddens, at the time a physician assistant working at Duke. She was seeing children in the sexual abuse clinic and noticing that the girls she was seeing seemed to have signs of puberty much earlier than what she had read in the textbooks. That was our first really “from the field” clinician study. Marcia went on to get her doctorate in public health and is one of the world’s experts on puberty, but she was a PA at the time who hadn’t gotten her doctorate.
DR. McINERNY: I’ll just ask you to back up a little bit and talk about the notion of getting the core funding for PROS and then the funding for each study, and then we’ll go into some of the studies.

DR. WASSERMAN: That’s a good point to bring up. We needed to fund the core, just to have the “laboratory” up and running, but what’s the “lab?” Well, the lab was initially 100 pediatric practices, so a couple of hundred pediatricians, their names, their addresses, the ability to communicate with them in those days by mail and fax. It was pre-internet. Nobody had email addresses at the time. We needed resources to do that, and our first resources to do that actually came from the Bureau of Maternal and Child Health, and that’s why when I cite the people who have really founded the network I always include Woodie Kessel with Barbara Starfield, Evan Charney, and Bob Haggerty as the core people. Because Woodie sold the idea of funding the Academy to operate PROS at what was then $200-300,000 a year, whatever it was. It was not inconsequential, and that paid for meetings, helped pay for a staff, it paid some of my salary, and that funding got the Academy’s attention as something — oh, this could be viable. Because you do correctly point out, this was an experiment for a membership organization to have a research group. No other national membership organization, not the American College of Physicians, or at that time the Academy of Family Physicians, or the American College of Surgeons had a research network. So, we were an experiment. It’s also worth mentioning in that context that our steering committee always included the chair of the AAP’s Committee on Pediatric Research, usually an academician, and therefore friendly to research, and the chair of the Advisory Committee to the Board on Research, typically not an academician and someone who was duly and appropriately skeptical of the whole idea. The thing that really convinced a series of ACBOR chairs -- I have a couple in mind, but I’m not going to mention any names -- of our viability was coming to PROS Chapter Coordinator meetings where pediatricians would get together with academicians and hash out these new ideas I had just alluded to, like the idea for a study on febrile infants. Well, Bob Pantell had these fancy ideas for the study, and then he met up with a room full of 35 or 40 pediatricians who told him what could or couldn’t be done in their offices.

DR. McINERNY: I think that was part of the key to the success of PROS was to have the primary care pediatricians say, “Listen, this just isn’t going to work in a busy pediatric practice. We have to change it.”

DR. WASSERMAN: Right, and therefore when they came up with something that they said, “Oh, yes, this would work,” it was, in a way, partially pilot tested, at least in their minds. We went on to do actual pilot
testing, but they felt it was viable. They could recruit people to do the studies.

The PROS meetings are some of the most exciting meetings I’ve ever gone to, because there’s a very honest give and take of what I had experienced as the principal investigator of the first PROS study. We would break up into small groups, and each small group would take an aspect of a proposed study, whether it was the data collection form, or a study research question, or the parent questionnaire. We’d get individual input from pediatricians in the small groups, and that was important because if you just do these discussions in large groups then certain people tend to dominate the discussion. We learned that if we broke into small groups that people who might be a little shy about speaking up in a large group were perfectly happy to speak up in a small group, and each of those small groups would have a scribe and a discussion leader, and then the small groups would report back to the large group.

Each PROS study was either approved or turned down, and there were a bunch turned down by a vote of the Chapter Coordinators. That was what we call the PROS process. So we were working on a bunch of ideas. I mentioned febrile infants, the puberty study, and then of course the one you were involved in. Barbara Starfield had recruited for us 2 people who were PIs [principal investigators] of eventual PROS studies, Kelly Kelleher, of the PROS Child Behavior Study, and Chris Forrest of the PROS Referral Study. Now we have all these great ideas, and we’re starting to write grant proposals, and our grants are getting rejected for the most part, but eventually we start coming up with the money to do studies.

DR. McINERNY: So could say a little word about the principal investigators and then how that worked? You had the core funding from Maternal and Child Health Bureau.

DR. WASSERMAN: Right.

DR. McINERNY: And then you had the PIs and what they had to do.

DR. WASSERMAN: Right. The PIs were the intellectual leaders of each study, and typically they had their own teams at their research institutions. So, for instance, Bob Pantell had infectious disease specialists, epidemiologist Tom [Thomas] Newman, other people, and his research team might have a statistician, he might not. Kelly Kelleher at that time was at the University of Pittsburgh, and he had a team he was working with. Marcia Herman-Giddens didn’t have a team, and so we sort of put together a team for her.
Chris Forrest certainly had a team at Hopkins. PROS evolved into the -- what’s the term for a group that is the research --

DR. McINERNY: Facilitator?

DR. WASSERMAN: Yes, well, in most NIH [National Institutes of Health] networks there’s a data coordinating center, a place that actually runs all the data collection, and that’s what PROS evolved into, a recruitment and data-cleansing organization. PROS could also be the data-analytic organization. So, there were negotiations that had to be done between the PROS staff and the PIs at the individual institutions in order to even write a grant, because when you write a grant, what’s in a grant? A budget. And what’s in the budget? People’s salaries and how you’re going to spend the money. So, Eric Slora and I became very skilled at putting together budgets and sniffing out other people’s budgets, because there’s a limit to the size of any budget you can send to the NIH. There were lots of negotiations back and forth. We always got to a “yes” when we were applying, and then if we got the money, which we did very successfully from then on, with ups and downs, there was the business of actually running the study, which meant the PI dealt with the PROS infrastructure in helping to recruit, and the PROS infrastructure actually went out and got the practices to participate, and that meant the Chapter Coordinators in each state often went out and sold the idea to individual practices in their state. We used that mechanism for quite a while until it became insufficient, and we learned that we could advertise using the AAP News, the fabulous monthly vehicle that actually is opened and looked at by many pediatricians, to advertise studies for the network too. By far the most popular study PROS ever had was the study on the Management of Febrile Infants Less Than Three Months of Age.

DR. McINERNY: By the way, if I remember correctly, the ideas for the study were proposed by a member of the AAP or a member of PROS, I forget which.

DR. WASSERMAN: Well, there always had to be a member of the PROS coordinator group who sponsored the idea -- co-sponsored in your case. You and Kelly Kelleher were the team. You were the practitioner, and of course you had a deep experience in child behavior studies, because you’d been part of the Goldberg study back in the late 1970s in Rochester. So, you were the ideal colleague for Kelly Kelleher, who was a pediatrician health services researcher. So there always had to be a PROS pediatrician involved in every study on its steering committee; each study had its own steering committee. I’ve a little bit lost my train of thought.
Oh, with recruitment, I just wanted to say that we hit the jackpot when we were doing the secondary sexual characteristics study, and 2 of our large grants got funded, the Child Behavior Study grant, and the Management of Febrile Infants grant. All of a sudden we didn’t have enough practices to do the studies, and that’s been a recurring theme in PROS. So, we advertised each of the studies in the *AAP News*, and so this is one of the fabulous advantages of being part of the AAP is that that didn’t cost PROS a dime. Eric Slora would speak to the editor of the *AAP News* and speak to the Director of the Department of Research, because other research groups within the AAP might want an article in the particular month. But we advertised the Febrile Infants Study, and we had a little clip-and-mail coupon, and so PROS grew from 100 to 500 practices using that mechanism of the *AAP News*. Eric and the PROS staff would write the articles with a little assistance from the PIs, and they’d be published. The names would come in, and then we -- the way PROS works, it still works, is everybody who is going to be a PROS member had to fill out a questionnaire on herself and on her practice, and so that way we knew about who the pediatricians participating in PROS were, and we knew about the practices.

DR. McINERNY: Yeah, and I think the fact that you ended up with 500 practices was a verification of Bob Haggerty’s original idea that pediatricians would be interested in the research.

DR. WASSERMAN: Especially if it was about something that they felt was worth studying, and by the time the febrile infant study was done, there was a guideline on the management of febrile infants that had been generated largely by the pediatric emergency medicine community and by the pediatric infectious disease community that said anybody under 3 months who had a fever, no matter what, had to be admitted to the hospital with a spinal tap, blood cultures, and a urine culture. That just did not jibe with what pediatricians in the community were doing and what they felt was probably good care. Some of it can be traced to the fact that those researchers who came up with those recommendations were all practicing in impoverished inner city settings, and that wasn’t the setting for every pediatrician who had patients with a working telephone, intact families that were well supported, and transportation to the doctor’s office.

DR. McINERNY: In great communication.

DR. WASSERMAN: Yes, and a longitudinal relationship with the family. That validated Bob Haggerty’s idea. Two of my practice-based research network colleagues came up with a law of practice-based research which was, basically, if people were interested in the idea, you had to pay them little or no money to collect the data, and if they weren’t so interested, you had to pay
them a lot of money, and they had a figure with a diagonally sloped line reflecting the different situations. That was Jim Taylor and Paul Darden, who have had research networks of their own, regional networks, and who have both served on PROS steering committee actually and as PROS coordinators, even to this day for Paul Darden. So, we were busy all of a sudden, and in fact we had a problem. We had to sequence the studies, and we had to allow one to go first. Actually we had the Child Behavior Study recruit first, because in fact it was the less popular study, so we wanted to give them the first shot. But we had no problem getting sufficient numbers for the Child Behavior Study, as we collaborated with the ASPN network on that study. That was the first instance of combined pediatric and family medicine research, and it was a longitudinal cohort study where parents, as you know, coming into the office, would fill out a questionnaire about whether or not the child had a behavior problem. These were all comers. Then the pediatrician would fill out a questionnaire on whether he or she identified a behavior problem, and then we followed up the kids with identified problems who had been referred and found, of course, that they didn’t go to their referrals half of the time. We were finding something very similar in the Chris Forrest/Barbara Starfield referral study, which is that there is a substantial voltage drop in the process from identifying a problem - now, first of all, we don’t identify all the problems that are there. When we do identify them, we don’t refer them all, depending on whether they need referral. But if they do need referral and we do refer them, only a fraction of the parents manage to keep those appointments. I think that’s a lesson that trickles through right now to our present day with the management — the medical home and the medical neighborhood and how to manage chronic conditions.

DR. McINERNY: They may actually see the specialist once.

DR. WASSERMAN: Right.

DR. McINERNY: But then never again.

DR. WASSERMAN: Right. And, of course, you may never hear from the specialist. So, there was all of that.

A lot of PROS studies were descriptive efforts that my mentor, Jerry Lucey, liked to say were like turning over a rock and seeing what crawled out. And in fact, that was a theme. Among the leadership, there initially was a concern that if PROS studies showed that pediatricians’ work could be improved, that would be damaging to pediatricians, and if they showed that pediatricians’ work was stellar, that people would just write it off as, well, it’s been studied by the Academy of Pediatrics. But actually the leadership
has been fine about that -- they always like to know what our studies find so they can help manage it, and if there's fallout manage the fallout. But nobody has ever interfered with the research process.

DR. McINERNY: Yes, and there are some examples where the research findings changed textbooks and led the academy to institute programs to help pediatricians deal with those problems.

DR. WASSERMAN: Absolutely. Our vision screening study, the very first study, led to a change in vision screening recommendations, because we discovered that when pediatricians did try to screen 3-year-olds, which was younger than the age group recommended, in fact over half of them were successfully screened. That was translated by the Committee on Practice and Ambulatory Medicine, with the Section on Ophthalmology into a new recommendation to start screening at age 3, which affords a better chance of preventing amblyopia. Our Secondary Sexual Characteristics in Girls study showed that girls were starting puberty much earlier than was written in the textbook based on Tanner’s work from the institutionalized girls, from photographs, I might add, from the 1950s. So, that led to a change in guidelines by the pediatric endocrinology community. And the forthcoming febrile infant study, should it ever leave the Academy, will show a change in the guideline on the management of febrile infants. Let’s take a break for a second.

(break in audio)

DR. McINERNY: One thing I think that was kind of interesting and a little bit fun to talk about was the opening of the box in the practice that was going to be participating in the research project.

DR. WASSERMAN: That’s great, the box. In the paper-and-pencil era of PROS, and I’ll talk about how we have moved a little bit from that, we would send a box full of study materials, and that would include perhaps questionnaires for the parents on a study, questionnaires for the clinicians, training materials, maybe gizmos, things we were handing out to the families, informed consent forms, I mean, you just name it. Boxes were pretty large, and we experienced something we called box shock, which was, even for a practice that had really been excited about a study, when they got that box they were terrified of opening it. And so our staff created a protocol for talking people down from the ledge. In fact, we learned to tell them not to open the box until we had them on the phone so we could guide them through it, because it was just a lot, a lot of materials. Because we were doing everything by paper and pencil, which meant if you needed a birth date or a date of a visit, every single thing needed to be written down.
DR. McINERNY: That’s a good lead-in to talking about the PROS staff.

DR. WASSERMAN: Right, OK. The thing about the PROS staff, the first and most important staff member, as I mentioned before, is Eric Slora, with his background in psychology and very strong in statistics, but who rapidly had to become skilled, and he was skilled in this, at navigating the environment of the Academy of Pediatrics, which wonderful organization that it is, research is only one of the things it does. Secondly, whereas those of us in academic institutions are used to this sort of free-flowing entrepreneurship idea that if I have an idea, and it’s a good idea, and I can get money to do it, I can have independence in the way I run the study, and that’s simply not the case at the Academy of Pediatrics. It has the Research Department, and research staff have to pretty much play by the same rules that the rest of the staff play by. So, for instance, early on it became clear to Eric Slora and me that our phone calls were fine, but that email might be a good idea, and, well, the Academy really didn’t have an email set-up. So initially I had a University of Vermont email, and Eric had a private email, and we communicated privately until the Academy got its own email, and he helped to -- you know, we weren’t the only people at the Academy who wanted to enter the 20th century before the 21st century was upon us, but he helped to do that. We wanted a Listserv, well, the Academy didn’t have the abilities to do a Listserv, and so we ended up creating a PROS Listserv out of the University of Vermont. Eric had to handle all our negotiations. We had, at the time, 2 meetings a year, and so he had to deal with travel. We were getting CME credit for all our meetings, as a carrot for coordinators who would come to meetings, so we had to deal with the Academy’s CME apparatus. If we wanted a new piece of software, we couldn’t necessarily get it without it being made available to the entire Academy, so that bit of statistical analysis software might turn into a long-term challenge. Eric navigated all of that stuff. He also hired fabulous staff, some of whom stayed with us for a long time. Eric himself was with PROS for over 20 years. He hired Alison Bocian, and Stacia Finch, and Donna Harris, and Donna is still with PROS. Alison and Stacia have moved on. And then he managed them, he managed the staff. In the beginning, in the girls Secondary Sexual Characteristics study, Eric was not only the Director of the Division of Primary Care Research, he was also the research assistant and really had to help design the materials and get them printed up. I mean, he was doing all this stuff. Eventually we had other staff involved, and he became a supervisor of staff and the person who negotiated on the part of PROS when we needed the collaboration, and we got lots of collaboration from other parts of the Academy. We learned that, from the experience of the Secondary Sexual Characteristics Study that it would be important to involve any committee or section that would touch upon a study that we were doing.
We made this mistake in the Secondary Sexual Characteristics in Girls study. Although we had pediatric endocrinologists involved, they were not part of the leadership of the Section on Endocrinology. That would have been a good idea, and every PROS study since has involved either section leadership, committee leadership, so that nobody was ever surprised when we were doing a study to find out that we were actually doing that study. And also we got lots of very valuable information from those leaders.

DR. McINERNY: I might add that Eric Slora was very effective and well loved by the pediatricians that were doing the studies. He was very good with them.

DR. WASSERMAN: Absolutely. He had a great fan club. Eric “got” what it was like to be a busy pediatrician for whom research was not her first priority, or even second, or third priority, but who really wanted to do a study, and so he would mentor our research staff to not be impatient with the pediatricians and to treat them with the utmost respect, and if the pediatrician went into a bit of a tirade, to just let it blow over, because ultimately the pediatricians were the core for what we were doing. He played a big role in organizing agendas, and he always oversaw the production of the minutes from these coordinators. Just countless tasks that he oversaw within the network, and it was a big blow to lose him. But eventually he had his differences with various folks at the Academy, and for a variety of personal reasons decided to leave PROS and has since been replaced by a wonderful new division director for the Division of Primary Care Research, Laura Shone, someone that you, Tom, know from her Rochester days. There are just so many things you could talk about with PROS -- individual studies. We had, I don’t know, probably between 2 and 3 dozen major studies.

DR. McINERNY: How many publications? Similar?

DR. WASSERMAN: We have close to 100 publications. It depends on how you want to count a publication. We have gotten known in the research community, as I said. The PROS won the APA research award in 2005.

Probably it’s time to talk about the move from paper and pencil to electronic. That’s been a staged effort. It became apparent to most of us that with the advent of electronic health records there were a lot of really good data sitting out there that, if we could get our hands on them, would be very valuable to help learn and generate new knowledge, but would also take some of the burden of data collection out of the hands of the PROS pediatricians. As it was, as pediatricians began using electronic health records, they were becoming data entry clerks of a sort. The last thing they needed was to do additional data entry, and we’ve always tried to minimize the burden of a
study on the practice, while maintaining the scientific integrity. So, we were fortunate enough, at the time I was doing a sabbatical on the use of electronic health records in primary care research, and we’d learned a lot about this, by the way, from the family medicine community. They were ahead of us in this.

DR. McINERNEY: When was that sabbatical?

DR. WASSERMAN: That sabbatical was in 2010. But I’ll rewind a little bit. Primary care research really didn’t have a home in the federal government until the Agency for Healthcare Research and Quality, AHRQ, took it up in the late 1990s. David Lanier, who was a project officer there, suggested it to their research leadership, and AHRQ began a practice-based research network program around the year 2000 and actually provided infrastructure grants. PROS got one of those infrastructure grants and AHRQ started a series of practice-based research network annual meetings. The networks involved were mostly family medicine, with some internal medicine and pediatric as well. At the meetings we would gather together yearly and share ideas about how to run networks, both regional networks and national networks. I began to see presentations on electronic health record research, from the family medicine community. I also noticed some really superb research being done by a regional pediatric network based at the Children’s Hospital of Philadelphia, CHOP, which had instituted an electronic health record in the 30-plus practices that it owned, and they were doing fabulously innovative stuff. So, I wanted to do a sabbatical on this to learn more, and I went to CHOP and met a bunch of people who became PROS collaborators there. I’ll mention some names along the way. But at the same time, as part of the stimulus package -- remember the stimulus package?

DR. McINERNEY: Yes.

DR. WASSERMAN: Late in the century’s first decade, the Maternal and Child Health Bureau made available the opportunity for a research network to apply to set up an electronic health record network. That was the beginning of ePROS, the electronic PROS network. While I was at CHOP I met Alex Fiks, now my successor as director of PROS, and his colleagues Bob Grundmeier, and Jim Massey, and we applied for the ePROS opportunity, and we got the ePROS grant. Subsequently the Maternal and Child Health Bureau, with the collaboration of NICHD, the National Institute of Child Health and Human Development, made a second grant opportunity to build a larger research network, so the ePROS network has been folded into what’s called CER², Comparative Effectiveness Research through Collaborative Electronic Reporting. ePROS, coupled with the CHOP research network, coupled with MetroHealth in Cleveland, and the Boston
Medical Center research network, and a family medicine research network called eNQUIRENet, have now formed a 1.2 million child electronic health record database, and we published a few studies from that and many more are on the way.

So, that was the big leap PROS took into electronic health record research. We’ve learned a lot from that. One lesson is that the issues of governance, and HIPAA, and confidentiality, and the technical side of data transfer represented a very steep learning curve, which I believe we have navigated now. Also, that the electronic health record, as wonderful as it is in some ways, just doesn’t have all the data you need for research purposes, and so ultimately practice-based research will always need to supplement electronic health record data with data collected from pediatricians and families often specific to their research problem. That is something I definitely wanted to cover.

DR. McINERNY: And that’s where you see PROS going really, mostly it’s through now electronic?

DR. WASSERMAN: Well, not entirely. By the way, the person who’s overseen the electronic health record era at PROS is Jenny [Jennifer] Steffes. She’s another staff member worthy of specific mention among our fine staff. But we have discovered that there are limitations to the electronic health record data, and we are constantly trying to do studies where we can use pieces of electronic data without having to get the whole record, because that turns out to be a real challenge. For instance, PROS just got a study funded -- Alex Fiks and Melissa Stockwell of Columbia are the PIs -- on using texting as an intervention for flu immunization in infants who need 2 flu shots in their first flu season. It’s a big problem in that infants who are at the highest risk for influenza complications and death need 2 shots in a given season, and many of them only get one shot. How can you get them to get a second shot? Well, we’ve learned that it’s just very hard to do. But Melissa Stockwell had done a small study where she showed that if you could get text numbers, you could get cell phone numbers, you could send a series of reminders that would then bring the pediatrician back into the picture, in the family’s mind, and bring the infant back or toddler in for that second immunization. That’s an example of using electronic communication in a different way.

We have had a portal study on asthma to show how electronic portals can enhance asthma care. And billing data, if we can even get claims data or growth data alone, we can learn a lot. We don’t need the entire electronic health record, and it may be possible for practices to get their billing data about immunizations to know whether they’ve administered an immunization without them having to fill out a paper form. We’ve learned
that it’s really hard to get the whole record, and there are wonderful things you can do with a whole record, but there also are limitations. It’s often easier to get claims data, billing data, than it is to get the whole record. We always want to have studies that are available to the full complement of our membership, including those who don’t care to involve us with their electronic health records.

DR. McINERNY:   Interesting. Anything else you want to say about PROS before we move on to some other topics?

DR. WASSERMAN:  I might come up with something else, but we can always, through the miracles of tape recordings and transcripts, we can probably get them cut and pasted. Yes, I just have to say, you know, PROS is the ultimate collaborative enterprise, although we removed the word “collaborative” when we changed the name to PROS. It is a true collaboration.

And, one other thing. Who is missing in this collaboration recipe? We had academicians, we had researchers, we had practitioners, and not just pediatricians, we had family medicine docs, we had nurse practitioners, certainly physician assistants. But we were missing the parents, and that simply doesn’t cut it. We had done some studies where we’d done focus groups with parents, so that we’d gotten input on questionnaire design, on critical issues, but we never really introduced parents into leadership. You’ll remember that you were the first PROS steering committee chair who was a practicing pediatrician, and that’s when we decided to turn over control of the steering committee to the practicing pediatricians. We made a practicing pediatrician be the chair, and then we increased the number of voting practicing pediatricians so they could outvote any other constituency. But we were missing the parents, and so last spring, I believe it was, we added our first parent to the PROS steering committee. The next step is to add some youth as well. Haven’t quite figured out how to make this work so that the parents and youth don’t feel overwhelmed and out of water, but every one of my colleagues who has involved parents in the operations of her practice has found it an exceedingly rewarding, life-changing, practice-changing experience. So, that’s an important next step that we’re taking.

DR. McINERNY:   Yes, I think particularly encouraging practices to involve parents at their level, not only in research, but in everything else they do --

DR. WASSERMAN:  Right. What we’ve learned is that parents actually like research. Parents think it’s good, it makes their pediatricians and their pediatric office more up to date and on top of things, and so why not have
them in the mix? I think that’s about it for PROS. If something shows up, we will get it.

DR. McINERNY: Well, I think related to the PROS experience, in reviewing your CV, if I added correctly I think you’ve had over $35 million of grants since you started this research business. Getting that much money in NIH, and Maternal and Child Health Bureau, and AHRQ grants is pretty fantastic and very impressive. Do you have some thoughts on how you’ve been so successful?

DR. WASSERMAN: Sure, by just being one person on a team, sometimes leading the team, sometimes just participating in the team. Those grants, for many of them I was not the PI of the whole project, but just of the PROS piece. It’s all about collaboration, it really is, and nobody writes a grant on her own. It’s hard enough to write them with a team. As Barbara Starfield once said to me in an aside, “It’s hell every time,” which was a very sobering thing to hear from Barbara, who was about as successful in getting grants as anyone I ever knew. It’s a lot of hard work and persistence. We’ve had many situations where we got the grant on what used to be allowed 3 shots, so we got them on the third try. Paying careful attention to what the reviewers say, and educating them where you can, and bending to their ideas where you must. I guess one final PROS study that I haven’t mentioned, but I think is worth mentioning is the Brief Motivational Interviewing to Reduce Child BMI (BMI²) study, which was the motivational interviewing study. It’s worth mentioning in that I started off being interested in the way we talk with families in clinician-patient communication. The BMI² study was about helping pediatricians learn different styles of communicating with families that might be more effective than the unsolicited advice check list, which I’m sad to say still sort of predominates. Motivational interviewing requires a lot of listening, and you know it’s working when the clinician is doing the minority of the talking, and the family is doing most of the talking. That’s been very gratifying, to show that an intervention study using motivational interviewing -- and this wasn’t just the pediatric clinicians, it was also dieticians -- could help children actually modify their weight gain and improve their BMIs. Really, that’s certainly the first American study to ever show that, and for me coming back to something that attracted me in research from the very beginning.

DR. McINERNY: Yes, right. So, you mentioned that you have had about 100 scientific publications. Could you highlight a few of them that seem particularly groundbreaking, or earthshaking, or changing practice?

DR. WASSERMAN: Yeah. Stop it for just a second while I call up my CV, please.
DR. WASSERMAN: It’s hard to select. Most of the publications I care about are PROS publications, for sure. I will say it was gratifying to see that the very first study I did on pediatric clinicians and how they support the parents of new infants still gets cited from time to time. It’s very gratifying to see that. Any study that changes a guideline is huge, so the Vision Screening Study, which was the very first PROS study, the Girls Puberty Study, which changed the national guidelines, with some controversy, but we’ve been validated on when it’s wise to refer girls for evaluation in precocious puberty. The Child Behavior Study which really drew attention to the fact that pediatricians are seeing more psychosocial morbidity between 1980 to the end of the 20th century than ever, and that it was attributable to increases in poverty essentially, and I think has helped, along with many, many other people’s work, to get the Academy of Pediatrics to now focus on poverty as a key issue. The Febrile Infant Study, which demonstrated that a way pediatricians managed febrile infants under the age of 3 months was not associated with any additional risk to the infants and saved them considerable morbidity of hospital admissions or occasionally spinal taps. As I mentioned, the BMI² motivational interviewing study, which showed that the way we speak with families can make a big difference. And certainly I am proud of the fact that we moved on to electronic health records. That’s a change in research infrastructure.

For me actually my interest in research has gone from being interested in specific research topics to being interested in research infrastructures, and what I was involved with in helping to set up a Clinical Research Network Special Interest Group at the APA. We actually had an NIH grant to bring the leaders of research networks together back in the early part of this century, to share challenges and solutions. Because it turns out the research challenges we were facing PROS aren’t that different from the ones in the Cystic Fibrosis Therapeutics Development Network, or the Pediatric Emergency Care Applied Research Network. Clinical research on a large scale has a common set of problems.

DR. McINERNY: All right. Well, let’s talk a little bit about, shall we say, your life in addition to your academic research and clinical care, what do you like in the way of hobbies, and travel, and major family events, etc.?

DR. WASSERMAN: Right. I love music and listen to as much music as I can, which now there’s too much music to listen to, so there’s no shortage of music. But I like to attend live music. As you know, for 20 plus years I led an annual blues cruise for the stalwarts of the PROS network who would, after our Saturday evening dinners, be willing to drive down to Rosa’s Blues
Lounge in west Chicago and stay up a little later and hear some live Chicago blues, and maybe have an alcoholic beverage. But I’ve been involved in our local jazz community on the advisory board of our Burlington Discover Jazz Festival for many, many years, and helping to raise money for that, and I love to listen to jazz. I love classical music as well. So, there’s music.

DR. McINERNY: And do you play an instrument?

DR. WASSERMAN: Well, I grew up playing the French horn. I can play a little bit of harmonica, and was embarrassed after my recent final PROS meeting to play alongside Billy Branch, who’s a Chicago blues harmonica player and who our PROS steering committee chair Ben Scheindlin invited to show up with a guitarist, and to have me get up there with a harmonica and play. That was a terrifying experience. So, I play a little harmonica. Since that terrifying experience, I’ve been working on my harmonica skills a lot more. Love to cook. Love to eat and love to cook.

DR. McINERNY: What kind? Special?

DR. WASSERMAN: You know, I have shelves full of cookbooks, and I like them for inspiration, but all kinds of ethnic cuisines, many of which are not available in Vermont, where I live. But just good fresh ingredients. I like to go to the market and see what looks good, and pick it out, and take it home, and I have a lot of ingredients at home, and just make something. Yes.

Another hobby is I love to hike, and I try to do that more and more. A couple of years back, August 2014, having turned 65, I hiked Vermont’s Long Trail, which goes from the Massachusetts border to the Canadian border, along the ridge of the Green Mountains.

DR. McINERNY: Anyone else went?

DR. WASSERMAN: I did it over 28 days in August of 2014, being accompanied by my son for the first 7 days, which was good, because he’d done it before and helped me through my darker moments on the trail, and then did the rest on my own.

DR. McINERNY: How many miles, and what’s the altitude?

DR. WASSERMAN: It’s about 270 miles. Well, there’s no altitude to speak of. It never gets over 4300 feet, but sometimes it gets down to 100 feet, so you’re climbing a lot. In total climb it’s something like a 60,000 feet climb, because you’re constantly going down and then going up. But Abby, who was interested in seeing that I was alive from time to time, would resupply
me every 3 or 4 days. She’d meet me on a ridge where a road crossed the Green Mountains, crossed the Long Trail, and bring some fresh food, which I would inhale, and give me my next 3 or 4 days’ supply, until I got to southern Vermont, where I had mailed stuff ahead to someone who did the same thing for me.

DR. McINERNY: How many miles did you say?

DR. WASSERMAN: 272 miles, plus the probably 10 or 15 miles of wandering around lost that I did from time to time. Well, you don’t get terribly lost, but you might go a mile in the wrong way, realize it, and turn back, and whoops, that’s 2 extra miles. Do that 5 times, and you’ll get 10 extra miles. That was a great experience.

DR. McINERNY: I’ll bet.

DR. WASSERMAN: But I like to hike, and I really like to hike alone actually. So, I hope to do not long hikes like that a lot, but short, I like to go for short hikes.

DR. McINERNY: I assume you read Bill Bryson’s *A Walk in the Woods*?

DR. WASSERMAN: I did. I did. It’s very amusing, and also Cheryl Strayed’s book about her disasters on the Pacific Crest Trail. They all describe well the mistakes that every single long-distance hiker makes in terms of carrying stuff, too much stuff, and the wrong stuff.

DR. McINERNY: Good. Any major family events of note?

DR. WASSERMAN: Let’s see. Well, I’ve got 2 grandchildren, my daughter Nora has 2 sons. One’s nearly 5, and one’s pushing 2 and a half. We have the family weddings. You know, I have one sister, and I’m very close to her and try to see her as much as possible, given the fact that she’s in Silver City, New Mexico. Occasionally we go out there. That takes an entire day of flights to get to, but she comes east as part of her business, and that’s good.

DR. McINERNY: Travels?

DR. WASSERMAN: Been to Europe a bunch, love to travel. I’d like to go to other places as well, but I don’t have this burning bucket-list wish of places I need to see. There’s lots of really cool places in the United States I’ve never been to. I love Western Europe because of the food, the cheeses, and the wines, the beers. Now that Britain is leaving the EU, I’m sad, but I’ll still visit Britain.
DR. McINERNY: All right. How about some plans for the future?

DR. WASSERMAN: So, as I’ve told you and many other people before, I do not want to write grants for a living anymore.

DR. McINERNY: (laughs) Understandable.

DR. WASSERMAN: For a variety of reasons, but mainly because it’s just not fun. I don’t have any immediate plans to retire, but I’m sure I will retire at some point. I like seeing patients a little bit, and I only do it half a day a week, and that’s precious. I want to continue to do that.

My work on data extractions from electronic health records, combined with my using an electronic health record, has interested me in the field of clinical informatics, and so I have a sabbatical leave starting in January of 2017. I’ll be doing a qualitative study in which I hope to interview maybe 2 or 3 dozen folks who work on the research side of clinical informatics to learn what the best way to structure governance, and staffing, and hardware, and software might be so that a medical school faculty can actually get more research use and more quality improvement use out of the data they enter. Right now, certainly at my institution, it’s poorly done. I’ve visited some of the institutions where it’s done the best, and even there it’s a struggle. So, I think we’re in the beginning stages of using electronic health records to truly create a learning healthcare system. That’s what the Institute of Medicine has called for, but we’re not there yet by any means, so I will be interviewing people. I also plan to take some coursework in informatics and perhaps sit for the specialty boards in clinical informatics as a “grandfathered” person sometime, while it’s still possible to do that. Currently the deadline is set for I believe the fall of 2017, so I need to accumulate enough informatics experience -- I’m doing that one day a week at Vermont -- and enough background and expertise to actually participate. Then I hope to be of some use locally at the University of Vermont and at the University of Vermont Medical Center in working on improving clinical informatics systems.

One thing that’s got to be pointed out is that we’d get better data out of the system if clinicians were involved in designing the data that went in. That’s a piecemeal process. It’s done better in some institutions than in others. It’s interesting because our residents take for granted that they need to spend the extra hours entering data in the electronic health record after they get out of clinic and go back to whatever they were doing. Pediatricians who spend a whole day seeing patients, they probably spend some evenings entering data as well. Most of them do. And it’s just not the way it should be, so we’ve got to make that system better, and I hope to be involved in that.
DR. McINERNY: Great. That’s great. By the way, we didn’t talk about when you stepped down as full-time director of PROS and what you’re doing with PROS now.

DR. WASSERMAN: Let’s talk about the PROS transition. In 2011 we had a PROS steering committee retreat, and I happened in an offhanded remark to say, well, I wasn’t going to be director forever, and Jon [Jonathan] Klein asked me when I was going to stop being director. So, I said 2016. That stimulated the search for an associate director or 2, actually 2 associate directors initially, who were recruited and who started in 2012 I guess it is. Is that right? Maybe 2013 actually, by the time they were recruited. Alex Fiks and Laurel Leslie. Laurel left to go work as head of research for the American Board of Pediatrics, but Alex served as the PROS associate director and did a fabulous job writing grants, and learning the ropes, and working with me, being co-investigator on electronic health record projects. Then there was a search for the director, and Alex was chosen, and so he started as director in 2016, January 1st, earlier this year. I have stayed on as a senior advisor. I didn’t want to take the emeritus title.

DR. McINERNY: Good for you.

DR. WASSERMAN: Yes. So, I’ve been a senior advisor, and basically I’m sort of serving as Alex’s associate director, because in fact he doesn’t have an associate director. But that position is being recruited for now and will be filled by the end of 2016, and at that point that will be the end of my work with PROS except for participating and writing on the manuscripts that I have been involved in.

DR. McINERNY: Wow. A long and fantastic history, Mort, making PROS the success that it is.

DR. WASSERMAN: Well, the most gratifying thing is stepping away from it with some first-class leadership in place, Alex Fiks and Laura Shone replacing myself and Eric Slora, with a bevy of new grants that have just come in. So, the network which has had fat times and lean times, and I’ve used -- I don’t know if you were around when I used the 7 fat cows and the 7 lean cows from Genesis metaphor, but we’re back with the fat cows. In the lean times the Academy of Pediatrics has really stepped up and supported us, so that’s one of the great things about being a research organization within the Academy of Pediatrics. Although the AAP itself is not a research organization, it values PROS at this point, and I think it considers PROS part of the furniture.
DR. McINERNY: Well, more than that, I think it considers PROS as one of the jewels.

DR. WASSERMAN: Well, a jewel, we’ll take a jewel. So, they support us in the lean times, but they like to see us get the grants.

DR. McINERNY: Sure. Anything else you can think of I haven’t asked you about?

DR. WASSERMAN: I don’t think so, Tom. I will say it’s exceedingly flattering to have this opportunity. I can think of dozens of other academic general pediatricians who probably ought to be afforded this honor. I think you ought to be. We’ve got to get your oral history. We could switch it around; I’ll do you the next time. But it was a good chance to get the PROS history out there. As I said, I hope we can turn it into some sort of a publication somewhere. A monograph.

DR. McINERNY: Good. Good. All right.

DR. WASSERMAN: Great.

DR. McINERNY: Thank you very much.

DR. WASSERMAN: Thank you.

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CURRICULUM VITAE

Name: Richard C. Wasserman
Address: 957 Orchard Road, Charlotte, Vermont 05445
Date of Birth: June 3, 1949
Place of Birth: New York City, New York

Education:

1971 B.A. Williams College, Williamstown, MA
1976 M.D. Jefferson Medical College, Philadelphia, PA
1982 M.P.H. University of Washington, Seattle, WA

Postdoctoral Training:

Internship and Residencies:

1976-77 Intern in Pediatrics, Medical Center Hospital of Vermont, Burlington, VT
1977-78 Junior Resident in Pediatrics, Medical Center Hospital of Vermont, Burlington, VT
1978-79 Senior Assistant Resident in Medicine, Children's Hospital, Boston, MA
1979-80 Chief Resident (Ambulatory), Children's Hospital, Boston, MA

Research Fellowship:

1980-82 Robert Wood Johnson Clinical Scholar and Senior Fellow, University of Washington, Seattle, WA

Licensure and Certification:

1977 Vermont License No. 42-6028
1980 Massachusetts License Registration No. 45524
(lapsed)
1980 Washington License Registration No. 18752
(lapsed)
1981 American Board of Pediatrics, Certificate No. 26208

Academic Appointments:

1976-78 Clinical Fellow in Pediatrics, University of Vermont College of Medicine
1978-79 Clinical Fellow in Pediatrics, Harvard Medical School
1979-80 Instructor in Pediatrics, Harvard Medical School
1980-82 Acting Instructor in Pediatrics, University of Washington
1982-83 Instructor in Pediatrics, Harvard Medical School
1983-89 Assistant Professor of Pediatrics, University of Vermont College of Medicine
1989-98 Associate Professor of Pediatrics, University of Vermont College of Medicine
1992 Visiting Scholar, University of Washington School of Medicine
1998- Professor of Pediatrics, University of Vermont College of Medicine
2010 Visiting Professor, University of Pennsylvania School of Medicine
2011- Adjunct Professor of Pediatrics, University of Pennsylvania School of Medicine

Consultant Positions:

1990-2015 Director, Pediatric Research in Office Settings (PROS) Network, American Academy of Pediatrics, Elk Grove Village, IL
2000-04 Senior Associate, National Initiative for Children's Healthcare Quality (NICHQ)
2001- Physician Advisor, Vermont Child Health Improvement Program (VCHIP)
2016 Senior Advisor, Pediatric Research in Office Settings (PROS) Network, American Academy of Pediatrics, Elk Grove Village, IL

Hospital Appointments:

1980 Medical Director, Emergency Services, Children's Hospital, Boston, MA
1980-82 Medical Staff, University of Washington Hospital, Seattle, WA
1980-82 Medical Staff (Special Assignment), Children's Orthopaedic Hospital and Medical Center, Seattle, WA
1982-83 Assistant in Medicine, Children's Hospital, Boston, MA
1983-94 Attending Physician, Medical Center Hospital of Vermont, Burlington, VT
1995- Attending Physician, Vermont Children's Hospital, Fletcher Allen Health Care, Burlington, VT

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<td>Best Doctors in America, Northeast Region -- Woodward-White Inc.</td>
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<td>2000</td>
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<td>2000</td>
<td>American Pediatric Society (elected)</td>
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<td>2001</td>
<td>Alyia Hefner Endowed Visiting Professor, University of Oklahoma School of Medicine, Oklahoma City, OK</td>
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<td>2001</td>
<td>Pfizer Visiting Professor, Mount Sinai School of Medicine, New York, NY</td>
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<td>2003</td>
<td>James T. Rosenfeld Lectureship in General Pediatrics, Oregon Health Sciences University and Doernbecher Children’s Hospital, Portland, OR</td>
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<td>2003</td>
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<td>2004</td>
<td>Visiting Professor, Robert Wood Johnson Clinical Scholars Program, University of Washington, Seattle, WA</td>
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<td>2004</td>
<td>William Bradford Visiting Professor, Children’s Mercy Hospitals &amp; Clinics, Kansas City, MO</td>
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<td>2005</td>
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Health & Human Development Board of Scientific Counselors

2011  David Cornfeld Lecture, Children’s Hospital of Philadelphia, Philadelphia, PA

2013  Joel and Barbara Alpert Lecture in General Pediatrics, Boston Medical Center, Boston, MA

2013  Waldo E. Nelson Lecture, St. Christopher’s Hospital for Children, Philadelphia, PA

2014  Keynote, 2nd Annual Children’s Health Services Research Symposium, Indiana University School of Medicine, Indianapolis, IN

2016  Paul Beaven Lecture, Rochester General Hospital and Golisano Children's Hospital, University of Rochester, Rochester, NY

2016  Selection for Oral History, Pediatric History Center, American Academy of Pediatrics, Elk Grove Village, IL

2016  PBRN Pioneer Award, Agency for Healthcare Research and Quality/North American Primary Care Research Group (NAPCRG), NAPCRG Practice-Based Research Network Meeting, Bethesda, MD

2016  Emil Stratton, MD Lecture and Research Visiting Professorship in General Pediatrics Visiting Professor, University of Oklahoma School of Medicine, Oklahoma City, OK

Major Committee Assignments:

National

1985  Task Force on Collaborative Research, American Academy of Pediatrics

1986-90  Steering Committee, Pediatric Research in Office Settings Network, American Academy of Pediatrics

1987-  Research Committee, Ambulatory Pediatric Association

1990-99  Board of Directors, Ambulatory Sentinel Practice Network

1995-99  Scientific Advisory Committee, Practice Research Network, American Psychiatric Association

1995-97  Board of Directors, Foundation for Pediatric Holistic Health Research

1996-98  Region I Co-Chair, Ambulatory Pediatric Association

Pediatric Association

1998-2001  Board of Directors, Ambulatory Pediatric Association

1998-2001  Maternal and Child Health Bureau and National Eye
Institute Task Force on Vision Screening
2001-2007 Advisory Committee, American Academy of Family Physicians
National Network for Family Practice and Primary Care Research
2002-2009 Board of Directors, National Initiative for Children's Healthcare Quality
2004-2005 Nominating Committee, Ambulatory Pediatric Association
2005-2009 Practice-Based Research Network Steering Committee, Agency for Healthcare Research and Quality
2008-2010 Child Health Research Working Group, Federation of Pediatric Organizations
2010-2014 Steering Committee, Developmental-Behavioral Pediatrics Research Network
2011-2015 Board of Scientific Counselors, Eunice Kennedy Shriver National Institute of Child Health & Human Development
2011-2016 Chair, Pediatric Clinical Research Network Special Interest Group, Academic Pediatric Association
2011-2014 CTSA Consortium Child Health Oversight Committee - Operations Group
2012-2016 Steering Committee, North American Primary Care Research Group Practice-Based Research Network Annual Meeting

Regional
1980 Emergency Medical Services Committee, Boston, MA
1984-87 Advocacy Committee, Childcare Resource and Referral Center, Burlington, VT
1985-90 Advisory Committee, Childhood Injury Prevention Program, Vermont State Health Department
1985-90 Community Child Protection Team, Burlington, VT
1987-89 Medical Assessment Program, Vermont State Medical Society
1989-90 Family Health Advisory Council, Vermont State Health Department
1989-95 Medical Practice Committee, Community Health Center, Burlington, VT
1996-2001 Vermont State EPSDT Periodicity Schedule Update Committee, State Health Department
2011-16 Clinical Utilization Review Board, Department of Vermont Health Access
Institutional

1979-80 Residency Training Committee, Children's Hospital, Boston, MA
1980 Disaster Planning Committee, Children's Hospital, Boston, MA
1984-89 Medical Records Committee, University Health Center, Burlington, VT
1984-89 Automated Medical Record Committee, University Health Center, Burlington, VT
1989 Committee to Review the Chair of Pediatrics, University of Vermont College of Medicine
1989-90 Committee to Review the Chair of Family Practice, University of Vermont College of Medicine
1993-94 Research Development Committee (Chair), Department of Pediatrics, University of Vermont College of Medicine
1993-94 Search Committee for Chair of Family Practice, University of Vermont College of Medicine
1995-98 Research Committee, University of Vermont College of Medicine
1995- Promotions Committee, Department of Pediatrics, University of Vermont College of Medicine
1995- Nominating Committee, University of Vermont College of Medicine
2001-04 Research Development Fund Review Committee, Fletcher Allen Health Care
2008- Center for Clinical and Translational Science Multidisciplinary Advisory Committee, University of Vermont
2008-09 Chair, Search Committee for Vermont State Medicaid Medical Director
2010-11 Health Economist Search Committee, Center for Clinical and Translational Science, University of Vermont
2012-13 Chair, Search Committee for Vermont Medicaid Chief Medical Officer
2015-16 UVM College of Medicine Research Strategic Planning Committee
2015- Clinical Research Center Scientific Advisory Committee
2016- PRISM Electronic Health Record Clinical Team
2017- University of Vermont Health Network Population Health & Quality Committee
Editorial Boards:

1994-2001  *Ambulatory Child Health: The International Journal of General Pediatrics*
2001-2004  *Ambulatory Pediatrics*
2002-2016  *Annals of Family Medicine*

Memberships in Professional Societies:

1981-  American Public Health Association
1981-  Academic Pediatric Association (formerly, Ambulatory Pediatric Association)
1982-  American Academy of Pediatrics
1982-  Society for Developmental and Behavioral Pediatrics
1993-99  American Academy on Physician and Patient for Health Services Research
1993  American Academy on Physician and Patient for Health Services Research
2000-  American Academy on Physician and Patient for Health Services Research
2013-16  AcademyHealth

Principal Clinical Service Responsibilities:

1978-80  Pediatrician, Comprehensive Child Health Program, Children's Hospital, Boston, MA
1980  Medical Director, Emergency Services, Children's Hospital, Boston, MA
1980-82  Pediatrician, Pediatric Clinic, University of Washington Medical Center
1982-83  Physician, Comprehensive Child Health Program, and Ward Attending, Children's Hospital, Boston, MA
1983-  Pediatrician, University Pediatrics, Burlington, VT
1995-  Pediatrician, University of Vermont Children's Hospital, Burlington, VT

Grant/Contract Support (Direct Costs):

1985  "Infant Temperament and School-Age Behavior: A Longitudinal Study," American Academy of Pediatrics Memorial and Endowment Fund -- Principal Investigator ($3,000)
1988-89  "Vision Screening of Young Children in Pediatric Practice: Application and Effects of a Preventive Measure in the Personal Health Care System," Maternal and Child Health Bureau #MCJ-173400 -- Principal Investigator ($149,935)

1990-93  "Improvement of Children’s Health Care in Pediatric Practice," Maternal and Child Health Bureau #MCJ-177022 -- Pediatric Research in Office Settings Director ($521,722)

1993-99  "A National Practice-Based Network to Improve Children’s Health Care," Maternal and Child Health Bureau #MCJ-177022 -- Principal Investigator ($1,731,900)

1993-97  "Assessment of Febrile Infants Under the Age of 2 Months," Agency for Health Care Policy and Research #RO1HS06485-01A3 -- Pediatric Research in Office Settings Site Director ($1,939,800)

1994-97  "Management of Psychosocial Problems in Primary Care," National Institute of Mental Health #RO1MH50629 -- Pediatric Research in Office Settings Site Director ($1,646,500)

1996  "Life Around Newborn Discharge," American Academy of Pediatrics Research in Pediatric Practice Fund -- Principal Investigator ($13,100)

1996  "Life Around Newborn Discharge," American Academy of Pediatrics Corporate Friends of Children Fund -- Principal Investigator ($100,000)

1997  "Enhancing the Effectiveness of Practice-Based Primary Care Research: Using Information Technology and Linking with Community Health and Managed Care Networks," The Pew Charitable Trusts -- Principal Investigator ($125,000)

1997  "Disseminating a Tanner Staging Manual to Medical Trainees," Genentech Foundation for Growth and Development -- Principal Investigator ($41,117)

1997-99  "Effects of the Change From Oral to Inactivated Polio Vaccine on Infant Immunization Rates," Supplement to MCJ #177022-06-1 via Intra-Agency Agreement, Maternal and Child Health Bureau and Centers for Disease Control and Prevention (Agency location codes CDC 75-09-0421 MCHB 75-03-0030) -- Pediatric Research in Office Settings Site Director ($791,316)

1999-03  “Life Around Newborn Discharge,” Maternal and Child
Health Bureau #R40 MC 00117-02 (formerly MCJ250825) – Pediatric Research in Office Settings Site Director ($1,411,431)

1999-04

"National Practice-Based Network to Improve Children's Health Care," Maternal and Child Health Bureau #2R60 MC 00107-09 – Principal Investigator ($1,763,372)

2000-01

"Enhancing the Capacities of a National Pediatric PBRN," Agency for Healthcare Research and Quality #P20HS11192-01 – Principal Investigator ($89,965)

2001-02

"Defining Patient Visits in a National Pediatric PBRN," Agency for Healthcare Research and Quality #U01HS11192-02 – Principal Investigator ($146,952)

2001-05

"Child Abuse Reporting Experience Study," Agency for Healthcare Research and Quality #R01 HS10746-01A1 – Pediatric Research in Office Settings Site Director ($1,978,360)

2001-05

"Randomized Controlled Trial to Prevent Child Violence," National Institute of Child Health and Human Development #R01 HD42260A1 – Pediatric Research in Office Settings Site Director ($1,876,411)

2002-03

"Translating Pediatric PBRN Research into Practice," Agency for Healthcare Research and Quality #R21HS13512 – Pediatric Research in Office Settings Site Director ($149,997 total)

2004-09

"National Practice-Based Network To Improve Child Health," Maternal and Child Health Bureau #R60MC00107 – Principal Investigator ($1,520,913)

2007-10

"Secondary Sexual Characteristics in Boys," Pfizer, Pediatric Research in Office Settings Site Director ($446,000 total)

2007-12

"Addressing Parental Smoking by Changing Pediatric Office Systems," National Cancer Institute #R01CA127127 – Pediatric Research in Office Settings Site Director ($4,057,193 total)

2008-13

"BM12: Brief Motivational Interviewing to Reduce Child BMI," National Heart Lung and Blood Institute #R01HL085400-01A2 ($3,451,189 total) – Pediatric Research in Office Settings Site Director

2009-12

"Pediatric Clinical Research Networks: Optimizing Effectiveness Through Cooperation," R13EY019972 – Principal Investigator ($45,000 total)
2009-12  “National Research Network to Improve Child Health” Maternal and Child Health Bureau #UA6MC15585 – **Principal Investigator** ($900,000 total)

2009-12  “Translating an Effective Teen Driving Program for Parents to Primary Care” Centers for Disease Control and Prevention #1R18CE001730 – **Pediatric Research in Office Settings Site Director** ($1,289,554 total)

2010-13  “Pediatric Primary Care EHR Network for CER” Maternal and Child Health Bureau UB5MC20286 – **Principal Investigator** ($3,499,979 total)

2010-15  “Adolescent Smoking Cessation in Pediatric Primary Care” National Cancer Institute 1R01CA140576-01A2 – **Pediatric Research in Office Settings Site Director** ($2,640,025 total)

2012-15  “National Research Network to Improve Child Health” Maternal and Child Health Bureau UA6MC15585 – **Principal Investigator** ($1,200,000 total)

2012-17  “National Center for Pediatric Practice Based Research & Learning” 1P30HS021645 Agency for Healthcare Research and Quality – **Principal Investigator** ($600,000 total)

2012-17  “Comparative Effectiveness Research through Collaborative Electronic Reporting” Maternal and Child Health Bureau R40MC24943 – **Principal Investigator** ($4,997,606 total)

**Grant and Other Review Panels:**

1995  Maternal and Child Health Bureau, Division of Systems, Education, and Science, Maternal and Child Health Improvement Projects

1995  Agency for Health Care Policy and Research, Emergency Medical Services Special Emphasis Panel


2000  National Institute of Mental Health, Special Emphasis Panel ZMH1-CRB-C-09

2001  Maternal and Child Health Bureau, Emergency Medical Services for Children Network Development Demonstration Project Review


2003  National Institute of Mental Health, Special Emphasis Panel ZMH1-CRB-C-01S
2004 Maternal and Child Health Bureau, Emergency Medical Services for Children Targeted Issue Grant Review, Panel 1
2004 National Institute of Dental and Craniofacial Research, Special Emphasis Panel De-05-006
2005 Maternal and Child Health Bureau, R60 MCH Research Network on Pregnancy-Related Care Program Review
2005- AcademyHealth HSR Impact Award Selection Committee
2008 National Center for Research Resources/ National Institutes of Health Roadmap Initiative Clinical Research Network Feasibility Awards, CRNFA RFP-W08-001
2011-15 Board of Scientific Counselors, Eunice Kennedy Shriver National Institute of Child Health & Human Development
2011 Maternal and Child Health Bureau Emergency Medical Services for Children Network Development Demonstration Project HRSA-11-079

Bibliography:


17. Wasserman RC. Screening for vision problems in pediatric


27. Wasserman RC. Book review: The Holistic Pediatrician: A Parent's


Presentations at National and International Meetings (2012-2017)


8. Forrest CB; Halfon N, Simpson L; Wasserman RC; Alpert JJ; DeAngelis CD; Stein REK. The science of equity in children’s health: honoring the scientific legacy of Barbara Starfield. (Presented as part of the State of the Art Plenary presentation at the 2012 Pediatric Academic Societies meeting, Boston, MA, April, 2012)


10. Wasserman R. Using motivational interviewing in primary care. (Presented at Excellence in Paediatrics meeting, Madrid, Spain, November 2012)

secondhand smoke exposure (CEASE) in pediatric outpatient practice. (Presented at the 2013 Pediatric Academic Societies meeting, Washington, DC, May 2013)


Zaoutis T, Fiks A. Comparative effectiveness of broad vs. narrow spectrum antibiotics for acute respiratory tract infections in children. (Presented at the 2017 Pediatric Academic Societies meeting, San Francisco, May 2017)