Preface

This interview with Dr. Julius B. Richmond was conducted on April 17 and May 18, 1981 in the National Medical Audiovisual Center at the National Library of Medicine, Bethesda, Maryland. Dr. Richmond was about to retire from his positions as Assistant Secretary for Health, Department of Health and Human Services, and Surgeon General of the U. S. Public Health Service, and was soon to return to academic medicine. Two related sources of possible interest to the reader are Dr. Richmond's book, Currents in American Medicine: A Developmental View of Medical Care and Education (Cambridge: Harvard University Press, 1969), and "An interview with Julius B. Richmond, conducted by Milton J. E. Senn on July 12, 1972" (Interview No. 58 in Oral History of the Child Development Movement, National Library of Medicine, Bethesda, Md.). Dr. Richmond's papers are preserved in the National Library of Medicine.

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This is Dr. Peter D. Olch in the National Library of Medicine. The date is April 17, 1981. I have the pleasure this morning of speaking with Dr. Julius B. Richmond, Surgeon General of the United States and Assistant Secretary for Health in the Department of Health and Human Services. Dr. Richmond, it's a pleasure to be able to spend some time with you. This is a very interesting time in the history of the Department of Health and Human Services, and I think a very worthwhile experience will be to review your career, not only your time with the federal government, but certainly to go back further to those incidents which led up to your becoming surgeon general.

We certainly ought to start with the beginning. You were born September 16, 1916 in Chicago, Illinois. I wondered if you would tell me what family influences you may have felt that you can look back on now that have had some bearing on the career that you chose.

Dr. R.: Well thank you. It's a pleasure to have this opportunity to chat with you this morning and to try to look at some of the developments that have taken place, historically, recently, but also, as you suggest, to be a bit autobiographical about this.

I was born, as you indicated, in Chicago not too long after the turn of the century about the time World War I was on in Europe. The United States hadn't yet come into World War I, so I have had a chance to live through most of the developments of the twentieth century. Since so many technological developments have taken place, I think it's been a very interesting period.

My parents were immigrants from eastern Europe. They fled eastern Europe during the period of czarist rule in Russia, a period in which certainly many Jews felt they had little or no future by staying so my parents emigrated to this country and settled in Chicago. I think those early years were interesting for me as I recall them, in that there is a great deal of emphasis on intellectual activity and cultural activity. There was a lot of interesting reading--literature and books--and my early recollections are those of great emphasis on excellence, certainly academically, and participating in the cultural life of the community in which we lived. I think it is important also to emphasize that it was an era in which the public schools, as I recollect, placed a great deal of emphasis on quality. If one can just jump forward several decades, I think that one of the issues in the nation today that one would be concerned about is the erosion of quality in public education. I had some validation of this not too long ago when I had a conversation with Admiral Rickover. During the course of our conversation it turns out that he grew up in the same neighborhood that I did in Chicago. It was very interesting to me in the light of the fact that he has written rather extensively on quality in education. I think we agreed that some of our respective interests in the quality of education stemmed from these early experiences. We, it so happens, had some teachers in common. He preceded me by a number of years but there were still some teachers teaching in the high school that I attended-----

Dr. O.: What high school was this?

Dr. R.: That was the John Marshall High School.

Dr. O.: Right, in the public school system of Chicago? Who were some of the teachers that you can think of off hand that may have made a mark ------

Dr. R.: Well, I think they were highly varied and they run all the way through the elementary grades and the high school grades. A high school teacher that I had by the name of Mr. Simon, who taught American history, taught probably the best course I've ever taken at any level of education. He placed a great deal of responsibility on the students. It was a project kind of teaching where students were encouraged to do library research and to debate issues and particularly to look very critically at the dynamics of the development of institutions and governments historically. A woman by the name of Harsch who taught us English--very excellent, very demanding, but always very fair. Another teacher who taught us French by the name of Miss DeGeis--also a very interesting, dedicated woman, originally from France and again, very demanding in terms of our performance, but it was really a pleasure to try to accomplish or reach the goals that they had essentially set for us.

Dr. O.: I've had the pleasure of reading your interview with Milton Senn that was done in 1972. You indicated in that interview that the fact that you were in Chicago in the presence of Hull House in a sense had some effect on you at this stage in your life as you look back in retrospect.

Dr. R.: Yes. I think the Hull House effort; its involvement of people in the community in a variety of cultural and intellectual activities, I think, set a tone. You saw the community, the neighborhood really, being complementary to the public educational system and there are a lot of

opportunities for adults and my parents were very involved in various activities. I would also mention one interlude in my childhood years. We were talking about public education--but I did spend three years in a private school setting northwest of Chicago, a little school called Allendale which still exists. That school attendance was precipitated by the death of my mother when I was ten. My father had to seek out some kind of setting where I could be cared for and go to school. This was a most remarkable little school founded by a man from the east--a man we referred to as Captain Bradley--founded it in 1898. I went to the school in 1927, and he was still the director of the school and just a remarkable old patriarchal figure full of great wisdom. I think he, too, was a most influential figure in terms of his interest in children and also his remarkable integrative capacity. In addition to fund-raising for the school and directing all of its activities, essentially being the personnel director and the supervisor of the physical plant, he also conducted the chapel services every morning and did it with quite a flair and played the organ for the chapel services. Yet he was always available, so that it was quite an experience in group living and also got me out into a cultural setting which was very different from the one in which I had been growing up. So I had an opportunity to see contrasts and to get a comparative view. The youngsters at the school came from all kinds of family settings. There was generally the loss of at least one parent. In that era it was not uncommon for children to have lost both parents, and that's an interesting commentary just from the health point of view that we have virtually no orphans any longer because ------

Dr. O.: That was 1927, conceivably the influenza epidemic, a variety of things I suppose -----

Dr. R.: Yes, with morbidity and mortality rates from the infectious diseases, still quite high even for adults. We've had a transformation really. As a matter of fact, that school, which at that time would have been considered a school for dependent children otherwise normal, has now essentially been transformed into a residential treatment center for youngsters because the need is no longer for the placement of children who are simply dependents since parents are generally available. There's enough of a social support system in communities generally to enable parents to care for their children at home.

Dr. O.: At what stage in your early education did you start considering the field of medicine? I know you went to the University of Illinois. You got your Bachelor of Science degree in 1937 followed by a Masters in Physiology in 1939. At this time in your career were you looking toward medicine?

Dr. R.: Well, I think that would really go back to a very early stage in my life. My mother was really quite a social support system in and of herself for other family members and people in the community. I think the notion of being of service to others really took root very deeply and early. I think early on, because again medicine as a career among immigrant Jewish families was highly valued. I think I saw that even prior to the age of ten as a potential outlet for being of service to others. There's another facet that developed, that rivaled that interest. When I went to Allendale, one of the unique features of the school was each youngster had some work responsibility. There was a farm that was connected with the school which in part provided some of the supplies for in the school--milk and other things--there were dairy cattle. But there was a man who

operated the farm by the name of Mr. Duncan who was a Scotch-Canadian who had a great interest in purebred sheep. As I came to know him and his interest, I became interested in animal husbandry, particularly the care of this flock of sheep which he exhibited at the various fairs. Because of his skill and competence, he had developed this flock into what was probably the best in the world of its breed, that is, if one judges by the prizes that one would get at the various fairs. What began to develop was my interest in animal husbandry rivaling my interest in medicine. When I went to the university it became known to the people in the School of Agriculture because of this interest in sheep husbandry, they just sort of assumed that I would enroll in the College of Agriculture. I was really torn between those two directions and finally decided I would have more flexibility if I went into medicine as my career opportunities would be broader. Also getting back to my feelings about doing something more directly for people, medicine won out.

Dr. O.: Even once you made the decision to enter medicine, I gather there was a period as you went through your residency training of getting interested in delivery of health services to larger groups rather than strictly the one-on-one doctor-patient relationship. At least there was an element of--I wouldn't call it conflict at all--but there was an element of interest in this, far more so than many of us have at this stage of our medical training.

Dr. R.: Yes, I think that you're quite right in highlighting that because I think I was able even at an early point to conceptualize directions. Again in terms of social commitment and perhaps what one might call social conscience, I kept thinking about some way whereby one might have a broader

impact than exclusively through the one-on-one relationships with patients. I didn't minimize this, but I kept reflecting on how one could really have a broader impact. I did think seriously about public health even though I didn't know very much about it.

There is a very interesting incidence of coincidence. In my first year in medical school, because my father's apartment was some distance from the medical center, I took a room near the medical center. Evenings it was better to study at the library than it was to go to my room--you had more things available that you might want to draw on and all. The reading room of the library was, of course, lined by books and one of the places I happened to sit down one evening contained the volumes of the report of the Committee on the Costs of Medical Care. I found in that first year that it often was more interesting to be reading that report than it was to be studying anatomy. So I had that kind of dual set of volumes before me and that began to stimulate me to think that there might be some broader ways to approach problems. The report came out in about 1933--I think the committee ended its deliberations in 1932, but I think the volumes didn't actually become available until 1933. Here I was in '35; I recall it was a fresh report, and indeed the volumes looked untouched. I think I had probably been the first one to really dig into it.

Dr. O.: I know when I discovered the existence of that report and of that committee--when I first came to the library and got involved in the history of medicine--I was just staggered by it, I truly was.

Dr. R.: Yes, well I was just about to say the thing that impressed me then and it impresses me now--and I said this to the staff of the Robert Wood

Johnson Foundation on Wednesday when I gave a little seminar for them--I said you can go back into that report and I think you will find that there has been no proposal since then that really hadn't been anticipated in that report. Later on when in the mid-sixties we developed the community health centers--we then called them neighborhood health centers--and a lot of people claimed credit for priority. While I thought we had generated the notion in the Office of Economic Opportunity, I didn't feel that anybody could truly claim priority other than the group that had written that report because if you go back there the design was clearly laid out.

At any rate, I began then to wonder well, the recommendations of the report were so comprehensive, so logical, I began to wonder why might they not be adopted. I think that a number of things intervened to minimize their impact, one being the depression years, since we were in the midst of the depression when the report was issued. Even though, interestingly enough, the committee was established before the crash of 1929, so that people must have been worrying about costs even before we entered upon the depression. Then with the coming of World War II you essentially had two decades lost to the opportunity for any renewed kind of inquiry into the recommendations and what might be done with them. At any rate, that was very much in my mind but as I moved into the clinical years I ------

Dr. O.: Internship at Cook County Hospital.

Dr. R.: Yes, yes. I found that I was fascinated by clinical medicine and pretty much resolved that I never wanted to be without some kind of relationship with clinical medicine, so again here was another kind of tension:

how do you integrate your interests in broader health policy issues in public health practice with being a clinician. I then also had the interest in children, I think stemming from the fact that I had spent some time at this children's school and had an opportunity to be exposed to a variety of family problems. So I began to see a blending of my interests in broader public health issues. It seemed to me around child health and child development and health policy--child health policy--that one had coming ------

Dr. O.: This really was my next question. What were those factors that led you to the decision to go into pediatrics, which you have just very nicely answered there.

Something else struck me, if I may refer to the Senn interview again. I gather that during your period of house staff training at Cook County Hospital in Chicago, you were impressed by the impact of the poverty of these individuals on their health. You experienced, as certainly even in the fifties I did in medical school, that there was very little consideration given to the social and economic factors of these individuals. The disease was the thing--you were treating a disease. There was little thought of the patient as an entire individual, and that this made a mark on you apparently even at that time.

Dr. R.: Yes, I think that it was a most remarkable experience. That internship in that era was much sought after. It is rather interesting that these days hospitals avidly recruit for interns and residents. In those days we competed by written examination for places and felt very proud to compete successfully. But the emersion into the social problems

of families was never explicitly dealt with. It was not until some years later in about 1960 or '61 that I published a paper on the patient and the teaching and research hospital in which I dealt very briefly with my retrospective analysis of what we were exposed to. Because of the prevalence of social problems and poverty all around us, the house officers, I think, had to develop really defensive armor against looking. One of the points I made in this little paper was that to some extent the jocularity of the house officers, when they were in their own quarters--a lot of the horseplay and all, is kind of a reaction to what they were experiencing. As I recall, it was a kind of overdone sort of jocularity and when one I think examines that, it seems to me it was a reaction to what we were experiencing--nobody had prepared us for it. But I remember very consciously thinking what an unfortunate sort of experience it was to have to try to behave as though you were really insensitive to all of that. If one stopped with any one patient and tried to see if one could do anything about all of the complexities of their social and economic circumstances, you of course couldn't survive through a day's work, the medical needs of the patient were so great. I think that without anyone's very explicitly talking about this, in the post-World War II period a great deal of progress has been made as we develop the teaching hospitals more fully and more effectively. As much of the teaching has been shifted from the large public hospitals to the teaching hospitals and their outpatient departments, I am impressed with the fact that students are introduced to this (the social, economic, and psychological issues) in a much slower fashion. I think over time that they see these problems and I don't feel that there has been as much insensitivity to all this. I think a lot of it isn't made as explicit as it might be during the teaching process.

But I think that students are brought into dealing with the social and emotional problems of families along with our medical problems in a much more appropriately phased way than was the case in my day--it was sort of a sink or swim proposition.

Dr. O.: Yes, it still certainly had not come in the mid-fifties when I was a medical student. As I look back on it, listening to your comments about the jocularity and so on, that's really a very accurate statement. You had to put up a shield between yourself and the patient. We didn't get that sort of gradual exposure to it nor any instruction as to the importance of consideration of these issues at all, certainly not at Johns Hopkins.

Dr. R.: I think that exposure did reinforce my determination to try to do something in relationship to the broader social aspects and public health aspects of medicine.

Dr. O.: I gather again that it's during this period of house staff training in Chicago at the Cook County and the Contagious Disease Hospital that you began doing some reading of your own on the side of material dealing with growth and child development, the sorts of things that, at that time, were not part of your routine. Perhaps you may have been considered a little atypical as pediatricians of the day were stacked up.

Dr. R.: Yes, well, I think that I was struck by the fact that the attending staff was really very well versed in disease, but that they had very little comprehension of the developmental process. They really were imbedded in disease. Of course, it was the descriptive era of medicine--we didn't know a great deal about causation of disease and when we did

know about causes there wasn't any really specific armamentarium with which to deal with it. I began to become much more interested in process, the dynamics of how things developed, the dynamics of how personality developed and the interrelationships between the biological and the psychological and the social dimensions. In 1954 I published a paper on Total Health: A Conceptual Visual Aid which sort of brought some of these concepts together. But during those house staff days I then began to read, I wasn't guided in my reading so I latched onto whatever I could find. Gesell's volumes at the Yale Child Study Center were readily available, quite descriptive, but to some extend highlighted the developmental process. Then I began to read more widely. I think that my interest in the psychological and the social development of children was strongly stimulated too by my experiences in World War II ------

Dr. O.: Yes, as a flight surgeon?

Dr. R.: Yes, my residency in pediatrics was interrupted when we got into the war and I volunteered for the service and became a flight surgeon. That gave me the responsibility for examining large numbers of Air Force cadets. What I was struck by was the tremendous amount of disability among young adults and after all, the cadets had been through a screening process by the time they came to us as flight surgeons at training installations. I was struck by the large amount of psychological and social disability in these young people. It just struck me that there had been many failures in their earlier lives in terms of child rearing but I didn't really have much expertise about this. But that reinforced my determination, when I came back to my residency, to really pick up on this and to try to learn more about it and see if it couldn't be taught more effectively than I had been taught.

Dr. O.: Well, you returned from the service to the University of Illinois, completed your residency, and were offered a position in the Department of Pediatrics. Off the top of my head I cannot remember exactly--you were there a number of years in that department.

Dr. R.: Yes, from 1946 to 1953.

Dr. O.: I gather that you at this point were interested in inserting some child development in the curriculum--studies in child development--but these were not successful. In a sense, I suppose, this was because this was considered rather new and untested or was it the usual problems of trying to compete with the internists and surgeons for time. It's a somewhat loaded question because I know of some of the people that were on the faculty at that time, for instance, Warren Cole, the surgeon. I know he was then and still is a rather conservative individual. Harry Dowling I also know. I'm just wondering how this developed.

Dr. R.: This was a very interesting period, the period immediately after World War II. I think, in academic medicine it was a period of considerable ferment. A lot of young people coming back from the service and beginning to more into academic careers. As a consequence of the fact that there was a fairly large number of young and vigorous faculty people, the dean at that time decided that it might be interesting to have the curriculum committee made up of not the power structure of the school but groups of young people. So I was asked to serve as chairman of the curriculum committee, then called the Committee on Instruction. It was rather an exciting group. I remember Howie Armstrong, he had just come from the Brigham in Boston to Presbyterian Hospital which was the old Rush complex then affiliated with the University of Illinois.

Dr. O.: What field was he in?

Dr. R.: He was in internal medicine. He came there a Professor of Medicine and that served as one unit of the department. He had worked in the field of immunology particularly the gamma globulins. He brought both an intellectual flair and some of the eastern flavor of medical education, particularly house staff training, and also an emphasis on a full-time faculty which in the clinical years in Chicago, interestingly enough, was still fairly recent. I think Warren Cole, as a matter of fact, was the first full-time chairman of a major department at the University of Illinois just prior to World War II. So he was one of the people. Bill Whitehorn, who was Professor of Physiology and a very popular teacher and very thoughtful person also was on the committee. He later went onto the University of Delaware when they were interested in founding a medical school, to be the dean. For political reasons, that never came off. But a number of people like that [were on the committee]. We worked over a couple of years, and we developed what we thought was a very exciting and very novel kind of curriculum which substantially focussed on human development as a vertical core in the curriculum. I thought we were politically very savvy about this because we recognized that if we invaded the time of any of the departments in a very significant way that it would not be a tolerable situation. So as we developed this we were very cautious to make certain that various people on the committee, who had some deep interest would negotiate with their departments so we would essentially use some of their time--some of their curriculum time--for this core curriculum. It wouldn't be a tremendous number of hours in any one year, but if you added it up vertically, it became a rather significant core. Some of the unique aspects were to start with human development as a process and then to see if one could do some

integration of the disciplinary teaching--whether it be anatomy, biochemistry, physiology, or whatever--around the developmental process. One could teach a lot about biochemistry and nutrition around breast feeding and all. Also the notion was to get students--and that was a very popular notion at that time--to try to get students involved in some kind of clinical exercise early on. It was our thesis that one could do this around the development of the infant starting with conception and going through the prenatal period. It made sense to introduce the student initially not to disease but to a clinical setting where he could play some functional role. Again since human development is phased, one can in a prenatal clinic phase the kind of care. In particular with infant development there's a lot that a student can learn without having to use a stethoscope. A lot of the development of the infant is based on observational skill. We thought that would be a good skill to teach them. You can stand and watch a baby and tell a good deal about its development and then the rest is largely weighing and measuring for which also he had the tools. My thesis was that we ask student nurses to serve in well baby clinics and certainly medical students in their first year are fully as able as student nurses are. So we thought it was very realistic and indeed I pilot-tested this on Saturdays with first year students over the course of a year with several and found that it worked out well. Also they could read in advance if the two-month old baby is coming in for his well baby checkup, they could read and determine what a two-month old baby should be expected to do and also what his nutritional needs might be so that they in some meaningful sense could participate in the feeding of the infant and making some judgments about what his immunization needs would be and all. These were definable packages. So for the first year we developed that kind of program with some lectures that would

complement those clinical experiences and then we would follow that infant over the four years. Western Reserve some years later in '52 introduced and still retain that concept in their curriculum. In fairness to them they didn't copy that from us because our proposal never got wide distribution and I don't recall that we ever particularly talked with them. I think it was just an idea that was generating in various places at that time. But they didn't have the rest of this core. We then would go on into the second year to deal with the development of the older child and begin to let the students learn something about adolescent development. Then in the two clinical years to go on and try to integrate the observation not only of that family but to give them a patient or two with some chronic disorder to observe over time. We also then for the fourth year broadened this to include some aspects of what one might today call health services and public policy. This would include the financing of health care, the economics of practice, the public health implications, etc. That curriculum would then, we felt, have prepared a student to look at the policy issues as well as his own personal issues as he went out into the community.

Well, we thought that was such a logical kind of thing. Indeed I had by then gotten to know some of the people on the staff of the Commonwealth Fund--Lester Evans, in particular, was a very imaginative, forward looking foundation executive. He said, "Gee, if you could really carry that off, I think the Commonwealth Fund would be prepared to provide some funding for that." In the piloting of this we probably would have needed a few other faculty people. This got all the way up to the executive faculty which then was the power structure, and I think they began to see this as

a threat. Now Harry Dowling, to his credit, was very supportive of this whole thing, and the Professor of Psychiatry, Francis Gerty was supportive. But in the power structure of the school if the Warren Coles of the world weren't supporters. They were reluctant to think of change which was to be so extensive. So essentially they decided that they wouldn't go along. I was the one who essentially presented this and defended it at the meeting of the executive faculty and I thought, some external validation would be a good idea, so at some point in the debate I said, "Well some people who are forward looking in medical education, like people on the staff of the Commonwealth Fund think this is a very exciting idea." The retort was "Well, we don't want any outsiders telling us what to do." So I think that kind of curriculum yet remains to be done as an integrated package. I think various schools have picked up various pieces of this. About five years ago one of my young people in Boston was going off to the University of Massachusetts in Worcester to head the Department of Psychiatry. That's a new school and he said, "You know, that's a new school, what can we do that would be new and different?" So I got out this old proposal, dusted it off and gave him a copy. He said, "Gee, this is great. I'm going out there and try to implement this."

Dr. O.: Would it be an overstatement to say that the fact that this did not come to pass was somewhat instrumental in your deciding that the University of Illinois was not where you wanted to stay and you started looking for other places? Or was that just a happenstance of chronology actually that you left I guess not too long after that?

Dr. R.: Yes, I think that that was somewhat of a turning point for me. Also I was aware of the fact that virtually all of my experiences, academically, had been there and that it might be well for me to move on.

I guess even though that was home, and I was most comfortable in Chicago, in addition to the academic setting, in spite of this rebuff it was still very congenial and pleasant and I had gone from an assistant professorship to a full professorship in seven years which was kind of unheard of at that time. I was, I think, thirty-three when I became a full professor there. I felt that it was more a matter of just putting a little oil on the machine and keeping it greased and that I really would never have the feeling that what I had developed was truly my own until I moved to another setting. So I began then to feel that that would be appropriate. The other facet was that I had become sufficiently known by then so that my name was beginning to appear on lists for chairmanships in other places. So I think those were the combinations of factors.

Dr. O.: We might at this point give you an opportunity to say a word about two people who seem to have had a fair amount of influence on your development, Drs. Franz Alexander and David Shackow, psychologist, who of course was here at NIH for many years.

Dr. R.: Recently deceased, just in the past few weeks.

Dr. O.: I had not realized that.

Dr. R.: Yes, yes, very recently. Well, there were a number of others during that time because as I casted about for some ways to learn more about psychological and social development and began to develop my own educational program, as it were, I quickly recognized there wasn't any charted course for this. There were no fellowships, not in the sense that there are today, so I began to do some work with some of the people in the Department of Psychiatry. Dr. Francis Gerty who chaired that department as I mentioned.

While he didn't personally have any professional interest in children, he was very supportive of wanting to see new developments take place. Some of my interests moved into what had been thought of as psychosomatic interests and in order to develop some clinical programs for this I began to interact with some of the psychoanalysts in the community who were working with children. There were several that became influential--Franz Alexander was such a leading figure and he was the director of the Institute for Psychoanalysis. There was a period when psychoanalysis was really making quite an impact on the academic scene across the country in psychiatry. It certainly was the dominant kind of movement. But psychoanalytic education was largely in psychoanalytic institutes separate from the university. But he was on the University of Illinois faculty. He had a seminar on psychosomatic medicine which was attended by a large number who had such interests. So I began to get some of his conceptual background incorporated into my thinking. There were people who were interested in children in that group--a woman who was not a physician, interestingly enough, but who was the associate director of the Institute for Psychoanalysis, Helen Ross. This is just a bit of incidental intelligence, but she was a sister of Charlie Ross who was Truman's press secretary--all came from Missouri. But she had been to Vienna and trained with Anna Freud during that period when almost everybody who had child psychoanalytic training had been to Vienna. She was very supportive of my interests. Then there were three others, a Dr. George Mohr, who gave a lecture course in child psychiatry to the medical students. I felt the medical students didn't know anything much about child psychiatry. I thought it was because they had never been taught, and I learned that he had been giving these lectures so I went and attended those lectures and they were superb lectures. It was just that the students had no background for understanding it; they were too early in their careers

to appreciate it, but I understood what he was saying and had some appreciation for it. So I involved him in some of our clinical work in the psychosomatic unit. Then there was a very talented woman, Dr. Margaret Gerard, married to the neurophysiologist, Ralph Gerard. She was just a remarkably talented and insightful clinician who unfortunately had never written a great deal about her experiences. We involved her heavily in our clinical program. We developed a twelve-bed unit for children with psychosomatic disorders which gave us a lot of opportunity to try out various notions in the management of children with very difficult disorders like asthma and ulcerative colitis and anorexia nervosa and a number of others. Then Dr. Irene Josselyn who was interested in children but with a heavier emphasis on the adolescent. There's an interesting relationship that developed further in that this Helen Ross that I had mentioned, not being a physician, had always had the notion that you ought to get other people who deal with children--whether they be psychologists or social workers or teachers--that they ought to have more psychoanalytic background in their education. This again is a reflection of Alexander's liberalism or flexibility in that he was not doctrinaire to the point of saying only physicians could become educated in psychoanalysis. So they developed what they called a psychoanalytic child care course for people from these various professions. Since these people didn't have much background in biology or medicine they wanted them to have some understanding of the broader development of the child including biology. They asked me to teach in that and this got me involved in wanting to get some psychoanalytic training and again because of Alexander's flexibility, I was admitted to course work at the Institute for Psychoanalysis for physicians while I was teaching in this other program that they had developed. In order to do that one needed

to have a personal or what they called a training psychoanalysis and Dr. Irene Josselyn became my training analyst so I had that psychoanalytic experience during that time. So it was out of that interaction with that variety of people that I then began to develop some of my own notions and thoughts about child development and tried to incorporate psychoanalytic concepts into my understanding of children.

Dr. O.: With this background then you were called to be Professor and Chairman in the Department of Pediatrics at Syracuse in 1953 and you remained until 1971 with some periods of absence, of course. This is really where you began to have the opportunity to develop your own department with the aspects of research in early child development. Is there any element of that part of your career that you'd particularly like to delve into, your tenure in the Department of Pediatrics?

Dr. R.: Well, first you know what was attractive about Syracuse at that time most particularly was the presence of a person who was a new dean there then, Dr. Bill Willard, who is currently retired in Alabama. Bill Willard had come to Syracuse when the State University of New York took over the medical school from Syracuse University during that era when Dewey was governor. Again in that postwar period various groups within the state were looking for better opportunities for their children. The State University came into being rather late for a state like New York, but their resources at that time were quite generous. Bill Willard, who had been teaching in the program in public health at Yale and who was a Yale graduate and a person of great vision in terms of public health practice and particularly the involvement of communities in health affairs, had come there to develop the medical center. He really was interested in moving that

school forward in various ways. He particularly was interested in incorporating concepts from social work in sociology and public health practice in the medical curriculum, and so he had quite a collection of people there for that era. There was a woman from the field of social work by the name of Grace White, two sociologists, Bob Straus who later went with Bill Willard to Kentucky to develop a new department of behavioral science, and then a black sociologist who later followed me to Harvard by the name of Charles Willie. This was very attractive to me in that the school until then had been really a very provincial school perceiving its mission as educating students for that area of upstate New York. This kind of satisfield my aspirations to see if one could develop a program that one could really call one's own because essentially there had been no academic program other than for basic clinical teaching of students to go out into practice. Again, how Bill Willard managed this I don't know, but when he outlined to me the numbers of positions that would be available--faculty positions--in that department, I recognized that practically no place in the country had those kinds of resources. I thought, well, I don't know how well one could succeed but it wouldn't be for lack of resources. So I decided that it was a good opportunity and so we did decide to leave Chicago and to go there.

I think we were really quite successful in attracting young faculty. My first objective was to round out the pediatric academic program and not neglect the traditional pediatric areas in favor only of my own so we quickly recruited people in the infectious disease area, cardiology as it was then expanding considerably in pediatrics, and endocrinology, genetics, and hematology, etc. Then I began to develop my own program in child development

within pediatrics. Again the Commonwealth Fund came to the fore. When I asked them if I could develop a fellowship program, they provided some support for this to see whether we couldn't train some people in the psychological and social development of children as pediatricians. I think that came along reasonably well. I continued my interest in psychosomatic medicine there but we also then began to really look at infant development in a much more detailed way and particularly some psychophysiological developments. Because of my interest in psychosomatic medicine I began to think about something that Franz Alexander always referred to as the X factor. It was the constitutional factor--that you could have two people exposed to similar stress, one person might develop peptic ulcer and the other might not. What were the predisposing factors and presumably there were some constitutional factors? I then began to speculate, well, in terms of autonomic function, how different might babies be initially and would these differences persist? So that set me and some of my fellows and younger faculty people off on a number of studies on autonomic functions of the newborn. One of those fellows has currently moved into the whole area of sudden infant death syndrome because of some of the findings that stem from observations of deviations in autonomic function. He developed a hypothesis of a neurophysiological basis for sudden infant death syndrome which seems to be working out in a practical clinical way. The notion that one might now be able to identify infants who are vulnerable to sudden infant death syndrome has led him to develop a monitoring system so that if an infant develops apnea ------

Dr. O.: There was an excellent piece on him--was it "60 Minutes" several weeks ago?

Dr. R.: Yes, I didn't see it but I ------

Dr. O.: ------ on this very topic with these monitoring systems.

Dr. R.: Yes, I think he was on that program. This is a good example of serendipity because we didn't start out studying sudden infant death syndrome. He really, in my view, has become almost the leading figure in that entire field now in terms of some of the new developments.

Dr. O.: Permit me to go back slightly and ask you somewhat of a general question that interests me. That is the attitude I gather was present in the forties or early fifties, I certainly experienced it as a medical student, toward the psychological and social aspects of pediatrics. My personal experience was that we essentially had no training in this. We had an occasional lecture from Dr. Eugene Meyer in psychosomatic medicine at Hopkins. People--I don't know how to put it--it was almost as though without saying it, he was held at arms length. It was something we had to be exposed to with the folks in pediatrics. Of course, that was the unfortunate time of Francis Schwentker who did not stay with us terribly long as professor. It was really very disappointing and anybody interested in this area in my era had no exposure to it at all. In fact, I almost sensed amongst the Department of Internal Medicine and those pediatricians we were exposed to that it was played down as not terribly important.

Dr. R.: Well, that's a very interesting point; very glad to hear of Eugene Meyers' role, Bill, we call him. He's an old friend in the psychosomatic area. I think he played a very important role and ultimately became president of the American Psychosomatic Society. I think in academic pediatrics, certainly in the late forties and early fifties there was so

much research in traditional areas that was burgeoning--molecular biology was coming on the scene--we had just seen the great advances in antimicrobial drugs and immunizations were coming to the fore increasingly and the development of new vaccines for polio and measles, so that one could understand the excitement about traditional pediatric concerns. Going back, very briefly, I became convinced, as a consequence of my observations in World War II and the tremendous amount of disability from emotional causes, that the future of pediatrics was in a very major way going to be in an understanding of the psychological and social development of the child and so I was sort of betting on that area. Intuitively I was led in that direction but I didn't have any lesser interest though in traditional pediatrics so I kind of tried to bring these together. That was why I felt it was important for someone with my interest to chair a department of pediatrics that dealt with the spectrum of pediatrics. At that time one of my former students and I published in '54, Pediatric Diagnosis. I think it may have been the last of the encyclopedic books on pediatrics, rather the last of the encyclopedists in terms of the two of us wrote every word in that book with one very minor exception.

Dr. O.: That sort of single author, dual author medical text has almost disappeared.

Dr. R.: Yes, the third edition of that has just appeared and with each edition we debate whether to go to multiauthorship. Well, so my view was you weren't the complete pediatrician, if you didn't incorporate the psychological and social dimension. But not only was there a feeling among many that this was not very important but there was really some real resistance to it, the feeling being that this would ultimately dilute what pediatrics

was really supposed to be about. So that in a sense we were swimming upstream. When I say "we"--Dr. Senn pioneered this more but I think Dr. Senn didn't retain a foot in general pediatrics as fully as I did even though he became chairman of the department at Yale for a brief time. He really by then had become sufficiently involved in predominantly psycho-social issues that he didn't have the same kind of role to play in the mainstream of pediatrics. I tried to cultivate both of these, but I was betting on the fact that this would ultimately become a very dominant theme in pediatrics. My daughter-in-law, who is now on the pediatric faculty at Georgetown, recently in going through some old volumes of Pediatrics, found something that I had forgotten about that I wrote in 1950 with my then chief, Henry Poncher, on pediatric education. Well for all the world that could have been incorporated in the report of the task force on pediatrics that was published just three or four years ago, because what that task force says today is that pediatric education hasn't really included enough of the psychological and social dimension. And now what we predicted then--I used to say to Dr. Senn, "There'll come a day when departments of pediatrics will be pounding on our door wanting faculty members who know how to teach this and who know how to do research in this area and we wont have them." And that's where we are today.

Dr. O.: I was fascinated to learn of your studies at Syracuse with infants and young children in poverty situations that indicated they literally underwent a developmental decline. This raised the issue of the need for intervention with well-staffed day care centers--a concept which met resistance.

Dr. R.: Well, again you see the process of serendipity at play. Because of our interest in psychosomatic disorders and my feeling that time, that early experience as well as constitutional differences in early life probably are important, we began to want a look at a population of children from the prenatal period on and to look at the parent-child interactions--really childrearing practices. We wanted to see what we could learn about this in an anterospective fashion because there was always the problem of so many intervening variables when looking back. You'd never know what those real experiences were like early on. So we wanted to develop a longitudinal study where we could observe such interactions. With very modest funds we were able to set up such an observational clinic in one of our teaching hospitals there. The population that was available to us was the population that was in the environment of the medical center, and that was a very low income population.

Now, the interesting thing about studies up until then on child development--longitudinal studies, watching the same children over a time--was that they'd almost uniformly been done on middle class, in particular, on the upper middle class children, children of faculty. That was because most of such centers were on university campuses. Now, we were doing this at about the same time the civil rights revolution was beginning to take hold. We, in effect, had begun to study poverty in a way that no one else quite had until that time. Even though that wasn't the reason, that is, we didn't set out explicitly to study poverty, during the course of our observations we did indeed observe that as these children got to be somewhere between twelve and eighteen months of age, particularly as language began to become important for development, we began to see what we later called

developmental attrition. Developmental performance by any kinds of standard tests, began to decline. I had a very talented psychologist working with me, Betty Caldwell. She and I began to think about that decline and the ethical issues that arose. If you see children under your very eyes declining in function, don't you have an obligation to see if you can do something about this? The problem of the clinician doing a double blind study, as it were, is similar. If you see some subpopulation that seems to be doing much better, don't you have an obligation to stop the study and to intervene. Well, there was no point to not following those children, but then we began to explore a little. Well, there were two options in terms of how one could intervene. One could intervene by providing some kind of stimulation beyond what the parents were providing in the home setting or to try to arrange for some group setting like day care. Group care for young children, particularly infants, was then sort of a taboo because there had been so much emphasis on separating experiences and their impact on infants and young children due particularly to the writings of John Bowlby, a British child psychiatrist who had popularized that issue. He wrote a World Health Organization monograph on Mental Health and Maternal Care. People felt that it was inherently had. We recognized that the care at home was not providing enough stimulation. Betty Caldwell thought that if we provided some expert help in the home that we might be able to reverse this. I felt that we might lose a lot of valuable time because we'd never know for sure what those children got if we tried to teach the parents to do this. So U proposed the setting up of the day care program which we ultimately did. That was very difficult to do because of the intense opposition. Finally a man by the name of Charles Gershenson who was the director of research for the U. S. Children's Bureau was bold enough to

say, "Well, this is worth doing," and we were able to demonstrate then that we could reverse that developmental decline and that did pave the way for programs like Head Start. By then other groups--again the notion of an idea whose time had arrived--had begun to look at the impact of poverty on the development of children, so this was sort of bubbling up from several sources at the same

Dr. O.: It dawns on me, I just happened to notice that the tape is getting close to the end. I really didn't ask you what your schedule was like. I don't want to wear you out the first sitting. If you are game to go on or ------

Dr. R.: Well, I ought to get away about eleven so if you think we've got enough tape to go that long, okay.

Dr. O.: Well, why don't we go to the end of the reel, as it were, which is just a short distance off now. That'll give you plenty of time to get away. Perhaps this is the time to get started at least in your first trip to Washington. In 1965 you were indeed approached and accepted the call to serve as the first director of the Head Start program. Anything you would like to cover in this era we'd be delighted to hear.

Dr. R.: Well, as I had indicated, we had made the demonstration that one could certainly prevent that developmental attrition. The civil rights revolution, of course, brought with it a focus on poverty so you had the two going hand in hand. In 1964 we had the passage of the Economic Opportunity Act and the Civil Rights Act in one Congress in one year. With the establishment of the Office of Economic Opportunity, Mr. Shriver was asked to be the first director of that office. Here again you have an incidence of--coincidence--Mr. Shriver had been serving as the Executive Director

of the Kennedy Foundation which had an interest in the problems of retarded people and what one could do about both prevention and improved care for the retarded because of the Kennedy family's interest in that issue. Well, during the course of his work with the Kennedy Foundation he had learned a lot about child development--he had talked to the experts all over the country and on, so he had the feeling that something important could be done, but he didn't know quite what could be done. He convened a group of experts, an interdisciplinary group of about fifteen people chaired by the then Professor of Pediatrics at Hopkins, Bob Cook. They had arrived at the notion that a program for preschool children that was a comprehensive program, not exclusively health, not exclusively education, not exclusively social services, but all of these put together in the interests of children and their families would be potentially an effective program to help them. Well, and they casted about to see who might direct this and for reasons that I've already indicated, there weren't very many people around the country who had had much by way of directing experience with these programs. It was at that point that Mr. Shriver asked me to come to Washington and to implement that kind of effort. I can recall talking with him about whether he oughtn't to get somebody who had some broader experience in public health administration because they were really talking about a fairly sizable program. In typical Shriver fashion he said, "Well if I had wanted a bureaucrat I would have looked for one." He also said, "Well, gee, for most of your professional career, you've really been an advocate of programs like this," and I said, "Yeah, that's true." He said, "Well, now it's time to put up or shut up." So I felt that in spite of the fact that I didn't feel I was particularly prepared to manage such a program and particularly to do all of the initiating of such a widespread program, I found myself agreeing to do

it. I must say I was fortified by the fact that I had already met Jule Sugarman who was sort of doing the background work for it and he was one of those career civil servante who had remarkable managerial capacities and also realized the importance of this kind of effort--had a deep personal interest in it. So I realized that I would have a lot of help on the management side which indeed I did have. So that was what got me involved.

There were a number of very important kinds of judgments that had to be made early on in the development of that program--what age group should one target on. We made the judgment--I say we, because this advisory committee was heavily involved in participating in the making of judgments--we decided if we spread the money over all of the five preschool years, it might not go very far, and we decided to focus on the year prior to school entry. I think, in general, that was a very wise judgment because I think we were able to make a more major impact and indeed it is possible to improve performance even if one starts relatively late. So it was, I think, a very significant kind of judgment ot make. There were issues like how many adults per child should one have--teacher-people ratio. Because of the experiences which Betty Caldwell and I had had, I had the feeling that if we had an unfavorable kind of ratio--at that time they were projecting what the public schools had, one to twenty-five or thirty--my own view then was, well, if we didn't show significance gains we would never really know whether the program could work. So I made the judgment that we would have one trained teacher per fifteen children with two teaching assistants, people who weren't fully trained. So that was one adult per five children, and I felt that that would give it a reasonable trial and if it didn't work then maybe it just wasn't something which could be done effectively. I can

recall the debate because people were very apprehensive--they said well, if you go to one trained teacher per fifteen children you double the number of teachers, and I said, "Well, if that means serving half the number of children, I think we'll just have to take that risk because the worse thing that could happen to this program is for people to say that it's a total failure." So we stood by that decision and again I think in retrospect, it was a wise one. The interesting thing about what happened as we were proposing this for a first summer's program--the judgment to try to have a program that summer was made in February so we had to go through the whole process of trying to implement something by mid-June. We took the plunge, but the interesting thing is when we sent out the announcements of the program we got responses from about thirty-four hundred communities across the country. We ultimately found that about twenty-seven hundred of them really were prepared to do a reasonable job and actually fielded programs in that first summer, so we were able to really carry that off, I think with a lot of luck and a lot of work on the parts of a lot of people.

Dr. O.: Well, I gather this continued and with the change of administration there were some people who were starting to take pot shots at the program, be critical of it, wonder whether it was the best expenditure of monies and so on. Is this a correct assessment?

Dr. R.: Well, there was of course a good deal of early enthusiasm and that seemed to be sustained. People in communities embraced the program and it gradually was shifting to a year-round program. I developed a tuberculous lesion in the fall of '66 so I essentially dropped out of any management of the program after that but stayed in very close touch with the people who were managing it. At the time the administration shifted, by 1969, then

there were people who were saying, "Well we don't have a lot of positive proof that it really does work and maybe the program ought to be cut back." Moynihan was then on the Nixon domestic council in the White House and he was raising a lot of such questions. He wanted studies done and the administration ultimately decided against the advice of some of us to do what became known as the Westinghouse study. When I say against the advice of some of us, Dr. Urei Bronfenbrenner and I made a trip to Washington to talk with the then acting director of OEO, a man by the name of Bert Harding who was a career civil servant. We pointed out to him what we thought the flaws in such a study might be. I never found out what the political pressures to do the study really were, but it was clear that he felt it had to go forward. The Westinghouse Corporation that had the contract, subcontracted with people at Ohio University in Athens, and they did what some of us would have called a quick and dirty study looking at only children one year out around the country drawing a sample and looking at school performance and some IQ test measures and concluded that it didn't really make a difference. Moynihan made much of this and there were many things about the study that were inappropriate. As Betty Caldwell once said, "If you want to design a study to obscure the gains or the differences among children you would have designed it that way." You know, you can design studies to highlight where gains have been made. Of course, what this did was spawn a whole cottage industry of reanalyzing the data and then there are many reanalyses of the data. A psychologist by the name of Campbell, then at Northwestern, published a whole series of studies pointing to some of the flaws in the study. But also if you then analyze subgroups you could find, even within their data, that some groups had made significant progress. The important thing is to look at the differences and not exclusively to homogenize all of the

results and average them all out which was basically what they did. Well, of course, over time and fortunately we had the vision to fund a number of university groups who would watch children over extended periods of time. There's now, I think, a sixteen center consortium of research workers pulled together by a man by the name of Irving Lazar from Cornell. And in looking at the long-term data there is little doubt but what the children have sustained a good deal of progress over the years, performing better in school, with fewer of them repeating grades, and with better psychological and social adaptation. I think the long-term results have been very good and that's reflected of course in this administration's making the judgment that Head Start would be one of the seven programs that would not be cut, which I thought was highly significant.

Dr. O.: Which, I think, is a fairly reasonable vindication. If one needs a vindication. That perhaps is a pretty good place to stop, seeing as you want to get away at eleven and I think Leon's going to tell us our tape's about to run down. We've gone about, what, an hour and a half all told I guess.

End of Side One.

The date is May 18, 1981. This is the second interview with Dr. Julius Richmond. This is Dr. Peter Olch of the National Library of Medicine.

Dr. O.: Dr. Richmond, last time we closed our interview with discussion of your role in the Head Start program. You gave us a fair amount of information on the various problems that were faced and how you and your staff handled them. We did not touch upon at all, I don't believe, the neighborhood health centers program in which you were certainly intimately involved during your time as Director of the Office of Health Affairs of the Office of Economic Opportunity. Could you say a few words about this program?

Dr. R.: Yes. When I came to the Office of Economic Opportunity my primary responsibilities were to organize and to direct the Head Start program. It turned out I was the only physician in the headquarters of the Office of Economic Opportunity and some of the people who were responsible for program development, particularly a person by the name of Dick Boone and another, Dr. Sandy Kravitz, would come to me with various proposals that they had received in the field of health. I then began to recognize that there were some remarkable opportunities to improve health programs for the poor if one could develop some delivery system which was specifically tailored for them. Fortuitously, a Mrs. Lisbeth Schorr, then Li Bamberger had just come to the Office of Economic Opportunity from the AFL-CIO where she had been involved in their campaign to pass the Medicare legislation. It was clear that the Medicare legislation was in the process of passing and so she felt her job there had been accomplished and she came to OEO. She had considerable experience in dealing with financing issues in relationship to health services. We began then to think about what OEO could do in a more ordered way in

improving health services for the poor rather than just ad hocing programs in terms of responding to those applications which came in which were highly varied and which I didn't see as adding up to any very major impact in improving services for low income groups. So she and I then began to keep our eye out for people who might be involved in developing such programs, and the incidence of coincidence is sometimes fortunate in that just about the time we were thinking about this we received two proposals, one from the Health Department of the City of Denver, from a Dr. Johnson who was then the Health Commissioner, and another from Tufts University Medical School where Drs. Count Gibson and Jack Geiger were developing programs in community health. Their proposal was a rather interesting one in that it provided for the development of a health center at Columbia Point in Boston which was a low income housing development and a program in rural Mississippi. We thought this would be an excellent opportunity to see these two developments go in tandem under the leadership of one group. The auspices of Tufts University in Mississippi were rather interesting because they would appear to be interlopers in the state of Mississippi. On the other hand at that time programs were so segregated in the state of Mississippi and the resources in the low income community, particularly the black community, were so few that it wasn't likely that such programs could have developed without some input from the outside. So over time in working with them these proposals were generated.

We had developed an internal memorandum which really outlined, in effect, the kind of neighborhood health center program they were proposing. Mrs. Schorr and I had done some homework on the numbers of poor--at that time we estimated to be at about 35 million--and we had developed some notions as to how many centers it would take to really provide for the large

majority of low income people. We were able to get these programs funded. Mr. Shriver became quite an enthusiast for this development. It received a rather warm reception. In Congress people like Congressman Fogarty, who then chaired the health subcommittee in the House, and Senator Lister Hill were very interested in this. They recognized that this seemed to deal with an unmet need.

Over the next several years, approximately fifty such centers were funded around the country and ultimately in return those centers were transferred to HEW and became what is now the Community Health Centers Program.

Dr. O.: Was the center in Watts one of the early ones?

Dr. R.: Yes, that was one of the early ones and that came relatively shortly after the Columbia Point and Mississippi, the Mound Bayou Program in Mississippi. What has developed subsequently is a proliferation of many such centers, not all under federal auspices. I might just historically go back and say if one goes back and looks at the report that the Committee on Costs of Medical Care talked about earlier, one can find essentially the paradigm for this kind of development recommended in that report that had never come to fruition. I think that's an interesting point to have on the record because as neighborhood health centers programs developed, various people were beginning to try to establish credit in terms of priority for the idea, the notion, and I would always in a rather amused way just point to the fact that in 1932 the Committee on the Costs of Medical Care had essentially recommended that kind of development. So I don't think anybody at a later point could truly claim priority.

Dr. O.: I was interested to note that there was a span of time there when you actually were Dean at Syracuse as well as Professor and Chairman in the Department of Pediatrics and at the same time very active here in Washington. I assume you were on a leave of absence from Syracuse when you first came down in the period 1965 to '71.

Dr. R.: Well, it was '65 to late '66 that I had the responsibilities in Washington in a direct way and you put your finger on a rather interesting arrangement which probably has never existed in the federal government before or since. That is that I was running these national programs while actually on a part time basis because I hadn't really given up those responsibilities in Syracuse. I still carried on some of the key responsibilities there while spending part of the week in Washington. I sort of did this on an ad hoc week by week arrangement depending on what kinds of responsibilities I thought I had back in Syracuse and what responsibilities in Washington were in spite of the fact that it might have seemed like an inordinately large number of responsibilities. Then I come back to the fact that I have always had highly competent people to work with so there was a lot of responsibility delegated on both ends. But what made it feasible was of course the advent of the jet airplane and the availability of long distance telephone. That way one could actually accomplish a great deal. So, in fact I was really carrying on all four of these jobs somewhat simultaneously.

What brought the tour in Washington as well as my jobs in Syracuse to a halt, however, was the development of pulmonary tuberculosis in 1966--in September of '66. I developed some hempotysis and this was diagnosed as pulmonary tb. I had a small cavity in my left upper lobe and so I was at

home for a period of about six months. I was on PAS and INH during that time and made good progress. That was the time that I used to write the book Currents in American Medicine. I had that book pretty much organized in my head and I just never had enough time to get it down on paper, so sometimes I'm inclined to say if I had stayed sick longer it might have been a longer book.

Dr. O.: Well, I found it a very, very fascinating book and, as I mentioned to you in a note, I think I'd classify it along with Rosemary Steven's book which you may be familiar with. I did find that the Harvard Press indeed had a copy that I could obtain, much to my delight.

In 1971, you did close the chapter as it were at Syracuse and accepted a position, really a dual position, at Harvard. Can you give us a little of the background to this? Perhaps some of the reasons may be somewhat obvious, but still it might be interesting to hear you describe what went into the decision to leave Syracuse where you had accomplished a great deal and to move to Harvard.

Dr. R.: Well, after I came back to my full time responsibilities at Syracuse in '77 there were a number of things that I felt remained to be done at the ------

Dr. O.: '67?

Dr. R.: Sorry you're right, '67, you're correct, got ahead by a decade, '67. When I came back to full time activities, I found that there had been a number of departmental chairmanships that were open and this provided a unique opportunity for the school to sort of undergo a self renewal through the appointments of new chiefs of departments. I set about to try to do

that and over a time we did accomplish the recruitment of the various chiefs. Once we had done that I felt that I had done about as much in the deanship there as I was going to accomplish. The presidency of the center was then open and there was a recruitment process for that position. When that appointment was made--and I think that was in either late '69 or '70--I had felt that I really ought to go back to the department full-time and pick up some of my responsibilities there. That's what I still enjoyed perhaps the most of all of the things that I had done, so I was in the process of doing that. But by then I had been in Syracuse for about seventeen years and began to wonder more generally, even in relationship to pediatrics, whether that department had developed to the maximum what it was going to develop under my leadership. Constraints were beginning to set in budgetarily which hadn't been there before. While I was really very happy with my situation and wasn't looking for any new opportunities I did see the call from Dr. Leon Eisenberg who was chairing a search committee to find a professor of child psychiatry for the Harvard institutions and particularly to be Chief of the Psychiatric Services for Children's Hospital Medical Center there and simultaneously to be the Director of the Judge Baker Guidance Center as something to explore. Well, that was rather a different direction from the one I had been pursuing because my interests had been more to bring psychiatry into pediatrics and not to move from pediatrics into another discipline. Indeed in some of my writings I had written about the need for pediatricians to incorporate these principles and to retain their identity. And I suppose other institutions never would have really thought of taking someone from another discipline and and appointing them in a field like child psychiatry whose clinical skills and a body of psychiatric knowledge was rather basic. Now, I am being interpretive

because from what I had heard about that committee's search--they had already been searching for about three years and they felt that the field of child psychiatry didn't have many individuals in it of the academic strength that Harvard tradition demands. They kept looking and looking and one or two people that they thought might have met their specifications were in no position to move--I think mainly people from abroad--and the committee, and again I'm now speaking from hearsay, then raised the question: Well, might they look at people from another discipline? Well, once apparently they made that judgment, my name came up. I indicated in the initial contact that I didn't think that that would be an appropriate direction for me, but they asked if I wouldn't come and talk with them and serve as a consultant if not as a candidate. So I agreed to come on that basis. I found the committee to be very open about what they wanted. They seemed to think that I could fill that position effectively. I did have--I can be immodest about it--think I had unique qualifications as a pediatrician in that I had a great deal of psychiatric training and I'd been involved with psychiatric colleagues over the years so I didn't feel particularly strange in that environment. Then when I weighed the fact that I had been in Syracuse for almost eighteen years, I thought well, this would be a new challenge that might be worth taking on. Also, since I had thought of myself to a considerable extent as an institutional change agent, I did have some thoughts about how one could perhaps begin to attract more talented young people with an academic orientation into the field of child psychiatry and begin to redevelop the field with more academic young people or people with academic potentialities. And since the resources ther were so rich I felt that there was a uniquely favorable place to try to effect that kind of institutional change. The people on the committee, I think, were quite

influential in getting me to shift my position about my potentialities. Dr. Janeway, who was then the Chief of Medicine at the Children's Hospital Medical Center, and Dr. Jerome Brunner, who was then still Professor of Psychology at Harvard, people that I had known as colleagues in various capacities--felt that it would be a very excellent match. So ultimately I decided that it would be worth doing even though to some extent I would be leaving pediatrics. I think if it hadn't been a position in an institution like the Children's Hospital Medical Center where one would be rubbing elbows with pediatricians everyday, I might have been more reluctant to assume those responsibilities. And then I suppose one could add in the Harvard factor--I had never been on the faculty at Harvard and I thought that that was worth giving it a try. And so that's essentially how that transition came about.

Dr. O.: I was very interested to note, referring to your 1972 interview with Dr. Senn, that you did make the statement as you left Washington and your responsibilities with the federal government, you hoped you could keep your hand in planning public policy and continue to be involved or at least get reinvolved in direct implementation of programs if possible. So you must have looked back on your federal experiences as being worthwhile and stimulating to make such a statement.

Dr. R.: Yes, very much so. I think the time I spent in Washington in the sixties was a kind of once in a century sort of opportunity. I was quite conscious of this at the time, that is the opportunity to start two national programs from scratch with no established bureaucracy, no established resistances. To have the funding for these programs readily available and to be able to do this within the course of one year, that is to get both of them

off and running in effect within one year, was a very stimulating experience. The job was not completely done, obviously, by the time I left Washington and such jobs are never completely done, but the leadership of these programs after I left was in the hands of people that I had essentially picked. Even though I was not in Washington in any official responsibilities after late 1966, I in effect was an informal consultant to both programs on a very active basis. In that sense I did maintain considerable level of activity, a fair amount of consultation through committee activities and other work as well.

Dr. O.: And when you say both programs you mean Head Start program and the Neighborhood Health Center program.

Dr. R.: Right. The Head Start program was largely in the hands of Mr. Jule Sugarman after I left who later on went on to become the Secretary for Human Resources in New York City and later, the Deputy Mayor of Atlanta. More recently he has been the Vice-Chairman of the Civil Service Commission, which later became the Office of Personnal Management. The Neighborhood Health Center Program was directed first by Joe English whom I had brought over from the Peace Corps. We had recruited Dr. Tom Bryant from Atlanta--Tom is both an attorney and a physician--to work on our staff, and then when Joe English went to HEW, Tom Bryant took over that program. I was called on very actively by them for a lot of consultation in connection with the programs.

Dr. O.: The five-year span that you were at Harvard, prior to your return to Washington which we will certainly get into--do you have any thoughts or highlights of that period you would like to record in this memoir?

Dr. R.: Well, that was a very interesting period as I think any time spent at Harvard inevitably would be. I think in connection with the program in child psychiatry in my involvement at the Children'Hospital, I quickly learned that one of the major differences between Harvard and other institutions is the tremendous depth of talent that one has at Harvard. In psychiatry and psychology there are just so many places where there are Harvard faculty that one finds interesting and stimulating. There are of course numerous clinical settings where interesting things are going on and one immediately begins to recognize that one can spend almost all of one's time interacting with interesting people. One has to set some limits on that in order to accomplish one's primary objectives. I did set about to try to develop a corps of trainees who would be interested in pursuing academic careers in child psychiatry. I think we were moderately successful in doing that. I found that the resources for such training were very good. I had in my department at the Judge Baker Clinic and the Children's Hospital, a research unit headed by Dr. Peter Wolf which was carrying on highly competent and sophisticated research in some aspects of child development. Dr. Leon Eisenberg, who had been chairing the Department of Psychiatry at the Massachusetts General Hospital but is a child psychiatrist, was willing to give up that post and join me at the Children's Hospital and that, too, strengthened our academic base. So that we did, I think, reinvigorate the program in the department. I found myself also, because of my pediatric background, rather actively involved in the medical staff affairs at the Children' s Hospital perhaps somewhat because of my seniority and level of experience. I found that I was soon elected to be chairperson of the Medical Staff Executive Committee which is sort of the professional power group at the Children's Hospital and that kept me rather actively involved

in the development of new programs. I saw the need for some transformation of that Center, in the light of the new developments in community child health programs, to establish some new programs which I was largely influential in doing, with Dr. Janeway's collaboration. With the Brookline schools, we developed a Brookline early education program and several other programs, one related to research on juvenile delinquency--health problems associated with delinquency. I think we helped to develop the programs in mental retardation there. They had been doing reasonably well, but again I lent some support to that.

But I hadn't been there but a few months when there was an interesting development. The Dean of the medical school, Dr. Bob Ebert, was an old friend. He and I were in the first group of Markle Scholars that were appointed back in 1948. He knew a lot about me and they were, at that point, searching for a chairman of the Department of Preventive and Social Medicine because Dr. David Rutstein, who had chaired that department for twenty-five years, had recently retired. He still is an active and vigorous person, but decided that he had chaired that department long enough and also was of an age when he could retire and do things that he had been wanting to do for quite some time. Well, that search committee had been casting about doing a lot of looking and didn't seem to be coming to any resolution. Also at that time the Dean of the School of Public Health had recently retired. The matter of the Department of Preventive and Social Medicine establishing relationships with the faculty of the School of Public Health became a more visible and active interest on the part of both the School of Public Health and the medical school administration. I am not sure who got this idea initially, but the idea developed in the light of the publication of my book and in the light of my experiences in Washington that perhaps I might be the

one who could build the bridges between the School of Public Health and the medical school through the Department of Preventive and Social Medicine. So the Dean called me in and asked if I would be willing to take on that responsibility, that the committee had recommended the appointment. This was somewhat unbeknownst to me--they'd sort of done their own homework. Dr. George Thorn was still Chief of Medicine at the Brigham and he was chairing that committee. He called me and asked if I would come and chat with him and I must say he was quite persuasive in terms of some of the things that could be done potentially. When I protested to the Dean that I had come to do two other jobs in the Children's Hospital and the Judge Baker Clinic, his retort was "Well, you've always been with more than one job and so this wouldn't be much of an add on for you." So with the notion that this would be a relatively short-term arrangement until those relationships developed and the new dean got appointed at the School of Public Health and we could then sort of see what kind of a match one would want to make between the medical school program and the School of Public Health, I felt that within that interim period I could carry on that responsibility. I had by that time incidentally brought with me from Syracuse one of my key right hand people. He had come to Children's Hospital, a pediatrician, Dr. George Lamb. I knew that if I took Preventive and Social Medicine on he would be available to me and was very able in that area and that proved to be true. He proved to be very valuable in facilitating that development. So it turned out to be a period that was even more interesting than I had anticipated when I assumed the responsibilities of that department. That department really had a very heterogenous faculty because some of the people who were hospital administrators in the Harvard complex held nominal appointments there. Then we had people like Paul Densen and his staff in the Center for Community Health and

Medical Care who were epidemiologists and biostatisticians and economists--the economist being Rashi Fine, in particular, a very distinguished medical economist. That whole group, too, was available to me and I did find the faculty of the School of Public Health, Dr. Brian MacMahon in Epidemiology and Dr. Al Yerby in Medical Care and Medical Administration, and people of that sort were very cooperative so that we were able to develop we thought some interesting programs for students. I might just interject, that at Harvard at that time, because of the nature of the institution relatively little had been done by way of developing primary care training programs for both undergraduate students as well as graduate programs--postgraduate programs--for house officers. I began to see that there would be great demand for such programs throughout the country and that it would be unfortunate if Harvard as a leading institution played no role in that development. That was just about the time the Robert Wood Johnson Foundation was beginning to get off the ground--they started in '72--and one of the first things they began to explore was the development of primary care training programs again anticipating what the nation's needs might be so they were interesting in facilitating such developments. They did make a grant to Harvard for such a development, but the academic base for the program--since no other department was really ready to provide the auspices for primary care training--that fell to our department. We developed some rather unique administrative arrangements to do this because we didn't actually ourselves control any of the clinical training programs or the clinical institutions. But again in rather unique Harvard way things evolved and this all came to pass. So that was interesting from that standpoint. That was a unique development in Preventive and Social Medicine because there had been nothing like it in that Department before and indeed there had been nothing like it at Harvard before.

Dr. O.: Well certainly all these things you've been describing were molding you into an experienced individual which would just fit what sort of comes up later on the horizon. As I said, to you prior to our beginning these interviews, I think that you are unique amongst recent surgeons general in the background that you brought to the position when you came to Washington in '77. We might at this point take up this very interesting era when you were approached by then President Carter in June of 1977 to leave your position at Harvard and to return to Washington as Assistant Secretary for Health and Surgeon General of the United States. I imagine that gave you mixed feelings but certainly the opportunity to bring to fruition some of your programs that you had been involved with earlier. I wonder if you would touch on your feelings when this opportunity arose.

Dr. R.: Yeah, it was a very interesting period of development in my professional life. As you properly point out, there was the very interesting interplay of experiences at Harvard. What was happening in clinical medicine--various parts of clinical medicine--and a lot of managerial experience and what was happening in the academic institutions; all of these things became additionally incorporated as part of my experience. There was one other development that is significant in relationship to the invitation to come back to Washington to administrative responsibilities. That was the fact that in my book, Currents in American Medicine, I had spoken rather pointedly of the need for some institutional development of policy options in health, that we had never really developed this in an institutional sense. I end that book, Currents in American Medicine, with a quotation of Eleanor Langer's which she wrote and published in about '66 or '67 in which she makes the point that the policy makers in the United States have

available to them the greatest array of expertise and information and yet they seem to be afraid of systematic solutions and so they do a little bit of everything at once. That quotation, it seemed to me, rather succinctly summarized the state of affairs and in the book I proposed that there either needed to be something like a presidential council of advisors on health, somewhat the analogue of the council of economic advisors, or some extra-mural body like the National Academy of Sciences or some university-based settings. I did feel that the development probably had to be outside of government because of the tendency within government for the urgent to drive out the important, and even though people tried to develop long-range planning for policy development it just never seems to happen very well. So during that time what started out as a board on medicine developed into the Institute of Medicine under the aegis of the National Academy of Sciences. It was having growing pains but I was very actively involved in the development of the Institute and then served on the Council and not too long prior to my being invited to come back to Washington had chaired the Executive Committee of the Council which sought a president of the Institute of Medicine when Don Fredrickson had decided to give that post up in order to come back to NIH as the Director. That was when we had recruited Dr. David Hamberg. Well, I saw that development as very important to policy development but it had kept me quite active intellectually on the national front in terms of looking at what are the major issues in health, or what directions might we go in and could we develop some more systematic approaches. The opportunity came along in early 1977. While I was sworn in in July, in fact it was about May that it became rather clear that I was going to be the designee. As I began to talk with Secretary Califano about the potentialities, we began to talk about priorities and the setting of policy and

the fact that his values, those of the President, coincided pretty much with mine in terms of directions that we ought to move in and the potentiality for doing this in some systematic way over time, made the possibilities very attractive to me. The post, per se, since I had been in Washington and knew what it was like--the status and the power aspects didn't especially interest me, but the status and power along with a congruance of values made me feel that it was a very opportune time to really try to put one's shoulder to the wheel and to see if one could begin to develop health policy directions in a more systematic way.

Dr. O.: My impression would be that the tenure of your time as Surgeon General and Assistant Secretary for Health was marked not just by establishing a more defined program, a direction to go, but also there was a more obvious prevention aspect to the programs. Of course, there has always been preventive programs through Public Health Service, but it seemed to be more stressed at the time you were in office. I wonder if you'd explore this a little further with us.

Dr. R.: Well, as I talked with the Secretary and with the senior staff of the Public Health Service about priorities, I focused on, what in the vernacular might be thought of as the bottom line, that is, an improvement of health outcomes. I began to emphasize from my first day in office that we wanted to look at every potential program, not in terms of amounts of money, not in terms of turf, not in terms of bureaucratic issues, but basically to answer the question, does any program that we're funding and we're involved in--sponsoring--really improve the health of our people? I think we were able to convey that notion in very significant ways. In addition to those programs that are specifically under the auspices of the

Public Health Service, that is, where there is funding and where we operate programs through the six operating agencies of the Public Health Service, I recognized the importance of what I think of as the "bully pulpit" functions of the Office of the Surgeon General in particular. Probably given great emphasis by the Surgeon General's report on smoking and health of 1964 and with cigarette labeling concerning the dangers of smoking, the title of Surgeon General symbolically has come to have a good deal of meaning to people across the country. So that it seemed to me one could use that role also to try to improve health outcomes. Early on I defined the priorities in relationship to improving health outcomes in, rather simple but I think in rather significant terms as I view it. Now, I would insert kind of a parenthetical statement to indicate that I was interested in health outcomes. What the decision makers on the Washington scene were so involved in, however, was something that they called health but wasn't really quite so directly related to health outcomes. They were concerned about financing and we had been through at least a five to ten-year period in which there had been in the media the popularization of the notion that we were in the midst of health care crisis. Well, the crisis was really related to financing and particularly the increasing health expenditures in the nation--not exclusively from federal sources but we had gone from spending twelve billion for all of health in 1950 to 244 billion in 1980 over a thirty-year period. Now, one can comprehend that that's not all inflationary if one recognizes that in 1950 that was four and a half percent of the gross national produce, and in 1980 it was about 9.6 percent of the gross national product. So in terms of the total economy there was a doubling and so there was great recognition of the importance and we achieved a level of expenditure of over a thousand dollars per person in this country for health.

People were consumed by that in terms of the public policy issues, but what was being lost sight of is what was happening to health in the nation. So in 1979 I started out what we called the Surgeon General's Report entitled "Healthy People" and the subtitle is "Health Promotion and Disease Prevention." We started that report out by saying the health of the American people has never been better, but that doesn't mean that there isn't a lot more to be done. Well, having made that parenthetical statement, when I began to focus on what we could do to improve health outcomes, it seemed to me there were just three rather simple kinds of directions. The first was to continue in the direction of extending our services--health services--for those who were underserved or unserved in the nation. Even though we'd made tremendous progress since 1965 with the community health centers, with the migrant health centers, with the National Health Service Corps, and more particularly with the coming of Medicare and Medicaid in 1965, poor people on the average were seeing physicians and other providers as frequently as the more affluent population but there remain somewhere--the best our statisticians can tell us--there remain about twenty to thirty million people--roughly about ten percent really of our population--that still don't have good access or adequate financing of services. So we know that when people aren't getting services they're not likely to be fully immunized, their hypertension will not be detected, infant mortality rates will be higher, etc. I thought extending services to that group will clearly provide us with an improved yield in terms of health.

Then the other direction was clearly in my mind in the direction of prevention because most of the improvements in our health statistics were largely the result of advances in the field of public health and public health practice. It was very clear that we had gone through what some of

us had called the first public health revolution, the revolution largely associated with the control of infectious diseases and bringing those under control to the point at which on a worldwide basis we have now eradicated smallpox. Having made that tremendous progress in the control of infectious diseases, and again I can't help but include some anecdotal observations. During the course of my pediatric training I had literally gone back and sort of calculated how I spent my time, and between twenty-five and fifty percent of my training time as a pediatrician was spent in either diagnostic care of children who might have poliomyelitis or the care of them clinically during the acute phase or the convalescent phase if they had developed paralysis. Well, a medical student and intern and resident today in pediatrics should never see such a case. So that we see the tremendous shift had taken place, but we were at the end of that revolution in public health. It seemed to me we were needing to move toward the second revolution which is the prevention of noninfectious disease and also particularly minimizing the development of disabilities associated with illness of all kinds. The British epidemiologist, Archie Cochran, refers to this as the shift from curing to caring because he sees the shift from predominant preoccupation with acute disease to the care of people with disabilities of one sort or another. You mentioned earlier of having gone off to the meeting of the Osler Society and in a similar vein I can recall an observation of Osler's when he said, "the way to live a long time is to get a chronic disease and take good care of it." In a sense that's what Archie Cochran was saying too, that disabilities will develop. At any rate, there had been a great deal of skepticism about prevention and health promotion among health professionals for many years, feeling well, we had done the job to a considerable extent in the infectious diseases but in the noninfectious diseases we really

weren't very sure that we could accomplish much. But something had been sort of sneaking up on health professionals and that was a rather considerable reduction in mortality from cardiovascular disease. This started in the sixties but it wasn't until the early to mid-seventies that it began to dawn on some people that there was a lot of progress being made and that we hadn't quite recognized it. Our staff at the National Center for Health Statistics has calculated that we've had about a twenty-three percent decline in mortality in heart disease over the past decade and a thirty-six percent decline in mortality from stroke. These are very significant advances. I thought at that point that getting out the report "Healthy People" would be important in terms of highlighting what could be done in prevention. We were successful, I think, in attracting the attention of decision makers in Congress, for example. Even though we were dealing with diseases caused or associated with multiple risk factors, we didn't have a specific single etiologic agent. When we added up hypertension detection and control, the antismoking campaign which was certainly having some impact especially on males who seemed to be more vulnerable, and dietary factors and exercise and physical fitness and dealing with stress in more effective ways, each of these was probably contributing in some subtle way. My thesis basically was that because we don't know everything about causation doesn't mean we know nothing and we can begin to act on what it is we know. Now we set in motion a very interesting process at that time. That was convening of experts from all around the country and from all disciplines largely under the auspices of CDC and my office for health information and health promotion. What we began to build was a consensus among the experts having taken various issues around which prevention could develop and asking them to quantify how far they thought we could

go. I think this was unique, historically, because I think until then no one had ever tried to put down in quantitative terms what we ought to try to achieve in terms of infant mortality and cardiac mortality and stroke mortality and many other kinds of problems. In that document one begins to see such quantification, first for age groups and then for specific problems. We quickly defined three areas in that report around which one could focus. There are the prevention activities that go around health services, that is, one needs a good health service system in order to institute prevention activities like immunizations and hypertension detection and other things. One needs a kind of regulatory or community-based activities like the fluoridation of water supplies, the control of toxic waste disposal, and many of the issues related to occupational health, all in themselves to a kind of a community-based or institutionally based activity. Thirdly, the life style issues that really depend on health education and that's where I felt the "bully pulpit" functions of the Surgeon General's office could be important. So that was the second category.

The third direction in terms of priorities relates to the other two and that was the support of research. I felt that if we underwent any erosion of the quality of our research endeavors in this country that we would not be contributing to the growth and development of health services and prevention activities in a way that would be productive for the future. There was also the generic problem that our biomedical and behavioral research enterprises were generally regarded as the best in the world and I felt that they could be readily eroded. Probably if they were eroded in terms of quality as well as quantity that we probably would have great difficulty in rebuilding them because they depend so much on the development of people to carry those activities on. If we underwent any serious attrition in the development

of highly qualified people there would be a serious deficit. So those were the three major priority emphases--many other things fed into those but they were the major directions.

Dr. O.: I must say that I was rather intrigued as I really looked into the research enhancement and the philosophy that developed about limiting the number of new research grants. Obviously the idea was to put some sort of ceiling on the expense. It's quite uncanny by doing this you can far better justify not supporting some of the peripheral grant requests and literally narrow in on those areas which seemingly are the areas that need most exploration. I gather that this has been quite well received. Certainly the National Institutes of Health did not raise up in great furor and say that this is too limiting.

Dr. R.: Well, to a very considerable extent, that approach sort of comes out of some of the thinking at NIH. Again, if one is interested in the constant self-renewal of research, the stability of the resources available for new and competing research grant proposals becomes key because that's where you really do have the redevelopment of people and the institutional capacity and the directions in research. In a time of constraint, it became important to recognize what should have the highest priority. While if one has relative abundance of resources to distribute, one can go in the direction of institutional grant supports of various kinds, the development of centers of various kinds. But if one really wants to look very hard at what it is one wants to protect most, it's really the research grants, opportunities for people all across the country to compete on an equitable basis. There might have to be some attrition in the support of some of the other programs or at least they may not expand, but the priority certainly was on the new and competing grants.

That raises another very important issue which you've brought up in terms of constraints and how many grants and something that the biomedical research establishment in this country generally has never wanted to face up to in any finite way is: well, how much is enough? That is at some point in every society one has to make the judgment that at some point we have enough. If we get out of the research area, it's very clear in this country that following World War II we decided we didn't have enough hospitals and hospital beds so we built, we overdid, and we're in a very interesting period in this country of saying: well, we're no longer behind, we now have probably more than enough and how do you equilibrate now? The problem there is the beds aren't always in the right place so one needs to develop some way of equilibrating. We've done the same thing now with physician output. We were coming from behind after World War II. We perceived very significant shortages and our institutions responded very, very well so that now we're projecting that we' ll certainly have an adequate supply and, if anything, people are beginning to talk about surplusses -- that's a new phase. And so in research I think we're going to have to say: well, this won't expand proportionately higher than the overall health expenditures as to some extent it had done for some time. But we'll have to make some judgment as to what for the nation is an appropriate level of research investment. And there'll always be dialogue about how much is enough but I think we've never been willing to face that issue.

Dr. O.: I must say it's been very interesting seeing the reaction of the medical community at large to such things as the GMENAC study. The editorials that appear in the Bulletin of the American College of Surgeons have been critical of the GMENAC study and the idea that somebody can

dictate or control the number of people in each specialty. Obviously this is coming, something has to be done. A community can support only so many cardiac surgeons.

Dr. R.: Well, I guess in that sense I've begun to think of the decade of the eighties as one of equilibration, rather than charging forth and saying we're going to expand everything which has been our thesis over about three decades. We now have to begin to say: well, we really have made up for a great many of the perceived deficiencies and we now need to look at how much of various resources we're really going to need. In connection with manpower, you've made an interesting point. It's not only uneconomic to have cardiac surgical units scattered indiscriminately or only on the basis of what the surgeons themselves would like to establish, but we do know that qualitatively it makes a big difference whether a team is working on a sufficient number of cases so that their competence is maintained. It's not exclusively an economic question in connection with such programs as renal dialysis which the nation sort of backed into through Medicare funding of renal dialysis without any clear perception. At least, many of the architects of that legislation said they wished they had known then what they know now. I'm not sure they would have done things very differently, but certainly the expenditure of a couple of billion dollars a year for one single program is an important commitment. What directions should we go in from this point on? One could of course anticipate many other potential problems of a similar nature.

Dr. O.: We are now in a new era, a new administration. You of course can look back with reasonable and well-deserved pride on what went on during your tenure as Surgeon General and Assistant Secretary for Health. I gather

from some of the things we've just been talking about that you certainly have a different basic philosophy about many aspects of the directions the present administration would be taking in health. You have said that you agree that this is going to be a period of equilibration, obviously the brakes have to be put on. Would it be fair to ask how you view the direction the present administration appears to be going in light of the programs that you felt needed support and should continue to be supported. That's a very poorly put question, but do you feel uncomfortable about the future of some of the gains that were made in your administration?

Dr. R.: Well, I think that the reduction in total expenditures is not necessarily an unfortunate development, as I view it. It seems to me if one has clearly defined priorities that do relate to health outcomes, one can tailor the expenditures to where one might get the greatest yield. It's a little early in this administration's term to really define how this is going to get played out. I don't think that kind of attention has been given, at least up to this point, to how the expenditures will be reallocated for the simple reason that they wanted to move so fast. If one moves very quickly to cut budgets, one must get a handle on discretionary monies and unfortunately, the discretionary funds which, from what I see of the total federal budget, there's only twenty-five percent of it that a president can move around. The rest is largely entitlement programs where you don't have any significant flexibility. Although if one thinks of the large numbers of dollars in the entitlement programs (Medicare and Medicaid, for example), one could make a fraction of a percentage point cut in many of those and have a dollar yield that far exceeds anything in some of the discretionary programs. For example, if one puts together Medicare and

Medicaid which are two entitlement programs as federal health expenditures, one gets up into about 63 or 64 billions of dollars while the total Public Health Service, including the NIH budget, is going to be somewhere between 7 and 8 billion. So you see, we're talking about a very small fraction of those total expenditures so that if one could get a quarter of one percent or a half a percent of those entitlements one could do a lot in terms of flexible programs. So I'm apprehensive only in that sense. I'm apprehensive, for example, since discretionary programs, like the Community Health Centers and the Maternal and Child Health Programs, and all, that one might see if one permits the health services programs for the poor, for example, to be eroded that we might see a slippage in infant mortality rates. They might start going up. Incidentally, the trend has not been uniformly down since the turn of the century; in the fifties we plateaued and even had some increases some years in infant mortality rates. So that I'm apprehensive that some of the health improvements that we have seen might be eroded. Immunization rates which over the past four years we were strikingly successful in improving so that now over ninety percent of the school-age children are immunized to all of the diseases against which we can immunize. As a consequence if we keep going the way we're going we should eliminate measles as an indigenous disease in this country by 1982. So one could potentially see some erosion in programs like that. Now, the administration is saying: well, we'll save money administratively by handling those monies over to the states largely as block grants and let them make the allocations for community health centers and for maternal and child health and other programs.

Well, in the sixties we went in the other direction of putting those funds out there with federal guidelines and federal constraints because there was

a general feeling that the states weren't doing their job. Now, what the dynamic will be, it'll be interesting to see. I sense that at the present time Congress isn't as ready to turn over monies en bloc to the states as the administration has been willing to do more recently. It may well be that there will be much more categorical specifications for the funding to the states. That's the kind of arena we're in at the present time. But I think unless there is great pressure on state and local health officers, unless they know that people are really doing a lot of monitoring over their shoulders, I think that one might not see the maintenance of effort in these programs that are largely going in the right direction. My concern is that twenty to thirty million largely poor people who now do not have access to services might get hurt the most. That's the group that disproportionately contribures to the higher morbidity and mortality rates. If we are going to bring infant mortality rates down further, we have to concentrate on that group rather than neglect htem further. So I don't think it's the total dollar amounts that I'm quite as worried about as I am the clear targeting, the setting of priorities, in trying to insure that those who need the services will get them. I'm inclined often to say that if we take the top two-thirds of our population, incomewise, what we do in terms of funding health services isn't going to make a great deal of difference in terms of health outcomes. It's the lower third where there is so much difference. The insured population, is in the upper two-thirds in terms of income. By and large they can make their way around the community and get what they need. By and large they have access to information into the health care system in ways that low income group doesn't.

Dr. O.: What do you see in your future? I know you are planning to return Harvard University as Professor of Child Psychiatry. Are you actually returning to the same position?

Dr. R.: No, no.

Dr. O.: Oh, well, please do inform me.

Dr. R.: No, I felt that I've had more than a fair share of management experience in the past four years. I don't feel any passion for further administrative responsibilities, and so I will be going back to Harvard with an appointment as Professor of Health Policy which is a new title. It is related to the development of a new program at Harvard. Last year they invited Dr. David Hamburg, who I mentioned earlier, as president of the Institute of Medicine, to come to Harvard to develop a program in health policy. And again getting back to the concern I talked about earlier of having some health policy groups around the country, this represents an effort at institutionalization of health policy studies. He has been there this past academic year. That program is called a divisional program at Harvard--it cuts across various schools-although the base is at the Kennedy School. He also has a base at the Medical School. The department that I chaired--preventive and social medicine--has been split in two and there is now a Department of Preventive Medicine which Dr. Alex Leaf is chairing, and Dr. Leon Eisenberg is chairing what is now Social Medicine and Health Policy, a new department. So I will have my academic appointment there although I anticipate that I will also have an appointment to the pediatric faculty after I get there. I also will be dividing my time between that program and the Children's Hospital Medical Center because some of the policy developments that David Hamburg and I would like to see generated are in the child health policy area and there is a critical mass of very able people there. So I will be spending part of my time in that development, and I will serve as a consultant for the Judge Baker

Guidance Center and to the Department of Psychiatry but also more broadly to pediatric training at the Children's Hospital Medical Center. So that's basically how I'll be spending my time. It's, at the present, not highly defined in terms of responsibilities but I expect that during the course of the next several months we'll define directions a little more clearly.

Dr. O.: And then you can sit back and look down to Washington and then smile.

Dr. R.: Well, it's great to be a consultant, to advise other people how to do things. It sort of reminds me of early in my Head Start days, there was a pediatric colleague that was here in Washington in one of the governmental agencies whom I'd known for some time. He came to see me and he said he'd be glad to serve as a consultant to me since I was a novice in Washington and I said, "Well, what would that involve?" and he said, "Well, I could take a half day away from my other responsibilities and I'd spend that time talking to you and advising you," and I said, "Well, I don't have time to talk; I've got to find people to go to work," I said, "if you're ready to go to work we can ------" So I know what the role of a consultant can be to busy people in government, but there will be people who will be generating recommendations and doing studies and so on.

Dr. O.: Well, you're going to be part of an organized group that has built into it this institutionalization of health policy that you've been striving for for a good while. It's a golden opportunity. One can almost see it when one reads your book.

Dr. R.: Yes, there is a flow historically.

Dr. O.: It certainly is right in this direction.

Dr. R.: Well, that's why I guess I need to write the sequel because the decade of the seventies wasn't dealt with, and I've got some thoughts about what one might write about the seventies and prospectively about the eighties.

Dr. O.: Well, I must say this has been a great pleasure for me, Dr. Richmond, to have a chance to talk and to listen. Are there any areas that we haven't touched on that you would like to explore any further?

Dr. R.: I think that we've really touched on all of the points. I guess I've been impressed by how detailed an analysis you have done on the various phases of my career and how you picked out particularly the kinds of overlapping responsibilities that I had at various times. I think that's something a lot of people who haven't known me intimately and been involved with some of my work in a direct way--most people sort of tend not to pick that off--and it has been, I think, a significant aspect of my career over the past two or three decades.

Dr. O.: It has indeed. Well, I do thank you very much and wish you well as you head north. You have left your mark here in Washington which will be around for quite some while, I'm sure.

Dr. R.: Well, thank you, and I appreciate the time and effort you've put into this. Also I appreciate the very remarkable resources which the staff of the National Library has developed here and the remarkable contributions it, as a national resource, has been making to medicine and health across the country. But even more significantly as I travel around the world, it's very clear that when people think of health resources in the U. S. they think of NIH and the National Library of Medicine as the major institutions with which they're interested in establishing relationships.

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