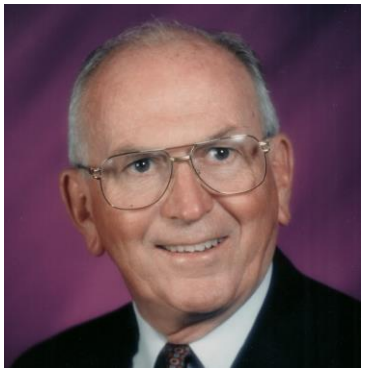

Robert Haggerty

- Born 8/20/1925 in Saranac Lake, NY
- Spouse – Muriel Haggerty
- B.A. (1946) and M.D. (1949), both from Cornell University

Major Employment:

- William T. Grant Foundation – 1980-1992, President
- Cornell University Medical College – 1980-1992, Clinical Professor of Pediatrics
- New York Hospital – 1980-1992, Attending Pediatrician
- University of Rochester School of Medicine & Dentistry – 1992-Present, Emeritus

SRCD Affiliation:

- Member from 1958-1994

SRCD ORAL HISTORY INTERVIEW

Robert Haggerty

Interviewed by Lonnie Sherrod
May 13, 1993

Sherrod: This is Lonnie Sherrod interviewing Robert Haggerty on behalf of the Society for Research and Child Development. It is May 13th, 1993. Bob I guess the first category of questions in the interview have to do with your intellectually history. They begin with family background sort of where you were born, and grew up what your schooling was like and early adult experiences.

Haggerty: Thank you, I never had any formal training in child development, but I'll tell you some of the things I think may have influenced it. I grew up in a small town in upstate New York. My Grandfather was a general practitioner and I from a fairly early age, wanted to be a family practitioner like he was. And among other things in the summertime, I'd spend two or three weeks with him. And he would make house calls and take me along when I was maybe 14 or 15. And I think that probably set a stage, both for looking at the life span development because most of these households had two or three generations in them. And there also was the reverence with which he was treated in these houses and the comfort of them. He was well known in each of these homes. And so I think this idea of family continuity was fairly early implanted.

Sherrod: Do you have any idea of what size population he served?

Haggerty: Yes it was a town of 1500 people with perhaps two or three thousand surrounding. Turn of the century when he went into practice there, there were five physicians and I think he had a tough time making a go of it. It was a time when the U.S. had produced too many physicians through those proprietary medical schools. Although he went to Albany medical school. But by the time I knew him there was one other physician in town. When he died there were 3000 people, who came to his funeral, in this little town. So that gives you some idea of the reverence in which he was held, I think.

Sherrod: Is there any particular event that you remember, I mean like, you know of your visits with him, I don't know, a particular crisis?

Haggerty: No it was all very pleasant I think. And most of the patients he visited were not crisis, they were what he called shut-ins. And largely old people with chronic illness that couldn't get out in those days. So he would make a visit maybe once a month to check their blood pressure or tumor or whatever. He did make emergency visits, home visits. The main emergencies I remember were always, every other Sunday we went to one Grandparents, and then the alternative Sunday to the other. But he had his office right in the home and I don't think we ever got through a Sunday dinner without somebody coming in. And he lived in Richfield Springs he was right on Route 20, and that was the main

east/west highway at that time. So that in those days there were lots of automobile accidents and those kind of trauma, but that part was less interesting to me I think than the kind of support that he gave a lot of these old people. I think another background fact is that my father had tuberculosis after World War I, which is why I was born in Sarinac Lake, he was still curing from tuberculosis at that point. So chronic illness was a feature I think of my early life, and I recognized that he had this. When I was about seven years old he had a bad relapse and went back to Sarinac Lake and I lived with an Aunt that year and I actually thought he was going to die. There actually was an interesting medical cure and he had a staphylococcal empyema, which in those days, pre-antibiotic you would have thought it would have killed him. But it cured and with it the fibrous tissues around the lung gave him in effect a thoracotomy or a thoracoplasta collapse of the lung. And he never had any further trouble from his tuberculosis. It was an interesting side light. But chronic illness and the effect on the family was another effect of my early life. I think the other thing I've mentioned to several people the tolerance of deviant views. This Grandfather who was the physician was an ardent Democrat, was actually the town supervisor of this little town for over 30 years. And was quite a gregarious person and knew everybody and liked people and talked about them. But knew Roosevelt personally and Jim Farley and so this was in the 30's. So on Sunday's that I'd spend with him he was always touting what a great man Roosevelt was. My other Grandfather owned a leather tanning mill and was an ardent Republican. And so the alternative Sunday I would get nothing but damnation of this communist that had been elected. And they were both very nice men and I loved them both. So I think I did learn to keep my mouth shut and also to learn that people could have deviant views without being bad people, that you could disagree with them. My education was a very small town high school. In which two of us out of a class of 17 went to college. But we were both very close friends from the age of 4 or 5. Went through high school together. He was the pitcher on the baseball team and I was the catcher. We double dated a lot and we both went to Cornell. And I was best man at his wedding. So we had a close attachment and what one might think was a poor education we for instance, when we knew we had to college, or wanted to go to college we didn't have trigonometry or solid geometry wasn't taught in our high school and the science teacher took pity on us and was very interested in us both. And he tutored us both in those subjects and we both got a 100 on the regents examination. But he learned along with us, he never taught those before. So that there was a clear personal interest there, in the students by the teachers. And those of us that were interested in education did well. Now at Cornell.....

Sherrod: How did you choose Cornell?

Haggerty: Purely economics. I got a regents scholarship there. I'd only applied to two schools, there and Harvard. And the regents scholarship paid for most of the tuition there. At this stage we still didn't have a great deal of money. My father had just actually bought the drug store by the time I went to college in this small town. And he'd had several years where he was out sick. In college interestingly enough I was very much a biological science major. I majored in Zoology.

Sherrod: What did your friend major in?

Haggerty: He was an engineer. This doesn't have much to do with child development, but we kept touch for a long time then we lost touch. He came here to New York and was in the insurance business. And after ten or twelve years of not having any contact, the second year after I moved here to New York in '81 or '82, a mutual girlfriend of ours from the class behind us, with whom both of us had kept a Christmas Card contact. Wrote us and said you must see each other, you both live on Sutton Place South. And it turns out he's a president of an insurance company and lives right across the street from me here.

Sherrod: So did you renew contact?

Haggerty: Somewhat. We didn't pick up quite as close as we did in the past. But in college with this, really a scientific background, I'd always been interested in science. The only other career I ever contemplated was chemical engineering. So I took straight science background. And this was during the war when we went year round, so I didn't have an awful lot of time for electives. I started college the day after graduating from high school. We went three trimesters a year with a day or two between each trimester. And completed college in two years. I hadn't completed enough hours to graduate, but by going to Cornell Medical School I got enough hours. So I got a Bachelor of Arts after one year of medical school. I'd completed all my major and minor by the time...in the two calendar years. But in the final two semesters my advisor, who was Doctor Adleman an eminent embryologist, and you wouldn't have thought of him being in the social and behavioral sciences. He said, well you've had all science you should take some sociology this year. And so I took two courses in sociology, and this opened up a whole other field. Which at the moment I didn't think I'd

ever use, but I suspect planted a few seeds in behavioral science. And there were some eminent social scientists although I can't remember their names now, at Cornell at that time in the sociology program. Then at medical school I think some of my major interest in....

Sherrod: Now where were you?

Haggerty: At Cornell Medical College. And again that was partly because I got scholarships there, and partly because of this getting the degree. Again I applied only to Harvard and Cornell quite different from today, when you have to apply to dozens of them. But by going there I also got the
bachelors degree. Which is probably not any great use, but it seemed important at the time. But at Cornell there were two or three things. We had a fairly strong psychiatry department and one person who was very interesting to me was, Thomas Renny. Who was really one of the fathers of community psychiatry. He did the studies of prevalence of mental illness back in the 40's and some of the differences in social class and some of the influence of environment on mental illness But among other things, he had us write an autobiography, I think in between the third and fourth year. And that was the whole theme of it was what it was that led you where you were now. There was this developmental sequencing to it. And psychiatry was made, under him at least, a dynamic kind of thing. I must say, the chairman of psychiatry was Oscar Detelm who was a famous Germanic nosologist. Because all we did there was study schizophrenia and the German classifications of it. So most of us didn't like that. But many had this dynamic approach to psychiatry that was mostly analytic but more a, what we call social psychology today.

Sherrod: I was going to ask because I thought psychoanalysis was the name of the game.

Haggerty: Well it was to some degree, but I single out many. But also I spent a months elective with Harold Wolf the famous neurologist. Who was a very early psychosomatic person. And he was the one, among other things, who studied Tom this man who had the hole in his stomach. And he created certain environmental stresses for this poor guy and then we'd suck out his gastric juices and study what it was that effected his gastric juice and his blood pressure. So that was fairly early in the whole field of psychosomatic medicine, introduced to that. There were probably other influences, but for that period, interest in behavior was fairly strong at Cornell. Then I took a two year mixed internship at Rochester the first year it was offered in 1949. With a goal to being a family doctor or an internist. Those were the, I hadn't really thought of pediatrics at that point. But one of the reasons to go there was Doctors Romano and Engle had just come a year or two before. And it was rapidly gaining the reputation of being a place where the behavior aspects were melded into general medicine. And Doctor Engle of course is the origin of the bio-psycho-social field. And I think from them I certainly got a strong interaction relationship. It wasn't psychiatry I was interested in, it was the influence of behavioral aspects on physical disease and visa versa. But it was also there that in my six months on pediatrics, I found that one, I felt could do things, that I couldn't in internal medicine. You realize in those days in internal medicine, in all our training mostly, was done in the wards in the hospital. And most of my internal medicine experiences were exiting people from this life. I remember one day I had five deaths among ladies all over 80 years of age. And I thought is this the way I want to spend the rest of my life? Now actually if I'd thought of my Grandfather I'd realized that you take care of them before they died, but in the hospital all you saw was death. Where in pediatrics, kids got well. And that appealed to me and this Doctor Clawson who was the professor, was a wonderful teacher and my assistant residents were very nice. So I decided to do that. And I think that a crucial experience there was that in 1950 the Polio epidemics were still in their peaks. And for some reason I was picked, among other house staff, to go off and get training in management of children in Polio, we went to Pittsburgh for that. And then we were on call during epidemics for this. And I was sent to Utica in the fall of 1950 on a Polio epidemic and, the person who, the other young person who was there was a resident from Boston Children's Hospital. Who seemed to know a lot more than I knew about Polio, and had a lot of experience. So I was convinced if I wanted to be a pediatrician I needed to go to Boston to get the training. And Doctor Clawson called Doctor Janeway, who was the chairman there and told him about me. And I went up and had a long interview with Doctor Janeway, this was in the spring of '51. And was accepted on the spot, and he said, well you come in July. Well then the Korean War was in existence so, I got drafted for that.

Sherrod: Pittsburgh, was this at the end of your two year internship?

Haggerty: No that was purely during, as a matter of fact, that was during the first year of my internship. They sent us off for training in polio. The national foundation, which was called the March of Dimes then. Trained young people for this.

Sherrod: So Boston would have been the second year of the internship.

Haggerty: Well it was a two year internship at Rochester. So in 1951 that I was due to go. Now that internship at Rochester was quite unique. There were about 15 years of it and it was six months each of medicine, of pediatrics, and of psychiatry and then three months of emergency room surgery and three months of OB. And I think again it did sort of solidify my interest in the life span aspect. Even though I was going to be a pediatrician, I had taken care of people of all ages. And I think particularly the linkage of the birth aspect to pediatrics. I still think one of the great deficiencies of pediatric training is they don't see the mothers during the pregnancy. So much of the attitudes and the values are set during that time. I must have delivered a couple of hundred babies during that time. So I saw a lot of obstetrics. I purposely did not do much operating room surgery or much operating room gynecology. I was focused on obstetrics and emergency room. Interesting, it was designed to produce a generalist in an era when there wasn't such a thing as a so called family physician. That was a later development they were called GPs then, but it was designed to overcome the deficiencies of the one year rotating. Which was usually a month on each service and everybody agreed that was too short. Six months was really a considerable block of time. But out of the 150 or so people that completed this program in the first 15 years, it was finally abandoned because of the Vietnam War, and the fact that they got drafted after one year, you couldn't stay two years out any longer. There were, I think, only 6 or 7 family physicians out of this group and there was something like 25 department chairmen, 10 deans, almost everybody went into academic medicine of some sort or another from this. So it was more productive for academic medicine than all of the other straight programs. Well then, when I did get out of the air force, incidentally I did internal medicine in the air force again a broader experience. And I went to Boston and I had a wonderful experience. Although Boston at that time, and still is, a super specialized pediatric hospital. But from the developmental point of view, Dane Prughis the child psychiatrist there and he was very effective as a teacher. And I think indicated again the biological and psychological interaction in effective ways. I was all set to be a cardiologist, I had my had fellowship in cardiology all set, with Doctor Nodas a very charismatic pediatrician there.

Sherrod: This was at then end of....

Haggerty: This was at the end of my chief residency there.

Sherrod: Now where did that come from that sort of seems....

Haggerty: Cardiology? Well as I say it was a very sub specialized school or hospital. Nodas was a very charismatic person. Cardiology at that point was just breaking out to do the physiology of cardiac congenital anomalies and the ability to diagnose them by angiography and cardiac catheterization. So it was at that point the hot field, if you would, different fields at different times. So you were attracted by the intellectual challenge and all that. But, the theme running through the course of my time, I had talked to Doctor Janeway, that I thought the training there was too specialized. For instance, one time I was called down to the emergency room when I was chief resident to see if a child had a rash, and the fellow had had two or three years there at Children's didn't recognize it as an ordinary case of measles. He thought it was some rare disease. I'd had a lot of, I'd had two years of internship, two years in the air force and then three years of residency there. So I'd had a considerable more experience than some of them. And I guess I complained to Dr. Janeway that we really ought to train the residents in some of the more ordinary diseases here. But Dane Prugh had gotten a grant from the Commonwealth Fund to develop a home care program. And then he accepted the job as chief of child psychiatry at Rochester, where he'd been in the past. So really at the last minute, Doctor Janeway said, well you've always said you thought our residents ought to be trained in something more general and here's your chance. And I said, well I have this commitment to Dr. Nodas and he said, don't worry about that I'll take care of that, and he did. And I remain close friends with Dr. Nodas. But that was really the turning point, my career would have gone probably totally different. Except you had to do a research project with Nodas. And I remember I'd designed a project already, and it was to study why do kids with congenital heart disease not grow. They don't, even though they're sometimes, half of them have no cyanosis and all and they eat all right, but they don't grow. And I thought this was an interesting growth sort of a problem. At any rate....

Sherrod: It sounds like your interest in kids and pediatrics had remained through the cardiology.

Haggerty: Oh this is pediatric cardiology.

Sherrod: Oh OK.

Haggerty: This is all kids. Yes, no it was not adult cardiology at all. Then as I say, I took over this commonwealth grant that Dane Prugh had gotten. And Dr. Janeway was, as he usually is, extraordinarily generous with time, let me think about what I wanted to do. Didn't have to be home care program, one of the flexibility's of some foundations in those days. And I did several visits to New York to Barbara Karsch at Cornell where they had the comprehensive program, to Hopkins, to Pittsburgh and to other East Coast places. Finally I decided that we would do a family health care program. Oh ,George Silver at Montefiore Hospital was running a family health care. You know some of these are probably unconscious things but it did seem to me it was useful to take care of families over time if we're going to teach younger people medicine. Home care as it was set up then, and there were some models, there were models in Boston actually, were episodic. They responded with home visits for people who called in with acute sickness. And that appealed to me less than idea of taking quote "ordinary families". There was one thing that I learned rapidly was not to call any family normal. There aren't any such things. And we recruited finally about 1000 families, largely lower social class, working class, Irish families from Roxbury. Which was right across Huntington Avenue from the Children's hospital, to be in this program. And from the very beginning we took care of the whole family. I hired an internist and an obstetrician to take care of the adults and the obstetrics. And we had a couple of psychiatrists, but the longest one was Peter Wolf, a famous developmental child psychiatrist, as the psychiatrist. So it was a team of pediatrician, internist, obstetrician and psychiatrist. And we had a medical social worker and a public health nurse. So it was very much an early team model of care. And then on to that we grafted the first year pediatric residents of Boston Children's they all picked up 50 or so of these families and took care of all the kids in them. And then we did an experiment in medical education. We actually randomly assigned entering, not entering but third year Harvard Medical students to this program. Or to a control group without ever going through a institutional review board and the student's didn't know whether they were in the control or not. I mean those in the experiment obviously knew. But we took about 32 a year into the program and there were matched controls. And they started with a pregnant mother in the beginning of their third year medical school and they delivered the baby and they provided health care, preventive services for the whole family and these were mainly intact families at that time. So they got the father and they made a few home visits. That is probably the most generative experience of my entire career. I learned from those families the impact of psycho-social factors on health. I saw the families, I was there for 11 years. And so I saw the development of families.

Sherrod: And how long did the program last?

Haggerty: It lasted another decade or so after I left. Funding finally, lack of funding finally did it . Plus I'll get to it in a moment. There were very interesting demographic shifts that made a big difference there. But I learned from those families an enormous amount. In my real interest in bio-psycho-social, came from taking care of some of these families when acute crisis would happen in the family. One case I published was a girl who failed her, or her family thought she was failing her catechisms for confirmation and just made life miserable for this girl. And she woke up on the day of her confirmation with a strep throat and her four siblings who lived in the same house and all of them cultured positive didn't have symptomatic disease. And that led to probably the best research project I ever did, which ended up in the stress and strep paper that looked at the fact that acute illness was more likely in occurring after acute stressful events of that sort. But the social worker was very instrumental in my learning about families. Remarkable two women social workers. The public health nurse was remarkable in knowing what to do for these families. Peter Wolf was a wonderful teacher of development and so that context between the other faculty members I had and the families that's where whatever I've learned about child development, I think occurred. Now I shouldn't leave out my own family. I think all of us learn development from our own family. I got married in 1949. We had four children between '51 and '58. And so seeing them develop you can't help but...

Sherrod: Now map this back onto the career projectory, this was just as you were heading back to Boston?

Haggerty: I got married in the fall of my first internship. And then the first child was born while we were in the air force. And the second back in Boston. It's an interesting historical period. I was on surgical rotation, three months on surgery, when we got married and I went into the chief of surgery at Rochester and told him I was taking my vacation on surgery. He Said, "Well that's all right you're not going to be a surgeon anyway. What are you going to do on your vacation?" And I said, "I'm going to get married". He said,"What? If you were a surgeon I'd fire you right now". It was a day when you could not be married and be a the surgical house staff. And it is only fairly recently you cannot be married in any internship. That was a rapid period of change. And going back to Boston after two years internship, two years in the air force, I now had the second child and the Boston house office residency did not pay anything. So we lived for two years on the GI bill. Still a remarkable social invention. I hope we see some kind of a similar thing today.

And during my chief residency I got $1000 for lecturing to nurses. Actually that was a extraordinarily good experience. Because I had to organize the whole field of pediatrics for a relative, they were bright and sophisticated, but relatively non-physiologically oriented group of people. So you had to condense your thinking into fairly simple terms. I learned an awful lot from giving all those lectures. As I say, I got paid $5 a lecture, which kept the body and soul together at that time.

Sherrod: Now you, we've got to move into the second category of questions that they have for the interview, that really deals with your research contributions. Was the cardiology study that you actually didn't do, was that your first experience with research, in terms of...

Haggerty: The cardiology project I didn't do, incidentally was done 15 or so years later, and showed that these children both didn't eat as much and they also burned up more calories. Then in the course of studying these families, particularly with the stress and strep study, I realized that I didn't have the ability to measure the psychological factors going on in these families. And I can't remember how I met, but I met two people; Bob Rapaport and Bob Wilson who were then running a sociology in medicine program for, who was the famous sociologist at Harvard at that time?

Sherrod: Oh Parsons?

Haggerty: Parsons. Talcot Parsons. And they had a seminar, I never actually asked Dr. Janeway and he sent me over talk to somebody at Harvard. That is probably the way, I should mention incidentally that Dr. Janeway a brilliant man, immunologist, pediatrician actually an internist briefly, was most supportive, understood what I was doing in the fields that were quite different from anything else in Boston at that time and very supportive. And I think there was, I credit him with most all of what I was able to do. At any rate I somehow made contact with Wilson and with Rapaport and for about a year, maybe two years, I spent every Friday over in Cambridge in the seminar series. There were about 18 to 20 people, 2 or 3 or 4 each year were physicians, but the rest were mainly sociologists and a few psychologists. And the seminars were the presentations of their research. Most of these people were post doctoral fellows. I was sort of an odd man in and I was only spending that one day there. But during that time I both got introduced to their research methods, but also realized the need to get more training. And it was Bob Rapaport who arranged for me to work for a year with Margo Jeffries, who is a medical anthropologist at the London School of Hygiene at that time. And Dr. Janeway arranged for me to have an appointment at the Paddington Green Children's Hospital in St. Mary's Hospital. Which the children's hospital in Boston had, had an affiliation with. And then I should mention another key person in my career, Dr. Joseph Garland, who was at that time the editor of the New England Journal. And Dr. Janeway had recommended me to him. He was looking for two young people to assist him in the editorship of the New England Journal. Dr. Joe Stokes an internist preventive medicine person at the Massachusetts General and I from the Children's would meet with him and review manuscripts and write editorials. He was a pediatrician in practice for many years. And so he and Janeway were really my intellectual father figures. And he arranged for me to meet a variety of people in England, because the was the time that formal letters of introduction were written. And I carried these around to the editor of the British Medical Journal and Lancet and to some of the leading figures in academic medicine in Britain. All of whom accepted me extraordinarily courteously and invited us out to home for the weekends. And we had a wonderful time. I took courses in epidemiology and bio-statistics and social medicine at the London School of Hygiene. And I did a research project developing, what was a very crude but early measure of family function. I called it a family function index, which I did largely with Margo Jeffries. I interviewed a whole group of families in England and I did a test/re-test in that I did the same questionnaire a month apart. And I did what a thought was a validity check by interviewing independently the mother and father. And also interviewing their primary care physician about the families so I had different view of the family. And I think the main thing it taught me is the relative unreliability of questionnaire data. I remember the highest test / retest was the date of marriage and that was only 97% recorded the same thing. On the other hand I also got into the whole issue of reliability of medical tests. And it turns out if you give the same X-ray to two radiologists, or even the same radiologist a month apart you only get about an 80% agreement.

Sherrod: We should publicize that finding more widely.

Haggerty: I wrote this up in the American Journal of Public Health and that was the point I made, that at first glance it seemed that interview data was unreliable, it in fact, was just as reliable as most any other thing that people sort of thought was a gold standard.

Sherrod: But the England training was in kind of specific methods of research. I mean, how did your interest in research and kind of understanding what research was all about, come from? Was that just the general science background? Because physicians don't get that so much these days.

Haggerty: Probably some general background. This John Morrison my chum from early days, we used to spend Saturday nights in high school in my basement doing chemistry experiments. So I guess there was a certain scientific bend to it. But I think Boston Children's with it's heavy emphasis...and Harvard Medical School were all part of the same....probably accentuated this. Plus there's no doubt the publish or perish phenomenon was catching up with me. If I was going to stay around there I had to get tools to really do the research. And I'd say Dr. Janeway was a crucial figure. Without prodding he pushed this. Now there's another very important thing I left out here in this, and probably the most important developmental aspect. When I took on the family health care program Dr. Janeway made me the chief of what was called the Child Health Division. There were cardiology divisions and endocrine divisions and all that. And the previous chief had been Harold Stuart, who was a very well know pediatrician, who had moved from the children's hospital to the Harvard School of Public Health as the chairman of maternal and child health. But he'd continued the chief of the child health division. But he was nearing 70 then and otherwise I wouldn't have been given that at such a young age. But he was the person who, starting in the 30's, did the longitudinal studies of growth, the Boston growth studies are Harold Stuart's. And so the first actual project that I did was starting, it wasn't my project I just did the measurements, starting in the fall of 1955, when I started the faculty level. I did the 21 year examination on these 200 kids who were part of his Harvard longitudinal study. Each kid would come in with a book from birth, these kids had been followed from the day of birth. And they had almost all of the exams had been done by Harold Stuart. And they were well written and meticulously documented and of course the growth charts that we use now are the results of that. But I was impressed with several things; one the continuity of physical development, he would describe a very muscular hyperactive newborn, and in would walk this 21 year old kid full of muscle just brimming with energy. Or he'd describe a very loose jointed placid child and in would come this loose jointed kid. But with some exceptions, there were some obvious very different things from the continuity. So I think the idea of continuity and yet change and the effect of the environment on this was solidified in that experience. So to that degree I did learn some research methods from him. And also I should say, that before I went to Britain, I know how I got to Dr. Rapaport, I started out by taking epidemiology and bio-statistics and the sociology of medicine at the Harvard School of Public Health. And one of the young faculty members there was Levine.....

Sherrod: Bob?

Haggerty: No the one who'd been at Boston University for last many years.

Sherrod: Mel?

Haggerty: No, much older than both of them, my age. I'll come back to his memory (Sol Levine). But he's the one who suggested that I ought to go over and see Rapaport. So I'd begun through the School of Public Heath. And actually had an appointment in maternal and child health there because of the child health connection. And we took students from the Harvard School of Public Health in this family health care program to show them what you did in well baby clinics. So there were some other strands of....

Sherrod: Why don't you say a little more about those first two research projects. The one in family health and the one in the random assignment. And then your first visit with this 1967 paper on chronic disease.

Haggerty: I think it was earlier, '62 maybe. I think at the Harvard School of Public Health I did get the idea of random control trial, random clinical control trial. That medical education experiment was one of the early and I suspect still today, a relatively unusual random control trial of assigning students.

Sherrod: And what were the results?

Haggerty: Well there was a little bit of, first of all I should go back and say there was a lot of resistance to this. Because we took students out of their regular clerkships if their baby was coming, or the mother's, the mother they were taking care of baby. And the surgeons for instance, objected to this violently. But Dr. Janeway and Dr. Thorn the chairman of medicine and the chairman of obstetrics and the Dean, George Barry were solidly behind this. So that I had support at that level, but frequently had to defend it at the faculty meetings. This was disturbing experience. So one of

the things was merely to prove that these kids didn't loose anything in the traditional areas. So we monitored their experience on examinations and national boards and all that. Of course there wasn't any difference between them. We also monitored their career choice and there was an increase in the medical careers among these people. There was some diminution in the sub specialty, surgical sub specialties, and increase in psychiatry, pediatrics and medicine. The numbers were small so it wasn't a terribly significant thing. And then we also monitored their write ups on the surgical and medical services. To see if they included more family history and social history in the write up. One example shows the effect of environment, one of the young woman medical students, who was very sensitive, very good in our family health program, I was reviewing her write ups on her surgical service at the Massachusetts General Hospital and she had a young man who had ulcerative colitis and had social family history negative...non-contributory, not negative, non-contributory. Well first of all, he was having his whole colon out and nothing more, that was certainly it. Nothing about whether he was married or not married, what was his psychology, his psychological situation. So I went and talked to her about this and she said "Oh my goodness." And then she spelled out in half an hour all this material, she had taken a wonderful history. She knew all about him and all of this, and I said "Why didn't you write it down?" She said, "Well if I'd written that down, all the surgeons would have called me soft." And she said, "I know you don't write that stuff down when you're on surgical rotations." So we abandoned that method of assessment, but I think it does show how sensitive students are to the perceived environment. And that was not something to do. So the results were that they didn't choose traditional things, they certainly changed career a little bit more, or were influenced in career a little bit more. And then I did, we used critical incident method to try to show that they in fact learned some things from critical incidents. Those are not easy to prove, but for instance, on a New Year's Eve, one of these families, the McCann family, father was a gas meter reader and a philanderer and his wife who was an in and out depressive, they labeled her a schizophrenic, but in retrospect she was probably depressive. She got depressed after each baby and she'd had five, I think that I'd done. She called me at home and said she was committing suicide and hung up the receiver up. I called the medical student and he together with my wife and I went out on New Year's Eve to this house in the projects and she was out absolutely cold and there was a bottle of Phenobarbital or Seconol maybe next to her. And the father was out cold from drunkenness and here were five little kids. What do I do with five little kids, well I called the social worker and she told me abut a place in Boston called The Home for the Little Wanderers. And so we packed the kids up and we took them up there and we took the mother to the Peter Bent Brigham Hospital. We wrote those up as anecdotes that students experienced and having known such family before that event occurred, I can't help but think there is an educational experience that goes along with it. Especially when one can do something. I think the whole area of social problems and social treatment, is that they very often leave people feeling there is nothing they can do about it. These students realized that there were some things that they could do. And the stress experiences that they would understand. They were on call 24 hours a day. They could sign out to each other but they had to provide coverage for these families 24 hours a day. And that too was an experience that they hadn't experienced before. There was an enormous amount of bonding, especially around the delivery. I still think that taking care of a family during pregnancy and then delivering the new baby, is a really wonderful bonding experience for physicians. And to this day I have students some of whom became surgeons, there was an opthamologist in Florida, who I've seen a couple of times. Every time he sees me he asks me what happened to his family.

Sherrod: So they each just had one?

Haggerty: The students each had only one family. Sometimes that was enough to, that family, that fellow that had the McCann family could learn all of medicine, because they had all kinds of infectious diseases and they had all kinds of....

Sherrod: What happened with them, did the mother survive?

Haggerty: Yes the mother survived and they went back together and struggled along. One of those, no perfect solution. Let me, you asked about research, let me also deviate here, partly because of my interest and partly because the way to get ahead at Boston I suppose, was
to try to do some traditional kinds of medical research. So I did a series of studies. I was the director of the Boston Poison information center. And we started an answering service for doctors who had a case of any unknown poison. And we created a list of the ingredients of common household products. And over the course of time I studied a number of cases of poison. And put together a series that were published in the New England Journal of Clorox swallowing and various other things of that sort. I also was interested in infectious disease so that I did a controlled trial study of one of the early steroids methyl-progesterone and bacterial meningitis which we randomly assigned, we had the pharmacy make up bottles that looked identical, they were labeled either odd day or even day. And if a kid came in on a 1, 3, or 5

they got odd day, if they came in on 2, 4, or 6, they got the other one. And I didn't know, nobody knew which was the active ingredient. And then I did a yearly follow-up on these kids. Which was also sort of developmental in that, the main things we were looking for were difficulties in the hearing, speech development of these kids. And we published that, interestingly showed no difference. And subsequently now it has been shown that you have to give it 20 minutes before you give the first antibiotic. Now it is standard practice to give steroids prior to the, 20 minutes prior to the antibiotics, apparently if you give the antibiotic first you get such a release of toxins that a lot more damage is done and the steroids seem to prevent that. I think it was a good idea, but we didn't get the right answer at time. But I was a big fan of random control trial experiments. Medical education, standard therapeutic ones. Then before I left Boston we started the big study, which was again funded from the Commonwealth Fund, which was to randomly assign families who were using the hospital emergency room as their doctor, to our program. Or to stay in their traditional thing. And that was called the family health experiment. As I say, we randomly assigned family, again didn't go through any institutional review board, but half of them, some 500 families got the care in our program and half got the traditional services. And by that time I had a fellowship program going. The first fellow was Dr. Roger Meyer, who later has been in school health out on the west coast, but the second fellow was Dr. Joel Alpert who particularly carried this project through. And when I got back from England I was so impressed with the need for behavioral science, that I hired Dr. John Cosa and Dr. Leon Robertson. Cosa was an anthropologist and Robertson was a psychologist, to our program. And with them we designed this study and carried it out. And I think that resulted in a book that was published and really was a very early effective, showing the effectiveness of this kind comprehensive approach. That kids have far fewer days in the hospital, they have fewer illness days. Cost of medicine and of diagnostic tests was less because we knew them and didn't have to do the tests all the time. So it's become a kind of a classic I think.

Sherrod: What was the book?

Haggerty: It's called "Changing the Medical Care System Experiment in Comprehensive Care"

Sherrod: In what year was it published?

Haggerty: In '65 or '66. In '64 I was offered the chairmanship of the pediatric department at Rochester. So we went to Rochester. And I'd say the major research activities at Rochester were organizing health services research. We got very much involved with the whole 60's Medicaid neighborhood health centers, migrant, health programs, we did a lot of new service programs. We started the migrant projects, we started the city drug program. We started four neighborhood health centers. And in the neighborhood health center area we compared two poverty areas of town, one with a health center and one without. And I got very much more into health services research then, then bio-psycho-social. Went on to health services research study section and later, became chair of it. After that actually went on the council of the NIH. So that I was very much caught up in the health services at that time. But among other things we did start the adolescent clinic which was a new venture. And recruited actually both psychologists and sociologists to the department over some opposition. The Dean felt, what was I doing hiring people who weren't pediatricians in the pediatric department. And I said that these people were much like bio-chemists in the department of medicine. Then maybe to go into more of that, because that was a very exciting period of time. Then in 1974 I was nominated to spend a year at Stanford at the Center for Advanced Studies in behavioral science. But as a health service, there were 6 physicians there that year, who were supposed to come together and look at quality assurance among other things, which we did to some degree. But again I was exposed to 40 some odd senior behavioral scientist, including my neighbor there David Mechanie. Oh I should go back, Sol Levine, is the Levine, he was very influential in my getting started in this behavioral science field. And that was a very good experience, but I had been frustrated enough at Rochester with the difficulties with the University and what I was trying to do in community pediatrics. And this, what I've often called a seamless whole of children, mainly the fact that they are the product of their genes, their environment, their family. You had to look at all pieces of them and to do that I had to have faculty members that could look at all that. The Dean was not very sympathetic to that kind of approach, interestingly enough, in spite of Engle and Romano and all. And so I thought that when I was at Stanford that year, it would be better to do this in a non-departmental kind of school, the school of public health and the offer came to go back to Harvard with an endowed chair the Roger I. Lee chair of health services. And to attract me in part and partly because the school needed to consolidate some things, they put three departments together. The old department of health services and administration, the maternal and child health department and the behavioral science department, which Latent had been the chairman of, he was retiring at that point. So I inherited some behavioral scientists in that department. And it was there that John Eckenroad was a fellow with me for instance.

Sherrod: Oh I didn't ever realize that.

Haggerty: We did some studies together. So that I had this weaving in or out of behavioral science throughout my career. And mixed with health services which uses behavioral science methods, I don't see that much difference, although they are not focused on children always. And yet that experience was the one time in my life I've not been happy professionally. I got caught in a period of conflict, not me with the Dean, but many of the other faculty. At a time when, at Harvard, there were 30 tenured faculty at the School of Public Health and 20 of them petitioned the president to fire the Dean. And so it was a difficult time and different groups would try to get you to join them. And I was more on the Dean's side in the things that he wanted to do. But also frustrated by the conflictual situation and frankly I had trouble getting money to do what I wanted. I'd had a much greater success in the department of pediatrics getting money.

Sherrod: Do you think that was because it was field specific, as opposed to multi-disciplinary?

Haggerty: Well that's an interesting question. I think the conflict at the school interfered. For instance I put in a 3 million dollar grant to the Robert Wood Johnson Foundation to develop a community laboratory. And was turned down, I did get a Kellogg grant to do that. But the departments in Schools of Public Health don't, the school doesn't have any endowments, so you don't have any backup. And you don't have clinical income, which you can always find a few dollars to do something in the clinical department, and I couldn't. So the combination of all those features, I left the School of Public Health, went back to children's as a professor in 1978. And I started a medical education journal there. And was doing some other things there when the offer came to join the William T. Grant Foundation. And it's unlikely background for this particular foundation, I think. I'd sort of woven in and out among some of these issues but when the board asked me and then gave me the freedom to say what I thought we ought to do. It did seem to me it was time to move from the infancy field, as they had been so successful in developing, to the adolescent field. And I think we did that successfully. Here of course I didn't do any more research. But I count those twelve years as among the most happy and intellectually stimulating in my career because I had contact with leading behavioral scientists throughout the country. And the fact that the board had outstanding behavioral scientists on it and that fact that I was able to get you and John Butler and Frank Kessel to join me intellectually. I always said that the time here was like a department chairman except that I had none of the problems of the department chairman. I didn't have to find space, and deal with salary, and negotiate promotions. All I had to deal with was their intellectual development. So it was a very productive and satisfying time.

Sherrod: It's about to the end of that. So maybe if when we start, two of the questions here is one; has to do with research funding and most of the funding you've mentioned actually has been private foundation. So maybe we can start with that on the new tape.

OK, this is a shorter tape, it's only a 15 minute tape I think, but we're almost through.

Haggerty: You asked about research funding. Yes I think the first funding for the commonwealth fund and then our large scale funding for the commonwealth fund. But when I went to Rochester we really started to tap federal funds. And I was on the Health Services Research study section, as I indicated. And so I began to know that source and also the maternal and child health children's bureau. I got a training grant from the maternal and child health bureau to train fellows. That was my fellowship support at Rochester. I was able to get first a specific grant and then a series of program project grants for our community child health surveys. We did total community, not total community, but random sample of the total county of Rochester, four times. And in '68, '70, 72, and '74, monitoring the development of child health services as we put these new services into affect. And that very generous support, I think the first was around $300,000 a year, program project support, which is just the most wonderful kind of support. And I think we were very productive, with Klaus Rogmann, the sociologist and Evan Charney and Barry Pless and Stan Friedman, we published the book "Child Health in the Community" which incidentally we just published a second addition, updating it in 1992. And so we had generous support during that time from both private and public sources. And I remember towards the end of my time at Rochester we began to apply for the primary care training grants the ones that came along. And we were turned down, I think that was the first grant I'd ever applied for that I was turned down. The climate was changing. There were far more applicants the competition was greater and times were a lot tougher. But we had an enormous flexibility in the 60's with grants. Both the children's bureau grant allowing us to train various disciplines and the health services research grants. So total dollar wise, I certainly had a lot more from the Federal Government. But the crucial roll the foundations played in getting me started in all of these, and one little minor one,

but it's an important aspect of my career, in 1962 when I was in England on that sabbatical, and studying with the London School of Hygiene and Mayo Jeffries. Dr. Janeway got me nominated for the Markle Scholarship from Harvard. And those were an interesting thing because each school had to nominate one person, and I'm sure he fought very hard to get me into it. Because I was a different sort of person and most of the people in it were in fact surgeons and internists. And the fact that I got it, gave me enormous prestige at Harvard. And now the surgeons would talk to me and thought I was somebody. But it gave $5000 dollars a year for five years and I think the last couple of years it got increased to $6000. And Dr. Janeway had my salary from these other sources so that was available for whatever I wanted to do with it. I think it was with that, that I hired Dr. Kosa, as a matter of fact. So I had some flexibility there. But when I moved to Rochester I still had $5,000 or so of that left. And the Markle foundation let me take that with me. And that was a source of starting, I think I began to hire Dr. Roghmann with that. So those kind of small but flexible sums now, they're probably worth 30 or 40,000 a year now, that 5,000, were really very, very important. And I think today when you see the struggle that people go through to get started in research and get the funding for it there needs to be some of that kind of flexible funding.

Sherrod: Well I recollect that the Grant Foundation Faculty Scholars Program which you started, I think, is based in part on the Markle Fellowship model.

Haggerty: Absolutely. It's about the same level with Markle, was generally assistant professor level. And I do think that's the period when it's particularly difficult to get funding. In later years, in 1978 when I went back to children's, I was really trying to develop something of the same thing that I'd done 20 years before, namely the more generalist training. And we talked to people at the Johnson Foundation and eventually they set up the general academic pediatric training program. A program to train academic generalists, people who had research training, but were general pediatricians. And they asked me to be the senior program associate to run that program. So that was an important aspect, and that just finished in 1988. Carried that on even after I got here. So I've worked with the Johnson Foundation a lot, since mid 70's certainly. Should not leave out my roll with the Academy of Pediatrics. Because I've remained a pediatrician, with that short movement into public health. Although I've always remained a public health oriented pediatrician. I became more and more active with the Academy, I actually was on a couple of their committees, accident prevention committee and others. And then also in 1978, they started a program of education for pediatricians who would be facing the recertification examination. And I had been a co-editor of their major journal of pediatrics, with Dr. Lucy since '72 maybe. And that was really based on the experience I'd had with the New England Journal. That's what got me the reputation of being an editor. Although I don't think I was a terribly good one. So I started in 1978, this journal called Pediatrics in Review. Which is a continuing education journal, for the pediatrician. And I continue with that today. It currently has around 26,000 subscription in this country, some 11,000 Spanish editions and 5 or 6,000 Italian editions. So that's been a, that education of the pediatrician through that vehicle has been another strand of my interest. I've tried to bring in development and community and prevention as themes in those publications, which I think otherwise might not have been as strong.

Sherrod: Now as you pointed out a couple minutes ago, your research career has spread both to kind of bio-psycho-social, that is the sort of interaction between mental health and physical health, which could be kind of basic research, and very applied research, which is really medical practice, delivery of health services and so on. Do those contribute to each other, as sort of where you consider your most important research contributions in both areas. And does your heart lie in one more than in the other?

Haggerty: I would say that even the bio-psycho-social is very applied. I don't start from the theoretical base, it's I suppose, the lack of training. The ideas have come almost entirely out of clinical experiences. Any good ideas I've had I think, have come from practical experience. So I move back perhaps into the more basic firmly applied. It is all started at the applied level. I don't think one can, at least I can't, define what is basic science, and applied science. I don't like those two terms. I think, first of all it should be good research, or not good. And if it's good research it can run that spectrum and hopefully you can push from both ends. You can start from theory and move to application and you can start with application and move back to theory. I think theoretical versus applied may be a better distinction. Because basic carries with it a good sense and applied a bad sense. And I just don't think that's a useful distinction.

Sherrod: Well what do you consider your most important research contributions. Or the ones you're most proud of?

Haggerty: Well I think the stress and strep is one that has stood up over time, and stimulated a lot of other people. Secondly I think the health service research that we showed that comprehensive care does make a difference in the community approach to care and the total population approach makes a difference. The educational research probably the most ambitious we did, but probably the least impact. A matter of fact I'm kind of skeptical that you could make an awful lot of impact in education it's an awful hard thing to do.

Sherrod: Medical education.

Haggerty: Medical education in particular. But look at the problems we have with elementary education. That's a tough one. And an interesting little side light. I've recently learned that the med line search only goes back twenty years. And I was at a meeting recently where some pediatricians are again wanting to see if they cannot teach medical students better, to take care of families, and be familiar with the behavioral and emotional development. And I mentioned this paper that we published in 1962 which was a control/ed trial and none of them had ever heard of it. And I said, "Well don't you survey the literature." And they said yes, but when they survey with med line it stops at '72. So there's a loss of old research, which in a sense is too bad. But I guess every generation has to discover it's own. I mean those three areas I think, bio-psycho-social research, the health services and to some degree educational research now, that makes me a dilettante. That's what a generalist is. And I've had interest in so many different fields that I think some people have to have that kind of broad interest. And I think the reason that I've stayed interested in the interaction of all these factors and tried to foster interdisciplinary work, comes from that. But you can get too narrow, I think you need both, you need people who narrow in and pursue it to it's depth, you need other people who branch out and look at interaction between different areas. I'm very much the later.

Sherrod: Actually then that gives us a segue to the next big category. Things that have to do with your institutional contributions. And most of your jobs have actually been jobs in which you were in charge of something, rather than writing an individual investigative program. And I think the generalist world contributes to that.

Haggerty: Absolutely.

Sherrod: Were those just accidental. Or do you think that those were the kinds of things you were looking for.
Haggerty: Well I think after I'd been 3, or 4, or 5 years at that initial job at Boston, people began looking at you for other jobs and they were increasingly administrative jobs. And after I came back from that year in Britain, then I began being looked at for department chairs and there were 3 or 4 before I went to Rochester. I'm glad I didn't take any of them, they turned out not to be the kind of community that Rochester was to do things like we did there. But yes I think that after I recognized that I could do academic research, and I must say, young people have to realize, at least I went through a lot of soul searching. And every year, every month, my wife and I would talk about; do you really want to stay in academic medicine. And you could go out and practice and life would be a lot simpler. She was a public health nurse, and we talked a lot about, we could set up practice together, why do we go through all this hassle and problems of getting money and problems of getting research done, and academic rivalries and all this. But after I'd realized that I could do it, then I think I wanted to be a department chair. And that probably is the generalist approach and in those days at least, I think more so than today, department chairs were the change agents in institutions. You could do things, and I think we did at Rochester. I thing as a chair there I was able to do things. There were only thirteen full time faculty in the department when I went there. And when I left there were sixty-five. So you could really put your imprint on an institution with that kind of a thing. And I must say that three of the succeeding chairs after me were all students of mine.

Even though Doctor David Smith, who was my immediate successor was an infectious disease person, he had, I had actually interviewed him as an intern applicant at Boston. He had worked closely with me there and I knew him well. And the second one, Dr. Hoekleman, I recruited out of practice to head our outpatient department. And just now Doctor Elizabeth Mac Ananery has been appointed his successor. And she was one our fellows at Rochester. So I think there's been a continuity of the kind of institutionalization that I was able to do. I don't think I achieved the same kind of institutionalization at Harvard School of Public Health, I wasn't there that long.

Sherrod: So you think Rochester....if you ask the question about most important contribution institutionally, as opposed to research.

Haggerty: I think no question about it. As I said earlier, the family health program finally was discontinued at Boston so I didn't leave an institutional piece there. But we did for a long time and I think maybe an impact on that institution. But no question a much bigger and more permanent institutional change at Rochester. And I like to think here too. Foundation and an institutional change and we certainly moved into an older age group and I think the commission of which I was only one piece, focusing on youth from developmental initiative. I think that may be the most important thing this foundation has done. It has highlighted the fact that here's another stage of life that hasn't been very well looked at. So I think that's for the time being at least left at institution....

Sherrod: I think that's true. Maybe you could say two things about the work at the foundation. One is that, sort of having been a grantee and now coming to the grantor role, and what do you think were the most important aspects of your experience as a researcher, or a departmental chair, or a fund seeker, that you brought to your role as president and now deciding to give money to.

Haggerty: Well one thing that I very strongly believed in was to be user friendly. I'd had, as I think everybody does, the impression that a lot of private foundations were rather of difficult to deal with and not always sympathetic to the demands and problems that you have in carrying out something. And even to the picky monitoring of grants. I was determined that this would be a user friendly foundation, and I think we have remained that. So that's an administrative kind of role. I also think that they should be risk taking and not too narrowly restrict their grantees into a field or to a topic. I think I mentioned also the flexible money that comes from foundations, needs to be very carefully used. And I don't think you can micro-manage that use from a foundation. You pick people and trust them and let them have their way. And let them find things that they don't think they're going to find. The trouble with much federal funding is it's already, the projects been done, and they're just getting paid for the last grant. And it's too rigidly restricted. Foundations need to be the risk capital in the field. And I think we were able to do that to a greater or lesser degree. But with good review. You can't just throw the money out. I tell one little story, when I was ready to come to the foundation, Dr. Janeway was dying of his terminal illness and not very clear. And we had dinner with him one night, and I started out by saying, "I have this wonderful opportunity, the board has given me pretty carte blanche in what we want to do. But what would you do if you were me in this situation." And he was not very clear that night. It was a sad night, but at the end as we got up to leave, he put his arm around me and he said, "Bob, bet on young people." And I think that's perhaps another thing about foundations, is that we're allowed to bet on people who aren't well established. The well established people can get their money from other sources. But we ought to be the risk takers, in both ideas and in young people.

Sherrod: What do you think were the most important differences between running the foundation and running the department in your previous jobs?

Haggerty: Well the department running is a far more difficult task in terms of, particularly the clinical department, in one sense you've got a big service load. I mean I had 110 pediatric beds and 60 70,000 outpatient visits a years. And a staff of several hundred, a budget that's now 30 million dollars a year. It's a big operation administratively. And you need some awfully good people to help you run it. And the financial aspects have got to be more complex and all. And the personnel, I mean you've got a lot of people and they're always jockeying for power and position. Just personnel management and money management is complex. On the other hand, as I've indicated, you also have powers, you have the levers of power that you can do things. Foundation you work through people it's much more indirect. And the relation to the board of trustees, there's nothing quite like that. I had never had that direct responsibility, trustees weren't my boss in any of the other jobs. They were sort of above the bosses I knew. And so relating to trustees who have a different background and interests, again I think our board of trustees have been remarkably good here. And I'll tell another anecdote, when I was thinking of coming here I called David Rogers who was then the president of the Johnson Foundation. And his first comment was, well you have a good board. And I think that's true. And I think the combination of dedicated business people and this half of the board being behavioral scientists, is quite unique and precious. But you also have to be willingly to work much more distantly from the action and that's both a benefit and not. It's a benefit in that you don't have to deal with all these administrative things. It's a much longer range and slower process you don't see.... The one thing that I missed in the foundation is the interaction with young people day to day. I think you can get remote from the action. You need to make sure that, and that's why I think foundations do become user unfriendly at times. It's not malice, it's just that you get away from those daily problems that people have.

Sherrod: The next thing I was going to ask about actually, which is relevant to interaction with young people was about education. Now you've always I guess taught only medical schools or for the most part.

Haggerty: Well School of Public Health is a multi-discipline.

Sherrod: But in the graduate students, not much undergraduate contact. And have you always been able to sort of teach what you cared most about, which was the bio-psycho-social and community approach to health practice and so on?

Haggerty: Well not always. But I think in the clinical sense you can because every patient is a product of all of those. So you can bring those out. I think that's harder in the School of Public Health, where you have to deal more theoretically. I guess one of the frustrations I had at the School of Public Health was the larger number of people who were not really interested in that aspect. We had a large number of health services administrative people in my department who were learning to be administrators of clinics and hospitals and health departments. And they were less interested in that psycho-physiologic pathology side. I have not been a scientist in the administrative sense. Nobody ever taught me how to do it, and I probably didn't do it very well. But I think there was a tension there between my effort to try to influence them as to why we were doing things and frequently they just wanted to know how to do it. One of the nice things about the foundation was the wonderful relation with our grantees I think Exemplified by the faculty scholars meetings that we've had, by the consortium meetings that we've had and culminating last year. Those were wonderful experiences which I think in a more distant and indirect way we did have some impact on them.

Sherrod: Yeah I think it's important, as you mentioned, in terms of the contribution from the foundation the consortium program has kind of reflected multi-disciplinary orientation, being a very valuable contribution along with faculty scholars and.....

Haggerty: As you know we tried to push the inter-disciplinary approach. And again universities seem to be resistant in other than the medical school areas. That's not the only place that there's trouble with them. I should raise, I had on my notes here, that I am pleased with the number of people who have been fellows of mine over the years. And just to mention department chairman, is Doctor Alpert and Charney, who are current department chairmen. I had two from Rochester and in addition Glascow and Hanshaw, and then Hoeklemen and now Mac Anarney. And then people like, Ecknroad in the behavioral science field. I think the number of people that you train are another measure of success.

Sherrod: Are there other institutions that you should mention? I mean you've done, I'm thinking of professional associations and journals. You mentioned pediatrics, and then particularly this next category, is sort of your involvement in SRCD. You've been involved with SRCD in your career.

Haggerty: I should have mentioned SRCD and it goes back to Harold Stuart. Soon after I moved into that job at Boston and was chief of the child health division. And as I was saying, I was doing these examinations on these 21 year old follow-ups. He one day said to me, "You should join SRCD." And he was one of the founding members of SRCD. He said there aren't enough pediatricians in it anymore. This was in 1956 and I think that same thing could be said today.

Sherrod: Today, yeah.

Haggerty: But I probably wouldn't have gotten into SRCD without that kind of stimulus. I didn't know it existed. And through him and through the publications and all that has been one of the societies where there is this interdisciplinary mix. Which I think that is wonderful
and I don't know of any other professional group I deal with that has that same kind. Probably the Society of Adolescent Research comes closest to it now.

Sherrod: Well you have been a member for more than 30 years?

Haggerty: Yes although I think I must have lapsed my membership in the middle years there I don't remember paying my dues there for awhile. But since 1955 or '56.

Sherrod: Now the other aspect of SRCD that you might want to comment on is that it has been, I guess more an organization of theory based research than of applied research. Have you seen a change in that over the years? Or has that been something you have worked with and worried about?

Haggerty: Well I think you're right, I don't have enough data points to say whether it has changed or not. Certainly the development of the policy committee is one evidence of application. That role of the foundation was not my doing, but I learned a lot from it. That I think was Bert Brim when he was on the board here and president of the Foundation for Child Development, that they developed the policy fellowship program between the two foundations. And then the selection of those people and the continued following of their careers. And most of them are active members of SRCD, and have become leaders. Certainly they're on the applied side by and large. So I think they have moved in that direction. From my point of view, they were also the place where I would go and learn some theory and that was a more theory based place.

Sherrod: What about meeting attendance and some of the major journals on child development. How important have those been.

Haggerty: Well I must say that child development has been, from my point of view, a too theoretical journal. I don't find too many articles in it that have been useful to me, until fairly recently. And also maintained it's focus on younger children and it really didn't move into adolescents at the same time that we were moving here in the foundation. Some of the monographs have been very useful but depending on their interest. The meetings have been among the more useful because of the hearing people with different discipline orientations. So SRCD has not been my major professional organization, but has been a kind of unique one with this inter-disciplinary focus. I have remained basically a pediatrician, and relate more to that. And then I guess I should mention, that I'm what somebody once called me a respectable rebel in that I've been respectable about not a radical kind of person. But I have been a rebel, in the fact that I was one of the founding members of the ambulatory pediatric society which was an effort to break out of the mold of purely biological research of the pediatric research societies. And it now is a strong arm of the pediatric research communities, 1500 members, multi-discipline. And I don't like the name, I prefer general, but it was voted again last week to stay ambulatory for a variety of reasons. But within pediatrics I think we've been able to make some moderate changes of that sort through starting a new organization. I didn't then start either the adolescent, Society for Adolescent Medicine or the Society for Developmental and Behavioral, but I've been a member of both of those. They have also split, if you will, off from that main stream of biological pediatrics. Yet I've tried to keep them together I've been a integrationist in the organizational issues as well as in research. When I was president of the American Academy of Pediatrics, perhaps the biggest thing I did that year was to go up to the Society for Pediatric Research and the American Pediatric Society, both academic societies, research societies to join with the academy in a variety of efforts. And it's actually culminated now in that they have their headquarters all together in Chicago. So being an academic I was able to bring the practicing community and the academic together. So I've always been that kind of an integrationist among organizations.

Sherrod: Well do you think that there's a way that SRCD could attract more pediatricians? Or do you think that desirable?

Haggerty: I think it's desirable to have a mix of disciplines and pediatricians would be one group. It would be good for pediatricians in that they should learn more in the way of developmental research. Incidentally in the biological field that is the basic science of pediatrics. People who work at the molecular level or the biochemical level are always in pediatrics, studying the sequence of change in chemistry. But they don't do enough of the interaction with other disciplines. And I think to some degree that introduction to the biological measures today which are so sophisticated, so powerful, so exciting, into the behavioral sciences would be a useful thing. Time is a problem, everybody has got too many organizations, too many meetings to go to, and I am a little bit, a lot frustrated by the size of almost all of these meetings, whether it's SRCD or the Academy of Pediatrics. Just last week we were at the pediatric research, the American Pediatric Society, Society of Pediatric Research, they are too big. You dart between one of twenty different sub-specialty things with ten minute presentations. Maybe it's my slowness in learning today, I don't get that much out of them. I think going back to our comment, to me the consortia were the best inter-disciplinary research kinds of things. I think what we need is, rather than just bring all the societies together is to try to have a vehicle for fairly prolonged intense interaction between disciplines. As I say, I think the consortia idea was a good one. And there with ten or fifteen or even twenty people together for two or three days from different disciplines, you really learn some things. Learn to respect other peoples views. I find all of these national meetings now, less satisfactory than I used to.

Sherrod: I'm going to interpret these last two categories called the field and personal notes, as basically the future, because they talk about the future of the field and your hopes for it and your personal feelings. Why don't you say something about the things you are doing now. One of my fond anecdotes is to say that I think you

and Bert Brim are the only two people I know who in quotes, retired and actually became more busy than you were before. So maybe you could talk about the biography of Professor Janeway and say something about where you're headed.

Haggerty: Yes that's certainly one interesting thing, the history and biography are not terribly interesting to young people. I don't know that, and I certainly don't bring any interest, any skill to the history. But I think there are things to learn from that and just collecting the anecdotes about Charles Janeway and trying to write them up, showing his multiple aspects of his career. Carried on a biological research, administration of a large department, teaching world health and at the same time was serving on this little town health board and trying to get fluoridation through the local township. A multi-faceted career which I think is a very good example. And the fact that SRCD is taking this kind of history it's interesting that a lot of organizations are trying to get oral history and to find out where they've been and where they're going. So that's an interesting thing. The thing I'm doing right now is, international child health. Which is, I guess I've moved from the individual child, to the family, to the community now to the world, which is a grandiosity. I'm the executive director of the International Pediatric Association and we're a group that brings pediatricians from the world together in various ways. Doctor Janeway who was my mentor was the president for awhile and wrote a wonderful article called pediatricians for peace. Which at the height of the cold war this association was one place where pediatricians could come together from the soviet and the western block and talk about what was good for children. And didn't bring much in the way of nationalistic views into that. And all during the cold war people from the Republic of China were members and Vietnam was a member, the US was a member. So I think we can use such a vehicle for those kind of peaceful needs. I think we also can use it in a way to publicize the terrible plight of children today. I'd like to see it become much more of an advocate about the misuse of children in international affairs. Which is terrible. Whether we can do anything more than television does, I don't know. We also are working at an international policy level. For instance we now have a series of meetings with either the national pediatric societies or regional ones, with a combination of WHO Unicef and the International Pediatrics Association coming together to try to influence policy in these countries about children's health matters. Which is not limited to traditional physical health, for instance we have a meeting coming up in Senegal in February that will be on child labor. And incidentally I'm going back to Phil Landragon, one of our previous grantees to help on that. We have one in Pakistan coming up on maternal and child care. The whole issue of preparation of mothers for motherhood and not just physiologically but for parenting afterwards, and bringing in the parenting specialist there. So I think I can introduce both broadening of the concept of what is health and things like the labor, childrens labor. And the integration across discipline and across the life span into that organization. But that's an interesting and challenging, and I feel at times like I'm Si Vance and Lord Owen you have to negotiate between countries that are basically very antagonistic. But underlying them I do think the vast majority of pediatricians are out for what's good for children. There are sincere useful groups. So that's one of the major things I've taken on. That's not a research, it's even the most policy and applied level, if you will. But I think it's an important function for children and I'd like to see people in the child development field become a little more international. I think that SRCD could well expand it's international kind of role. I know it does a fair amount with Western Europe. But in this International Pediatric Association I'm becoming much more aware that there's an enormous amount of cultural differences in the way children are reared around the world. And understanding that and bringing in other cultures, I think would be something SRCD could well do.

Sherrod: That's an interesting point because actually organizations like Unicef and Unesco are now reaching out to a number of SRCD members. I know people like Larry Abrahams for example, Jim Corborino, Roger Hart, a lot of them are now doing projects for them. So it will be interesting to see if that ….

Haggerty: And I hope they report back to the younger members. That's an educational thing that younger members could well see. Because I think in all fields, it's awfully easy when
you're starting out to bury yourself in a narrow field for a variety of reasons put blinders on. And we need to have those blinders lifted from time to time.

Sherrod: Do you feel like doing any crystal ball reading and saying something about where you think the future of your field of pediatrics is going. Or should be going?

Haggerty: Well most people predict the future wrong. What I would like to see them do is what I guess I've been talking about. I'd like to see them be much more long term viewing of the child. There's been too much concentrated I think, on the health of the child today and tomorrow. And not enough on what happens today and tomorrow in terms of the life span of that child. I see one of the big fields in the future of pediatrics is the prevention of adult diseases while

in childhood. It is tough to think about 20 or 30 years or 40 years from now, when you're taking care of a child. But I'm convinced that there is a field there, and we need much more of that long term kind of approach. We still need an enormous amount of disciplines brought into the care of children. I think the average pediatrician does not understand much about child development. Doesn't have the, research doesn't get translated into the kind of terms that are useful to the person in practice. I think most pediatricians are interested in it and would like to do more of it. But it needs translation, is my complaint about the Journal of Child Development, it doesn't give us much in the way of translation into practice. That could be a very useful thing I think. Then of course the whole social economic environment, this is an open ended challenge, where do we draw the line between what is appropriate for us in the children's areas to get engaged in and where does our expertise end. I mentioned earlier I think we need to try to be an advocate for children and some of the terrible things that happen to children around the world. On the other hand we're not experts in some of those things that are happening and to know where to draw the line and not dabble into everything, in things we have no business dabbling in. I think that's a big challenge we could easily go too far in thinking everything is our business, which it is but, we may not be the ones to do anything with it.

Sherrod: I don't know how we should wrap up. The last question has to do with, we sort of early on talked about your personal family life and its role in your career as we moved increasingly through your professional life, it seemed to become less important.

Haggerty: That's omission if it seems that way. No I think that I've been blessed by a wife who is very supportive all of these years. And did a wonderful job of raising the children and taking care of me. A woman who understood a lot of what I was up to. I think partly because she was a public health nurse, but more must because of who she is. And there's satisfaction of four kids and four grandchildren who are all doing reasonably well. But also had their ups and downs as life deals everybody I think. No I think without that kind of support, certainly in the early days, I know lots of people who were starting out as I did in the faculty, who were poor and their wives couldn't give them the freedom to work for a long time on a relatively low income. And the kind of sacrifice which many people are not able to make. And now a days it's both sides, at least in pediatrics and I think even more in child development. At least fifty fifty are women and the challenge of dual careers today is a particularly difficult one. Muriel basically has not worked for money since we were married and I think, I don't know what we would have done if she had been pursuing two careers during this time. It's a big challenge I think for people today. One of the reasons that we moved back to Rochester is that all four kids live there. So it's satisfying to live around them. You get involved in their problems, but that's somewhat satisfying most of the time. So no I think family has been a very strong factor in the ability to do what I've done over the years.

Sherrod: Maybe one final question, if you look back over your professional life is there anything that you would change or do differently?

Haggerty: Well that School of Public Health experience, as I said, was not a satisfying one on the other hand it's good to fail once in awhile I think. I really have had so few things that I haven't been able to do well. I've kidded with Bert Brim that one thing I've never been able to do is make good wine. I grow some grapes and I try to make wine and it's terrible. And it's probably useful to realize that you're not expert in everything. There are a couple of forks in the road which I could have gone in a different direction. One of them and I don't think, now I think it's good I didn't take it, but if I'd stayed at Harvard instead of taking a pediatric chair, I think we probably would have been able to develop a department of family practice. I was beginning to train fellows who were family practitioners and Lynn Carmichael who trained as a fellow with us who then started the Department of Family Medicine at the University of Miami. And we were beginning to get the leaders, people who became the leaders in family medicine. And I was getting enough of a reputation that I think we could have probably pulled off a department at Harvard. Harvard still doesn't have one. Harvard does not train family physicians, I think it's too bad for the field. I certainly wouldn't have done child development. I might have done family development in that case. But that's one branch that I've always wondered whether I should have taken or not. Some branches I know very well I shouldn't have taken and didn't in that '78 to '80 period, when people knew I was a little footloose in not staying at the School of Public Health. I began getting offers of Deanships and Vice-President of Health Affairs. I could have easily at that stage, gone into a purely administrative position. I don't think I would have enjoyed it. And I don't think I would have done a particularly good job at it either. I think you have to be a lot tougher I guess than I am, in terms of, getting rid of people and being mean to people. I hate to think that that's the way you have to be. Anyway those were a couple of turns that I could have taken. I have to say that I just feel the luckiest person alive to have done what I have done and have been able to do, and had such satisfaction and reasonable success doing it. I just wish other people could have that same kind of enjoyment out of their careers that I've had.