ORAL HISTORY PROJECT

R. James McKay, Jr., MD

Interviewed by
James E. Strain, MD

October 27, 1996
Boston, Massachusetts
R. James McKay, Jr., MD
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PREFACE

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

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

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ABOUT THE INTERVIEWER

James E. Strain, MD, FAAP

Dr. James Strain graduated from Medical School at the University of Colorado following his undergraduate education at Phillips University in Enid, Oklahoma. After completing a rotating internship at Minneapolis General Hospital and a pediatric residency at Denver Children's Hospital he entered the private practice of pediatrics in Denver in 1950. He served on the pediatric clinical faculty at the University of Colorado and was appointed Clinical Professor in 1969. He was elected Chairman of the Colorado Chapter of the American Academy of Pediatrics in 1967, became Chairman of District VIII in 1975, and was elected Vice President of the American Academy of Pediatrics in 1981. He served as president in 1982-83 when the care of disabled newborns was an issue. He returned to the private practice of pediatrics in Denver following his tenure as president. In 1986 he was called to assume the position of Executive Director of the American Academy of Pediatrics where he served until his retirement in 1993. Since then he has continued to be involved in Academy activities, including serving as the Academy representative to the National Advisory Commission on Childhood Vaccines. Dr. Strain appreciated the opportunity to interview Dr. McKay, a friend with whom he served on many committees in the Academy.
Interview of R. James McKay, Jr., MD

DR. STRAIN: This is an interview of Dr. R. James McKay, Jr., conducted by Dr. James E. Strain, on the 27th of October 1996. The location is Boston; we’re in the Brandeis Room of the Boston Marriott Copley Place. This will be tape number one, side number one. And we’re just going to talk.

Jim, we appreciate you taking the time to visit with us a little bit and letting us hear from you about your early days and later days in the Academy and in pediatrics. First of all, I wanted to have you tell us a little bit about your background, where you were born, something about your parents and siblings.

DR. McKAY: Well, I was born in New York City, at the New York Lying-In Hospital. My parents were living on Staten Island at the time, just a short ferry ride across the bay. We moved around quite a bit because my father worked for the International Nickel Company as a chemical engineer and corrosion expert, so we moved from Staten Island to Pittsburgh, where he was working at the Mellon Institute, and then back to Staten Island, adjacent to the Staten Island Tennis and Cricket Club. We were there, I think, only about a year, and then we went back to Pittsburgh for about a year, and then we came back to Summit, New Jersey, and lived there for two or three years.

In 1925, we moved to Basking Ridge, New Jersey, which is the place I really felt was home. My parents lived there from 1925 until about 1957 or 8.

DR. STRAIN: That’s where you went to grade school?

DR. McKAY: I went to grade school through the second grade in Summit, New Jersey; then to public school in Basking Ridge; then to a private day school in Far Hills, New Jersey for a year and a half; then to Lawrenceville School, also in New Jersey, for high school years.

DR. STRAIN: Did you have any brothers or sisters?

DR. McKAY: I have one younger brother, two years younger.

DR. STRAIN: When did you decide you wanted to be a doctor?

DR. McKAY: Well, I think I definitely decided the year I was 17; but I pretty much made up my mind before that. I started thinking about what I wanted to do when I was 14, and I debated between teaching, ministry, being a lawyer, and being a doctor. Those were definitely the things I considered. I gave up the preaching first, because I got so disgusted with organized religion and its hypocrisy and contradictions that I just could not be honest...
with myself and pass that junk on to other people. I hope I’m not offending you.

DR. STRAIN: No, not at all.

DR. McKAY: [Laughs] My parents thought I should be a lawyer, and that interested me, but I felt I could not be a lawyer and maintain my personal integrity by defending people or companies or whatever, whom I knew darn well were guilty. Saying they were not guilty was too dishonest. And I think I also wanted to be able to be reasonably materially successful so I could send kids to college and so forth, and that sort of ruled out teaching, to some extent anyway.

When I was 17, I lived in Germany for six months because I wanted to learn a foreign language. My first choice had been to go to Paris, or to elsewhere in France and learn French, but my parents had doubts about French sexual morals. My father had business connections in Germany, so I went to Germany. Little did they know that a 17-year-old in France at that time was still very strictly circumscribed, but not in Germany! Not that I ever got into anything they would have disapproved of, but nevertheless it was sort of ironic to me.

That year I met some American medical students in Frankfurt, who took me to some of their lectures, passed me off as another medical student a couple of times, and I really fixed on being a doctor. However, I do remember talking with the Dean of Admissions at Princeton in the Fall of 1934 about my not entering college with my Lawrenceville graduating class, and saying I definitely planned to be a doctor and a children’s doctor. I didn’t know there was such a thing as a pediatrician in those days, especially in New Jersey, which had almost no specialists. But I wanted to be a children’s doctor, because I remember in the fall of 1934, I was very definite. So I guess it was a little earlier than I thought at first.

DR. STRAIN: You decided to be a pediatrician at the same time you decided on medicine?

DR. McKAY: Well, I’d always been interested in children. I remember when I was nine years old, I started keeping a diary of the ways that adults did not understand how much children understood and how responsible they could be as compared to adults. Unfortunately, I only kept it for about, I guess, six or eight months. And I’ve lost that. It would have been very interesting to look back on that, but I always felt that adults didn’t understand children and I wanted to do something that would further the understanding of children by adults.

DR. STRAIN: Did your brother go into medicine?
DR. McKay: No, he’s a naval architect.

DR. Strain: I see. When did you meet Liz [Elizabeth Stewardson Foote]?

DR. McKay: In medical school on a blind date.

DR. Strain: Now, she’s not a physician?

DR. McKay: No, she’s a medical social worker. She was a medical social work student when I met her. At Simmons College School of Social Work.

DR. Strain: Well, I wanted to go back to your undergraduate work a minute, because in your CV [curriculum vitae] you talked about spending time in Munich. And I think that was in the pre-war years, was it not?

DR. McKay: Yes, it was.

DR. Strain: Can you tell us a little bit about what Munich was like, and what Germany was like?

DR. McKay: Well, I actually spent two periods in Germany. The period to learn a foreign language when I was 17; that was in 1935. I spent six months with a family who spoke no English in Frankfurt am Main. Then I went into college the following fall and learned from a guy who had done it about the Junior Year in Munich, and decided that that was for me; I’d like to do that. And so I applied for the Junior Year in Munich and it ended up I was accepted and went to Munich.

DR. Strain: Now that was ’38 or ’39, wasn’t it?

DR. McKay: That was ’37 and ’38.

DR. Strain: ’37 and ’38. A lot was happening in Germany at that time. Did you know politically what was going on?

DR. McKay: Oh, yes. Well, I’d known that in Frankfurt. I can remember both in Frankfurt and in Munich, I went to the U.S. Consulate and said that what was being said by politicians and diplomats in this country [United States] did not jibe with what I observed going on there. It was obvious there was going to be a war. And I remember in Frankfurt, being out at the local beer joint, which I went to frequently with the law student fiancé of my landlady’s daughter, saying, “It sounds to me as if there’s going to be a war.” We were sitting around a table, probably eight or ten people drinking beer. And they’d say, “Yeah,” and I asked, “When is it going to be?” “When we’re ready,” was the answer. “And when will that be?” “About five years.”
This is in February or March of 1935, and the war started in September of ’39. When I went to Munich and sat in the local beer joint, same conversation, and same timetable. It was a very interesting thing.

DR. STRAIN: Now, these were students you were talking to? This wasn’t the military? I mean, they weren’t soldiers?

DR. McKAY: Not military. These were not all students; they were just the beer hall clientele.

DR. STRAIN: But they were getting ready.

DR. McKAY: Oh, absolutely.

DR. STRAIN: I mean, the population in general.

DR. McKAY: Oh, absolutely. I know I came back convinced there was going to be a war. When I started college after getting back from Frankfurt, I tried to go into ROTC [Reserve Officers’ Training Corps] and the dean very strongly advised me against it, because, he said, “As a doctor, you’re going to be drafted anyway to do medical work. So it’s just a waste of course time for you to take ROTC.” So I took his advice and didn’t. But I felt that it was part of my national duty to be as prepared as possible.

To sort of go back to the Consul business, I went to the Consulate in Frankfurt, and told them what I’d heard in the beer joints, and they just brushed me off, “Bye-bye, little boy!” The same thing happened in Munich two years later. They just weren’t interested.

DR. STRAIN: Were you aware of any discrimination, any of the pogroms at that point?

DR. McKAY: Oh, yes.

DR. STRAIN: I mean, that was already happening?

DR. McKAY: Oh absolutely, in Munich. especially. I remember seeing Jews being literally beaten in the street by SS [Schutzstaffel] people. One heard all the time about Dachau, the concentration camp in southern Germany, which was a political prison originally. And there were a lot of Jews there, but also any political disagreeer ended up in Dachau. That was a favorite threat, “You watch your tongue or you’ll end up in Dachau.” I mean people were saying that to each other all the time if they were a little injudicious in what they said.

DR. STRAIN: They didn’t criticize the government!
DR. McKAY: No. Incidentally, everybody thought they’d never get away with the occupation of the Saar territory, which was in the spring of ’35. Everyone expected England and France to march into Germany, or at least into the Saar and depose [Adolf] Hitler, but it didn’t happen. Then of course the same thing occurred a couple times later, in Czechoslovakia and Austria.

DR. STRAIN: You said you married Liz after you graduated from medical school, when you were an intern. Tell me a little bit about your children. How many children do you have?

DR. McKAY: We have four sons.

DR. STRAIN: And what do they do?

DR. McKAY: Our eldest Rob, named after me and my father, is a professor of philosophy at Norwich University, which is a small military college in Vermont. The second one, David, is a psychiatrist in private practice in Montpelier, Vermont. The third one, Dan, is a lawyer in Bangor, Maine. The fourth one, Tim, is a district conservationist in the northeast corner of Vermont, with an office in St. Johnsbury. He’s with the U.S. Natural Resource Conservation Service, used to be the Soil Conservation Service.

DR. STRAIN: OK. Tell me a little bit about your medical school experience. You went to Harvard [Medical School]?

DR. McKAY: Yes.

DR. STRAIN: Tell me about some of the people with whom you came in contact at Harvard, in pediatrics or any other field of medicine.

DR. McKAY: Well, I had somewhat of an unusual experience in that regard, because of my parents. My father’s father was a Presbyterian minister in Shushan, New York, which is right next to Cambridge, New York, where Dr. Kenneth [D.] Blackfan’s father was the general practitioner. And they went to the Presbyterian Church, and the two families became very close. Dr. Blackfan’s sister married my father’s eldest brother, and so his daughter was my first cousin. My father knew Ken Blackfan as a child very well, and everyone in his family. When Dr. Ken Blackfan married his wife, who was a widow with no children, nobody from my father’s family, although invited, or the Blackfan family, went to the wedding because of prejudice against marrying even a widow whose husband had died. That was sort of scandalous! So my father and mother were the only representatives of either the Blackfan family or the McKay family who went to Ken and Lulie’s wedding. They always had a soft spot in their hearts for my parents after that.
When I went to Boston, to Harvard, my parents kept asking me if I contacted the Blackfans yet, and then apparently the Blackfans wrote and asked them what had happened to me because they hadn’t heard from me. Finally, my parents kept at me enough that I called the Blackfans and they invited me out to Sunday dinner. The Blackfans were people whose sole method of entertaining was having the Boston bigwigs of medicine to Sunday dinner. And I went out there to Sunday dinner probably at least every other Sunday from then on. I met all of the Boston bigwigs in medicine at their house for Sunday dinner. So I really got to know everybody who was anybody in the Boston medical arena. Except for Frank Lahey; he wasn’t invited. [Laughs]

DR. STRAIN: Do you remember anything about these people that you’d like to tell us about; any of the previous luminaries from the generation just immediately preceding you? In pediatrics or any other specialty?

DR. McKAY: Not particularly. I remember the [James L.] Gambles, because they were actually quite frequent guests and they were very nice to me and Liz afterwards, nice and hospitable to us. That was about it. I didn’t have contact with any of the others afterward, except for the Gambles.

DR. STRAIN: Was [Charles A.] Janeway there at the time?

DR. McKAY: Yes, he was an instructor in bacteriology when I was in medical school; but that was how I knew him, just as a fleeting acquaintance, as an instructor. That was it.


DR. McKAY: Oh yes, he was one of the people who was a frequent guest at the Blackfan Sunday dinners. I learned to know him better than most of the other people who were in medicine, neurology, surgery and so forth.

DR. STRAIN: Did you have any impressions of him?

DR. McKAY: Yes, very bright, I liked him. We got on well together.

DR. STRAIN: What about your internship and residency? That was, as I understand, at Columbia-Presbyterian [Medical Center] in New York.

DR. McKAY: Yes.

DR. STRAIN: Is there anything you want to tell us about that experience?

DR. McKAY: Well, I think how I got into it was somewhat interesting. I had wanted to go to New York, go elsewhere than Boston, because I was very
conscious of the “drag” I had in Boston, and I wanted to get where I got on my own. I didn’t know anybody in New York pediatrics, and Dr. [Rustin] McIntosh at Babies [Hospital] had a reputation of being probably the foremost clinical pediatrician; and that’s what I wanted to do. So I applied there over the protestations of Dr. Diamond and Dr. Gamble who tried to recruit me for Boston Children’s [Hospital]; but they were very understanding of my motives for wanting to go to New York where I didn’t know Dr. McIntosh or anyone else. So I applied to Babies Hospital and was accepted.

DR. STRAIN: Did you have anything you remember particularly about that experience? Was that a good internship, residency? How did you feel about it?

DR. McKAY: Well, Con [Conrad] Riley was my chief resident there for three or four months, and then he was taken into the Navy. It developed into a friendship that still exists. The second chief resident I had there was Nona [Winona] Campbell who is still a friend, so I made some really lasting friendships.

The chief thing I remember was that Morris Wessel and I were the only two males on the house staff. All the other male residents were drafted and Morris and I were left. There were seven women and us.

DR. STRAIN: When did you go in the army now, Jim? Was that after your residency at Babies?

DR. McKAY: At that time, they started offering commissions to medical students during my second year in medical school. I went right in and applied for it because I was sure there was going to be a war. I also felt, I guess, appropriately patriotic, so I enlisted early, at the first opportunity. So I became part of the AUS students, the Army of the United States. By the spring of the next year all medical students were either signed up or drafted. You signed up for the medical corps and then finished your studies and then went in the army, or you were drafted right away, as a private.

DR. STRAIN: Very little choice.

DR. McKAY: [Laughs] But I had already signed up, I guess six months or so before that occurred.

DR. STRAIN: Well, you went in the army then, after the year of internship at Babies.

DR. McKAY: Active duty, yes. February of ’44.

DR. STRAIN: What did you do in the army?
DR. McKAY: I was a battalion surgeon. Initially we had six weeks at Carlisle Barracks in orientation in Pennsylvania, and then I had six weeks orientation at LaGarde General Hospital in New Orleans. Then I was assigned to the 75th Infantry Division at Camp Breckinridge, Kentucky where I was assigned as battalion surgeon for the 75th Infantry Division, 275th Engineer Combat Battalion, and I was with them until after VJ day.

DR. STRAIN: Now you had overseas duty.

DR. McKAY: Yeah, I was overseas in Europe for 22 months. At first, our outfit went into action in the Battle of the Bulge. We relieved the 82nd Airborne, which had been fighting a last-ditch engagement with the invading German paratroopers. They were a tough bunch to us—I'll tell you! [Laughs] But anyway, we were thrown in, very green troops, into a situation that was tough even for very seasoned troops. We had 3,000 casualties on Christmas Eve and Christmas Day.

DR. STRAIN: From the Battle of the Bulge?

DR. McKAY: From the Battle of the Bulge. My battalion didn't have so many. We had some, but not as many as the infantry did. Although later we were sometimes ahead of the infantry because we had to put in the bridges for the infantry to cross, and stuff like that.

DR. STRAIN: Did you treat a lot of casualties yourself, which involved some surgical repair?

DR. McKAY: Well, no, because the battalion aid station was a triage station basically. We stopped bleeding and sent them back just as fast as we could. It was very clear, they told us, that the chief function of the battalion surgeon was morale, for the troops to know there was a doctor right there. So I tried to keep my aid station just as close to the troops as possible and, I think, was fairly successful in that.

DR. STRAIN: Now you gave transfusions up there and tried to stabilize them, and to get them out? Did they have MASH [Mobile Army Surgical Hospital] units in those days?

DR. McKAY: No, they didn't. They didn't call them mobile surgical units. The MASH unit was a mobile army surgical hospital, which would correspond with the clearing station of those days, which was a division outfit. But we did have three- or four-man surgical units, which traveled around and were assigned to areas of heavy casualties where they would do more definitive work under fire on very severely wounded people. And I know I had one of those working in conjunction with my detachment two or
three times during the Bulge and Colmar, which were our two most active engagements.

DR. STRAIN: Then, when you got out of the army you went back into your pediatric training program.

DR. McKAY: Well, when I got out of the army Liz and I took a two-month trip to the west coast, because that’s where we both thought that we wanted to settle and I looked at residency programs in the northwest and California at the same time. Then we came back and I went into general practice with my family's physician in Bernardsville, New Jersey, and did that for three months, until my residency opened up January 1st of 1947.

DR. STRAIN: Now where was that?

DR. McKAY: At Babies Hospital.

DR. STRAIN: And then you ended up going to Boston after that?

DR. McKAY: Yes. I’d actually already signed up for a fellowship in endocrinology with Allan [M.] Butler at Mass [Massachusetts] General [Hospital], and then I got a telephone call from Charlie Janeway asking if I would come up to be chief resident at Boston Children's the next year, succeeding Fred [Frederick C.] Robbins, who was going to go work with John Enders. That suited me much more than an endocrinology fellowship. I called Allan Butler, and Janeway called Allan Butler.

Actually, what had happened was that Janeway had asked Rustin McIntosh if he had anybody he thought would make a good chief resident to succeed Fred Robbins. I heard about all this later. Apparently Rusty had a meeting of the department, and everybody suggested me. Then Hattie [E.] Alexander expressed some doubts, although she actually had proposed me in the first place. And she expressed doubts as Hattie always did, and somebody asked her, “Well what’s the matter with him Hattie?”-- I guess it was Doug Damrosch, who was my chief resident at that point. She said, “Well he doesn’t like surgeons. Oh, he’s very critical of surgeons.” Doug told me everybody burst into laughter, “We’re all critical of surgeons, what are you talking about?” “Well he’s more critical than most, he’s even critical of the chief of surgery.” Which was true. [Laughs]

DR. STRAIN: That’s what she got hung up on. She thought that was just too critical.

DR. McKAY: Yes, but eventually they recommended me, and Charlie Janeway called me. He had already talked to Allan Butler, and then I called Allan Butler and got an official release and accepted the offer. The funny
thing about that one was that after all my gyrations trying to avoid any pull or family connection or anything, while Liz and I were living in an apartment in her parents’ house in Cambridge we were having dinner with her parents one night, and her mother said, “Jim, don’t you work with Charlie Janeway?” And I said, “Yeah, he’s my boss.” And she said, “Well, you know, say hello to him because his mother is a third cousin of mine, and as girls we were the dearest of friends.” So I got every place I ever got by “drag.” [Laughs]

DR. STRAIN: [Laughs] You know I need to go back and ask you what you thought of Rusty McIntosh, because he’s one of the real pioneers in pediatrics.

DR. McKAY: Very highly in every way.

DR. STRAIN: He was a clinician?

DR. McKAY: Yes. And I was very fortunate as an intern, because I had him as my attending for two of my nine intern months, which is very lucky. And he was just as good as they said he was; he was a very quiet, very sound clinician. Very good clinician.

DR. STRAIN: What about Hattie?

DR. McKAY: Hattie was good, too. And I got along very well with Hattie, except Hattie was noted among the house staff for her timidity.

I remember at the Christmas party they had back when I was an assistant resident; they had some Gilbert and Sullivan-based takeoff songs, and the one on Hattie was to the tune of Tit Willow and the refrain was, “But are you sure that you’re sure that you’re sure?” If you went through a whole workup and found nothing, Hattie would have you do it all over again. I refused to do that, and actually had two or three patients, when Hattie was my attending, whom I advised to sign out against advice. [Laughs] With very grateful letters from their parents later. [Laughs]

DR. STRAIN: Full-scale workup.

DR. McKAY: A repeat of the full-scale workup.

DR. STRAIN: Jim, after your residency, chief medical residency time, you took a fellowship in pharmacology?

DR. McKAY: Yes.

DR. STRAIN: Can you tell me a little bit about that?
DR. McKAY: Well, I got interested in the effects of digitalis in acute rheumatic heart disease. At that time the Boston official attitude was that digitalis didn’t work in patients with acute rheumatic heart disease. I was convinced that it did and cooked up a means of answering this objectively. I talked to Otto Krayer about it, and Janeway was interested in it also. I got accepted as a Milton Fellow in Pharmacology for the year after I finished as chief resident at Boston and pursued that investigation. It turned out positively, although I never published it because rheumatic fever was on the way out at that point; we were seeing fewer and fewer cases.

DR. STRAIN: Then you went back for a fellowship in pediatrics at Boston Children’s.

DR. McKAY: I was made a fellow at Children’s at the same time I was a fellow in pharmacology, with the clinical work sort of keeping me clinically in touch. I acted as attending two or three months during the year, and that was what that amounted to.

DR. STRAIN: I wanted to ask you what your salary was when you were chief resident?

DR. McKAY: One thousand dollars per year.

DR. STRAIN: [Laughs]

DR. McKAY: I was paid $67.00 a month as assistant resident at Babies Hospital; nothing as intern.

DR. STRAIN: That’s the way we judged residency and intern programs before, the less they paid . . .

DR. McKAY: The better they were. [Laughs]

DR. STRAIN: Exactly. It didn’t take you very long to end up as the chairman of the department at [University of] Vermont. You were there from 1951 until . . .

DR. McKAY: ’50.

DR. STRAIN: ’50, until when? When did you step down?

DR. McKAY: I was recruited to start a department of pediatrics there. The medical school had been surveyed and put on probation, and one of the major deficiencies was lack of a department of pediatrics. John Mitchell, who was later dean at University of Pennsylvania School of Medicine, surveyed it. So Dean William E. Brown at the University of Vermont wanted to get somebody to develop a department of pediatrics. Pediatrics had been
taught as a division of the department of medicine before, and they wanted to start a department of pediatrics. They didn’t have money to hire anybody with more experience, and in fact, I learned later that the dean had $3,000 in hand to hire me to come up there to start a department of pediatrics. And he was counting on me to get a Markle [John and Mary R. Markle Foundation] scholarship to finance it. And I was fortunate enough to get a Markle scholarship in February. The money was running out at the end of March. [laughs] That was $6,000, or $6,500, so that enabled the dean to pay me and me to hire a secretary. [Laughs]

I retired as chairman when I was 65, in 1983, but remained as a three-fourths-time professor until 1987, when I became emeritus at age 70.

DR. STRAIN: Well that’s something else I wanted to ask you about. How did you develop the department? You didn’t have any money to bring in full-time people.

DR. McKAY: No.

DR. STRAIN: How did you organize that?

DR. McKAY: Well, what we did was that I first sat in on all of the teaching, which was pretty sad from my standpoint. Pediatrics, at that time, consisted of a series of eight lectures in pediatric psychiatry during the second year, and 30 or 32 lectures on pediatrics—these were lecture room lectures—during the third year. The guy who did about eight of them literally read from Nelson’s textbook [Textbook of Pediatrics]. That was his lecture; he stood up there with Nelson’s textbook in front of him and read from it. The students in the third year spent eight hours a day, Monday through Friday, and four hours a day on Saturday, sitting in a lecture hall, listening to lectures. Their only clinical work was in the fourth year. They had one month on medicine at the hospital in Burlington, and one day of each week they made rounds for one hour with the attending on the pediatric ward.

DR. STRAIN: You did have a pediatric unit then, at the hospital?

DR. McKAY: Yes, there was a 13-bed pediatric unit.

DR. STRAIN: So they had this in the senior year, but it was one day a week that they had a clinical experience?

DR. McKAY: If it could be called that. They went on rounds with whoever was the attending for the ward for that month. One day a week, for an hour.

DR. STRAIN: Was there any outpatient experience at all?
DR. McKay: No. There was no outpatient; the hospital had no outpatient activities at all.

DR. Strain: Did you use any of the local pediatricians as adjunct professors to do any of this teaching?

DR. McKay: Yes, and one of them was the only thing that enabled me to survive, a guy named Ralph [Daniel] Sussman, who was a very good pediatrician. He was a big guy who came across as being very brusque with patients, but this was to cover up a very soft heart. I remember once a patient’s mother complained to me about him in a clinic, which was one of the activities I started, and I told him about it. It was about the language he used, and he actually broke into tears, because he had meant the exact opposite. He never swore in front of a patient again. He really changed. He enabled me to survive because he covered me clinically on the hospital cases which were sent in to me. When I took a weekend off or went on vacation or to a meeting, Ralph covered for me, and he was a very good pediatrician and did it very well. We were good friends.

DR. Strain: Now you added full-time people in, quote, “The Golden Years of Pediatrics,” when all the pediatric departments were growing?

DR. McKay: Well, what happened was that when I had been going about five years, I had a consultation practice which was supposed to add to my full-time salary to the extent of one dollar of my salary, and one dollar from the practice, and the practice was getting beyond the time I felt I could spend on it. And at that point I recruited Jerry [Jerold F.] Lucey, who had been sent up to see me by Rustin McIntosh. Jerry wanted to come up to that part of the country. He came in and it was really funny, because Jerry said that he left absolutely totally dejected, thinking I was the son of the professor and that he had been hoisted off to the son who had no power at all. [Laughs]

DR. Strain: So he was your first addition as a full-time practitioner. Did you make a neonatologist out of him?

DR. McKay: No, that actually came later. Jerry and I worked very closely together trying to develop the department, and Jerry was the idea man in a lot of ways. I’ve always been better at adapting things to uses than at new ideas, although I had a number of them in the teaching area. Jerry felt that neonatology was a coming thing. He was interested in it from the start, because he had had a fellowship with Clem [Clement A.] Smith in 1955, ’56, and then he came to Burlington in ’56. I had signed him up a year earlier.
I got the money for it from a combination of the dean’s resources and the consultation practice getting too big for one person to handle and still maintain full-time status.

END OF TAPE ONE SIDE ONE

DR. McKAY: I’d like to go back a minute as to how I got to Burlington, because it’s another of these serendipitous things that happen, that I learned about afterwards. Dr. [William E.] Brown, who was the dean at Vermont, was looking for someone to start a department of pediatrics. The three chief people he contacted were Joe [Josef] Warkany at Cincinnati, another was Rusty McIntosh, and the other was Charlie Janeway. And both Janeway and McIntosh suggested me. Liz and I had already decided we wanted to move to Burlington when I got through with my training. I was exploring moving there to go into practice, and in the course of it, a medical school and college classmate of mine who was a native of Burlington, said, “If you’re going to come to Burlington, you’ve got to meet the dean of the medical school.” So we had met, and apparently he had liked me, although I thought he was trying to get me to go into practice in Brattleboro instead of Burlington. [Laughs] But then, serendipitously, a month or two later both McIntosh and Janeway recommended me for the job he was looking to fill, so he [Dr. Brown] called me up and we went on from there and I got the job.

DR. STRAIN: What did you like about Burlington? You said you were really looking at Burlington before you looked at the job.

DR. McKAY: Oh yes. Before we visited the northwest, Liz and I discovered that we each had independently thought we’d like to live there, and so we were planning to settle there.

DR. STRAIN: You mean the northeast?

DR. McKAY: No, I mean the northwest.

DR. STRAIN: You wanted to go to Washington or Oregon?

DR. McKAY: Washington, Oregon, possibly northern California, Montana, Idaho or Utah. And so, when we got back and I was practicing in New Jersey, one night I said, “We’ve really got to decide where we’re going to settle.” Because I was going to be through in a year or two, we had to make plans. And she said, “You know, I’m not so sure I want to live in the northwest.” I said, “I’m not so sure I do either.” We found that our feeling was that the northwest still had all the disadvantages of the frontier, if you will, without the advantages of an established urbanization or culture. For instance, the houses in the best sections of town were too close together. A lot
of things like that. And I wanted to settle someplace where I could have an afternoon off and go fishing. So we got out a map of the country and started to look elsewhere for the same things, and fixed on Vermont to explore. And we explored it and liked it. I wanted to be associated with a medical school and be in practice, and Burlington seemed to fill the bill.

DR. STRAIN: Going back to the creation of a department of pediatrics, you mentioned that Jerry Lucey was your first addition. And then during the next ten or fifteen or twenty years, when you were head of the department, you began to add pediatric subspecialists to your program. How did that evolve?

DR. McKAY: Well, initially I was the only pediatrician in the state in any way qualified to do consultant work, and really acute hospital work—difficult hospital cases. Then as pediatrics became more sophisticated, I became busier, and I got other people to come in. When I got too busy in an area, we got other people to come in.

For instance, when I first got there, there wasn’t really anyone who knew much about the treatment of meningitis. In fact, the treatment of meningitis was just being developed and I’d been very active in that at Boston Children’s, so that occupied me at first.

Then the pediatric psychiatrist retired and I started getting a whole bunch of behavioral problems and psychiatric problems, so I took psychiatric seminars and so forth and, incidentally, became very well acquainted with Ben [Benjamin] Spock and some other people. I’d always had an interest in it. When I was an intern at Babies Hospital, Liz and I were invited to a housewarming that Hilde Bruch had in a new apartment. All of the child psychiatric group were there, and us, and it was because I was the only member of the house staff who evinced any interest at all in psychiatric things.

The next thing was cardiology, which was chiefly congenital heart disease and rheumatic fever in those days, and I knew quite a lot about rheumatic fever because that had been the area of my fellowship attention. The rest of it was congenital heart disease, so I attended courses in congenital heart disease and became moderately competent in that.

The first thing I had to do was to get psychiatrists and we did that through the department of psychiatry; I got the department of psychiatry to finance that and I got a pediatric psychiatrist. Then the department of medicine sent somebody away for pediatric cardiology training, one of their cardiology young people to work with Alex [Alexander] Nadas and then come back to Vermont and be a pediatric cardiologist financed by the department of medicine. It sort of went that way, and then finally we became able to get
people, not till the early 1970s, who were financed by the department of pediatrics.

DR. STRAIN: How many did you have in your department when you stepped down, and this was in ’80?

DR. McKAY: ’83. I think there were 11 full-time people in the department.

DR. STRAIN: Now you had to continue to generate some income to underwrite the salary. Did you have some kind of practice fund?

DR. McKAY: Well, the practice income was totally independent. I know from my own standpoint, I tried to restrict my practice income to $5,000 a year, figuring that was about all the time I could spend and still do my main job effectively. Most of the other people in the department, I think, were pretty much on the same basis. We didn’t have any formal group or anything like that.

DR. STRAIN: No pool of income.

DR. McKAY: Not at that time. About 1972, though, the medical school started what was called University Health Center, with pooled departmental income. The dean set the salaries to be paid out of medical school funds and out of the pooled departmental income source.

DR. STRAIN: Jim, you’ve been involved, I think, in the major changes in pediatric education, both undergraduate and graduate, through the years, from the time you began as an educator in 1950. What are the changes you’ve seen in the way we educate students and residents that you think are valuable, and anything that you think we’re not doing as well as we should?

DR. McKAY: Well, I think the first thing that attracted me to the teaching job at Vermont was that it was a small place with less inertia, where I was going to be in charge and I could do what I wanted to do. Jerry Lucey had exactly the same feeling. We both observed that where we had trained, the teaching was not medical-student-oriented, it was really resident-oriented. Medical students came to rounds, trailed along and got what they could out of it. Our idea was to have the teaching medical-student-oriented, with the residents trailing along and getting what they could out of it. We went on that principle until, I guess, the mid or late ’60s, at which point one of my residents (we had more residents at that point) came to me and said, “You really ought to drop this approach and have it equal between the medical students and residents.” Which we did, but our expressed, defined departmental mission, our goal, was to have the best teaching department in the country as far as medical students were concerned.
We thought that having the best teaching department as far as residents were concerned was out because of our lack of both financing and clinical material to have the appropriate amount of subspecialty expertise available for the residents to be able to have a really top residency program. So we always pushed our residents to have at least one year elsewhere. Usually we pushed our best students to go elsewhere for training, too, which they did. Jackie [Jacqueline A.] Noonan was one of our students, and we pushed her to go elsewhere, and we had a number of similar people who are now in quite good academic positions around the country.

DR. STRAIN: Well, the clerkship ended up with a definite curriculum for what, six weeks?

DR. McKAY: Well, the first thing I did after really learning firsthand what the curriculum was, was to get a month of pediatric clerkship established in the third year. And then we expanded that to two months, and then to an additional elective month in the fourth year. Subsequently, our medical college adopted a curriculum in which all of the clinical departments had students. Students could elect at the beginning of their senior year to major in something. It was an all-medical-school revision where the first year and a half was spent in basic sciences instead of two years. After Christmas the second year, the students started their so-called clinical rotations.

At first we had the basic science core, then clinical core, which went from January 1st to December 31st of the second year, and then the last 16 months, starting January 1st of the third year and all of the fourth year, was the so-called senior major program, in which the students picked their electives, and then each department had its requirements. The pediatric senior major program requirements were a minimum of a month on the inpatient ward, a month in the neonatal intensive care unit, and a month with a practicing pediatrician outside of Burlington.

That was very successful, because one of my theories or obsessions always has been that the practicing pediatrician and the academic pediatrician are just doing separate but essential parts of the same job as far as medical education is concerned. And the practicing pediatricians in town are too dependent on the medical school. It’s not the same as if they’re 40 miles or 80 or 100 miles away. I encouraged the practicing pediatricians, as they gained confidence in the students and the house staff who were working with them, to give them more and more independence, especially with the house staff. We required them to get licensed after their internship year, so that when they spent a month with a practicing pediatrician, if the pediatrician wanted to take the day off, he took the day off, and remained where he could be reached if necessary, but otherwise let the resident take responsibility for the practice, while the pediatrician remained available if needed.
You know, every medical school has had the problem of the “LMD” [local medical doctor]. He doesn’t know anything. Our residents learned very early (we actually started this back in 1958 and worked into it) that the “LMD” faces different things than are faced in the hospital. I always tried to emphasize this in teaching and in the [American] Academy [of Pediatrics]. Bob [Robert J.] Haggerty was much more successful at it than I was in the Academy, but I think I was the first one who pushed the importance of the role of the practitioner and the academician working together and complementing each other in the education of medical students and residents.

DR. STRAIN: So the ambulatory experience, both in the senior year of medical school, and the resident level, was out of the city.

DR. McKay: Yes, we had ambulatory experience in the city also; but that was a third-year experience. And an occasional fourth-year student. For instance, we had two or three women students who had two to four children and they obviously had to stay home. They couldn’t go away, so they did have their ambulatory experience in Burlington; but the rule was that they went out.

Generally speaking, the complaints of the house staff about having patients sent in to the hospital in the middle of the night or late Friday afternoon or whatever, virtually disappeared; and the complaints of referring physicians about our “snotty” house staff virtually disappeared. It worked.

DR. STRAIN: I understand. I can appreciate that. Jim, you served on the RRC [Residency Review Committee] did you not?

DR. McKay: Yes. Yes, I did.

DR. STRAIN: Early on. You know how that organization operates and works. And we’ve got a whole new set of guidelines that are going to be put into effect I think it’s February 1st of ’97.

DR. McKay: Yes, I haven’t seen those.

DR. STRAIN: I was going to get your opinion about those.

DR. McKay: Well, I’m curious because I think the guidelines in internal medicine stink. They don’t give the resident enough opportunity to function on his or her own independently. I am a strong believer in responsibility, and the confidence and learning developed in association with responsibility. I am afraid that in the new pediatric guidelines that there has to be somebody looking over the resident’s shoulder all the time. I think that is a bad error. There should be somebody available to the resident to talk to all
the time; but, looking back on it, the best parts of my training were situations where I always had somebody to consult, but I made the decisions. If I felt insecure about them, then I would consult with my senior, but I had the opportunity and the responsibility of acting independently, and that was very important.

I’m a strong believer in that approach to education. There are really very few errors made in the course of doing that. You have to exercise some judgment. For instance, we had outpatient preceptors, who were rated as fabulous by one resident and awful by another resident. The reasons given by the resident who rated them fabulous was, "He or she always let me see the patient independently and make the decision as to whether to get them to see the patient, too, or not." And the criticism of the guys who felt the other way was that, "He or she was always looking over my shoulder, I never got to see those patients by myself," and they were both right, because the good ones were given rein, and the bad ones were watched very carefully.

DR. STRAIN: They were watching those guys. Or girls.

DR. McKAY: There is another thing I introduced in our pediatric teaching, which I think was a contribution. I’ve always felt that practice, general primary care pediatric practice, was denigrated by the head of a department not participating in it, and often scorning it. So I made a point throughout my teaching career to always do some form of primary care practice. I had a primary care practice from the start among faculty members’ children, and limited it to that. Later on I ran a clinic with students and residents, once a week, in a town 80 miles from Burlington, which couldn’t get a pediatrician. Local practitioners really wanted a pediatrician. And so for ten years until they got a pediatrician, who turned out to be one of the students whom I’d taken there, I did that once a week. I’ve done essentially primary care clinics such as well baby clinics and more general clinics, too, all of my career and actually afterward. I did that until 1990 with students and residents.

DR. STRAIN: The guidelines do provide for some supervision but I think, in general, more independence. But I think the major change in what’s going to be in the new guidelines is going to be in ambulatory experiences. That’s going to be largely outside the teaching institution. It’s going to be in doctors’ offices; it’s going to be in community health centers; it’s going to be in schools, that kind of training and experience.

DR. McKAY: But we’ve done that...

DR. STRAIN: You’ve done that for a long time.

DR. McKAY: Thirty years. [Laughs]
DR. STRAIN: Well, that’s one of the new requirements! [Laughs] Well, I was interested in whether you supported that, and it sounds like you’ve been doing it for a long time.

DR. McKAY: Yes, I’ve always felt that hospital pediatrics isn’t the real world for the practicing pediatrician, although perhaps necessary to learn about it as a field, a source of clinical material. But I’ve also had the feeling, and had it when I went to Vermont, that the hospital clinic was no more realistic than the hospital inpatient service, as far as learning what practice was about. So I was always focused toward getting the student and the resident out into the independent practice office.

DR. STRAIN: I wanted to ask you a little bit about your service on the Committee on Medical Education or Committee on Scientific Meetings of the Academy. You served on that for quite a while; you may still be on that.

DR. McKAY: No, I resigned last year.

DR. STRAIN: Well, I wonder if you think we’re meeting the educational needs of the practicing pediatrician.

DR. McKAY: Well, I think fairly well. I think there was a period when there was a feeling they weren’t, but I think that they’re doing pretty well now. Warren [R.] Sisson got me on the education committee way, way back, about 1953 or 4. Then I was chairman, following Henry [L.] Barnett as chairman of the education committee in 1957 or 8, somewhere in there. The chair of the education committee was automatically on the program committee. Before that, actually, Chris [Einor H. Christopherson] was the program committee. Until about, I think, ’56 or ’57 and then it was a group of people. I remember at the 1958 meeting, there was a big conflict between the committee and the sections about speakers. I mean, it was the same in 1958 as it was in 1995. [Laughs]

DR. STRAIN: Exactly right.

DR. McKAY: But anyway, I think they’ve always done reasonably well. It’s always catch-up ball and responding to criticisms. As long as things seem to be going all right, why change? Then when you hear criticism, why you change; and I think the committees have been very responsive that way. I would have to credit Bob, the guy from Seattle. He was on the Board for awhile. Bob [Robert A.] Tidwell. He really changed the program committee for the better. I think that since his chairmanship of the program committee, things have gone much better.
DR. STRAIN: Good. There have been some significant changes in people going into pediatrics. And that leads me to the question, how many women were in your class in medical school? Zero?

DR. McKAY: Zero.

DR. STRAIN: Do you have any idea how many or what is the percentage in Vermont now of medical students, women versus men?

DR. McKAY: I know very well because I’m on the admissions committee. It varies from year to year; it’s either just over or just under 50%, and it’s been that way for the last five years, I think.

DR. STRAIN: Do you have any feeling about that?

DR. McKAY: No.

DR. STRAIN: Good or bad?

DR. McKAY: No. I think things have changed, and I used to be opposed to women taking up a place in medical school, because by far the greatest majority of them ended up not practicing or not practicing full-time. But things have changed, both socially and in what they do. I can point to women who have never used their medical education in my own area, and women who have done full-time and more than full-time jobs judged by male standards; they’re both there. They belong to different generations, but they’re both there in the same community.

DR. STRAIN: Do you think it’ll have any influence on pediatric person power?

DR. McKAY: What do you mean by that?

DR. STRAIN: Well, in terms of women working part-time versus full-time. In pediatrics.

DR. McKAY: I think in general, this has already had an effect, which has been inadequately recognized. A lot of the projections of general medical, including pediatric person power, if you will, have been made on the basis of the way things were 30 or 40 years ago, when almost all doctors were men who were married to very supportive wives who enabled those doctors to work 60 to 90 hours a week. And now the projections are still being made on that basis, and society is not this way. I mean, that’s not the way things are now, because there’s a much more equal distribution of work around the home than there used to be. But this means that the men cannot spend and do not spend as much time on their practices as they did before. And women are able to spend more time than they did before. But that means that we
have probably one and a quarter times, or maybe one and a half times, the amount of actual work being delivered by twice as many people. So that the projections for an overage of doctors, I think, are grossly exaggerated.

DR. STRAIN: Well that was my next question. Do you think we’re training too many or not enough pediatricians, or about what we should be training?

DR. McKAY: Well, I think probably about what we should be.

DR. STRAIN: We’re graduating about three thousand a year.

DR. McKAY: It all depends on the pattern of practice. And the pattern of practice right now is running toward more primary care physicians, and fortunately pediatricians are considered primary care physicians and function in large part as primary care physicians. I think we’ve had too many people in full-time positions in medical schools. I think we can cut down on that with no loss. I don’t think that we can cut down the number of physicians in general, especially if we have increased economic access to medical care; there’s going to be a lot more to do. Now it’s true that it’s possible to make doctors work more efficiently, spend more of their time on their medical work. And I think from this standpoint, the HMO [health maintenance organization] movement is a good one, insofar as it enables the doctors to spend a lot more time on medical work.

I just spent 18 months working in a continuing care retirement community, and doing my own Medicare billing, and I would say that I spent almost half the amount of time on the billing business as I did seeing patients. It would have been a lot more efficient for me to hire someone else to do the billing. I did the billing myself partly because I wanted to learn the intricacies of the billing, which I now have learned. [Laughs]

DR. STRAIN: You’ve seen general pediatric practice change through the years. What do you think the future of general pediatrics is going to be in this country?

DR. McKAY: I think it’s got to get a lot more efficient than it is. I think that there’s a lot of what pediatricians do now, which could be done as well or better by other people. And I think from the standpoint of the managed care business, I’m all for managed care in that respect. I don’t see it as saving a lot of money in the long run. I’m talking about doing things more efficiently and therefore better because you’ve released people of different educational levels to concentrate on what they do best, and each person does what they do best.

For instance, health education. I don’t think a doctor needs to do that, nor are they oriented or prepared to do it, most of them. On the other hand, many nurses or health educators are very good at it, very effective at it. And
they work better with patients in that sort of thing in many ways because they're not considered in a different category than the patient. You know, the patient is a lot more likely to accept that sort of advice from someone they think has faced and is facing the same sort of problems they face. And they look at doctors as being up here and just on a different level.

DR. STRAIN: Yes. That leads me to my next question, Jim, and that is, I’m thinking of the PNA [pediatric nurse associate] movement and the PA [physician assistant] movement in regard to pediatrics. Where do you think those people fit into the system of health care in this country?

DR. McKAY: I don’t think the present model or desired model fits too well. I think most PA’s and nurse practitioners try to be doctors and they are not really as well fitted for what they do as they should be. For instance, from my standpoint, I think the most skilled person should do the triage, not the least skilled. And it’s the other way around. And it’s perfectly true that everyone likes to be a doctor. If you watch the PA’s and PNA’s work, not all of them, some of them, I think, work very appropriately. They work as an arm of the doctor doing what they do best, and better than the doctors do.

For instance, in routine postnatal care and routine health care, they do just as good a job and probably a better job in many, if not most, instances than the doctor does. But in recognizing serious illness, again there are differences; because some nurses are very good at this, recognizing a serious illness and accepting their limitations in dealing with it and getting help right off the bat. But others are trying to be doctors, and they treat stuff they have no business treating, and they overtreat. Everybody wants to be a doctor.

DR. STRAIN: The Academy’s position has been that there ought to be a cooperative relationship between the PNA, the nurse and the physician, and not independent practice.

DR. McKAY: Well, I agree with that, and I think in the situations where the attitude on both sides is that attitude, it works very well.

I just had an experience, not in pediatrics, in the last few days. One of our sons called me and said that he had been having funny noises in one of his ears, as if there was water in it. He had gotten an appointment and asked to be seen right away because he was going away and was concerned about this ear business which he’d never had before. He was seen by a PA instead of his doctor. The PA diagnosed effusion in the middle ear, started him on a cephalosporin and an antihistamine; and it was probably the cephalosporin which made him quite ill within three or four hours. To my mind, he should have been told, “You’ve got some fluid in your middle ear. It’ll probably clear up in a few days. Go home and wait for it to clear up. Let me know if it doesn’t.” Anyway, he was sick. He was having chills and feeling awful,
and having diarrhea, and so forth. I told him to just quit all medication. At follow-up three days later the stuff in his ear had cleared up; the other symptoms cleared up as soon as he stopped taking the medicine.

This was a classic instance of overtreatment by somebody who didn’t really know what they were doing. I think this is the sort of thing where the doctor should take one look in that ear and say to the assistant, whoever it is, "I don’t think that needs any specific treatment, talk to them about it; good-bye." That would be the efficient way to do it, not the way the patient would like it, but…

DR. STRAIN: What do you think a pediatrician’s relationship should be with the family physicians?

DR. McKay: Well, that is a real toughie, because I think that the family physician has a real place. Knowing the family and working with the family has a real place in medicine. I also think that a good pediatrician does the same thing and has to do the same thing in order to be a good pediatrician. And I know that there is not only less professional skill in dealing with pediatric patients among family physicians, but there is waste in it. I ran a pediatric service for 33 years and almost all of the unjustified admissions and prolonged admissions, and so forth, that I observed, were patients of family physicians. Because they don’t deal enough with children to really know when a child is really sick or to have heard of the latest way to manage certain things. Also, I think the family physicians have been very shortsighted in insisting that all of their pediatric education in general be done by family physicians.

END OF TAPE ONE SIDE TWO

DR. STRAIN: I was going to ask if the pediatric department at Vermont had any input into the pediatric education of family practitioners?

DR. McKay: We do. Perhaps I should go back a little bit. I’d originally planned to be a family practitioner myself, and then if my practice got overwhelming, concentrate on the children part of it. So I was very sympathetic to family practice. Back in the mid-sixties, late sixties, when the family practice movement was getting going, the family practice idea was rejected by our departments of medicine and surgery, particularly medicine. So I introduced a family practice track with a pediatric major. So we had a pediatric major and a family practice track pediatric major. Both of those filled up at the expense of the department of medicine.

Because this expanded the influence of the department of pediatrics, the departments of medicine and surgery got very upset. They got the dean to forbid the department of pediatrics to run a family practice major [Laughs]
and approved the establishment of a department of family practice. The first chair of the Department of Family Practice was a family practitioner with whom Ralph Sussman and I had worked very closely. After he had a coronary, he became the director of the Division of Maternal and Child Health in the State Health Department. He went from that to being chair of the Department of Family Practice. So we worked very closely together, and this has pretty much continued. We don’t have problems in our medical school in this, with a lot of mutual respect.

DR. STRAIN: Good. In the latter part of your tenure as chairman, what percentage of the Vermont students chose pediatrics for their career?

DR. McKAY: Well, it’s run generally, on average, 12 students per year choose it out of a class of 93. And I don’t have my calculator with me, but…

DR. STRAIN: That’s very good.

DR. McKAY: That’s probably ten or twelve percent. But we’ve run consistently above the national average. Now it’s higher. Lew [Lewis] First has been very successful in increasing the number of students interested in pediatrics, and it’s way up now, up to 20% I think.

DR. STRAIN: What do you think the future of pediatrics is? How do you project it down the road?

DR. McKAY: I don’t know, because I think the future of pediatrics is going to be strongly influenced by the future of medical care, managed care, and how that goes. I think if the trend toward managed care continues, there will be a trend toward fewer primary care pediatricians. I think they are concentrating on trying to have the most efficient type of care.

Now, I think the most efficient type of care is to have different people doing hospital care and doing ambulatory care, for many reasons. It’s inefficient for the practicing pediatrician to spend the amount of time in the hospital that he ought to spend in the hospital with his real sick patients. He’s relatively inefficient at it because they’re relatively small in number compared to the rest of his practice. He doesn’t know the hospital staff as well. There’s a lot of efficiency in having people and staff work together who know each other and are used to working together. That’s an efficient way of doing it; they know what to expect of each other and what not to expect of each other. When you bring somebody in who only comes in once a month, who only has one patient a month or so, they don’t know each other. And they are not able to keep up with the changes in laboratory personnel, x-ray personnel and so forth. You are just a lot more efficient and effective if you’re working in the same place.
You throw a hospital pediatrician into an office, it’s the same way. Or you throw a practicing pediatrician, office pediatrician, ambulatory pediatrician, into a hospital floor, it’s the same way. Doesn’t matter which way you do it. I don’t know whether the most efficient way will be carried out. I’m afraid that they’ll have the primary care physician, the family practitioner, do all of the pediatric care. I think there’s a danger to this, and if they do, it will lower the quality and lower the efficiency and increase the cost.

DR. STRAIN: Well, you think then general pediatrics is going to be largely ambulatory pediatrics.

DR. McKAY: Yes.

DR. STRAIN: There’s going to be a separation between what happens in the office and what happens in the hospital.

DR. McKAY: No, I don’t necessarily think that. I think that would be the most efficient way to do it. But whether the people who decide this will have the knowledge to see it, is a toss-up.

DR. STRAIN: The system in England is pediatricians in the tertiary care hospitals and . . .

DR. McKAY: Family practitioners outside.

DR. STRAIN: Doing the general pediatric care.

DR. McKAY: Yes.

DR. STRAIN: And we’ve got 70,000 pediatricians in this country.

DR. McKAY: You mean we’ve got that many members of the Academy.

DR. STRAIN: 53,000 members of the Academy, and that’s about 75% of the total board certified pediatricians. So I’m saying close to 70,000 pediatricians; the majority of whom give primary care, general pediatrics.

DR. McKAY: Right.

DR. STRAIN: The question is whether that’s going to be the care that’s going to be given children in the future, or is that going to be delegated?

DR. McKAY: And I don’t know. I know I ran across some old correspondence when I was clearing out some files recently. I’ve forgotten who came to Burlington to interview me on the subject of the future of pediatrics. I came out very strongly about it being ambulatory pediatrics,
and that we ought to be doing more teaching in it and so forth, to prepare for it. A more realistic approach to it, which I tried to do in our program. But what’s actually going to happen, I don’t know. I’m very afraid that, maybe I already said this, that they’re going to put family practitioners in the position of doing all ambulatory care other than things like outpatient surgery and so forth. Even there, there’s a trend to having the primary care physician do that, which I don’t think is the best as far as quality is concerned, except in geographically remote areas.

DR. STRAIN: What do you think of the future of the subspecialties in pediatrics?

DR. McKAY: I think there are too many. There’s been a movement toward too many pediatric subspecialists, which has been recognized by the endocrinologists, for instance. They limit the number they turn out themselves. I think a limited number of subspecialists is very appropriate, but I think we have far too many people in subspecialty fellowships. But that’s gradually going down for the lack of financial support. But I see a continuing need for subspecialists. I mean, the greater the technology the greater the need for subspecialists. People may have to travel further to get to the true subspecialists, but that has its pros and cons.

DR. STRAIN: Were you involved in telemedicine at all up in Vermont?

DR. McKAY: Yes, we’re very involved in that. We have had a national TV program on it, on University of Vermont College of Medicine’s telemedicine program. And Lew First is very into that. In fact, I think the first real practical use of it was in Vermont in a pediatric situation, in a hospital 80 miles away where I used to take students.

DR. STRAIN: OK. I want to change the subject a little bit, Jim, and I want to talk about your editorship of a number of publications. Could you tell me what you’ve done in that regard through the years, and what some of your experiences have been?

DR. McKAY: Well, I guess it started with me getting a call from Bill [Waldo E.] Nelson asking if I would take over the section on the newborn in his textbook. That must have been about 1957. It was a result of Bill Nelson and me sitting together at a table during a Mead Johnson banquet that occurred at that time, and getting along well together. Stu [Stewart H.] Clifford and Clem [Clement A.] Smith had been doing it; Clem doing the neonatal part and Stu Clifford doing the non-neonatal part.

Stu Clifford wanted to back out of it because he was just undertaking a big project backed by the NIH [National Institutes of Health]; I’ve forgotten what it was. It was following children for six or eight years, something like
that, to see what happened. Anyway, he wanted to get out of it. Bill had asked him for suggestions, and he had suggested me as one of a number of possibilities. Then Bill had called Clem Smith and asked him how he felt, and Clem said that I would be acceptable to him. So Bill called me.

I was very flattered and I accepted, after making sure that Clem found me acceptable, because I didn’t know anything about the stuff Clem did. [Laughs] He would have to continue with that. So, that’s how I got into it.

From there, I got to know the [W. B.] Saunders guy who did the Pediatric Clinics of North America, and I think I wrote for the Pediatric Clinics. And then in 1960, I was appointed to the [editorial] board of Pediatrics just as Charlie [Charles D.] May went off. I remember meeting with George Wheatley at his office. He was with, was it Aetna?

DR. STRAIN: Met.

DR. McKAY: Metropolitan. Yeah, Met Life [Metropolitan Life Insurance Co.], to select a new editor. I knew about Clem’s having been a professor of English and knowing he really liked to write, I suggested Clem, and the others apparently hadn’t thought of that. So they said, “We’re going to contact Clem.” I guess I was elected to do it because I knew Clem. So I called Clem and he was interested, and then eventually ended up as the editor.

This was a funny situation, because of Charlie May, whom I’d gotten to know from the Sunday dinners at the Blackfans when he was chief resident and an instructor at the Harvard Medical School. He had been the one who put me up for an appointment to the editorial board. Then before I actually met with the editorial board, Charlie was bounced by the executive board and there I was, helping choose his successor. It was a very embarrassing situation.

DR. STRAIN: Now was that Pediatrics?

DR. McKAY: Yes, that was Pediatrics. I think I telephoned him [Charlie May] and talked to him about it, and he said, “Feel perfectly free to go ahead.”

DR. STRAIN: Now he was editor.

DR. McKAY: Charlie May was editor at the time, and he wrote an editorial called “The New Pediatrics,” which the Board didn’t like. Also, he was pretty independent and sometimes autocratic in his dealings, which the Board didn’t like. They felt some of their prerogatives were taken over by
him and they didn’t like that. So he was out anyway, but he had a lot of support.

During the first years that Clem was editor, the submissions to *Pediatrics* just went whoosh. Clem had asked me to work closely with him, and I was also elected chairman of the editorial board. Clem had established that position as a means of trying to get a little more support, because there was a lot of unhappiness about Charlie being fired, among the academic community particularly. Anyway, I remember I spent a lot of time in the first three or four years that Clem was editor rewriting articles that were awful, just so we had enough to put in the darn journal.

DR. STRAIN: Now he followed Charlie May?

DR. McKAY: Yes.

DR. STRAIN: And was Charlie May the original editor of *Pediatrics*?

DR. McKAY: No, the original editor was Hugh McCulloch. I remember the first issue of *Pediatrics* coming out in 1948 under Hugh McCulloch’s editorship. I had never heard of Hugh McCulloch. I said, “Who’s he?” [laughs]

DR. STRAIN: Did you ever know what the background was of changing from *Journal of Pediatrics*, to *Pediatrics*?

DR. McKAY: Oh yes. Gee, I thought everybody knew that.

DR. STRAIN: No.

DR. McKAY: Mosby was the printer and publisher of the *Journal of Pediatrics*. The Academy wanted a bigger slice of the profits, because when it started out, of course, it was sort of a loss leader for Mosby and then became very profitable. And the Academy wanted a slice of that. I wasn’t in on those deliberations, but Mosby either did not want to give at all on it, or did not give enough on it. Anyway, the decision was made by the Board to break off with Mosby and start its own journal under its control, which is what they did. And *Pediatrics* was it.

DR. STRAIN: It was economic problems.

DR. McKAY: It was economics, yes.

DR. STRAIN: And then after Clem, who was the editor?

DR. McKAY: Jerry. There have only been four editors.
DR. STRAIN: Well, now, you’ve been co-editor…

DR. McKAY: I’ve been co-editor of *Pediatrics*. I didn't want the editorship. When the editorship came up I thought of being a candidate. Several people asked me to be a candidate, but I just didn’t have time for it, so I said I wouldn't. And then Jerry [Lucey] was chosen, and he, I think, has done a very good job. He had the ideas; he’s a very good idea man.

DR. STRAIN: And then you did *Pediatrics in Review*, for the year that Bob Haggerty was vice president and president of the Academy.

DR. McKAY: For two years. I’d been associate editor. Jerry and I were both associate editors of *Pediatrics in Review* from its inception, and then I became editor during Bob’s sabbatical as vice president and president, and then turned it back to him.

DR. STRAIN: Now what’s your role right now on the editorial board of *Pediatrics*?

DR. McKAY: I’m out.

DR. STRAIN: You’re out completely?

DR. McKAY: Yes. I had started to serve on the editorial board in 1960. I resigned from the editorial board in ’64 or 5, when I was elected to the Board [of Directors] of the Academy. I think that started in ’66. I resigned because my term was up because I thought it was a conflict of interest for me to keep that. I was also on the RRC [Residency Review Committee] then. I resigned from that for the same reason. But I remained the Board liaison to *Pediatrics*, even after I resigned from the editorial board. And I had a continuous relationship with *Pediatrics* from 1960 to 1990, in one capacity or another. There was an interim of three or four years, somewhere along there, but I was associated most of the time for 30 years.

DR. STRAIN: Jim, I want to talk to you a little bit about your Academy positions. Why don’t we start with when you went on the Board, and who some of the people on the Board were at the time you went on?

DR. McKAY: Well, I went on the Board in ’66; I’m pretty sure that was the year. It was somewhat traumatic in a way, because that was the time of the Federation [of Pediatric Societies], you remember the Federation?

DR. STRAIN: I remember the Federation. Out of California.
DR. McKAY: Right. Glenn Austin, Leo [S.] Bell, Blackie [Richard] Joslin, Tom Cock, and Bob [Robert] Burnett were the leading figures in that. It was very interesting, because the Board was very antagonistic to the Federation and I was the newest member of the Board. I was pretty antagonistic to the Federation too, but I didn’t go into a fit of apoplexy every time the name Federation was mentioned. So I was assigned in my first Board meeting to deal with the Federation. That was my job. I was assigned to talk to the Federation because I had no established antagonism to the Federation, nor they with me. So I met with them, and then reported back to the Board at the end of the first meeting to the new president of the Board.

DR. STRAIN: Who was president then, by the way? Was that Jim [James G.] Hughes?

DR. McKAY: I can’t really remember, but it probably was Jim Hughes. He wasn’t as antagonistic to the Federation either. There were people who were more and people who were less antagonistic. Also, the guys in the Federation were more my age than anyone else on the Board; I was the youngest person on the Board by quite a bit, and the Federation guys were my age, or nearer my age. Actually we got along pretty well, and I came to agree with some of their positions, and I agreed with some of the Board’s positions too. I think I was able to calm things down so that they would start to work together more.

I remember one of the major things that the Federation was very strong on was having a Washington office, and I, having been opposed to that idea when I first started talking to them, became very supportive of it and really pushed it in Board meetings. From that time on, I was assigned to keep a watchful eye on the Federation; go to the Federation’s meetings and keep a watchful eye on them. So I met with the Federation all over the place for a number of years, and then eventually became very friendly with them. Actually, we worked together a lot. Eventually the Academy was hard up for a chair of the Committee on Third Party Payment Plans, and I was asked to be chair of that. That committee was so bad that I suggested the dissolution and then re-establishment a year later under another name, because I could not see that committee, as it was composed, accomplishing anything.

DR. STRAIN: Well, now, their [the Federation's] major concern was the lack of interest on the part of the Academy about socio-economic issues for the pediatricians.

DR. McKAY: Right, about economic issues involving the pediatricians. They thought the Board was very short-sighted. And I came to agree with that.
DR. STRAIN: What was the outcome of that? What did the Academy then do to really diffuse all of that concern?

DR. McKAY: Well, they appointed me as liaison to the Federation, and I was acceptable to the Federation, never having rubbed them the wrong way.

DR. STRAIN: Well, what was the end result of all of that discussion?

DR. McKAY: Oh, I think the end result was that the Board adopted some of the initiatives which the Federation considered to be most important, and eventually this led to the dissolution of the Federation, over a period of probably four or five years.

DR. STRAIN: One of the things then was the committee that you talked about, third party payment committee. It was dissolved and then reappointed a year later.

DR. McKAY: Well, no, that was later on. The third party payment committee existed beforehand. There was a practicing pediatrician from Boston, Ed [Edward C.] Dyer, who was very hot on the need for pediatricians to have appropriate representation vis-a-vis third party payers. He had gotten a committee established and was its chairman for a number of years. Then the Federation felt that wasn’t enough, and that the Academy was really lagging and needed to do more. What happened was that the Academy adopted, as I said, most of the Federation’s really urgent initiatives, and sort of did away with the need for the Federation.

The Academy had been keeping members of the Federation off the Third Party Payments Committee, and I got them to change that and appoint members of the Federation to it. Indeed, the Federation sort of merged into the Third Party Payments Committee and became the Third Party Payments Committee. And then we got the Washington office started, which they felt was very important.

DR. STRAIN: Was there a department set up, or a division set up, within the organizational structure?

DR. McKAY: Not until later. Eventually Sam [Samuel] Flint became that.

DR. STRAIN: There was somebody before Sam, too. I was trying to think of his name.

DR. McKAY: Yes, there was. He was a minister. He was a minister, right. Tom [Robb]. I remember meeting with him out at Phoenix. We met at the Hilton out there. Don [Donald W.] Schiff was on it at that point; but I was still meeting with the Federation or the committee for some reason. I sort of
functioned as a member of the committee anyway, for a number of years; I don’t know how many. In both official and unofficial capacities, mostly unofficial.

DR. STRAIN: Do you remember anything interesting about your time on the Board? Interesting or world-shaking?

DR. McKAY: Interesting, maybe. We had trouble with Sam [Samuel] Karelitz because Sam was very self-important. I don’t know how much I ought to talk about this. [Laughs]

DR. STRAIN: We’ll let you edit it.

DR. McKAY: Yes, you better. Sam was very self-important, and always had to say something about something. He’d stand up and talk in a very pompous way on and on, and everybody wanted to shut up Sam.

DR. STRAIN: Was Christopherson on board then?

DR. McKAY: Oh yes. Yes, he was. I was on the board when Rob [Robert G. Frazier] became whatever it was, executive director.

DR. STRAIN: I think he was an associate director. I think Chris had brought him on board.

DR. McKAY: Right. Hugh [C.] Thompson and I always got along very well together because we walked together. We were the fastest and most prolific walkers on the Board. We used to spend a lot of time talking while we walked, so I always had a close association with Hugh. And then Bill [William S.] Anderson and I had a close association. He and I were members of the Pediatric Travel Club, which was an eastern pediatric club. We had known each other there, and he had, I think, been actively behind getting me on the Board. Then, after I was on the Board, he became president. He had me sit on his left.

Bill was very anxious that the meetings keep moving and, actually, so was I, and he knew it. So, he told me to sit on his left, and the minute things seemed to stall, to make some sort of motion to get things going again. So I’d watch Bill, and Bill would sit there and Sam Karelitz would get up and start to bilge on, and Bill would motion, like this [tapping fingers], and I knew that was the time to step in [Laughs] with a motion, or to second a motion.

DR. STRAIN: That was the code?

DR. McKAY: Yes, that was the code. And then I remember Saul [Joel] Robinson. Saul was always sort of a prickly guy. He’d been certainly in the
forefront of getting the chapter forum going; he started the predecessor of the chapter forum [Annual Chapter Forum]. But he was sort of prickly in that, and he was prickly on the Board too. The Board wasn’t very happy when he was elected to it, and then he sort of increased that. I remember, we were meeting in Monterey when I was vice-president, and Russ [Russell W.] Mapes went out of the room for something. He had another meeting and left me to carry on, finish the meeting. Saul got up and started one of his unpleasant, unnecessary diatribes and I finally said, “Shut up, Saul, and sit down.” And he did. This was overt antagonism to him, and that was the first time there had been that. He had sensed it was there; I’m sure. He asked me to come see him afterward, and we talked it out, and became very good friends after that. And really, we were just good friends.

DR. STRAIN: Good. Was he a part of that Federation movement?

DR. McKAY: Well, sort of peripherally. He was not the heart of the Federation. He was supportive and knew about it, but he was not actually part of it. The moving characters, as I said, were Glenn Austin, Leo Bell, Bob Burnett, and Blackie Joslin. They were the real Federation.

DR. STRAIN: Did they ever come to the Board meeting? Make a presentation?

DR. McKAY: Um, I think so, but I don’t remember it specifically. I can remember Hugh Thompson getting very annoyed with Tom [Thomas C.] Cock and Glenn Austin, and they met with the Board at the Wednesday morning meeting when Hugh came in as president. And he sat them at the table and read them the riot act. Holy Moses, did he cuss those guys out! [Laughs]

DR. STRAIN: I remember that. Or hearing about it.

DR. McKAY: Oh boy. And I had to do a lot of personal repair after that. [Laughs]

DR. STRAIN: Interesting. What would you say, during your tenure as president, you are most proud of? What did the Academy do different then? How did you advance the Academy, or feel it advance during your tenure?

DR. McKAY: Well I think my tenure as president was a flop from that standpoint. The thing I was really interested in was trying to get the practicing group and the academic group to feel that they were working as one, and not in an antagonistic fashion, and I didn’t succeed in doing that. Bob Haggerty did, and I don’t know why.
DR. STRAIN: Well, you really were responsible for setting up the Washington office. I didn’t realize this had come as a suggestion from the Federation, but didn’t it occur during your tenure?

DR. MCKAY: I think it occurred before I was president. I’m not sure; it may have. But I know the beginnings of it occurred before I was president. My participation in it and urging it came through my contact with the Federation. They’re the people that wanted it. They should get the credit for that.

DR. STRAIN: George Degnon was the first director, do you remember?

DR. MCKAY: No. Now, wait a minute, I’m trying to think whether it was Jackie [Elizabeth J. Noyes] or George Degnon.

DR. STRAIN: I’m sure George preceded Jackie. I think George hired Jackie, as a matter of fact.

DR. MCKAY: Maybe that was it. That’s right, George was director for a couple of years anyway.

DR. STRAIN: Do you think the motive for establishing a Washington office was to deal with promoting issues that would improve the lot of the pediatrician?

DR. MCKAY: I think it was a mixture. This was one of the problems in all those dealings. On the surface, the Federation looked totally self-serving and that was why the Board was so opposed to them. Actually, when you got right down to it, their position was that the Academy needed to protect and espouse the practicing pediatrician on adequate reimbursement and so forth, and gain respect, in order that they would be there to serve children better. So it was a mixture of those things, and I think the Board on the other hand did not really understand the importance of that to the goal of serving children. It was a matter of melding the two.

DR. STRAIN: Now the interval between the time that was established and now, we have 16 people in our Washington office, five lobbyists and the rest are support people. How do you think we’re doing in that regard?

DR. MCKAY: I think we’re doing very well. The ex-wife of a nephew of Liz’s is a lawyer who went from California to Washington after they were divorced and worked in health law in Washington, and actually is now [Senator David F.] Durenberger’s wife. She worked first in another office and in his office, and she told me that the Academy was the only medical organization that had any respect, or any credibility in Washington, and that its credibility was high and universal. To me that spells success, because she’s a very smart young woman. I met some people a couple of times when I
was having lunch with her. When she had introduced me as being in the Academy, oh, the positive responses all the time. I’ve also gotten this in Vermont where we know our politicians personally, and I’ve heard this from Pat [Patrick] Lahey and Jim [James] Jeffords.

DR. STRAIN: The reason for that, Jim, is that I think we’ve gone to the Congress with our concerns about children. We really haven’t promoted the pediatrician in legislation or anything else; the focus has been on the welfare of children. And I think that’s come through in our testimony. Now I’m not sure that’s served the need for which this was originally designed at the time.

DR. McKAY: Well, I think it has and it hasn’t. It hasn’t provided the loud and obvious voice that pediatricians ought to be paid more, but I think it’s gotten the message across very well that pediatricians are important, that pediatricians are the best people to take care of children. That is something that in these days of family practice ascendancy, is very important for pediatricians. I think we’ve done so well in the credibility field that it’s going to be very hard to dislodge us if they try to. The feeling in Washington obviously is, as far as I’ve been able to gather, that the AAP has credibility. We work, not for ourselves, but for children, and we ought to be rewarded for it. So, indirectly, I think that it may have been more successful than in doing it the other way.

DR. STRAIN: Other medical organizations have taken different paths.

DR. McKAY: That’s right. And for the politicians, it goes in one ear and out the other. Pay no attention.

DR. STRAIN: Let me ask you, while I think of it, about the students selecting pediatrics. You had a high percentage of students, much higher than the national average, going into pediatrics. How much influence do you think the student loan problem has on career selection now? Do you think this is a significant determinant of people selecting, for example, O.B. [obstetrics], orthopedics, or ophthalmology, versus…

DR. McKAY: I don’t think it has any influence at all. The thing that does have influence, though, is income after medical school as a means of paying off student loans.

DR. STRAIN: That’s what I’m talking about.

DR. McKAY: The loans themselves have nothing to do with it.

DR. STRAIN: No, no. They’re leaving school with a 50 or 60 or 70 thousand-dollar loan.
DR. McKAY: What do you mean? A hundred twenty thousand!

DR. STRAIN: You’ve got an expensive school!

DR. McKAY: No, we have a lot of students with very little in the way of finances.

DR. STRAIN: Well, that’s what I had in mind, I mean they’re leaving medical school with that kind of debt.

DR. McKAY: Well, I think that’s an important factor.

DR. STRAIN: Yes, I wondered about that. Whether in your experience students are saying, "Well, listen, I can’t really afford to go into pediatrics."

DR. McKAY: And they’re right.

DR. STRAIN: Or general medicine.

DR. McKAY: They’re right. Or psychiatry.

DR. McKAY: Oh gosh. You know, to go back, Chris wasn’t the first executive director.

DR. STRAIN: No. [Clifford] Grulee was.

DR. McKAY: Grulee was.

DR. STRAIN: Yes, exactly. You didn’t know Grulee, did you?

DR. McKAY: Yes. I met Grulee, knew him by appearance, and knew his son quite well. I did not know Grulee, really know him, but he was around during my early years still.

DR. STRAIN: But he wasn’t executive director.

DR. McKAY: No.

DR. STRAIN: So you don’t have any impression of Grulee at all in his capacity as executive director.

DR. McKAY: No.

DR. STRAIN: What did you think of Christopherson?
DR. McKAY: He was the Academy. [Laughs] And he was very nice to me. Gave me opportunities.

DR. STRAIN: Oh, he did it by himself, he didn’t have a very large staff.

DR. McKAY: That’s right, he didn’t. I said earlier, he was the program committee basically, for many years.

DR. STRAIN: Now you wanted to go back and talk a little bit more about Pediatrics, Jim, and that’s important. I think we need to know how that came about and some of your reflections on it.

DR. McKAY: Well, I think the thing that I would like to go back to and emphasize is that beginning with the break-off from Mosby, the Board from time to time has gotten restless with publishers, and felt that the Academy should be getting more money out of it. My understanding has been that Mosby owned Pediatrics and that was what rankled the AAP Board. As owner, Mosby was getting the profits, which were by then significant, and refused to share them to the Board’s satisfaction. There was also an issue of control.

From my standpoint, a lot of the changes which they have made, particularly those which have tended to separate the publication of Pediatrics in some fashion to bring it totally under Academy control, have been ill advised. I think the separation from Mosby turned out well. But since then, there have been a number of times when the Academy has proposed, and a few times, I think twice, taken over the publication of Pediatrics itself.

There’s one quite long period when the publication process of Pediatrics was carried out in the Evanston office and then it was printed by a printer up in Michigan someplace. Those, in general, have not been good for the Academy. There was another time, well that was one of them, that the quality went down. The work from the standpoint of the editors was increased, so that they couldn’t give enough attention to things that the editors really should give attention to.

Another time was when the Academy hired an independent guy named [Walter] Suberg as the publisher. He had an office in Evanston, and he was a wheeler-dealer who was not good for Pediatrics. He made a lot of errors, gave us an awful hard time because there were months when because of his wheeler-dealering, we didn’t know whether the darn issue was going to come out, so there was a real risk of cessation of publication, which would have hurt the credibility of the journal and the Academy.

I think the association with Williams & Wilkins has, on the whole, been a very good one. I don’t know just what it is now, because I have not been
meeting with the Board or talking much with Jerry about it since the end of 1990. But they are professionals who know their job; they keep up from the standpoint of publishing; I know they’ve made some major technological changes, which have been for the best, and really it’s gone very smoothly. Or relatively smoothly at least. I don’t know of any attempts to bring it back into the Academy office, but I’m sure they’ll come in the future again because this has come up regularly. To my knowledge, every five or six years there’s been somebody who said we ought to bring it totally under our control and we’ll make more money and so forth and so on, but I am really convinced now that having it published by a reputable medical publisher is probably the best way to do it. It costs a little, may cost a little more, but, boy, it does away with a lot of bad headaches, reduces administrative time.

I mean there’s a lot of administrative time, if you have an editorial office in the Academy office, there is a lot of administrative time which has to go into it. Because it’s a small operation relatively speaking, you are subject to the vagaries of small-operation publishing. For instance, you use a small publishing company that may have only one press because it’s cheaper, but there’s no back-up press if something goes wrong with that press. With an outfit like Williams & Wilkins, and now Waverly, you have not only publishing and printing and advertising know-how, but also back-up people in case someone gets sick, dies, or quits unexpectedly. In short, it saves the Academy space, administrative time, and costly fumbling by senior administrators without publishing experience or know-how.

I think it’s very important for the Board to know in the future that there have been these repeated efforts to bring the publication into the Academy’s central office. It’s actually been done on two occasions, didn’t work out for various reasons, and it’s better to spend a little more money and not have the headache is what it amounts to.

DR. STRAIN: That’s good historical information. The Board needs to look at that.

DR. McKAY: Well, I don’t know whether they’re looking at that now or not, but they may be.

DR. STRAIN: I was going to ask you about the content of Pediatrics versus, for example, the Journal of Pediatrics. Some place along the line there was a decision made that these two journals are going to be different in terms of content.

DR. McKAY: Well, this is a very funny history, because, when Jerry took over as editor, the Journal of Pediatrics had a reputation of being the practitioner’s journal, the practical journal for the practitioner, and Pediatrics had a reputation for being a scientific journal, in which no practitioner could find anything applicable to his practice. It was sort of a
joint decision on the part of Jerry, Bob [Haggerty], me and whoever the Pediatrics business person was at the time to emphasize that Pediatrics was for the practitioner, and that there were practical articles in it, and so forth. They started putting out, in every issue, a little flyer, “Pediatrics, The Practitioner’s Journal.” I guess on the old Hitler basis, that if you repeat a lie often enough people will start to believe it. And soon it’s true. That’s what’s happened. Because now, the Journal of Pediatrics is considered too esoteric by the practitioner and Pediatrics is the practical journal!

DR. STRAIN: But that evolved over a period of years. Is that right?

DR. McKAY: Yes. Oh yes.

DR. STRAIN: Because they are very different.

DR. McKAY: Oh yes. And they used to be different the other way.

DR. STRAIN: Very well, that’s an interesting history because certainly I think everyone would agree right now that Pediatrics is for the general pediatrician.

DR. McKAY: And this has been a deliberate thing on Jerry’s part, and I think he’s done it very well, succeeded very well.

DR. STRAIN: OK.

DR. McKAY: You really ought to talk to Jerry a little bit about his view of the history of Pediatrics, since he has been editor. He doesn’t know much about it, if anything about it, beforehand; but, he obviously knows all about it since he got there.

DR. STRAIN: Yes, he’d have a good background. He would know something about Charlie May?

DR. McKAY: No. He was just starting at the University of Vermont at that time and didn’t know Charlie May, and didn’t know any of that. Wasn’t involved.

DR. STRAIN: Well, we need to talk with him and get his views about it. I wanted to ask you a couple of general questions, Jim, and this is one that we’re asking all of our interviewees. That is, do you think physicians entering pediatrics today will have as satisfying a career as you’ve had?

DR. McKAY: No doctor will. [Laughs]

DR. STRAIN: That’s a direct answer. Well, that leads to the question, would you advise a young person to go into medicine or pediatrics?
DR. McKAY: Yes, if they’re interested in it and really want to be doctors. I think it’s going to be a different ballpark. I have been on the admissions committee at the University of Vermont for the last five years, and a couple of years ago one of the young people I was interviewing said a very telling thing. We were talking about something that was happening in medicine that I wasn’t approving of. She said, ”Dr. McKay, you’ve got to realize that this is a terrible change for you and your generation, a negative change, but we’ve never known anything else. So we don’t miss it the way it was, because we’ve never known it the way it was.” It was a very penetrating remark. She was right.

DR. STRAIN: What do you think about the quality of applicants you’re getting now?

DR. McKAY: It’s good.

DR. STRAIN: You’ve been on the admissions committee for quite awhile?

DR. McKAY: This is my sixth year.

DR. STRAIN: You’re getting good quality people.

DR. McKAY: Oh, very good. I think more attention now is being paid to the qualities that the applicants have as far as becoming good physicians. I mean, there was this period that started back in the sixties, we’d want the “brightest and best” people in medicine and in pediatrics. Frankly, I always thought that that was not necessarily the best way to go about it. Because you know and I know that you want bright people, as bright as you can get, but the people who make good doctors for people are not necessarily among that group of people picked out on the basis of grades, scientific achievement and so forth.

DR. STRAIN: Or test scores.

DR. McKAY: Or test scores. And in a number of cases, they are not good people at all as doctors for people. Vermont is a good illustration of this, because when I went to Vermont the admissions criteria were very low according to national standards. And the GPA [grade point average] and SAT [Scholastic Aptitude Test] scores, and the MCAT [Medical College Admissions Test] scores for Vermont students were, I think, the lowest in the country, or among the lowest in the country. But the scores on part three of the National Boards were a little above the average. And that was what I observed in looking at our students and how they did after medical school.
It was a very interesting thing. There was an article about that published in one of the journals, I think it was *Journal of Medical Education*, having graphs showing the discrepancy. It was the standard statistical graph, with the drift back toward the middle from either end. Classical, I should say.

DR. STRAIN: Do you think there are, and should be, medical schools that train people more for research or academic positions, and other schools that train people for delivery of health care?

DR. McKAY: You’re deciding too early on that. Some of your best people are the best and the brightest from the objective standpoint who also have the other thing and may not discover it until they actually start having contact with patients. And vice versa, there are people who when they start having contact with patients realize that they really aren’t cut out for that, but they are challenged by research and science and so forth.

DR. STRAIN: Do you have very many applying for Vermont positions in medical school that just say they want to be researchers?

DR. McKAY: No, we don’t, because our mission has always been to prepare people for the practice of medicine, particularly in Vermont.

DR. STRAIN: And some schools are more focused on academic achievement and an academic career.

DR. McKAY: Yes, that’s right.

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

DR. McKAY: Yes.

DR. STRAIN: Why do you think that?

DR. McKAY: Well, I think in general they’re healthier and there’s generally a better infrastructure. It depends a little bit on how you define children. I think adolescents are worse off; very definitely. I think the small child is better off.

DR. STRAIN: What are some of the problems that you were thinking of in terms of adolescents?

DR. McKAY: Well, general violence, inappropriate sexual behavior which is damaging both to the individual and the society, lack of a steady and, if you will, unyielding, fixed moral structure that they can count on. I mean, you look at kids, they’re always testing, and they are happier if, when they
test, they know just where the wall is or just where the line is. When the line
or the wall keeps waving around, life becomes very uncertain and they are
less happy in that situation.

DR. STRAIN: It’s called situational ethics.

DR. McKAY: [Laughs]

DR. STRAIN: What about families? Do you see any change in families in the
last 20 to 30 years, in regard to your medical practice?

DR. McKAY: Well, I don’t know how to judge this, because some things, I
think, are better, some are worse. We don’t know. I think there is more
spousal abuse than there used to be, but I don’t know whether there really is
or not. It may be that it’s just the focus by the media and the law
enforcement agencies and the lobbyists on abuse, and the social workers who
are making a living from this. There’s a lot of involvement of vested
interests here, and it’s very hard to tell just what’s what.

There are undeniably more broken families than there were, but we don’t
know how broken the families were before. Nobody was keeping track of it
before. And we don’t know whether the children and the families were
better off where the parents weren’t speaking to each other or fighting all the
time, or now, when they’re split.

I feel very strongly about this, in contrast to Liz, who thinks everything’s
gone to hell. As far as I’m concerned, when you look back and read old
literature and so forth, the older generations always thought the younger
generation was going to hell. And I’m not going to get myself caught in that
trap. As that young medical school applicant pointed out to me, they’re
living in a different environment. Their experience is different. I think what
people like Liz and the older generation have been doing for ages is confusing
different and wrong. I refuse to do that.

DR. STRAIN: Things just aren’t like they used to be.

DR. McKAY: That’s right. And whether that’s better or worse...

DR. STRAIN: Who could say?

DR. McKAY: Who can say? That’s right.

DR. STRAIN: Well, Jim, we’ve come to the conclusion of the things that I
specifically was wanting to focus on, but I’ll leave it up to you as to whether you
want to comment on anything that we have talked about.
DR. McKAY: Well, I think I commented on the thing that I wanted to comment on, which is the history of the publication of *Pediatrics*, because that has important decisional aspects for the Academy. And I think otherwise I’m a strong believer in the younger generation making its own decisions. If they want to draw on the experience of the older generation, I think that’s a good idea, but I think they should make the decisions, even though we think they’re wrong or may think they’re wrong.

DR. STRAIN: They need to know what’s happened in the past.

DR. McKAY: That’s right. Well, that’s the basis for a sound decision. And I personally have found them very open to that. They become more closed to our advice and experience the more our generation bemoans everything they do.

DR. STRAIN: Well, Jim, I sure appreciate getting together with you; thanks for spending the time. We’ll get this transcribed and you can look it over.

DR. McKAY: I don’t envy you in the job, I used to be the editor, recorder-editor, for the APS [American Pediatric Society]. All of the proceedings, when I was recorder, were published. They were all recorded in shorthand, transcribed, and then I had to edit them into understandable form. And boy, that was a long, arduous job.

DR. STRAIN: Yes, I think so. I’ve talked to two or three people that have done this, and they say it is a big job.

DR. McKAY: Because the spoken word is so different from the written word, and in order for it to make sense you have to do an awful lot of rearranging, revision, slashing, substitution.

DR. STRAIN: Yes, that’s right. I think there’s something to be said for the oral history, because you can be a little bit free wheeling that way, but then you want to look it over and be sure that it makes sense to you, that you understand next week what you’ve said today. OK, that completes the interview with Dr. McKay. Thanks, Jim.

END OF TAPE
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CURRICULUM VITAE
Robert James McKay, Jr., MD

Born: 10/8/17 in New York, NY
Family and Childhood Home: Basking Ridge, NJ

Family Status: Married 56 years to Elizabeth Foote McKay, who died January 20, 1999
Married Martha Ann Wellman, March 18, 2000
Four adult sons and 11 grandchildren

Education: A.B. Princeton, Magna cum Laude in Modern Languages, 1939
M.D., Harvard, 1943
Kellogg Foundation Fellowship in Public Health, Coldwater, Michigan, Feb. 1943

Training: Intern, babies Hospital of Columbia-Presbyterian Medical Center, 1943
Assistant Resident, same, 1947
Chief Medical Resident, Boston Children’s Hospital, 1948
Fellow in Pharmacology, Harvard Medical School, 1949

Military Service: Feb. 1944 – Aug. 1946. Captain, M.C., AUS Battalion Surgeon with 75th Infantry Division (European Theater)>
Bronze Star Medal, three Battle Stars. Organized and directed first community medical dispensary for occupational troops and their families, Bad Nauheim, Germany.

General pediatric practice one day a week, Newport, VT, 1968-1978
General geriatric practice, Wake Robin Continuing Care Retirement Community, Shelburne, VT, 1994-1996
Private pediatric consultation practice, Burlington, VT, 1950-1990

Academics: Assistant Professor of Pediatrics, University of Vermont College of Medicine, 1950-1953
Chairman, Department of Pediatrics, University of Vermont College of Medicine, 1951-1983
Associate Professor of Pediatrics, University of Vermont College of Medicine, 1953-1955
Professor of Pediatrics, University of Vermont College of Medicine, 1955-present
Fulbright Lecturer, Department of Pediatrics, University of Groningen, Netherlands, 1960
Professor of Pediatrics, Emeritus, University of Vermont College of Medicine, 1987-present

Professional Societies:
Chittenden County and Vermont State Medical Societies
American Medical Association
New England Pediatric Society (Council 1951-56, President 1965-66)
Society for Pediatric Research
American Pediatric Society (Recorder-Editor 1958-65)
American Academy of Pediatrics
  Pediatrics
    Editorial Board, 1960-66
    Editor for Books, 1974-77
    Assistant Editor, 1977-79
    Associate Editor, 1979-
Committee on Medical Education (1958-65, Chair 1963-65)
Vermont State Chairman, 1963-64
Alternate Chairman, District I, 1964-65
Chairman, District I, 1965-69
Executive Board, 1965-71
Vice President, 1969-70
President, 1970-71
Long-Range Planning Committee, 1972-76
Third Party Programs Committee
  Consultant, 1969-80
  Chairman, 1981
Intraorganizational Management Committee, 1977
Nominating Committee, 1976-79
Council on Pediatric Education (Chairman), 1985-89
American Society of Human Genetics
Association of American Medical Colleges
Sigma Xi
Alpha Omega Alpha
Ambulatory Pediatric Association
Canadian Pediatric Society
Association of Medical School Pediatric Department Chairman
  President, 1979-81
Society for Developmental and Behavioral Pediatrics
New England Regional Genetics Group

Community and Professional Activities:
Pediatric Consultant to Vermont State Health Department, 1950-1983
Trustee, Vermont Tuberculosis and Health Association (former president)
Trustee, Johnson & Johnson Pediatric Institute
Trustee, Charles H. Hood Dairy Foundation
Medical Advisory Committees of:
  Vermont Association for the Crippled
  Elizabeth Lund Home (for unmarried mothers)
  Josephine S. Baird Children’s Treatment Center
  Champlain Valley Office of Economic Opportunity
  Planned Parenthood of Northern New England
  Vermont Branch of National Foundation for Infantile Paralysis
Rheumatic Fever Committee of Vermont Heart Association
Vermont Mental Retardation Planning Committee
Vermont Governor’s Committee to Study Child Abuse (chair)
Director, Vermont Regional Genetics Center
Director, Vermont Infant Apnea Program
Director, Vermont Poison Center
Founding Committee, Board of Directors, and Chair of Health Care Committees,
  Wake Robin Life Care Community, Shelburne, VT, with responsibility
  for development and oversight of health care facilities and programs
Volunteer, United Way of Chittenden County
Consumer Concerns Committee, New England Regional Genetics Group
Committee on Internships, Residencies and Postgraduate Education of
  Association of American Medical Colleges (1958-61)
AMA Residency Review Committee for Pediatrics (1960-1965)
Senior Pediatric Consultant, Vermont State Health Department (1950-)
Chairman, Medical Advisory Committee of CVOEO (1969-73)
Member of Parent’s Advisory Committee, Burlington Day Care Center (1968-71)
Head Start Consultant (1965-73)
Acting Director, Vermont Regional Genetic Center, 1986-87

**Hospitals:**
Chief of Pediatric Service, Medical Center Hospital of Vermont (1951-83)
President of the Medical Staff of the Medical Center Hospital of Vermont (1967-
68)
Attending in Pediatrics, Medical Center Hospital of Vermont (1983-90)
Past Consultant Staff Appointments:
  Porter Hospital, Middlebury, VT
  St. Albans Hospital, St. Albans, VT
  Moses Ludington Hospital, Ticonderoga, NY
  Champlain Valley-Physicians Hospital, Plattsburgh, NY
  North Country Hospital, Newport, VT

**Honors:**  Alpha Omega Alpha Society
  The Society of Sigma Xi
  John and Mary R. Markle Scholar in Medical Science, 1950-55
Distinguished Service Award, Chittenden County Junior Chamber of Commerce, 1953
Commissioned a Kentucky Colonel
Grulee Award of American Academy of Pediatrics, 1981
Abraham Jacobi Award of American Medical Association and American Academy of Pediatrics, 1984
Nu Sigma Nu Award for Excellence in Teaching, awarded by UVM Medical Students, 1957
Green Mountain Pediatrics Award of Vermont Chapter, American Academy of Pediatrics
Distinguished Alumnus Award of Babies Hospital of New York
Distinguished Service Award of the Vermont Medical Society

**Publications:**
(See attached list)
Published 26 articles in medical and various other publications
Associate Editor, 9th Edition of Nelson’s Textbook of Pediatrics
Co-Editor, 10th Edition of Nelson’s Textbook of Pediatrics
Co-Editor, 11th Edition of Nelson’s Textbook of Pediatrics
Associate Editor, *Pediatrics*, a journal published by the American Academy of Pediatrics, 1979-91
Associate Editor, *Pediatrics in Review*, published by the American Academy of Pediatrics, 1980-83
Editor, *Pediatrics in Review*, 1983-85
Associate Editor, *Pediatrics in Review*, 1985-1990

**Personal Publications:**