ORAL HISTORY PROJECT

Moses Grossman, MD

Interviewed by

Jean D. Lockhart, MD

August 1, 1996
San Francisco, California
Oral history has its roots in the sharing of stories which has occurred throughout the centuries. It is a primary source of historical data, gathering information from living individuals via recorded interviews. Outstanding pediatricians and other leaders in child health care are being interviewed as part of the Oral History Project at the Pediatric History Center of the American Academy of Pediatrics. Under the direction of the Historical Archives Advisory Committee, its purpose is to record and preserve the recollections of those who have made important contributions to the advancement of the health care of children through the collection of spoken memories and personal narrations.

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

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ABOUT THE INTERVIEWER

Jean D. Lockhart, MD, FAAP

Dr. Jean D. Lockhart graduated from medical school at Georgetown University in 1951. She completed a general internship at D.C. General Hospital and went on to residencies in pediatrics at Georgetown Hospital and at Children’s Hospital, all in Washington, D.C. After 10 years in the private pediatric practice, Dr. Lockhart spent 11 years at the U.S. Food and Drug Administration in various capacities. She then joined the staff of the American Academy of Pediatrics (AAP), serving as Director of the Department of Maternal, Child, and Adolescent Health for over 15 years. In 1989, she received the Grulee Award from the AAP. She continues to be professionally active following her retirement. She has served as Editor-in-Chief of *Current Problems in Pediatrics* and on the editorial board of *Pediatric Annals*. She is currently writing a biography of Dr. D. Carleton Gajdusek, FAAP.
DR. LOCKHART: Good morning, Dr. Grossman.

DR. GROSSMAN: Good morning, Jean.

DR. LOCKHART: How long have you lived in San Francisco?

DR. GROSSMAN: Well, I came to San Francisco in 1941, so I guess that makes 55 years. It’s a long time.

DR. LOCKHART: And where were you born?

DR. GROSSMAN: I was born in Kiev, now of course the capital of the Ukraine, but at that time it was still part of Russia.

DR. LOCKHART: You left Kiev when you were how old?

DR. GROSSMAN: I spent six years in Kiev with my family. My dad worked for the government railroad and then, when I was about six years old, an opportunity came to join the rest of the family who lived in Harbin. My uncle owned a business in Harbin. So we got on the train, went through Moscow where we stayed a day or two, and then got on the TransSiberian Railroad headed for Harbin.

DR. LOCKHART: Harbin was part of China?

DR. GROSSMAN: Yes, Harbin was part of China, before 1932. It’s in Manchuria, a part now called Northeastern Provinces, but at that time was Manchuria. Not long after I got there it became a puppet empire of Japan, called Manchukuo. It had a very strong Russian and Russian-Jewish presence. Some 200,000 Russians were brought in for the construction of the TransSiberian Railroad, and Harbin was a terminus of that railroad, with all the businesses surrounding it, a lot of cargo insurance business, and others.

DR. LOCKHART: Did that mean that you went to a Chinese school?

DR. GROSSMAN: My education was sort of interesting because when we came, the family was Russian-speaking. We didn’t know Chinese and we never learned Chinese, any of us, except for a few words. I had home tutors until I was nine. At the age of nine, I was enrolled in a Russian émigré school called Commercial School. It was a very good school in terms of education but I went there for only one year because it became clear that a Russian education and
Russian credentials in those days would not lead me to any university or to any higher education. My mother had hoped that I would become a physician and my parents were quite anxious that I go to a proper university that would be accredited. So after going for a year to Russian school my cousin, who grew up with me and who is now professor emeritus of economics in Berkeley, and I transferred to a German school.

DR. LOCKHART: And the language spoken was German?

DR. GROSSMAN: The language spoken was German.

DR. LOCKHART: Did you already speak German?

DR. GROSSMAN: Yes. In the first years when I told you I was being tutored at home, one of the things I learned was German, I guess in preparation to going to that school. So I was quite fluent in German. English in fact is my third language. I learned it as a foreign language in German school. It was a very good school, with German teachers. But in the second year it became very clear that it was not for me. The Nazis had taken over in Germany. The principal had a swastika on his armband. They maintained that they were not anti-Semites, but really you couldn’t continue going to a German school like that.

DR. LOCKHART: At that time you transferred again?

DR. GROSSMAN: Yes. At that time the family decided that the only kind of education that made any sense for those days, I guess it was roughly 1934, about that time, was an English education. At that time I learned English in a German school run by Russians, totally unaccredited, call Harbin English Secondary School. The principal was an American. The other teachers were Russians. The instruction was in English. Some of the teachers spoke good English, some did not. The math teacher was excellent, he was a former artillery officer, but his English was very poor. But you don’t need to know much English to teach math. So I went there for two years. Then it became clear that graduating from there, getting a degree from that school, would not lead me to any university. Then a decision was made, it was a family decision because, as I told you, my cousin and I were doing all this together, that I should go to a proper English school. There was no American school nearby. The closest English school was a school called Tientsin Grammar School, which was a British public school of the model that are all over the British Empire. It was allied to Cambridge University. Some of them are allied to Cambridge, some to Oxford. This one was to Cambridge. If you passed the Cambridge University local examination successfully, then you could go to any university.
DR. LOCKHART: How old were you then?

DR. GROSSMAN: I was 15. So my cousin and I went to Tientsin, not a boarding school. It was a very proper English school.

DR. LOCKHART: Not a boarding school.

DR. GROSSMAN: Not a boarding school. We lived in a boarding house, away from home rather early. It wasn’t a bad school. In fact, my cousin and I ended up first and second academically. He was first, I was second, much to the dismay of the students who had been there all along, mostly non-Chinese students. A few were Chinese, but the majority were a mix of nationalities. There was an American school in Shanghai but that was quite far away. So I graduated from that school in 1937. Then my cousin’s and my paths were separated. He came to the United States, directly to the University of California at Berkeley, a little too expensive for me. My dad was a chief accountant, on a lower salary, and we had two children, so my parents really didn’t feel they could afford Berkeley. I went to Hong Kong University, which was again very colonial, of course, but changed now. The whole instruction was in English, but 95% of the students were Chinese. It was like a British university so you go directly out of high school and have six years of instruction. We lived in a university dormitory called Lugard Hall. All foreign students lived in one dormitory, but the vast majority of the student body were Chinese. We started medical school there.

DR. LOCKHART: Oh, this was medical school! You go directly from . . .

DR. GROSSMAN: Yes, the British way is, you go directly from the high schools, which are a little more advanced than our high schools. You go a little further in math and chemistry. In the first couple of years of medical school you study more physics, organic chemistry, and traditional pre-medical subjects. The total instruction is six years.

DR. LOCKHART: And, in fact, how long...

DR. GROSSMAN: I started in 1938. The war in Europe started in 1939. I went through the school years 1938-39, and 1939-40. In 1940, after the collapse of France, the United States was not at war yet, but in Hong Kong it was absolutely clear that there would be a war. It was very clear. So my family decided that there was no sense in my being captured and being put in a camp, or killed, and we had an opportunity which everybody didn’t have to get a visa
to the United States. It took us a long time to get the visa, to get organized to get the documents; so I left in 1941. I came to San Francisco in May of 1941.

DR. LOCKHART: You told me once about an uncle who had made it possible for the family to come to America. Tell me about this uncle. He was in the sugar business?

DR. GROSSMAN: Sure. His name was Zikman, and he had arrived in Harbin in about 1913, being a representative of a large Russian insurance company. He did very well for himself, and was quite an entrepreneur, and began dealing in sugar and eventually bought a sugar factory. It was he who offered my dad employment so all of us could come to Harbin. That was the uncle. By that time he had married my dad’s sister, it was his second marriage, and after he married her he offered our family the opportunity to come. In 1936, when he was 50 years old, he came to the United States to celebrate his 50th birthday. He was a multi-millionaire. He brought a lot of his money with him. He spent a lot of money but when he was finished with his United States celebration, he had $25,000 left. Instead of taking it back to China with him he bought United States Steel stock, rented a safe deposit box at National City Bank in New York, and put the stock in there. When the war was over, that’s all he had left. Meantime, that stock in the safety deposit box was a guarantee to the United States government that different members of our family who were applying for a visa would not be a burden to the government, that the stock would be called on first to support them if that was needed. The stock in fact was never touched because each one of us supported ourselves.

DR. LOCKHART: So, it was the U.S. Steel Company that in a way enabled you to come to this country.

DR. GROSSMAN: That, and my uncle.

DR. LOCKHART: And your uncle. So then, after you had finished two years of medical school in Hong Kong, you transferred...

DR. GROSSMAN: I came in 1941, in May, so I went to the Berkeley admissions office to talk about my credentials from medical school in Hong Kong and Berkeley was willing to give me credit for two years of university. However, there was a small problem, could be small, could be not so small. I had not had enough zoology in Hong Kong, or enough biology in general, to meet medical school requirements. So they made a deal with me. If I took a course in human embryology, which at that time was considered a very difficult course, and got an ‘A’ in it, I would get credit for biology and zoology and everything and my requirements would be complete. If I got less than an ‘A’, I would have to repeat the courses, which meant another year of Berkeley. So,
needless to say, I worked very hard. I took it in the summer session of 1941, it was the year that war broke out in Russia. I was somewhat distracted by that, but I worked hard for that course, together with people who had been lifelong friends of mine ever since, and I got an ‘A,’ and that enabled me to complete the medical school admission requirements in one year instead of two. So I didn’t start medical school until 1943, because after I passed embryology I still had another year of pre-med requirements to repeat. So I completed another year, applied in the fall of 1942 for U.S. medical school, and did something stupid, in retrospect. I didn’t really have advisors. I only applied to one school.

DR. LOCKHART: Berkeley.

DR. GROSSMAN: Berkeley. Berkeley-San Francisco. Which at that time was not as difficult to get into as it is today, but still pretty difficult. I was pretty confident, I had a good grade point average, nevertheless I was a new immigrant. I had difficulty with some of my MCATs [Medical College Admission Tests], the difficulty due to not having lived here. Like, one of the questions was, “Who was the batting champion of the American League last year?” That was called “Current Knowledge.” I didn’t know anything about the American League and for that reason or some other reason, I didn’t get in. For a time, they were starting two classes a year, so I applied again for February of 1943, which was the next class to begin, and again applied to only one school, which was kind of crazy, particularly not having gotten in the first time, but it went much better. My interviewers were much more sympathetic than the first time.

DR. LOCKHART: You had accelerated term?

DR. GROSSMAN: Yes. The perception was that the Army needed physicians, and so two things were done. One, they started two classes a year, just for that one year. And secondly, medical school was shortened to three years, and there were no vacations. There was a week in between. No summer, no vacations, no electives that you might do during the summer.

DR. LOCKHART: How many were in your class?

DR. GROSSMAN: 74.

DR. LOCKHART: Any women?

DR. GROSSMAN: Five women, which was par for the course at that time. Supposedly ten percent.
DR. LOCKHART: When you graduated, how many graduated?

DR. GROSSMAN: I think 72 or 73. We lost one or two.

DR. LOCKHART: Then medical school was ‘43 to ‘46, because of the acceleration.

DR. GROSSMAN: That’s right.

DR. LOCKHART: I suppose you didn’t lose any people to the draft or to military service because you were all in medical school.

DR. GROSSMAN: That’s right. They took us all into military service in medical school. We were privates first class. We were in uniform going to classes. The Army paid the tuition. You know it wasn’t much of a tuition. But they also paid for our books and stethoscopes and instruments. It was a nice way to go through. Because I was not a citizen when I started medical school yet, I was a Polish citizen, I could not be inducted immediately. There was a process which involved our medical school year dean, not to discriminate against people who were in medical school. So I was accepted about four months after the rest of my class.

DR. LOCKHART: What year did you become a citizen?

DR. GROSSMAN: Well, when I was accepted into the Army, it was 1944. There were no non-citizens in the Army. Once you were inducted you became a citizen.

DR. LOCKHART: And you still had two more years in medical school. And during medical school, do you recall what you tentatively thought your interest was going to be?

DR. GROSSMAN: Well, I knew from the beginning that I was not particularly interested in surgery. I was interested in internal medicine, and right up until sort of the middle of the senior year I was going to be an internist. Then I was very taken by the person who was chief of pediatrics at San Francisco General [Hospital] at that time, Mary Olney, a person very well known. She was interested in heart disease, but particularly she was interested in family orientation, being interested in the rest of the family, being interested in social aspects of the family, and I really took to that. That was in marked contrast to what the internists were doing. They didn’t care if a person was married or not. They were just looking at the pathology. So that contrast struck me. And then I took two electives in internal medicine that turned me off. They were basically dealing with chronic diseases where patients were never going to get
better. They would have to live with their disease. And I liked the acute illnesses you see in children. I liked the aspects of well baby care and preventive care. So when I finished, I changed my mind. I applied only for pediatrics.

DR. LOCKHART: What was Dr. Olney’s position?

DR. GROSSMAN: She may have been clinical professor of pediatrics at that time. It was full-time, in the department for a while, and then she became part-time and had a big practice.

DR. LOCKHART: She would have been about how old then?

DR. GROSSMAN: Mary just died a couple of years ago, having lived to a ripe old age. But at that time, when I met her, she was probably in her early forties.

DR. LOCKHART: You say, “young child.” Had you never met a pediatrician?

DR. GROSSMAN: No.

DR. LOCKHART: No such person took care of you?

DR. GROSSMAN: No, a general physician, a Russian general physician took care of me.

DR. LOCKHART: You graduated from medical school, and then started, what was it, an internship in those days?

DR. GROSSMAN: Internship at that time. That was before the matching. I decided I wanted to go into pediatrics. I tried to find something on the east coast. However, the logistics were such that if you applied to UC [University of California], you got your answer fairly fast, and you got about five days to accept the internship or turn it down. That’s before your application even arrived on the east coast. So, what you had to do, and very few people did that, is reject an acceptance at UC, hoping for an acceptance elsewhere. I wasn’t that interested, to do that, so I was accepted as an intern. At that time they only took four a year. So four of us started that year, in the summer of 1946.

DR. LOCKHART: The time of acceptance was later changed, was it not?

DR. GROSSMAN: Yes. Before the matching occurred the next thing that happened is a time was set and no acceptances could be given before that time. So you could apply to Johns Hopkins or Boston or wherever you wanted to, and
UC was not allowed to accept you before and demand that you accept them before. There was a uniform date of acceptances. That helped a lot, if you wanted to have a chance to shop around.

DR. LOCKHART: By this time, you were pretty much a Californian!

DR. GROSSMAN: Well, almost, but not really, because I arrived in ‘41 and this was summer of ‘46, so I had been here five years. Not as much of a Californian as I am now.

DR. LOCKHART: So, your internship was where, Dr. Grossman?

DR. GROSSMAN: At UC [University of California San Francisco] Hospital. Same location where it is now, in the old building, which is on Third Avenue. Moffitt was not built yet.

DR. LOCKHART: And this was as general rotating, or a pediatric [internship]?

DR. GROSSMAN: Pediatric.

DR. LOCKHART: There was no general rotating internship?

DR. GROSSMAN: There was, but I took a pediatric internship. The general rotating internship was at San Francisco General. If I’d had an opportunity, I probably would have matched and listed some of the better hospitals on the east coast, for the experience.

DR. LOCKHART: Who was memorable in your pediatric training?

DR. GROSSMAN: The department of pediatrics was really very small. The ex-chairman of pediatrics, but who still had a lot to do with pediatrics was Francis Scott Smyth. The chairman of the department was Bill [William C.] Deamer. He was an allergist and an endocrinologist and I learned a lot from him. George Schade was involved in neurological disorders. Peter Cohen was concentrating on the nursery. We had no true neonatologists. Louise Yeazell and I became quite close. Louise was interested in tuberculosis. She is living in an apartment in Oakland now. She was a half-time member of the department. The department was very small.

DR. LOCKHART: Do you remember anything about child development?

DR. GROSSMAN: George Schade was interested in child development, and founded the Child Study Unit, which is still there.
DR. LOCKHART: And in pediatric emergencies? Anyone?

DR. GROSSMAN: No. The other very prominent person was the head nurse in pediatrics, whose name was Alice Henry. She taught us a lot about children. A child would come in on the ward and she could diagnose from the nurses’ station what the child had, just looking at the child. She was so good at procedures that if you could hold your needle steady, she could thread the child right on the needle. If your hand didn’t tremble, you could do a lumbar puncture, an internal jugular, an external jugular, all the things we did in those days. She taught us how to do procedures, how to hold, and so on.

DR. LOCKHART: Now, this is still internship and that means it’s 1946. You’re not married yet?

DR. GROSSMAN: No, not for a long time. Internship was nine months, because of the war. You started a residency then.

DR. LOCKHART: And was this also in pediatrics?

DR. GROSSMAN: Yes. I started my residency, again at UC, so I finished nine months of internship and nine months of residency at UC Hospitals, as a continuum. At the end of that time I had to go on active duty because the idea was that the Army only paid for your medical education. Then as soon as you finished you residency you were made an officer in the Army and had to go on active duty.

DR. LOCKHART: After the nine months of internship and nine months of residency, what was your next step?

DR. GROSSMAN: Well, then the Army called me to active duty. I had to serve for two years as a lieutenant and [was] then promoted to a captain in the Army. I accepted the commission, and then we all had to go to Fort Sam Houston in San Antonio, all of us, to get 30 days of basic training for being an Army medical officer. Then the question arose about what kind of assignment one would have in the Army. I made a mistake at that time because it would have been fun in 1947 to go overseas. But I said I wanted to do pediatrics and infectious diseases, in which I was interested at that time, and was assigned to McCormick General Hospital in Pasadena, near Los Angeles, and basically I was there for about two years--I’ll tell you about the exceptions in a minute--doing pediatrics and doing infectious diseases, which was not with children. I was on an infectious diseases ward.
The exceptions were two. One of my most interesting assignments was, I was in intelligence school at Fort Riley, Kansas. In 1947, when Russia invaded, I forget if it was Hungary or Czechoslovakia, one of those countries, the Army realized that there may be another war in east European countries, Russia in particular. They decided to give intelligence training to everybody who spoke certain strategic languages, which were, obviously, Czech, Slovenian, Yugoslavian, Rumanian, and Hungarian. It came out that everybody that was fluent in these languages had to go to Fort Riley, Kansas for four months of intelligence training, and I was one of those. I was in charge of a 100 bed ward at the Army Hospital in Pasadena. The ward was full and I was doing a good job and the commanding officer didn’t want to let me go. They didn’t tell us ahead of time why we had to go there but when I arrived at Fort Riley, Kansas, the *Junction City Gazette*-- Junction City is the nearest city--had a big headline, “Language Specialists Here to Take Intelligence Course,” so I found out why we were in Junction City. There, they gave us a language test first. Professors at Kansas State University screened us and those who were pronounced fluent then screened others. I was pronounced fluent.

DR. LOCKHART: Fluent in which language.

DR. GROSSMAN: Fluent in Russian. And I still am. I am bilingual. So, I was screening Army personnel who were there. Now, the problem was that some personnel officers used “F” for fluent in personnel records and some used “F” for fair. When the order came out, all “F”s were sent to Fort Riley, Kansas, from all over the world. So, I would ask a sergeant, “I see you came in from Berlin last night.” “Yes, sir.” “It says here you speak Russian.” “Yes, I do.” “Are you fluent in Russian?” “No, sir.” “Did you go to Russian school?” “No, sir.” “Did you take instruction in Russian?” “No, sir.” “Well, how did you learn?” “My girlfriend taught me.” Turns out he could say, “Kiss me,” “Let’s jump into bed,” and “You have pretty eyes.” That’s about the extent of the Russian. I’d say, “I’m sorry, sergeant. The Army didn’t have this in mind. Go back to Berlin tomorrow.” So there was a big waste in this effort. Now there were only two people in the United States Army who spoke Albanian, and nobody in Kansas could screen them, so they screened each other and pronounced each other fluent. Nobody ever knew whether they were.

Seven hundred people passed their language test and embarked on a four-month intelligence course, which was quite interesting. I found it interesting. And much to the dismay of many of my colleagues, because many of them were regular Army as their career, I came out first in a class called “Order of Battle.” First of 700. I took a course called something like “Elements of Information,” but I found it a little bit like differential diagnosis, finding out what troops are there, a little bit like finding out what lab tests to do. In a way
it was almost a bad thing, because the Army wanted me to stay in Fort Riley, Kansas, to teach “Order of Battle” since I had come in first, but that was not what I wanted to do. So I actually called the Surgeon General’s Office in Washington, and said that I had been drafted. I was not in the Army as a volunteer, and could not be teaching “Order of Battle.” They accepted the argument.

Everybody who was in the hospital, all physicians, had to take a turn as surgeons aboard troop ships and I did too. So, I went to Yokohama and back, as a ship doctor. That was quite interesting. I was at Fort Mason, here in San Francisco, actually doing pediatrics. Basically, I was assigned as an Army doctor at the Presidio. There were two temporary duties. One of them was to go to intelligence school for four months; the other was to go to Fort Mason.

DR. LOCKHART: Who ran the Fort Mason training?

DR. GROSSMAN: It was not a training. It was a clinic, for children of Army people. They were eligible to come to this clinic.

DR. LOCKHART: This was now ’47?

DR. GROSSMAN: ’47.

DR. LOCKHART: In ’47, as you remember, what antibiotics or anti-infective drugs were available?

DR. GROSSMAN: Penicillin was available. I remember clearly, when I was a resident at UC, we had to call Boston to get penicillin approved. It had to be given 10,000 units every three hours. There was a big hassle as to whether nurses could give it every three hours.

DR. LOCKHART: Why Boston?

DR. GROSSMAN: Because there was a very small supply. It was only for the military. A small supply was for civilian use, dispensed by a physician in Boston.

DR. LOCKHART: You didn’t have any in the hospital?

DR. GROSSMAN: No, none at all. It had to come for a particular patient, after he approved the purpose of using. That’s all we still had in ’47. The next one I remember quite clearly was tetracycline, but that came a little later.
DR. LOCKHART: I interrupted you. So you got through Fort Mason and you’re back at Pasadena.

DR. GROSSMAN: Back at Presidio now, and I had to decide what I wanted to do to continue my residency training, because I was getting out and I had an offer from UC. They wanted me back, but I was quite interested to see what medicine was like on the East Coast. I was quite anxious to get a residency on the East Coast. I applied for various residencies. Times were very different, of course. I applied to all the best places including the Boston Children’s. When that application came, there was a note in it which said, “You realize, of course, that this residency has no stipend whatsoever, and in the space below, would you indicate what funds you have available to live in Boston.” In retrospect, it was not an unreasonable question, but I was really offended, because they said they are not going to pay me anything and they want me to indicate what funds I had. In truth I had saved some money in the Army, but I was just offended by that approach, so I didn’t turn in the application.

I applied to Johns Hopkins, to Bellevue, to Babies Hospital in New York, to Cornell. I was quite interested in New York. Meanwhile, I was still at Fort Riley, in the intelligence school, so I went for interviews. It’s a little embarrassing but I came to Baltimore to interview for Johns Hopkins three hours early, because of train schedules, and I went for a walk around Johns Hopkins and I didn’t like it. If I was only going to spend a year on the east coast, it wasn’t going to be in the vicinity of Johns Hopkins, so I came to my interview and withdrew.

That left only the New York application, which was where I really wanted to be. I went to Bellevue, which is NYU [New York University], to pediatrics. The chairman was Emmett Holt, Jr. Saul Krugman was in charge of the outpatient department, and Robert Ward was in charge of infectious diseases, and in addition to these there was Edward Pratt, who had come from Cincinnati at that time. Other people who were very stimulating were Edith Lincoln, who was the mother of childhood tuberculosis, a very forceful, memorable person, and Janet Baldwin, who was chief of cardiology. Irving Schulman, who subsequently became chairman at Stanford, was my chief resident.

DR. LOCKHART: Was Krugman working in infectious diseases in those days?

DR. GROSSMAN: Krugman was in charge of the outpatient department. He was interested in infectious diseases and doing his research in infectious diseases, but the position he was paid for was in charge of outpatient. A very good teacher. There were many memorable people there.
DR. LOCKHART: This residency was pediatrics and infectious diseases?

DR. GROSSMAN: Straight pediatrics. No emergency medicine or child development.

DR. LOCKHART: So it’s now 1953, and you are back, full-time at the San Francisco...

DR. GROSSMAN: Well, I started at UC San Francisco, full-time, but principally working in the outpatient department, making some rounds on the ward, but without being differentiated into what I really was going to be or what my career was going to be. And then, in 1953 I believe, Henry Bruyn was a pediatrician in charge of infectious diseases services at San Francisco General with the Navy. He had not done his full time, and had to go serve another 50 weeks there. Even though I was inexperienced and didn’t have a fellowship, in those days a lot of people didn’t have a fellowship, the chairman asked me to go take his place. So that’s really what got my career going, because I had been to San Francisco General, of course, as a student.

They had 100 beds in infectious diseases, adults and children both, and the service was run six months by UC and six months by Stanford. For six months, I taught UC residents and for six months I taught Stanford residents, and students. We made rounds every single day, six days a week, and since there were 100 patients, rounds took a very long time and essentially, that was the job.

DR. LOCKHART: How long was long?

DR. GROSSMAN: About three or four hours. We saw every patient. We did a lot of teaching, and those were the polio years. Polio was very prevalent in 1953-54. There were big epidemics and if you were rich, you were provided all the supplies and equipment. If you were poor, you went to San Francisco General. The National Foundation for Infantile Paralysis (later the March of Dimes) had a peculiar attitude. It felt it was not its responsibility to relieve the citizens of the city and county of San Francisco from paying for the indigent. So they paid a lot for wealthy people, but nothing for the indigent, which created a pretty serious problem in resources because the Board of Supervisors did not appropriate much money. Fortunately, the [Sister Elizabeth] Kenny Foundation of Minneapolis stepped in, and I had a chance to meet Sister Kenny and I took care of really a lot of polio patients. It was a challenge being a resident on infectious diseases, because the day they came on, I put them in the respirator. You need to know what it feels like, what it feels like to give up breathing, to let the machine breathe for you, which is very difficult.
DR. LOCKHART: You mean, these were, as part of your training?

DR. GROSSMAN: When the resident came on the service, he had to go on the respirator.

DR. LOCKHART: Did you paralyze them with curare?

DR. GROSSMAN: No. No. We did many other things. We had people sitting in the hospital for a long time. If they had Salmonella or Shigella, they had to sit there till they had three negative cultures, which could be a long time, particularly with Salmonella. We took in the leprosy patients, and twice a year a train came through San Francisco on the way to Carville and we put them on the train.

DR. LOCKHART: On the way to where?

DR. GROSSMAN: Carville, which is a big leprosarium near New Orleans.

DR. LOCKHART: In Louisiana.

DR. GROSSMAN: Yes, near New Orleans, the only leprosarium in the United States at that time.

DR. LOCKHART: Where did they come from?

DR. GROSSMAN: Mostly immigrants from Mexico, through Mexico. If you had leprosy in those days, you had to be hospitalized and you had to be isolated, and eventually shipped to a leprosarium. So that was quite an interesting feature.

We also had outbreaks, in San Francisco. I remember clearly, one day, a bus drove up and disgorged fifty people with Salmonella, all to be hospitalized, all at once. There was a lot of meningitis, which I was particularly interested in. So it was a busy time. Then Henry Bruyn came back from the Navy and I went back to UCSF, and received an appointment as head of the children’s outpatient department at UCSF, at Moffitt. So I spent the next five years between 1964 and 1969, as head of the outpatient department at UCSF on Parnassus. But by that time my interest had already been evoked in infectious diseases.

DR. LOCKHART: You didn’t confine your work to infectious diseases?
DR. GROSSMAN: No, of course not. Actually all my research and writing essentially were in infectious diseases, but I was doing general practice and, as all faculty did, two afternoons a week in private practice, with house calls, and other things. I had some interesting heart diseases at that time, did a little bit of congenital heart disease but never went deeply into that. A lot of teaching.

DR. LOCKHART: As you look back on it now, you had all these extremely serious infectious diseases problems and you had so little treatment. You had the Sister Kenny type of treatment and you had some penicillin. When did that begin to change?

DR. GROSSMAN: Well, since I had been so close to polio, the very obvious change which occurred in the early fifties, actually after I got to San Francisco General, was that polio vaccine was introduced; first Salk, then Sabin. We had KO [knock out] polio days in San Francisco and after that there were no more wards full of polio. Then meningococcal diseases were cured by penicillin, by sulfas, actually, so that came in quite early. Hemophilus influenzae, really it wasn’t much later when more potent drugs came in, but you could treat it with a combination of drugs, serum and other things. It was challenging. You could do things, not as easily as you could today, but with every passing year, something else came out and you could do something.

DR. LOCKHART: Dr. Grossman, I wonder if you could tell me when and why you joined the American Academy of Pediatrics.

DR. GROSSMAN: Well, I was quite taken by the American Academy of Pediatrics from the beginning. When I took the boards—I passed them in 1951—I became eligible to be a fellow of the Academy. I joined, I believe, in 1952, almost immediately. I liked the Academy for two reasons, and still do. First, it puts children as a very high priority, rather than the care of physicians, and second, it provides a mix of practitioners and academic people with a fairly good forum to work together. I always liked that, I still like it. I know it has lots of politics and other things, but as organizations go it’s a good organization. So I’ve belonged all these years.

DR. LOCKHART: Did anyone in particular here in San Francisco encourage you to join the Academy?

DR. GROSSMAN: Well, of course. The ex-presidents of the Academy here. Ed Shaw had been a president and Crawford Bost had been a president. Most members of the faculty belonged. George Schade was full-time at the university.
I joined quite early, and became active, initially, in the local chapter, and rather quickly, still in the 50s, I became the chapter vice chairman. Very early in my professional life; I think entirely too early. Then I looked at the fact that next year I was expected to be chapter chairman. I also looked at the fact that I had an academic career to think about. I wanted to do research, and the kind of activities that you need to do as chapter chairman are not particularly worthy in academia. Nor was it the kind of thing I wanted to do so early, creating committees and functionaries who expected when you took alternate chairman you would become chairman. I said I wouldn’t. But I’m not sorry I didn’t accept at that time.

A similar sort of thing happened in CMA [California Medical Association]. I joined the California Medical Association in San Francisco and pretty early became head of the pediatric section, again, entirely too early in my career. I finished that year and then I withdrew.

DR. LOCKHART: You have served on a number of Academy committees.

DR. GROSSMAN: Yes.

DR. LOCKHART: Which is a more academic way of expressing yourself.

DR. GROSSMAN: Yes. Well then, subsequently, because of my interest in infectious disease, when I was at UC those five years as head of the outpatient department, I pursued research together with Valerie Hurst who was a collaborator, among others, in treating neonatal infectious disease in the newborn nursery, the spread of staphylococci through the nursery. I began to write about it, had some significant publications, which is how this is done. I was asked to join the Fetus and Newborn Committee of the Academy, in part to represent the interest of infections and in part to represent my district. Bill Silverman was chairman, it was a very good committee. It was my first committee, and I was really turned on. We worked very hard. We wrote the whole newborn manual [Standards and Recommendations for Hospital Care of Newborn Infants] during that time. We worked on PKU [phenylketonuria], which was the first screening we knew at that time. Towards the end of my stay on that committee we worked on hexachlorophene and, because of my interest, on staphylococcal colonization and what to do about colonization. I had written a lot about that; it was particularly close to my heart.

Bill Silverman worked us very hard. We always went to Evanston. We had two-day meetings. We worked all day, had lunch at the desk, broke for an hour, an hour and a half for dinner, came back after dinner and worked till
10:30. Bill said there was nothing to do in Evanston anyway, we might as well work.

DR. LOCKHART: It was true! Evanston was dry and there was nothing to do.

DR. GROSSMAN: It was very productive.

DR. LOCKHART: Was Bill Silverman at that time working on retrolental fibroplasia? He was still at Columbia, was head of neonatology, along with Stan James and others, but Bill was the head, at Columbia Babies. He was very good.

DR. LOCKHART: Who else was on the committee with you. Do you remember?

DR. GROSSMAN: No.

DR. LOCKHART: That must have been the first edition of the fetus and newborn manual.

DR. GROSSMAN: First, or second. it was one of the early ones. We put a lot of work into that.

DR. LOCKHART: Oh that was a lot of work. Among other things you defined the nursery, the contents, and arrangements . . .

DR. GROSSMAN: Yes. The cohort nursery. Exactly.

DR. LOCKHART: You met for several meetings a year.

DR. GROSSMAN: Yes. Several meetings. And, since there were no faxes, a lot of correspondence. Bill was not only a good taskmaster, he was stimulating. He kept everybody on the committee working. The other person I remember was Sydney Segal, he was from Vancouver, representing Canada.

DR. LOCKHART: I saw Sydney recently. He’s still living in Vancouver. He works a lot on child abuse and newborn drug addiction. At the Academy, each committee, no matter how academic it was otherwise, had to have at least one practitioner. Was that true in those days?

DR. GROSSMAN: Yes. We had even more than one; we had several. It was very helpful because they gave us a feel about how the practitioners felt about many of these things.

DR. LOCKHART: Oxygen and retrolental fibroplasia came about because . . .
DR. GROSSMAN: Because there had to be in a place where we could measure the oxygen.

DR. LOCKHART: That was it. And the practitioners felt this was very discriminatory.

DR. GROSSMAN: Everybody had oxygen. But they couldn’t measure it. They couldn’t measure oxygenation in the blood, which was also important. Well, the whole issue about what do general practitioners of pediatrics do in the nursery began to arise. But as time went on, of course, they lost more and more ability to do anything in the nursery, other than to take care of a normal newborn baby, and essentially were displaced from premature and special care nurseries to take care of normal newborns, which is the majority of newborns.

DR. LOCKHART: Was this an inevitable change, do you think?

DR. GROSSMAN: I think it was inevitable, because of the technical procedures you had to do, catheterizations. It was difficult for them to gain experience. It was also not really possible to sit in an office and at the same time take care of a very sick newborn. Just like subsequently, intensive care, regular intensive care wards; you can’t practice and take care of somebody who is in intensive care from hour to hour.

It produced a little tension. But I think the Academy was a very good place to exchange ideas. And of course, the same thing happened in infectious diseases because one specialty the pediatricians thought they really all knew a lot about was infectious diseases. And for a while I thought that, too. And initially I was not in favor of separate boards, thinking they would disempower pediatricians in practice. But again, some aspects of infectious disease became so specialized and so critical that we needed people who really devoted themselves to it.

DR. LOCKHART: What about other Academy committees?

DR. GROSSMAN: Yes. I actually spent a lot of time on Academy committees. My second Academy committee was the Committee on Pediatric Education. It, in turn, was a very stimulating committee. It was chaired by Dr. Bill Daeschner from Galveston for many years, very prominent in pediatric education. We began to talk about certification, recertification, and continuing certification exams for physicians who were already in pediatrics. It became very threatening to talk about recertifying people, so all this was debated in that committee. We also planned continuing education courses. We didn’t get involved with the annual meetings, because there’s a separate committee for
Bill Daeschner was very interested in education, and also, as Bill Silverman had been, quite stimulating in bringing thoughts together. We worked quite closely with the Board [American Board of Pediatrics], particularly when we began talking about recertifying examinations. Working with the Board was important. So we had many interesting meetings.

DR. LOCKHART: Were you active as well with the Board?

DR. GROSSMAN: [Richard E. L.] Fowler was another guy; he was from New Orleans. He was on that committee. I knew him well because, in conjunction with everyone, I spent three or four years on that committee, I think, with three meetings a year to write examination questions. The committee was required to prepare these exams, the written exams. I never was on the Board. I was considered for an oral examiner once. It was very subjective. You know, Ed Shaw used to say, “The American Board of Pediatrics was the best club I’ve ever belonged to.” And, in many ways, it was a club.

DR. LOCKHART: Are measures taken to keep it from being so exclusive?

DR. GROSSMAN: Well, the “club” was the club of the oral examiners, who went around the country with each other, had many dinners together. You couldn’t be accepted as an oral examiner, maybe I shouldn’t say this, if your wife wasn’t accepted, because she had to fit in with the other wives. And that wasn’t right. I think the Board itself, that makes policy and decides about what kind of exams . . .

DR. LOCKHART: Let’s get back to recertification a little later, but I wanted to catch up. We left off . . .

DR. GROSSMAN: On the committees. Well, my next committee was the Committee on Research. This was much later. This was a new committee of the Academy, a provisional committee on research. The Academy began to be concerned, stimulated by certain members of the executive committee, that children were not receiving their fair share of research allocations from the government. So the research committee was formed with several ideas in mind, as a provisional committee. One of them was to see that children receive their fair share from the government, [the second was to see] that research in pediatrics had something to do with problems that were prevalent in pediatrics, like behavior problems and injuries, poisonings, as opposed to unusual metabolic defects, which are very interesting.

So the Academy was interested to see that a) appropriate money and funds were channeled into pediatrics and b) this was sort of along the lines of the
Joint Commission [on Accreditation of Hospitals], which wanted to see that quality assurance was built on common issues rather than uncommon issues.

We were a very good committee. I chaired it. We worked closely with the Washington Office, rather than the Chicago office of the Academy. We went to Washington many times. We met with all the institute directors. One time, Dr. Donald Frederickson arranged a meeting for us to meet with all the directors, which was quite interesting. It was hard for him to tell how much of the basic research was directed to children, of course a lot was. That was his point, that if you do cellular work, or molecular work, that’s neither for children nor adults, and that’s most of what NIH [National Institutes of Health] does. Nevertheless, I think that the visits, the proddings, the request that they come up with inventory, led to higher visibility for pediatrics.

He was very defensive about not doing injury research. He recognized the importance, but he felt that the state of the science was such that you couldn’t do scientific research, and NIH was not interested in sub-scientific research. Now, of course, there is a national center at CDC [Centers for Disease Control and Prevention], and the latest information is that the NIH is also interested in initiating this research.

DR. LOCKHART: The committee also made efforts to see that pediatricians were represented better on the NIH committees that reviewed grants, which up until then had not been the case.

DR. GROSSMAN: Yes. Both committees and councils. I found out a very interesting thing during these years. They promised us that if we turned in a list of prominent pediatricians that they would see that they would be appointed to committees, which they had not been very much. However, these lists were screened by the White House, and in those days, it was a Republican administration and I found that very few of the prominent pediatricians were Republicans. One who was was Paul Quie. We had no trouble getting Paul on committees. But some very prominent people were not only Democrats, but were active Democrats, and the White House would not let them in.

But I think that what we began to do during those years was speaking with a single voice. Because, while the Academy had a Committee on Research, [other interested organizations were] the American Pediatric Society--and I was a Council member of the APS at the time when I was chairman of the committee, so I was very close to the American Pediatric Society--and the Society for Pediatric Research, which was not sure what the Academy was doing with research anyway; it was not the Academy’s thing; they had that turf. At the same time, they didn’t have a staff, they didn’t have a presence in
Washington, they conducted annual meetings, and probably most importantly, they didn’t have the organization. So that’s probably why I was appointed. I was on the council, I subsequently was chairman of the council. I could bring the APS council and the Academy together and . . .

DR. LOCKHART: Was the Washington Office helpful, in bringing about a better relationship between the APS and the Academy?

DR. GROSSMAN: Yes, it was very helpful. Well, not so much in that. The Washington Office was very helpful in contacting members of Congress and organizing things, arranging things with the institutes and so on, not so much with the organizations.

One of my other activities was, I went through all the steps and became president of the Western Society for Pediatric Research, which is composed of all the academic pediatricians on the West Coast. That was a very interesting group. We would go to each other’s medical schools and have meetings there. But that year we decided that what we really wanted to do was go to Carmel and join in with the other research organizations. We could do that, but we wanted to be sure that we got a fair share of the papers on the joint program. Mac Holliday was the secretary and we had to negotiate that. That went off very successfully and it has become a very good meeting.

DR. LOCKHART: They had two diplomats representing the Academy, for pediatricians. Neonatology, I remember, was a big feature, probably still is, at that Western Society meeting.

DR. GROSSMAN: Yes, well, neonatology is probably easiest of all, because that’s all pediatricians; whereas in all the other sections, the cardiology, pulmonology, gastroenterology, we wanted to be sure that we had a fair share of papers. Neonatology was then, and is now, an all-pediatric affair.

DR. LOCKHART: Then there was a final committee, at the Academy, oh, you became chairman of the research committee, that was it. Had you been offered another committee appointment at the Academy?

DR. GROSSMAN: Well, the committee that I never got on which I would have liked was the Red Book committee [Committee on Infectious Disease], because of my interest in infectious disease. But they pass these things around, and everybody can’t be on every committee. I’ve always had friends on the committee, and still do. I’m quite aware of what they’re doing, and have my input through my friends.
DR. LOCKHART: Let’s take a break.

DR. LOCKHART: We’re resuming after lunch. I’m about to ask Dr. Grossman about his academic career. We left off in 1953, I think.

DR. GROSSMAN: Well, I’ll summarize it fairly briefly. I spent five years with the department of pediatrics of the children’s clinic at the University Hospital, did a lot of teaching during that time, was quite active in the university, was on many committees of the university, rose fairly rapidly, and in 1960, because of a vacancy at San Francisco General Hospital, I was asked to become chair of pediatrics and infectious diseases, so, two departments, at San Francisco General Hospital. It’s a large city hospital, at that time it was huge. It’s become smaller.

The department of pediatrics when I first got there had about 130 beds. It’s down to maybe 40 beds, so many residents, many students to teach, and a large group of patients and what we were short of was faculty and money. But it was very stimulating, very challenging, and I spent 33 years in that department. Of course, the department changed a great deal, many new people, but we were highly respected by students and residents, who always thought it was a very good teaching department. The infectious disease department became smaller and smaller.

During that time, because of my leadership qualities, I was asked to become associate dean for San Francisco General Hospital. I spent ten years doing that. Those were very challenging, very productive years. We built a new hospital during that time. The faculty number increased from about seven to one hundred. New labs were built; new research facilities were built; new relationships were established, but the price I paid for that was that I gave up my research lab entirely. A mistake, in retrospect, because it’s just not possible to try and do a dean job and a pediatric job both. I managed to some degree, but it was at the expense of my family. The hours were very long and a lot of extra-curricular activities for both the department and the school.

So that went on until about 1975 or ‘76, when the faculty at San Francisco General wanted a full-time associate dean and I absolutely did not want to do that, because my pleasure was in taking care of children and teaching and doing clinical work. It was not in sitting behind a desk all day. I quit the dean’s office at that time and became full-time chief of pediatrics. I won’t go into all the various aspects of recruiting faculty, keeping the department afloat, keeping faculty, building research facilities; these occupied quite a bit of my time.
Inpatient pediatrics became smaller and smaller; outpatient pediatrics grew. The clinic became open seven days a week. Beds in the hospital diminished, which is probably the way community pediatrics really should be. We ran a service which was for poor people, for newcomers to the city. It was not a referral hospital, like a university hospital. Its emphasis was on trauma, on emergencies, and on infectious diseases. We had a lot of hematology, by virtue of sickle cell problems. We opened child abuse programs, which we'll talk about separately, I guess. [We] opened the Child Protection Center, which was for foster care, and had several other programs of home visiting, day care, all in the interest of treating and preventing child abuse.

DR. LOCKHART: I’m going to ask you a little bit about infectious diseases and the patterns of infectious diseases, and one of the things we could start with is the factors that have changed, improved, the management of infectious diseases. Would you discuss that for a little bit, Dr. Grossman?

DR. GROSSMAN: Well, if you start at the very beginning, the thing that has changed infectious diseases around the world the most, but it happened in the United States long before I came into the picture, was provision of sanitation. In the developing world the gastrointestinal diseases, which is part of oral-fecal contamination, are the principal causes of infectious diseases, along with malaria and diseases of this type.

Now, in the United States, the thing that has influenced infectious diseases the most during my tenure has really been, as I mentioned earlier in the case of polio, the introduction of polio vaccines. I could see remarkable changes in the infectious diseases picture, having spent a couple of years of my life in San Francisco General taking care of polio patients, and now polio has pretty much completely disappeared.

And measles immunization came in a few years later and complications of measles such as encephalitis which had been relatively prevalent, began to be uncommon, to the point that a few years ago there was a case of measles and none of the residents and none of the younger physicians could diagnose it clinically. They had never seen Koplik’s spots. Rubella followed; mumps followed. There is hardly a young pediatrician now who knows what mumps look like. And then as time went on, chickenpox, which still is the one disease that everybody sees on a regular basis, will disappear, because chickenpox vaccine has been introduced just recently.

My biggest interest, clinically, has been Hemophilus influenzae meningitis, and with the introduction of the conjugated vaccines, two or three years ago, Hemophilus influenzae meningitis disappeared almost immediately. So, as
immunization continues, and it is continuing at a rapid rate, I think we will see more and more disappearance of diseases. Antimicrobial agents work in a different way.

Of course, the diagnosis of infectious disease has become much easier, but we still remember the days when we used to put needles in a baby’s head to diagnosis subdural effusions, for meningitis, and that seems barbaric now. We have CT [computed tomography] scans and imaging, and nobody would put a needle there without imaging and seeing what you are doing. Biopsy has become very easy under direct either fluoroscopic or imaging control, so diagnostic techniques have become much easier. Now with the introduction of polymerase chain diagnostic methodology, it means that you don’t have to have the bacteria or virus alive. You can show that it’s been there or is still there.

The therapeutics, in terms of antimicrobials, I think, have made less difference. They made a big difference in tuberculosis, we used to send children with tuberculosis home to die; now we can cure them. But I think on the whole, otitis media is still with us. We have more powerful drugs to choose from, and treatment has become more complex, but treatment hasn’t eradicated the disease like immunization has.

DR. LOCKHART: Can you expand on new vaccines?

DR. GROSSMAN: Well, I’ve alluded to the fact that chickenpox vaccine will change the face of common pediatric diseases. I know that Merck Company was disappointed with the first year’s sales of chickenpox vaccine because it was not available to the public sector. Once that occurs and as pediatricians become more used to it and the government provides the funds available to purchase it, chickenpox will disappear pretty much like measles has disappeared.

DR. LOCKHART: How about the acellular pertussis?

DR. GROSSMAN: Acellular pertussis vaccine is going to make the eradication of pertussis faster, and most of all, to help pediatricians in the informed consent. Whole cell pertussis vaccine has gotten a very bad name, because of the reactions it may or may not cause, but we know that it causes fever and sore arms in 50% of all babies. Parents didn’t like that very much and the fact that the babies had fever and sore arms reinforced their belief that they may have encephalitis and other problems as well. The acellular pertussis was just licensed for infants just today, and I think more combination vaccines will be licensed.
I recently was chairman of a committee which helped introduce universal hepatitis B immunization in San Francisco. I know pediatricians are not very impressed by that vaccine because they don’t see hepatitis B late effects. Nevertheless, I think it will make a major impact on the incidence of chronic hepatitis and active hepatitis and possibly even carcinoma. I think we will wait 20 years before we see hepatitis B vaccine effects.

Hepatitis A vaccine for the moment is for travelers, but I know the pharmaceutical house that makes it would like to make it for everybody, and maybe one day we will. Rotavirus vaccine is in the works. Respiratory syncytial virus vaccine is in the works, so I think that what’s in store for us in vaccines is very exciting.

DR. LOCKHART: Are you in agreement with the recommendations of the Advisory Committee on Immunization Practices about the new polio vaccine schedule?

DR. GROSSMAN: No, I’m not. I know it’s not politically correct. I know that ACIP recommends it and I know for a fact that the majority of the Red Book Committee, the Committee on Infectious Diseases, also recommend it. However, I personally am not in favor of it. It seems to me that all it will do is prevent three, or at the most six, cases of paralytic polio per year. At the most six, maybe three or four. And the price that we have to pay for this is to increase the number of injections for all American children, without even talking about the money it will cost.

DR. LOCKHART: Chlamydia is a relatively new infection since you and I started our training. You’ve done a great deal of research in chlamydia. What have been the big milestones in this field?

DR. GROSSMAN: Well, I’ve been privileged because I had an opportunity to participate in the working out of the immunology of chlamydia in the perinatal period, working with one of my friends and colleagues. Juli [Julius] Schachter was one of them, one of the great chlamydiologists of the world. We were able to describe the incidence of chlamydial infections in pregnant women in various populations, the age of babies who become infected, who develop pneumonia, who develop inclusion blennorrhea. And we also developed guidelines for how to prevent this disease in pregnant mothers, and fathers, of course. So it’s been very satisfying to work on this. While it’s not a terribly serious problem in terms of mortality, it’s a very common problem, because it’s the most common sexually transmitted disease in our society.
DR. LOCKHART: As far as AIDS [acquired immunodeficiency syndrome] is concerned, San Francisco is almost the AIDS capitol of the world, or used to be. Has the management of pediatrics AIDS changed radically?

DR. GROSSMAN: Well, let me just say, Jean, since this is oral history, that my involvement with AIDS started really on a community basis, because babies of HIV-positive women were being adopted or sent to foster care or being boarded in various hospitals, particularly our own. And the problem was how to prevent them from transmitting infection to other children, the question of whether foster mothers should take precautions, whether foster mothers should be paid more. At the same time the issue about AIDS in the schools arose. You may remember that AIDS in the schools caused serious problems elsewhere.

I was appointed chairman of a committee to look into children’s AIDS from the community point of view, not necessarily from the clinical management point of view. I met with a series of community leaders, school principals, which was fairly successful. As far as the question you asked, SF [San Francisco] of course had the largest number of AIDS patients in the world, and I think that’s because of our gay population, and it doesn’t have very much to do with perinatal AIDS. But because I happen to be in a hospital which was a leader in the country, in the world, I had an opportunity to be on the Mayor’s Task Force on AIDS. We provided guidelines for infection control in the hospitals and clinics. So I’ve had a role in AIDS in this respect. As far as managing large numbers of AIDS patients, it’s been pretty much done by Diana Wara and others, principally at the University Hospital. But San Francisco doesn’t really have the concentration of pediatric AIDS patients like New York or Florida.

DR. LOCKHART: Do you feel that the new drugs that are now available are going to result in a cure or do we still need to think about a vaccine?

DR. GROSSMAN: Well, I think that we need to think about both. From the point of view of perinatal AIDS, in which I’m most interested, ability in our society to identify the pregnant women hasn’t come into force yet. But if we can indeed identify pregnant women, by use of two or more drugs, it seems to me that we can prevent infection in 98% or 99% of all cases, as far as the newborn is concerned. So the number of babies that are going to be treated will be much smaller.

In terms of adults with AIDS, I think the situation is much harder. While the new drugs have made an enormous improvement, it still remains to be shown that any combination is truly curative. Vaccines, it seems to me, would be
wonderful, if they worked. But the whole work of vaccines has been discouraging, so far.

DR. LOCKHART: Would you favor routine testing of AIDS in all pregnant women and mothers who come into the hospital to deliver, without any necessary informed consent?

DR. GROSSMAN: No, I would not, because identifying a person with AIDS, like a mother, can have very unpleasant economic and social consequences, consequences from the point of view of insurance, or even being evicted. San Francisco is pretty enlightened, but in many communities, finding out that someone has AIDS could lead to serious problems. So I think the mother needs to give informed consent. But I think if the health provider, whether it be a physician or midwife or a nurse, really herself is convinced that this is in the interest of the child, she’ll have no trouble convincing the mother.

DR. LOCKHART: If we can switch gears a minute, we were talking about the community and community health. You have had considerable activity in the area of child abuse. I wonder if you could talk about how that came about.

DR. GROSSMAN: Well, my academic interest, from the point of view of teaching residents and so on, has always been in infectious diseases. However, when I arrived at San Francisco General Hospital, in 1960, as chief of the department there, I found that child abuse is pretty prevalent in our society, in San Francisco as elsewhere. There were so many instances of child abuse, and the community resources for managing these cases were poor. There was poor coordination between the health department and or health resources, the social services, the police. Cases were not going well. The criminal part of the case was often out of phase with the child protection part. So I felt that because we were reporting all these cases it was very important for our department and for me personally to get involved with making sure that after the reporting, something constructive and not destructive was done.

So that led, over a period of many years, to organizing the San Francisco Child Abuse Council, which was the first one in the state, and has been instrumental for many good things, mostly educational; for development of facilities, many facilities, for child abuse. We organized a child protection center which meets and does the initial evaluation, including mental health evaluation, for children removed from the home and being put in foster care. We developed several home visiting programs over time, and one particularly successful program, which is no longer available because it’s not funded, based on day care in management of child abuse in the family. This has been a subject which has
become closer and closer to my heart, and I’ve done a lot of work on it over the years.

DR. LOCKHART: You had a center named after you, is that not true?

DR. GROSSMAN: Yes, the child protection center has been called the Moses Grossman Child Protection Center.

DR. LOCKHART: And you continue to be active in this center?

DR. GROSSMAN: Well, now that I’m emeritus, I’ve pretty much withdrawn from most everything. I’m sort of honorary.

DR. LOCKHART: What would you say were some of the dilemmas about child abuse?

DR. GROSSMAN: Well, the dilemmas about child abuse essentially have to do with balancing parental rights vs. children’s rights, and how much authority parents really have in terms of raising their own child, in terms of cultural behavior, disciplinary behavior, particularly when the city like San Francisco is a melting pot for so many cultures; and how much authority should the state have in dictating what kind of behavior one should engage in in protecting the child. I think it’s easy if one says, “Parents shouldn’t kill the child.” Although it’s interesting to remember that in Roman law it says that the parent owns the child in the same way as he owns a slave and can do anything with it, including kill. The Roman law actually says that. I think that if you look back at medieval times, it was not a very happy time for children. Children were badly treated. But coming down to our own times, what about corporal punishment? Is it OK to beat a child with a belt? There’s a lot of disagreement in our society. Without a belt? There isn’t a line that we can draw on, agree on, other than not killing and not maiming. I think these are some of the problems.

DR. LOCKHART: It’s particularly painful for the public to read about children in foster care who are abused, because it is the responsibility of the community when a child is placed in foster care. Can this problem be solved by more money, or more supervision, or how do you see it?

DR. GROSSMAN: I don’t know what the solution is, Jean. It’s a very tough problem and requires consistent pursuit and working on, unlike other things we’ve talked about. [You implement] immunization and chickenpox is gone. There is no such immunization for child abuse, including sexual abuse. Surely, better screening of foster parents, better incentives for foster parents, supporting them [are important]. Foster parents are poorly supported in our
society. If you look at what’s been done for foster parents of HIV-positive children, or for the medically fragile child; for those foster parents there is a lot of support. There are meetings; there are educational programs; and there is triple pay compared to ordinary foster parents.

Many of the kids who are removed are not that easy to deal with. Many of the newborns who are removed have been subjected to drugs, and foster parents need a lot more support than you get in our society. But who’s going to pay for it? A variety of schemes have been produced, but so far there is no magic answer.

DR. LOCKHART: Dr. Grossman, we’ve been talking about a lot of new developments in the treatment of children and they all seem to be expensive. The new vaccines, the newer drugs, the increased care and the increased cost of these things is a concern. We’re in an era now of managed care, and that may be a reaction to this increased cost. Do you think it’s a good reaction?

DR. GROSSMAN: Well, I think that we live in a real world and a real society and all these advances are not going to help us if we are unable or unwilling to pay for them. Just as a footnote, it’s quite clear that the developing world can not pay for all these vaccines that we are introducing. It remains to be seen how it will be handled there. There’s a lot of work going on in translating the vaccines to oral forms, so far not successful, but that seems to be the direction we’re going to go in the developing world. Coming back to what you asked, I think we need to do the new vaccines, we need to find a way to pay for them, and we need to find a way to pay less for something else.

If you look outside the health field, most people, including me, probably, will zero in on the defense budget. Do we really need to maintain such a huge defense establishment without having the Soviet Union as a threat? Who is threatening us? This year we’ve increased the defense budget and we’re going back to Star Wars, but who’s attacking us? But even if you look within the health budget itself, let’s say the other areas a taboo, I think the most money is spent in the last two weeks of life, or the last five days of life. Just look at the intensive care units and all the things that go on there.

Now we’re beginning to talk about rationing. I think if we’re going to be realistic about the future of health care and being able to pay for it, we’ll have to address the rationing issue, which Britain and many other countries already have. This is kind of anathema in our society. But I think you could immunize, I didn’t calculate it, hundreds of children for the cost of doing a bypass to a dozen individuals in their eighties! Do we really need to do that? That’s a very hard issue. It’s a political decision.
DR. LOCKHART: I sometimes wonder why it is we can talk about triaging, and that is a good word, and we talk about rationing, and that’s a bad word.

DR. GROSSMAN: I think you could substitute triaging, but in Britain it’s been accepted. People in their seventies don’t get dialyzed. We just have not accepted this.

I haven’t really directly answered your question about managed care. I’m not absolutely convinced that managed care is going to cost less. I think that remains to be seen. I think Kaiser [Permanente], which is the prototype of managed care, has been very successful, and hasn’t cost that much less. Maybe a little less, but not significantly less. As I look at managed care in the world today, namely, for profit managed care, the first thing I see is millions of dollars being paid to executives and million of dollars being paid to shareholders, at the expense of doctors and patients.

DR. LOCKHART: Dr. Grossman, most of your career has been spent as a medical educator, both formally and informally. Could you describe your relationship to your former residents, who are now in practice?

DR. GROSSMAN: Well, I’ve been very close to my residents, sort of like my extended family, particularly to my former chief residents. Over the years I’ve had, I think, 38 or 40 people who were chief residents of mine for a year. Initially it started with one a year and then it became two a year, and these people have been very close. I’m in touch with 90% of them all the time. They’ve given me a couple of dinners and reunions at the Academy meetings and other occasions. It’s been a real joy. Some of them have been quite prominent.

DR. LOCKHART: Can you name some of them?

DR. GROSSMAN: Yes, Brian Lauer, who is chief of pediatrics at Legacy-Emanuel Children’s Hospital in Portland, Oregon; Jim Padbury, who is chief of neonatology, in Providence, Rhode Island; Myles Abbott who is practicing pediatrics right here in San Francisco; Steve Abbott who is practicing pediatrics in Santa Barbara. And then I’ve had some fellows over the years, not that many, but people I’ve been very close to.

DR. LOCKHART: That’s quite a legacy.

DR. GROSSMAN: I like that the best about teaching.
DR. LOCKHART: Pediatric residency training has certainly changed. Which changes are good, and which changes are bad, in your view?

DR. GROSSMAN: Well, I don’t see any really bad changes. Pediatric training has had to adapt to changes in pediatrics. When I started both as a resident myself and as a teacher, most of the training took place on the inpatient service. But as the inpatients services have become smaller and smaller it became clear that since most of the practice for future pediatricians is in ambulatory pediatrics, except for those who are going to take fellowships and go on to a subspecialty, what was needed was two things. One was more and more ambulatory training particularly in things that are important today, like child development and common problems in pediatrics; and two, basic pediatric education for those who were going to go on and do fellowships in the different subspecialties, so they would have a ready-made base for future training, including inpatient training in common diseases. And that, essentially, is what has happened.

One of the real issues that remains and has become controversial over the years has been what to do with the newborn nursery. The newborn nursery requires a great deal of manpower and residents are often put into the newborn intensive care unit because manpower is needed, not because they are going to require so much training or because they’re going to be working there in the future. Perhaps the rationalization is that they’ll learn a lot of physiology and they’ll learn how to take care of sick older children. That may or may not be true, and we will probably have to think about other sources of manpower in the newborn nursery and intensive care units--like technicians, aides, just hired physicians--and not use the pediatric residents so much for manpower.

DR. LOCKHART: I take it that you’re in general agreement with the recent changes in the RRC [Residency Review Committee] requirements, including the increased emphasis on psychosocial aspects of child health, and on ambulatory and continuing care.

DR. GROSSMAN: Yes, I am.

DR. LOCKHART: To switch gears once again, in these oral histories we’ve been asking the question about what pioneers in pediatrics you’ve known and admired. Can you name some, Dr. Grossman?

DR. GROSSMAN: Well, the first person that I would name would be the person who influenced me the most into going in pediatrics, and that’s Mary Olney, not nationally known, but locally very well known, as a teacher, as a very compassionate, socially-involved pediatrician. The former chairman of the
department, and dean, Francis Scott Smyth, whom I knew only at the beginning of my career, I thought very highly of.

In San Francisco were two former presidents of the Academy: Edward Shaw, who was also president of the Board, was a major practitioner in San Francisco, and subsequently because chairman of our department. It was Dr. Shaw who appointed me to be chief of pediatrics at San Francisco General. He had a lot of influence on me as to professional behavior, role of the Academy, role of the pediatricians with the Academy. Crawford Bost, who was another past president of the Academy in San Francisco, had a different kind of a role. While Dr. Shaw was very interested in disease, and one of his sayings was, he would be glad to get up any day at 2:00 a.m. and walk five miles for the privilege of seeing a child with meningococcemia, Bost’s point was, he’d rather see a well baby and keep it well than see a meningococcemia that’s going to die in the next two hours. They were very different people, and so had a slightly different influence on me. Bost was all for the preventive aspects of pediatrics and Shaw really was not.

The person who I probably would mention next is my colleague in the department initially. When I joined the department, the two people who were already in it were Henry Kempe and Henry Silver. Henry Kempe then left us to be chairman at Denver, Colorado, and spent many years and was very happy when the Academy gave him the Jacobi Award. He was one of my closest friends and many of my values about infectious diseases, about training, really were shared with Henry and I was greatly influenced by him in terms of my participation on the national scene.

DR. LOCKHART: Finally, Mish, I want to ask you, in your career, what has been your biggest disappointment, and what has been your biggest pleasure?

DR. GROSSMAN: Well, my biggest pleasures in life have come from my wife and my family, basically, and many of the things we’ve done together. In my career, my biggest pleasures have come from continuing relationships with my chief residents and other residents, having an extended family in the world of pediatrics; and also knowing so many people in American pediatrics through my work with the Academy, with the American Pediatrics Society and with other organizations I have been involved with.

I’m a little embarrassed to say, maybe I shouldn’t be, that I really have no major disappointments. I’ve had a good career. I’ve been pleased by it. I was disappointed that I had to drop my research career but on the whole I have no major disappointments.
DR. LOCKHART: You have four children, Deborah, Pamela, David and Daniel. Did any of them go into medicine?

DR. GROSSMAN: Well, one went into medicine, but that perhaps is not the most important thing. The most important thing is that they are all great individuals and are all doing well. But to answer your question, David did go into medicine, went into pediatrics, and is now on the faculty of the University of Washington in Seattle, where he is involved in general pediatrics and injury prevention. Between them, they have eight grandchildren, unfortunately not all in San Francisco; but fortunately, five in Seattle—and so five in one city—two in Rhode Island, and one in San Francisco. So Verla and I spend much time visiting them and spending time with them, which is the source of a lot of pleasure.

DR. LOCKHART: Mish, thank you very much for this oral interview.
## INDEX

### A
- Abbott, Myles Bruce, 30
- acellular pertussis vaccine, 24
- Advisory Committee on Immunization Practices, 24, 25
- AIDS, 25, 26
- American Academy of Pediatrics, 15, 16, 17, 18, 19, 20, 21, 30, 31, 32
- American Academy of Pediatrics Committee on Infectious Diseases, 25
- American Academy of Pediatrics Committee on Pediatric Education, 18
- American Academy of Pediatrics Committee on Research, 19, 20
- American Academy of Pediatrics Washington Office, 19
- American Academy of Pediatrics, Committee on Fetus and Newborn, 16
- American Board of Pediatrics, 13, 18, 19
- American Pediatric Society, 20
- Antimicrobial agents, 23

### B
- Baldwin, Janet Sterling, 12
- Bellevue Hospital, 12
- Bost, Crawford, 15, 31
- Boston Children's Hospital, 12
- Bruyn, Henry B., 13, 14

### C
- California Medical Association, 16
catheterization, 18
Centers for Disease Control and Prevention, 20
chickenpox, 23, 24, 28
cold abuse, 17, 22, 26, 27, 28
Child Protection Center, 22
Chlamydia, 25
Cohen, Peter, 8

### D
- Daeschner, Jr., Charles William, 18
- Deamer, William C., 8
developing countries, 23, 28, 29
diagnosis of infectious disease, 23

### F
- Fort Mason, San Francisco, 11
- Fort Riley, Kansas, 9, 10, 12
- Fort Sam Houston, 9
- Fowler, Richard E. L., 18
- Frederickson, Donald, 19

### G
- general practitioners, 17
- Great Britain, 29
- Grossman, Daniel, 32
- Grossman, David, 32
- Grossman, Deborah, 32
- Grossman, Pamela, 32
- Grossman, Verla, 32

### H
- Harbin English Secondary School, 2
- Harbin, China, 1, 4
- Hemophilus influenzae, 15
- Hemophilus influenzae meningitis, 23
- Henry, Alice, 8
- hepatitis A vaccine, 24
- hepatitis B vaccine, 24
- hexachlorophene, 16
- Holliday, Malcolm A., 21
- Holt, Jr., L. Emmett, 12
- Hurst, Valerie, 16

### I
- intelligence training, 9

### J
- Johns Hopkins Hospital, 7, 12

### K
- Kaiser Permanente, 29
- Kempe, Henry, 31
- Kenny, Sister Elizabeth, 13, 15
- Kiev, 1
- Krugman, Saul, 12
L
Lauer, Brian A., 30
Lincoln, Edith M., 12

M
managed care, 28, 29
Mayor’s Task Force on AIDS [San Francisco], 26
measles immunization, 23
Medical College Admission Test, 5
meningococcal diseases, 15
meningococcemia, 31
Moses Grossman Child Protection Center, 27

N
National Foundation for Infantile Paralysis, 13
National Institutes of Health, 19, 20
Nazis, 2
New York University, 12
newborn nursery, 16, 30

O
Olney, Mary, 6, 7, 31

P
Padbury, James Frederick, 30
penicillin, 11
phenylketonuria, 16
polio, 13, 15, 23, 24, 25
polio vaccine, 15
Pratt, Edward, 12
Presidio, 11

Q
Quie, Paul G., 20

R
rationing of health care, 29
Residency Review Committee, 31
residency training, 8, 9, 10, 11, 13, 25, 30, 31
respiratory syncytial virus vaccine, 24
retrolental fibroplasia, 16, 17
rotavirus vaccine, 24

S
Sabin vaccine, 15
Salk vaccine, 15
San Francisco Child Abuse Council, 27
San Francisco General Hospital, 6, 8, 13, 15, 21, 22, 23, 27, 31
Schachter, Julius, 25
Schade, George, 8, 15
Schulman, Irving, 12
Segal, Sydney, 17
Shaw, Edward B., 15, 19, 31
Silver, Henry, 31
Silverman, William A., 16, 18
Sister Elizabeth Kenny Foundation, 13
Smyth, Francis Scott, 8, 31
Society for Pediatric Research, 20, 21
Standards and Recommendations for Hospital Care of Newborn Infants, 16
staphylococcal colonization, 16
staphylococci, 16
sulfas, 15

T
Tientsin Grammar School, 2

U
U.S. Army, 5, 6, 9, 10, 11, 12
United States Steel Company, 4
University of California at Berkeley, 2, 3, 4, 5
University of California, San Francisco, 2, 3, 7, 8, 9, 10, 11, 13, 14, 16, 21, 26, 32

V
vaccines, 23, 24, 26, 28

W
Wara, Diana, 26
Ward, Robert, 12
White House, 20

Y
Yeazell, Louise, 8
Yokohama, 11

Z
Zikman, 4
CURRICULUM VITAE
University of California, San Francisco

Moses Grossman, M.D.
Professor Emeritus
Department of Pediatrics, School of Medicine

EDUCATION

1938-1940 Hong Kong University --
1941-1943 University of California, Berkeley A.B. Pre-med
1943-1946 University of California, San Francisco M.D. Medicine
1946 UC Hospital, San Francisco Intern Pediatrics
1947 UC Hospital, San Francisco Resident Pediatrics
1949-1950 Bellevue Hospital, New York Resident Pediatrics
1950-1951 University of California, San Francisco Resident Pediatrics
1947-1949 US Army Captain Medical Corps

LICENSES, CERTIFICATIONS

1947 Medical License, California
1952 Certified, American Board of Pediatrics

ACADEMIC POSITIONS

1951-1952 University of CA, San Francisco Instructor of Pediatrics (half-time)
1952-1953 University of CA, San Francisco Instructor of Pediatrics (full-time)
1953-1954 University of CA, San Francisco Instructor of Medicine
1954-1958 University of CA, San Francisco Asst. Professor of Pediatrics
1959-1964 University of CA, San Francisco Assoc. Professor of Pediatrics
1964-1991 University of CA, San Francisco Professor of Pediatrics
1965-1969 University of CA, Berkeley Lecturer, School of Public Health
1970-1993 University of CA, San Francisco Vice-Chairman, Pediatrics
1963-1964 University of CA, San Francisco Asst. Dean, School of Medicine
1964-1973 University of CA, San Francisco Assoc. Dean, School of Medicine
1985 University of CA, San Francisco, Acting Assoc. Dean, School of Medicine
1991-Present University of CA, San Francisco Professor of Pediatrics, Emeritus
ANCILLARY POSITIONS HELD CONCURRENTLY

1953-1955 San Francisco General Hospital Chief, UC Com Dis Service
1955-1959 University of CA, SF Chief, Pediatric OPD
1959-1993 San Francisco General Hospital Chief, Pediatric Service
1976-1977 San Francisco General Hospital Chief, Com Dis Service
1976-1977 San Francisco General Hospital Chief, Medical Staff

HONORS AND AWARDS

1963 Education Award of the Western Society for Pediatric Research
1978 San Francisco Foundation Award
1978-1979 Best Teacher Award by Pediatric House Staff, UCSF
1982 Mayor’s Citation for Work for Children of San Francisco
1985 Alumnus of the Year, UCSF
1988 Mayor’s Citation for Pediatric Education
1992 Gold Headed Cane Speaker, UCSF
1993 St. Geme Educational Award from Western Society for Pediatric Research

MEMBERSHIPS IN PROFESSIONAL ORGANIZATIONS

1952 American Academy of Pediatrics
1953 Western Society for Pediatric Research, President 1969
1969 American Pediatric Society
1972 Society for Pediatric Research
1974 Infectious Diseases Society of America
1985 Pediatric Infectious Disease Society

PROFESSIONAL ACTIVITY

American Academy of Pediatrics
1971-1976 Committee on Medical Education
1978-1984 Committee on Research
1980-1984 Chairman of Committee on Research

American Pediatric Society
1971-1977 Member of Council
1977-1978 Chairman of Council
State of California
1976-1985 Child Abuse Prevention Advisory Committee
1983 Immunization Advisory Committee
1988-1992 California AIDS Leadership Committee on Pediatric and Perinatal AIDS, Chairman

Additional Professional Responsibilities
1974-1977 President of the San Francisco Child Abuse Council
1964-1980 Consultant to Center for Disease Control on Vaccine Immune Globulin and VZIG
1984-1987 Member of Mayor’s Task Force on AIDS
1985-Present San Francisco Health Department Task Force on Pediatric and Perinatal AIDS, Chairman
1988-Present Vaccine Injury Compensation Program, Consultant, US Public Health Service
1992-Present Chair, SF Health Dept Immunization Advisory Committee

Editorial Responsibility
1985-Present Pediatric Infectious Disease Journal, Editorial Board
1989-Present Present Editor, Pediatric Infectious Disease Journal

Campus and School of Medicine
1976-1979 Committee on Academic Personnel
1979 Chairman, Committee on Academic Personnel
1980-1981 Committee on Committee
1984-1987 Academic Planning Board
1980-1983 Alumni Faculty Assoc. Executive Committee
1982-1983 President, Alumni Faculty Association
1985 Executive Committee, School of Medicine
1986 Campus Committee on Child Abuse Prevention
1980-Present Several Review Committees for Department Chairman and individual faculty members
1987-1988 Chancellor’s Committee on Future of UCSF
1990-1991 Social and Behavioral Sciences Fact Finding Committee
1990 Chair, Celebration of 100 years collaboration between UCSF and SFGH
1994 Chair UCSF Fresno Task Force

Search Committee of School of Medicine
1982 Dean of School of Medicine
1983 Associate Dean, San Francisco General Hospital
1984 Chairman, Department of Psychiatry
1986 Chairman, Department of Pediatrics
1987 Chairman, Department of Family Medicine
1988 Dean, School of Medicine

**Department of Pediatrics**
- 1980-1993 Executive Committee
- 1980-1993 Committee on House Staff Education
- 1980-1993 Committee on Undergraduate Education
- 1985-1993 Advisory Committee

**San Francisco General Hospital**
- 1976-Present Infection Control Committee
- 1981-Present Executive Committee
- 1982 Chairman, Executive Committee
- 1986-1987 Search Committee for Chief of Surgery
- 1988-1989 Chairman, Professional Services Committee
- 1989-1990 Search Committee-Chief of Psychiatry, Chief of ENT

**SELECTED TALKS AND VISITING PROFESSORSHIPS (Since 1981)**

1981 North Pacific Pediatric Society, Portland, Oregon
1981 Los Angeles Pediatric Society
1981 University of Arizona, Tucson
1982 National Medical Association, Plenary Session
1982 National Medical Association, Plenary Session, Sweden
1983 University of North Carolina, Chapel Hill
1983 Visiting Professor China Medical College, Shenyang, China
1983 Plenary Session of American Academy of Pediatrics
1984 Southern California Combined Pediatric Continuing Education Course
1984 Blank Children’s Hospital, Des Moines, Iowa
1986 25th Anniversary of Children’s Hospital, Buenos Aires, Argentina
1987 2nd International Gyn Congress, Munich, Germany
1988 New Mexico Pediatric Society
1990 Toronto Sick Children’s Hospital
1990 International Congress on AIDS, Bangkok, Thailand
1992 Brenneman Lecturer, Southern California
1993 Benjamin Kogan Lecturer Cedar Sinai Hospital, Los Angeles
PUBLIC SERVICE

1974 Founder San Francisco Child Abuse Council
1986 San Francisco Mayor’s Blue Ribbon Committee on hard to place foster children
1984-Present Packard Foundation Advisory Committee on Health Care of Foster Children
1989-1991 SF Health Department Committee on Future of Children

RESEARCH AND CREATIVE ACTIVITY

Original Articles


**Books and Book Chapters**


1964 E. Shaw and M. Grossman, Chapter on Therapy of infectious diseases in *Textbook of Pediatric Therapy* under the editorship of H. Shirley.

1986 M. Grossman, Whooping cough in Rakel’s Conn’s Current Therapy, W.B. Saunders Co.

1989

1990

1991, 1994
M. Grossman, Immunizations, Chapter for Basic and Clinical Immunology. Appleton Lange Co.

1991
Diphtheria in Donowitz LG, Infection Control in the Child Care Center-Preschool. Williams-Wilkins.

1996

Abstracts
1966
M. Grossman and W. Ticknor, High levels of penicillin G in the neonate, Presented at Interscience Conference on Antimicrobial Agents and Chemotherapy. October.

1973
B. Lauer, E. Ten Broeck and M. Grossman, Battered child syndrome: Review of 130 patients with controls C1 Res, XXI, #2, 301

1974
E. Ten Broeck, A. Keller, S. Stripp and M. Grossman, Battered child syndrome: Eight year follow-up, C1 Res, XXII. #2:221A

1978

1979

1980

1984
S.B. Black, M. Grossman, R. Levin and R. Monalo, Fever in the first two months of life, C1 Res, 32:107A.

1986

1986
R.M. Levin and M. Grossman, Group A streptococcal infection in children under three years, 26th ICAAC, New Orleans, LA.

1997
Other Publications

1970  M. Grossman, Meningitis in the pediatric age group, *Excerpta Medica Symposium* (Changing Patterns of Bacterial Infections and Antobiotic Therapy)


Fellows Supervised

Ann Arvin
Stephen Spector
Steven Black
David Coulter
Jay Tureen
Janice Kim
Michelle Esterbrook
Alex Blackwood
Chandra Gordon

Visiting Foreign Scholars  (one year each)
Dr. Shen Ming Liu, China Medical College, PRC
Dr. Jia-Xiang Zhang, Chairman of Pediatrics, China Medical College,
    People’s Republic of China
Dr. Shi-Xiao Wu, Associate Professor, Chongquing Medical College,
    People’s Republic of China

Postgraduate Courses Sponsored by UCSF

Participate annually in Advances in Pediatrics, Family Practice refresher course
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