HSR Interview
Margaret E. Mahoney
Interviewed by Ted Brown
July 1, 2003

TB: **This is Ted Brown interviewing Margaret E. Mahoney, July 1st, 2003. Miss Mahoney, we are here in your offices in MEM Associates, New York City, and we are conducting this interview, as I explained, to get your perspective on developments in the field of health services research and the circumstances that influenced it. But let's first establish a biographical context. If you wouldn't mind, I'd like to have a review of your early life, and let me just suggest that you talk a little bit about your family. Perhaps you can say something about your academic and medical family, college years, career in the State Department and then, beginning in 1953, your work with the Carnegie Corporation. So if you will, a brief biographical overview of those years.**

MEM: **Well, I was born in Nashville, Tennessee. My family was Vanderbilt connected in medicine. My grandfather had helped set up the medical school. My mother was an architectural historian. She divorced my father, a scientist, with Oak Ridge.**

The early years for me were exciting, because I lived in a household that had anybody coming in and out the door. I might be at my aunt and uncles or I might be with my mother and my grandmother. But they were people who had friends

who were reporters, who were writers, some people in medicine but mostly from the broader world.

My aunt was a surgeon, following her father, and she was the president of the international AMA for women because AMA did not provide for women. She was a tough cookie, I learned a lot from her. I think that my mother put the greatest stamp on me, in many profound ways. One was that she was a student, and she also was one of the great designers of what was called manor houses in the South.

She did all the interiors, when I was very young. By the time that I was four years old, I was with her in New York, when she would be here to buy furniture from abroad. Everything would be made abroad – rugs, draperies. And I spent many years in the Metropolitan Museum as a child sketching while she was sketching. She did some work for the Baker [sp?] Company, which provided some of the American antiques in museums.

She knew many people. Arthur Vernay, who was one of the people involved with the development of the American Museum of Natural History, was one. And I was there as a child when Vernay's exhibition opened, a major exhibition that is still there in the museum.

I had an extraordinary life, as a single child, without a father. But with an uncle who was terrific. I led most of my life in Nashville, and I went to every football game that Vanderbilt ever played from the time I was about five years old -- on the

50 yard line. My uncle was a great football player. I went to every basketball game.

That kind of companionship from someone who was not my father, but was as a great friend, was very important. But when I wanted to go to Smith, it was the Second World War, and I was told I was not going, I was furious. I had to go to Vanderbilt, but I knew most of the faculty, I had worked for my uncle in his office, and he was the physician for most of the faculty at Vanderbilt.

And I knew a lot about them, as individuals, from their records. I hated going there, but it was the best thing that ever happened to me. I didn't go into the Art History world and painting, which is what I thought I wanted to do. But I did political science, economics. And I was greatly honored by having faculty that had nobody else to teach. There were only two men in my class.

TB: This was during World War II, right?

MEM: Right, right. Took a year off, made some money in Washington, came back and finished, finished in three years anyway, and then went back to Washington, to have some fun, got engaged, to my mother's best friend's son, who I later did not marry. And I had the fun of being there, 'till my mother said I had to work. I was just playing around. So that's when I went to the State Department. I began really as a, not part time, but a temp. But one of the people that I worked with and for was

William Benton, who published Encyclopedia Britannica, and he was the Assistant Secretary for Public Affairs. I was in a division called UNESCO relations staff. And I went to Mexico for the first general conference, which was an experience for me, because I'd never been outside the country that I had been living in all my life, and had lots of fun. And Benton had said that he wanted staff, clerks, everybody to be able to socialize with other people. And be smart enough to be on the staff. So I was not a typist, but I did typing. And that sort of gave me a different view of life. I decided not to get married, and have some fun again, and to have a job that evolved over some period of time, because my career was like the Peter Principal. I was a terrible typist. I used to write letters for Mr. Acheson as Dean Acheson, and his secretary, Mrs. Lincoln, who I will never forget, would measure my letters from top to bottom and send them back.

So the Peter Principal worked: I went up the ladder, and I became head of the documentation work, which I didn't know a damned thing about, and then became head of what was called the Science and Arts side and because I knew some people in the world of writing, I had some access points, and with Acheson himself, the access points were always there.

And I worked on the development from the arts, developing UNESCO's participation in this country, from the museums, the plastic arts, visual arts, and

theater, and also in science. I worked with the National Academy of Sciences as we re-entered the ICSU, the International Council of Scientific Unions, and worked on the copyright act.

I was actually in the room when we decided to put the "C" in the circle. I'd like to think that I had something to do with it, but I was there. This was an extraordinary time for me, because one of the people I worked with was the head of music at the Library of Congress, and one day he said, you know, I want you to meet someone for lunch, and just don't talk back.

It turned out that it was the Carnegie Corporation, a foundation in New York City, in which Harold Spivak had decided that I should be looked at as a young assistant to the new woman, the only woman ever made an officer of a foundation to that point, Florence Anderson.

And the short of it is, within a year, I did decide to come to New York for other reasons, personal reasons, and came to Carnegie Corporation. I didn't even know what a foundation was. I knew that my mother had been turned down by three. I had not a clue.

And it was the most extraordinary time for me. John Gardner was then the Vice President and he succeeded to President within the year. He shaped a lot of my life, and a lot of my thinking and discipline, as Florence Anderson did, in a different way.

James Perkins, who became President of Cornell, Floyd Morris –- these were all people I was working with. I was basically in the management side when I came in. I always sort of knew how to get things done, and studied how you structured organizations, which I've always been interested in.

But I also was interested in the arts. I used to "fan the arts" as they said in the staff. You get some monies for the individual, in visual art particularly. And then one day when I was working very much in education and child development, which I had evolved into, as I was still running the staff, the call came from the President, Alan Pifer, who said he had this manuscript that had come as a result of MIT (Massachusetts Institute of Technology) having, what did he say, a crazy mathematician, Jerrold R. Zacharias, working with a crazy physician at Mass General, Oliver Cope, and a psychiatrist Douglas Bond from Case Western Reserve. They put together a conference and they had no money, and they had 30 people coming. The short of it is, Jerry Wiesner who was MIT President asked for $15,000, which was denied, but in turn, Zacharias sent the manuscript from the meeting to ask Alan to do the introduction.

Alan was furious because he said we're not even in medical education, never were. Flexner's work was actually for the Carnegie Foundation for the Advancement of Teaching.

And I was one of two officers who he asked to read the manuscript, after he had read it. And the other officer who was on the science side said he wasn't interested in it so he said, well then it's you. Just like that.

TB: Were you at that time a program officer responsible for science?

MEM: No, I wasn't into science, and I wasn't in medicine at all. There's nothing there.

TB: But did you have program officer responsibility?

MEM: I had a program responsibility. I guess I was called program officer and also associate secretary. What evolved out of that was, and at the time the country was beginning to go into -- it was late 60s, early 70s -- medical care and research, which meant a change in the Carnegie Corporation's portfolio.

And I spent almost two years just reading. I suddenly realized that I could talk myself to death, but I needed to really find out who was doing what, and that's where I ran into Victor Fuchs, Howard Hiatt, Eli Ginzberg, plus other readings and the journals.

And the evolution of that was a joint program we developed between Carnegie and the Commonwealth Fund, that had some money but not much staff, and the Rockefeller Foundation, which was still trying to find out what it might be doing in community health care. It eventually went out of that business, but we were partners.

And I learned a tremendous amount from Quigg Newton, Jr. who was then the president of Commonwealth. Quigg was a politician, the youngest mayor of Denver, ever, who then became president of the University of Colorado, and then came to the Ford Foundation and then Commonwealth, in very short order.

And he was an extraordinary person in my life, in terms of learning how to operate within a structure that I hadn't done very much with, in terms certainly of medicine, but also in the overall politics of things, that related to health care research and health care.

And that evolution was something that propelled me to be very active and make grants jointly, frequently with Commonwealth and sometimes with Rockefeller. And then the Robert Wood Johnson Foundation evolved. And I would have been surprised if I had not been asked to come, although I was not prepared to go, and did not care to go.

TB: **Let me try to get a firm chronological fix on this. It sounds as if it was the mid to late 60s when you became particularly involved with medical issues.**

MEM: **Right. It was in the late 1960s when I really started to work. We had a conference, I think it was probably in 1968, the first conference that Carnegie had ever**

organized in any field. We went to Fort Lauderdale, and we brought everybody down there from medicine and economics – Rashi Fein, Eli Ginzberg, etc. That was a new mix, too, for physicians. They hadn't done that before. And great people in medicine. We talked about what the problems were in the country, and that led to a series of projects that were community health projects, and one of them was with Johns Hopkins.

David Rogers, who would later become the president of the Robert Wood Johnson Foundation, was Dean of the medical school at Hopkins, and one of the projects that we did, a very large one, was getting Hopkins into community health care. Hopkins had built walls between itself and the community surrounding it, and those people who lived outside were very poor and very much in need of health care. That really led to David being tossed out of Hopkins. But he landed on his feet, at the Robert Wood Johnson Foundation.

As I've said, I was not surprised that I'd be asked to go to Johnson because I was one of the few people at foundations who worked in health care. The upshot of it was, though I was reluctant to go for a lot of personal reasons, I did join that staff and helped to organize it from the very start.

TB: What do you remember of those days when the Johnson Foundation was coming together and suddenly appeared as a major new presence in the foundation world?

MEM: The early days of the Robert Wood Johnson Foundation were wonderful days of building an institution. Gustav Lienhard was the Chairman and CEO, something that David Rogers never quite understood. Gus Lienhard led without any knowledge whatsoever about medicine, except that he had come from J&J and knew a lot about the politics of life and the pharmaceutical business.

But he taught me a tremendous amount about how you work with a board, because he would take ideas which would sometimes frustrate the staff, and David particularly, because he wanted the ideas before they were put down in cement.

And he would take them to individual board members, over lunch, talking by telephone or seeing them. We never lost anything at the table, because Gus always began at the beginning. And he built the interest and met the concerns of the board. Mostly at that point they were J&J people, just a couple of people who actually had ties, but were not J&J staff.

And, the evolution of that place was, you know, David's very intense concern about primary care, which we had been working with before when he was at Hopkins, and the development of some very strategic initiatives.

Unfortunately the board never stayed with something long enough. You'd show, for example, that you could control for low birth weight. It's a very serious problem particularly for young people having children. We had probably the most advanced school health program in the country.

And while we did the evaluation and it showed what the affect was for such programs, the board would never take it forward as a model that you take around the country.

TB: Let's now focus on some of your early work with the Robert Wood Johnson Foundation in 1972, '73, when there seemed to be on your part and the part of others associated with the foundation, great interest in what were called at the time intermediate level health providers. One of the notions that you introduced in some of your papers from that period is the need to create a task inventory of what the actual medical process was about, and how much needed to be done by the highly trained physician, how much could be done by people trained at different, intermediate levels.

This sounds very much like one of the foci of health services researchers Kerr White and others. So if you can think back to what you knew at that time about the field of health services research, could you say whether you imagined that this work on intermediate level practitioners and medical task inventories was part of that, or related to it in some way?

MEM: Kerr White influenced me in a profound way, and I carry it forward practically every day. Because Kerr believes that you have to organize medical care by population, and one of the issues today is that we try to provide everything for everybody but we don't do it very well for everybody. So it's a fundamental

principle he wrote a lot about, and has a great deal to do with who does what kind of care.

Actually before I got to Commonwealth, Quigg Newton developed a nurse practitioner model, and he developed the physician assistant model from the Commonwealth base. I worked with him on that, although we didn't have money from the Carnegie side, but I worked with him on it. He also brought hospice to this country. These are profound changes.

Hospice was a system that took away a burden from hospitals or families, and of course today, it's one of the most extraordinary changes that we have in the system care.

But the nurse practitioner and the physician's assistant can also provide a different kind or level of care and take care of people in the right way.

So that I think the issue is basically how do you provide for care and who can give it. Today's world, I'm convinced, is totally off base still. We need a team approach; we need physicians to be taught to work with other people.

They do that in surgery, if they're any good, but not in most of medicine. So I think that Kerr's basic premise is the one I would begin with and talk about, if I were talking about it today in a systems way.

The questions today for me are still about the people that we need and the right people to do the right things. And that includes in health services research, where we need people who understand that research is for use.

We still do too much research that is basically because somebody has an idea, or has a claim on an idea, and wants to pursue it. I'm very practical. I just see the necessity of finding people who can relate to the ideas at the moment, and for the future, and who want to find ears for what they do.

Too many researchers are driven by the eye thing. They want to see published what they've written, but they don't think about it from an ear standpoint, who is listening. One of the issues that I felt was important early on, and I think I learned this at the Carnegie Corporation for totally different reasons, is that you need to develop new kinds of people, not just on the medical care side, but on the research side, and you need to think about it in terms of long-term investment to create the cadre of people. It takes a long time to develop any kind of capability when you're trying to produce people.

TB: **Let me connect that important observation with a bit of the history of the field of health services research in the 60s and 70s as I pieced it together. As the story is told by some of the participants, health services research emerged on the scene in the 1960s, with the interest of the Federal government and a lot of excitement. One**

national response to this ferment was the creation of the National Center of Health Services Research and Development in 1968.

MEM: The field seemed to be doing great things, but ran into trouble rather quickly in the 1970s, and that's just to tell the tale as I've heard it. By the Nixon Administration, it seemed in the perception of those involved in the field, that there were real troubles. I think that it was then understood that a new generation was needed, the development of a cadre of people who can do the kind of research that needs to be done.

There was a program that was developed when I was at Carnegie Corporation and Commonwealth came in as a cosponsor, called the Clinical Scholars Program. And I brought that to the Robert Wood Johnson Foundation. It was one of my provisos. And it's now almost in its 40th year. So you now have a cadre of physicians who know health services like many Bob Brooks around the country, and that's an amazing story of what you can do –- but it takes a long time. A foundation has to understand that it takes a long time to do anything that's profoundly important. Once you have found that it works, you've got to take it further, you've got to take it out. Whether it's the people or whether it's the model. The government has done that to some degree, certainly in the science side it has, to the detriment of the clinical side for a long time because the government has been so focused on basic science.

Now it's beginning to talk about translational physicians, who used to be called physician scientists, who could translate the science. But basically the problem always is who develops what information and who takes it out.

And I think that foundations don't really understand the long-term investment necessary if you really want to make a difference. Now, I think producing people is the issue. Take Joe Newhouse. Joe had been in a program that we did at Carnegie with MIT and Martin Feldstein. And that was because I wanted to see somebody as number crunching as Martin. Joe's going a little bit overboard, but nonetheless he produced a group of people that just wouldn't have been there, and we provided that money for him.

TB: **How important an objective of the Robert Wood Johnson clinical scholars program was it to produce leaders in the field of health services research?**

MEM: **That was the goal.**

TB: **You've mentioned Joe Newhouse and Bob Brook, with both of whom you've been critically associated and who both were centrally involved in the Rand Health Insurance Experiment. As people tell the story of the field, they often point to the RAND experiment as representing one of the major new developments of health services research in the 1970s and beyond, in part because of the role that health economists played, beginning to displace social scientists with less quantitative training from the earlier days of health services research. Another reason RAND is**

considered crucial is because Robert Brooks and others began to look critically at actual clinical interactions and tried to develop measures for the success or failure of those interactions.

MEM: The model really is Jack Wennberg. Bob didn't think that he was ever going to make it through clinical medicine because he was so afraid of what his career would be like if he diverted, because he could have done anything in medicine. He's very smart. He took the clinical scholar route but he was scared to death.

In a personal sense he was quite a different person from Jack Wennberg, who just had a love of looking at clinical interactions from the standpoint of how do you measure care and can influence it. Bob has had a very different career. He's now, I think, comfortable with it. But he still keeps his foot on the clinical side although it doesn't give him the platform that he might have had if he had stayed at Hopkins, for example, in clinical medicine. So those first clinical scholars, I think, were very nervous people. And he's a primary example of it.

The Jack Wennbergs come out of the woodwork. But again, Commonwealth, before I was involved with Commonwealth, was supporting Wennberg. The basic issue for foundations is that you have to have an open door. In today's world, you cannot get your foot in the door. I'm talking about people who have an idea, who may have a very different idea than what the foundation does.

Now it's no longer the investment with some risk that goes with it. It's now programs with grants. It's quite different from the past when I grew up and even

through the time that I was at Commonwealth. It's changed tremendously, so it's very hard to say that there's anything that's vibrantly new and exciting right now. On the other hand, there are some foundations that stay with things a long time. Ford has done that very well in other fields. But other foundations move around a lot, and have grant programs that last for three years in this thing and five years in that.

But the basic question for me is, what are you trying to change or improve? And the idea that you have all the answers is really pretty narrow, because that perspective is as narrow as that of the people who work with you. But the open door allows you to hear people coming in with ideas.

TB: **When you think back, who are the people, other than those you've mentioned already, who impressed you most as having the freshest and who found the open door, whether at Robert Wood Johnson or at Commonwealth?**

MEM: **Jack Rowe - Jack was at Harvard on the geriatric side, and he came in for a lot of money. We didn't have a lot of money, and I said, you know, Jack, that's not going to happen but come in with an idea. And he came in with an idea, a very extraordinary way of looking at geriatric care from the standpoint of the problems of incontinence. With a very bright young person there, he showed that incontinence was not just one kind of situation. They re-defined it.**

And that was just over the transom kind of thing that came in. I also think that the idea of living alone was born when I was at Commonwealth, with my colleague Tom Maloney listening to people who were saying that there were an awful lot of older people who seemed to be frail, and when we did some research we discovered if you were frail you were likely to live alone.

That evolved into a model that I think 12 of the 15 still exist, just fairly simple systems of putting people in touch with the system in a switchboard way, putting together the social services, the medical services, and the care people need.

But that came in over the transom, you know, somebody just came in and said they had this idea and Tom was listening. I think that the clinical scholar program evolved from the concern about the initial investment that Carnegie made in that investigation that MIT had in medical education about what people needed on the part of physicians.

And that led to this new recognition after a couple of conferences. Just people walking on the beach, thinking, you know, there's something else. We need somebody who really understands clinical care, who can then restructure it, so it'll work better.

The problem today is that we don't have the floor, the financial floor, for those clinical scholars to go and change the system, even though they know how to change the system.

TB: Much of what you're referring to are innovations in care or in organization or in training providers to fill roles that may be very different. What is the place of health services research specifically?

MEM: The role of health services research is to state the problem, and then to lay it out. And in some cases this research goes into the issues in-depth and may produce a model, or it may not, but it lays out the problem. I like it when it takes the problem and defines a model, tries it out, and then evaluates it.

TB: What are examples that you call to mind of the most impressive achievements?

MEM: Well one I love, because I'm actually working in a related area, was when I was at Carnegie Corporation, the superintendent of schools of Brookline, Massachusetts, Robert Sperber came in to see somebody, and he got me. Carnegie always saw people.

We hadn't even supported James Tolin in the high school study. I was looking at health care a little bit by that time, but I was working on child development.

Sperber said I've got kids in kindergarten who have no empathy, can't play with other kids. And most of them are not creative. He said, I think it's because the wealthy families at Brookline have the battery toys. I don't know but I've got a problem.

The upshot of that was something that Barry Brazelton, the physician in Boston, with a group of young people who are now very important in the pediatric world, put together called the Brookline Early Education Project, BEEP.

The studies have just finished, but have not been published 35 years later. The comparison group were Roxbury families. He didn't see a lot of change in the Brookline families but you certainly did in Roxbury.

The instruction was guidance, the basic principles of how you love and discipline from infancy on. Roxbury families showed 35 years later with the children who are now adults, that they've never had problems with the law, have finished school, and held a job.

So that was what came in over the transom in a different way, and we would never have picked it up, but we sort of slid it in through child development. And it's the prototype that I now have in a big program nationally.

The basic problem I think for foundations is to understand that it's the investment in people, their ideas, or developing a new kind of person like the nurse practitioner, the physician assistant, in medicine. But I think it's across the board.

I think in education, my god, we need to look at that talent -- what kind of teacher do we need today? I also think about the whole area of community health and the universities. For years, community health was a stepchild and it still is to some

degree, but now it's gotten more of a footing as we begin to look at it from a public health standpoint.

And you've got some people, like clinical scholars, who come into the medical school and are faced with that community health or public health base. But you need to produce people, and you need to listen to people.

TB: It seems clear to me that you most prize innovation, pragmatic results, and imaginative individuals wherever they come from, who can make the case for new ways of doing things or thinking about things.

MEM: Health services research provides the models you say, but it also sounds as if I've said that sometimes health service researchers can be rather narrow academics, without the full imaginative sweep of some of these other individuals I've mentioned. It's fair to say that it is important to have health services research to evaluate the results of some of these innovations but it's not quite the same as having the bold ideas primarily.

TB: I'm wondering if there is any ambivalence, perhaps on your part or perhaps on the part of the foundation world more generally towards health services research, because it may sometimes become a little too limited, a little too focused on the next publication and career development without keeping an eye on the big picture, and the imaginative new innovative turn.

MEM: I don't think it's whether it's the big picture or the small picture. I think health services research needs to be, in my opinion, focused on the fact that somebody's going to hear it, somebody's going to do something about it.

So it's all well and good to say that Medicaid doesn't work or does work for certain kinds of populations, or that certain things are doing very well in the Medicaid population. It takes a tremendous amount of keeping at that issue, and going after the politics of it.

You know, all of life is politics. We're sitting in this room right now with issues as political as can be between us. All of us - because that's what life is all about. That's what marriage is all about. That's what it's all about, when you look at it from the standpoint of change and trying to make a difference.

You have to think in terms of how you can do something that might be important. It's an investment with a risk. If you don't see it as an investment, you're just doing research to get an accolade or another paper published, and you may have produced something that would be very profound but it doesn't take, it doesn't go anyplace unless somebody picks it up.

Just recently there was a wonderful paper by a man named James Heckman, who is a Nobelist in Economics at the University of Chicago. He somehow or other fell upon data that shows the results of studies, over the last 40 years, of demonstrations that have been evaluated of intervention, early intervention, in the lives of children, particularly those at risk.

He writes a paper and he says, this country is investing in the wrong way. We're investing in the adolescent trying to do something about what's already been done, but you've got to prevent it by starting very early in life. Now that paper becomes very profoundly important if somebody takes it out.

TB: Would you say that, as a broad generalization, health service researchers have not been as successful as they ought to have been in getting their ideas out? They may have been distracted by the accolades and the academic career building, without communicating their ideas as effectively as perhaps they should.

MEM: Probably not entirely fair and a bit exaggerated, but I think that I would say yes. Because, I would like to see a lot more done. For example, Marie McCormick at Harvard has gone further than Robert Wood Johnson did, on low birth weight children, how you can control it so that they're born with a good weight. Somebody needs to take that out and make it into policy. All the documentation is there. The feds ought to take it out. But it's not yet part of the public policy base that I'd like to see.

I think we need to find ways to influence public opinion. I'm about to develop an initiative for grandparents to get a voting population for children. We don't have voters for children, for anything, whether it's schools or whether it's health. And if you look at it from the standpoint of what we've done in this country for children, we've always done something from a fed standpoint for the most

disadvantaged. In fact, every child needs exactly what Head Start does. Some get it, because their parents can buy it.

But it should be a seamless web, as it is in other countries, such as France, the Scandinavian countries, to some degree in England, and certainly in Australia, where from the moment of pregnancy until you have your child, into school age, there's a seamless web.

You're given instructions in pregnancy about diet, how to control habits, how to nurture your child, and how to get them into daycare systems that have been daycare systems that have been designed for child development.

We don't have any of that. We haven't even for the wealthy; it's a very spotty kind of issue. And if you've got a child with problems, even with money, it's very hard to find how to build that web together.

The most important thing in my opinion is to look at it from the standpoint of every child, using Social Security and Medicare as the prototypes. I don't care what happens to those two programs in terms of a little bit of downsizing, unless this present administration really does chaotic things with the economy.

Those programs will stay in place, because there are voters. That's what the prescription drug issue is all about. Why did they do the prescription drug thing right now? - for votes. And they're taking it out state by state. As Bush goes out, that's his platform, his political platform.

We don't have the same kind of effort for children, for all children, saying we need a basic health and educational system that gets children in the right path. If we did, some will deviate and some will be in bad trouble later, but most of them will look a lot better than they do now.

TB: How could the field of health services research specifically advance that objective?

MEM: I think that we have the data. There's Heckman's work that I mentioned to you, and we have some of Victor Fuchs' work. We also have the work that Karen Davis has done at Commonwealth, and Marie McCormick's work. We need to put it together as a platform to take it out, to bring it to the public's attention.

The story about Social Security and Medicare is basically that story. They became a political objective, and we brought the evidence from Germany that Social Security could work, and Medicare was just built on top of it, as an obvious thing to do.

The health services research side could show the difference between having care that is financed for elderly people and the problems if you didn't have it.

TB: Can you imagine the leadership for taking this initiative out on the platform coming from the health services research group, or does it require a set of individuals outside that research community?

MEM: I think you have to find ways to link with the public better than they do. It's not advocacy, I don't think that's the word at all. It's taking information out so that the public can use it, and the public needs to know, and you need to find the ways to do that -- it's not going to be a journal article per se.

We're very good about science, by the way. Look at what comes out of the New England Journal of Medicine and what comes out of JAMA. Front page - the latest thing that's learned, because it affects people. And that's what their readers want to know. How do you then get people to the standpoint that children's problems need to be looked at differently and that you need to take that same information out and make it into headlines and keep at it? I think it's very important. Again, if you look at the New England Journal, for example, I just was reading some things about obesity, and some very important clinical things that relate to cancer of the prostate. These issues get into the paper. The people who have the problem or fear the problem then go to their doctor, and the whole thing starts to move around, so that you get the politicians listening. It's a process. And that news piece that was out of a piece of research becomes crucial. Somebody can do something with it. They can hand it to somebody.

TB: Is there any leadership in the field of health services research that would be willing to take up that role, or is the field preoccupied with further professional development?

MEM: There's a woman in Massachusetts named Margaret Blood, strategist for change in childcare. She's terrific. She just gets a piece of legislation, she drafts it, and she gets it through.

There are people who know how to do this, and can take the information and use it.

TB: Are you impressed with the efforts of the AHRQ to get information out to the public?

MEM: If you're literate. Somehow you need to educate the public that, for example, if you've got cancer, then you really should go to the NCI website, find out what's the latest thing the National Cancer Institute is working on, and then where are the schools that are working on it.

Not many people are that educated. But I think that we have this capability in this country to really educate people on how to get information. But basically that becomes personal. You've got a cancer, you want to do something about it.

Social Security, Medicare become personal. But they're very abstract. Until breast cancer became very personal, and it's taken a long time, by the way, because a lot of people didn't want to talk about it. Think how men have lived with prostate cancer for generations and said nothing about it, in terms of forcing legislation for research that would build a whole new clinical approach.

We haven't educated the public on how they can impact Congress, but the NRA is very good at this.

TB: Let's see if you agree with the following formulation. It can be said that health services research has accomplished a great deal as a field, yet it hasn't reached its

full potential and hasn't had its maximum possible impact on the public or on health care policy.

Part of the problem may be that its practitioners have been stymied by a quest for too much rigor, and have been too concerned with career advancement and academic publication. Another part of the problem may be that federal agencies are too implicated in the political process and have been to be a bit too cautious about keeping in line with whatever may be the present administration's take on things, trying not to be too bold in making statements that might get those agencies in trouble and get them defunded or at least have their budgets cut.

On the other hand, it seems as if there's a special role for the philanthropic sector, which doesn't have these problems, and which is pragmatic in its orientation and doesn't have to worry about the political context in the same way as the federal agencies.

MEM: The federal government is bound by the politics of who is in the White House, in Congress. But I'm not certain that that's really basically the stumbling block for health services research. I think that it is a question of getting things clear enough as a problem with a possible solution, and taking it out, so that you create a public that is calling for change. I don't think we've done that very well in medicine. We've done it very well in science.

Mary Lasker, who I was fortunate enough to know, at one point brought me a newspaper, one page, as an example of what happened when she decided to go totally public on the issue of heart disease, cancer and stroke.

The page had the Congressmen and the Senators for that particular area, that state, that region, with their address and their telephone numbers. At that point you didn't have any email, because this was about, what, '53, I think?

And the message was that we have no knowledge of three of the major killers of human beings. It was beautifully phrased, and I'm not doing that any justice at all. You should pick up the telephone and write, don't just call but write, your Senator and your Congressman, and tell them you want action.

As Mary told it, Hubert Humphrey called her up and said, "Okay Mary, I've got about 70,000 letters stacked in my office in bags." He said jokingly, "If you'll pay for answering them, I'll get the legislation." Now that's a lesson, and it's profound, and it worked, and it will work.

The AARP is a good example. It now has a president who comes out of one of the big ad agencies. It will be interesting to see what he does, from that base, given what he knows. But I think that he knows a hell of a lot about how you can get the public aroused enough to take action. And that's the key, it's the arousal.

Health services research alone isn't the answer. It's basically taking it out, and trying to figure out a way to take it out so that someone will listen. It may be that

it's a piece of research that goes only to changes in practices. But in oncology, particularly in breast cancer, there are extraordinary leaps and bounds these days. And it's because they have taken out everything that they have, and they bring it forth both internationally and nationally. The leadership basically are people who want to take care of people. So they've taken the sciences and they've translated it into clinical practice -- some vicious stuff like chemo but some of that's working better and better.

TB: When you look to the future, do you see any leader or leaders emerging who can do this effectively, be the Mary Lasker for health services research in any particular area?

MEM: Well, there are a lot of people with money like Mary Lasker, who had it through her husband Albert. I don't see them understanding what it is to produce change, through, and I think that things won't change until they understand that. Gates does, Gates' father understands it. Gates' father is a very interesting man, and he has really tutored his son on the issue of how you can take your money out.

I don't know that all of the things that they've done under the name of Bill Gates will make a difference because a lot of it is very tough stuff, like going into foreign countries. Well, you can't control distribution. You may put vaccines on the dock, but whether they get to where they should be is another issue.

But I think that the Gates Foundation shows the way. It does help the public understand some problems like HIV and AIDS by virtue of how they're putting their money out. But it doesn't do what I'm talking about, which is changing policy. There's an awful lot of money. The rich are getting richer. And they have a wonderful example before them, of how to produce change, if they knew what they wanted to change. That's where health services research could be their partner.

TB: Is it a question of lack of knowledge or lack of will and lack of commitment?

MEM: Imagination. They don't listen to people who might have the imagination. They're very probably closeted with friends and people they feel comfortable with. But imagination is part of innovation. And I think that we have the talent, we have scores of people, the Bob Brooks, Joe Newhouses -- and I can put forth a lot of other names -- who really could take a subject and take it out.

They have the research, and they could do more research. There's a very interesting example right now. Catherine D. DeAngelis, who is the relatively new editor of JAMA, is a pediatrician who was in the clinical side, and then in Hopkins she became more of an administrator.

She's changed JAMA. Almost every physician I know, whether they've got a foot in science or not, read JAMA today, because she brings issues through research. And by focusing on them as a subject, she gets physicians to think differently about a problem, or even to get interested on the clinical side when they maybe work on the science side.

It's a change, it's a vast change. It's very different from the New England Journal of Medicine. The New England Journal still stays very much on its road to fame and fortune. Now what's happened is that Harold Varmus has teamed up with Jim Watson, Varmus first and then Watson and others. I think these have come together to say that we've got to take research out.

And we cannot be bound by the journals that have these deadlines, so that you can't take the research out until they decide to publish it. It should be on the Web the minute it's out. So that could be very, very important in health services research. Same issue as in basic research.

TB: **Why don't we leave the last few minutes for any other thoughts or observations you might like to make on the subject -- no prompts, prejudices from me. If you have any overviews, reflections you'd like to offer, fire away.**

MEM: **Well, I always count on the next generation. There are people like the Bob Brooks of his generation who went beyond where they might have been, to a whole new world. They scared themselves to death but they went into it.**

I think that now we're going to get people who are called "translational physicians", who will translate science and will work with the scientists, because they're gonna have to work with the scientists, to translate science into better medicine or clinical applications.

I think that health services research needs money, but I think it ought to be targeted where people want to work. One example is the issue Jack Rowe [sp?] picked up – incontinence -- who wanted to deal with incontinence. People didn't even talk about it if they had it, much less did physicians want to deal with it.

I think that he was a physician who was willing to step aside from a science base, and to work on it. And I think that that's the challenge today, which foundations could have if they would open up their doors, and their ears.

That's the biggest problem I think for foundations today, but it's also an opportunity. I believe that the Robert Wood Johnson Foundation is going in that direction with its new President. I think that rather than having program officers who have a program, it's better to say, there's a broad program area so let's look for where the innovations are.

That would be a much better thing than calling for requests for proposals. When I go out around the country, and I do, I see local foundations, and there are some very, very good foundations, by the way, regionally and locally. Many of them are conversion foundations, where the hospital was sold as a nonprofit and the Attorney General said if they are smart, put the money into a foundation.

This created some very good ones -- Kansas Health Foundation, Calimother [sp?] Trust, California Wellness Foundation, and the California Endowment. But what they say, which is true, is that both the feds and the national foundations parachute

money into a community without knowing whether they picked the right person, much less the right institution, or even the right topic.

And I think that's part of the problem, that both the feds and the national foundations don't make as much of a mark as they could with their money. They would do better if they looked at it differently, if they looked for partnerships with people who know something about the community, to better understand where the problems are.

And it's not by subject matter. That's not what it's all about. Basically it's trying to go around the country to see who is working on what, and where the problems are, and that's where health services research could be so important.

The local foundations are not likely to support health services research. They're more service oriented, so they need to be a partner with health services research, to better understand their problems. For example, the Hogg Foundation in Dallas is a superb place. Ima Hogg, her father named her Ima Hogg, led this foundation. And it's in mental health. They've done superb research that has changed policy in the State of Texas.

But the issue is being inventive from a foundation base, on the outside, feeling they can be inventive and not be hide bound by requests for proposals. The feds need that too, but that is probably hopeless. Right now, it's a question of really fending off some of the programs that maybe need to rest.

Head Start may be cut back, AmeriCorps may be erased. And if I were head of a foundation, I'd probably be trying to get some of the public to better understand what these programs are and how important they are.

AmeriCorps and Head Start are principal partners in stabilizing communities whether it's Harlem, the Bronx, or a piece of Denver, because they stabilize families. They're great inventions.

Head Start was, you know, started by a group of physicians, primarily Julie Richman. But he and Ed Ziegler as a child development person came together. Ziegler had the research, and Richman knew that the problem was there. It's a perfect example, frankly, of research helping shape policy.

The best thing for the country would be to think in terms of philanthropy as the spark for new ideas that will help people, rich and poor. And I say rich and poor, because I really think we have to think that way. We do in medicine. We don't think about a cure in cancer for the poor.

But we do in social services. We think about only the poor. And until you get that broader base, you will never have a political base in the social services, and so much of health care is social service.

TB: Thank you very much.