INTERVIEW I

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INTERVIEWEE: LEO GEHRIG

INTERVIEWER: Michael L. Gillette

PLACE: Dr. Gehrig's office, Washington, D.C.

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G: Let's begin with a brief discussion of your background and how you became involved in the administration of health policies during the 1960s. You're from Minnesota originally?

LG: Yes. I'm Leo J. Gehrig. I am a physician from Minnesota, educated at the University of Minnesota. I joined the U.S. Public Health Service during my internship at the University of Utah and served a full career with them. I have been trained and have my boards in general and thoracic surgery. After being chief of thoracic surgery in both our hospitals in New York and Seattle, I was brought into Washington at that time largely in an administrative role as an assistant chief of our division of hospitals across the country. Over the years my position moved up in that area, finally as assistant surgeon general, chief of the Bureau of Medical Services. I had been assigned by the Public Health Service, and then-Surgeon General Luther Terry to be the first medical officer of the U.S. Peace Corps when Sargent Shriver asked the service to assume responsibility for the health area of that program.

G: How did you happen to get that assignment, do you recall the background?

LG: I had been on a development program for the service in which I served in each of the major areas of the U.S. Public Health Service: National Institutes of Health, Bureau of State Services, and then Bureau of

Medical Services. I was a fairly loose individual at that time, having had several years in Washington, and because suddenly the Surgeon General was hit with a request from Sargent Shriver to plan the medical program for the Peace Corps, he advised me that that was my next assignment. So I went there without a great deal of past experience in the area, but a basic interest. While I went over ostensibly for one month of planning, it wound up that before I was through planning I was operating and I stayed on and was there for the first two years of the Peace Corps program.

Later, after I returned to the service as the chief of the Bureau of Medical Services, I was selected by then-Surgeon General William Stewart for the post of deputy surgeon general, and it was in that position that I remained until my retirement.

G: As a practical matter, what did your functions include as deputy surgeon general?

LG: I guess the easiest way to describe that [is to say that I] was to be available for such duties as a surgeon general needed on a regular basis and representing him in some areas where it was impossible for him to go. I guess that boils down [to] that there were relatively few definitive responsibilities, over the period, that I had as part of my job description. On the other hand, a very significant part of my time involved some of the legislative activities of the Public Health Service and, very particularly, the implementation of the Medicare Act and the compliance of providers with the Civil Rights Act of 1964, particularly Title VI.

G: There was some controversy over the withholding of Medicare funds from hospitals that were not in compliance. Describe that whole issue.

LG: To me--and now, at least in my judgment, President Johnson's fingers get into it, really. The passage under his push, if you will, of the Civil Rights Act of 1964 in, it seems to me, all areas of social concern was a major milestone and obviously in Title VI there was a provision that no one could discriminate on the basis of race, et cetera.

At any rate, the passage of the Medicare Bill, in which the government formally became a contractor potentially very widely with hospitals in the country and physicians, provided the first closure of the loop, if you will. In other words, such a contract brings in to bear in a legal fashion the compliance of the institution. So after the Medicare Bill passed, one of the first programs that the surgeon general was faced with implementing was an inspection activity of all the hospitals in the United States for their compliance with the requirements of the Civil Rights Act, as well, obviously, as their capabilities to fill a contract in health care and support for the federal government.

This was one of my delegated duties early in office. The Surgeon General said, "I can't keep my hand on this every minute, but the priorities that have been established in the department and the White House with regard to it make it a significant job for us that I want you to be responsible for, even though I will continue to be involved in it." Thus I think at least for the next year to eighteen months, roughly, we were involved. At that level I had at my disposal health manpower rather broadly-based in all of our institutions, both

direct-care facilities as well as others, and we were able to mobilize and, if you will, train individuals very rapidly for these inspectional requirements. It was our intent that people who evaluated institutions with this area in mind have sufficient training to make not only a medical judgment but a basic judgment based on the requirements of the Civil Rights Act.

G: Did you have people with legal backgrounds as well as medical backgrounds?

LG: Absolutely, yes. The area of involvement was certainly legal and medical, and a number of basic social areas of expertise. The hands-on, if you will, inspection of a hospital to see whether it was in compliance required all of that, but the ongoing one for the evaluation of medical activities and their role was largely in the hands of people who had backgrounds primarily in the health field.

G: What did your examiners look at to determine compliance?

LG: This is a broad one and there were developed evaluation sheets by individuals who had been primarily involved in the social side of this. For example, one of the very important areas, obvious areas of discrimination, the separation of facilities--by that I mean restrooms, restaurants. One of the key ones was the assignment of patients without regard to race, because in some areas of the country it had been long a pattern where there were "the separate but equal" so-called facilities, but they were definitely segregated.

These easy areas of obvious discrimination were important right off, but there are many other factors that were looked at that tended to be less obvious. Yet there were patterns that described such--in other

words, even the referral patterns of patients in a city area, certain hospitals getting largely the colored and et cetera. So it was a fairly broad look at the operation of a hospital facility, looking again for essentially patterns of discrimination.

G: Were there problems with black doctors not being allowed to practice at some of the hospitals?

LG: Yes. One of the issues that was faced was the matter of staff privileges and the availability. There are a host of problems within this. For example, certain hospitals, particularly your teaching hospitals, will have requirements that only board-certified individuals may be on it. There was a need to determine whether this requirement was medically important and necessary or whether it was a method of denying someone access that would otherwise get it? Certainly a lot of hospitals with the requirement for board certification could justify very well what their position was. On the other hand, those that were found for that or other reasons to be discriminating in staff privileges were off base. This was but one of a variety of areas of discrimination that had to be dealt with.

I think overall, having been in the Department of Health, Education and Welfare, I could especially appreciate that in the area of health, while we had our problems, resolution of the problems of discrimination was fantastic, and changes occurred over a fairly short period of time. I think, if I recall correctly, by July or so of 1966 a piece of data was that about 92 per cent of the facilities available in this country had been considered adequately meeting the requirements of Title VI and eligible for participation. The big concern, and it seemed

to me a very prominent one of President Johnson's, was the fact that everything was moving very fast and it was necessary that health care resources be available when Medicare was implemented. His concern was that once Medicare was implemented there be available the resources to treat people throughout our country.

G: When you say things changed, do you mean doctors' or hospitals' acceptance of Medicare or the change in, let's say discriminatory practices?

LG: I think, putting it broadly, the rate at which institutions could be considered in compliance with Title VI and available for Medicare beneficiaries.

But in order to further assure that the government was doing everything possible, the President's assistant Marvin Watson had weekly meetings to observe the progress in this area. There was established at the National Institutes of Health an emergency phone resource with calling available at no cost to individuals across the country to obtain help should they be unable to reach a hospital or find a hospital that was certified for Medicare. This focus could take other actions to authorize treatment. Well, it wasn't needed; when Medicare was implemented this service was used very little.

G: Was there a fear that doctors would not be sufficiently receptive to Medicare itself to make the program work?

LG: I think there was a concern that health resources generally--by that I mean doctors and hospitals--in some areas might not cooperate and thus deny care at government expense. This did not prove so.

At any rate, in the health area, while review of hospitals for compliance was a very important activity for the period of a year or so,

and there were pockets of problems that continued, great changes occurred. I have always been very proud of the effective way hospitals dealt with this issue.

G: Do you think it was money that was the factor?

LG: I think this was a club that gave the government a chance to insist on it. There's no question without Medicare and other governmental [programs] there wasn't anything one could effectively use to implement the Civil Rights Act in this particular area. But here as a major purchaser of care, the federal government made an insistence in the terms of its contract and thus was a factor. Further, the hospitals of this country, with the exception of the public hospitals run by local government, are by and large private facilities, the majority of which are non-profit private hospitals. These hospitals have boards of directors who represent the community. Many of the individuals who are board members are very conscious of the role and responsibility of the institution to all the members of the community. This group of people were also very important in assisting institutions to support this law.

G: Was there any pattern to the hospitals that did not comply? Were they in one geographic sector, or rural versus urban, or one state in particular?

LG: I'm afraid it's hard to be terribly particular about it. I think the more obvious discrimination was more frequently seen in what we consider the South, and it posed a little more obvious problem in several cities that I think better not be mentioned. But we saw motion in those areas and these things resolved themselves very quickly.

One of the more perplexing problems was a subtle discrimination in some northern cities where you couldn't really put your finger on it without an awful lot of data and you were, if you will, circumstantially proving your case. Now it's one thing to walk down and see something abrasive like a sign over a door, "Toilet for Whites Only." However, subtle discrimination is much less obvious and much more difficult to correct. One can't say it was primarily in any [one] area of the country.

G: Were there any cities that were exceptionally bad, in either the North or the South?

LG: I think those of us working with it at the time could identify a few cities that were for us at that time a very difficult problem, where we even went to the extent of mapping all the admissions in a major metropolitan area. It was a very detailed study. However, changes occurred and they were dramatic.

G: What was the role of Congress when you were pursuing this initiative? Did you meet resistance from Capitol Hill or--?

LG: This was an amazingly difficult problem, as you can readily picture, for some of the congressman and senators depending on from whence they came, but I will say this: there may have been, but in my judgment there was practically no one on the Hill that stood up and said, as was said by one governor in the South, "Nobody is going to get in this institution." And I think a number of them really took a leadership role in difficult circumstances in being very supportive.

G: Who, for instance?

LG: Without naming names, I can indicate a number of southern legislators did take important and difficult positions and resisted our efforts. The big part of congressional action in this matter occurred in the 1964 period of the passage of this legislation, a period in which the masterful legislative hand of the President was very significant. I think getting that through--voting rights and all that went into the act--was the significant Hill fight, if you will, and the solution. I'm sure that if you really had had a violently opposed Congress there could have been serious problems with funding for activities that went to implement it, like our own involvement. All of our programs in the Public Health Service contributed manpower and activities to this effort essentially as a part of their ongoing activity.

G: So you didn't have to get a direct--

LG: Now I don't remember our ever defending--now we did set up a separate office for this activity, but the assignees who worked in the field were largely temporarily assigned. We used people on temporary assignments across the country.

(Interruption)

In this area of implementation of Medicare I was so personally involved that it looms big in my mind, but it certainly only represented one of the pieces of activity that were so important in this whole period. To mention a few others in which I had some knowledge--during this period the growth of the National Institutes of Health and support for medical research was fabulous. The activities of Lyndon Johnson as vice president and then the president in the development of the Peace Corps was a very significant one.

[I'll always remember] the swearing in of Sargent Shriver as chief of the Job Corps.

G: Of the War on Poverty?

LG: The War on Poverty. I must say I was so impressed. The President was so positive and said, "We are going to remove poverty from this country," and he certainly supported that program, even though it became more difficult when it ran down the road in terms of the congressional support--it was a fabulous effort.

The other things that I saw, [from] his whole support to the area of mental health, mental retardation, to the training of health manpower, the Clean Air Act--

G: Going back for a moment to the question of compliance, Lister Hill, I guess of all the members of the Senate, had a special responsibility and interest in health legislation and yet he was from a southern state. Tell me how he faced this problem of--?

LG: I'm not sure I know the whole answer. But I do recall, number one, he was in charge of two things. He was in charge both of the legislative authority for programs in health in the Senate but he also had his hands on the appropriation. So this is what's known as having both hands on the throttle. I can recall his comment on the difficulty of satisfying some constituents, but feeling a very strong point of view that this was what had to be done and what was right.

G: So he didn't flinch from--?

LG: I don't think he ever stood back. Now there may be some better examples where he initiated but I will say in terms of vocal reaction, it was a very supportive one. And to my knowledge, he stood that way all the way

through. This was kind of like a number of other people who were under real pressures but nonetheless stood up and said, "This is the way it's going to be."

G: In the Senate?

LG: I think both in the Senate and in the House. I just can't remember a leader on any of our relevant committees that wasn't somewhat of that posture. What you see publicly and what you see privately may be in some instances two different things.

G: I wondered about Dick Russell in particular. I know he was not on--

LG: He was not on the health committees but he was certainly a strong member of the Senate. You know these people, even if they're not on the committee, this sort of trading that has to be involved makes them a leading hand. I just don't know. I don't have any recall of any actions that he took.

G: One other thing on the compliance. The National Medical Association in 1966 was critical of Robert Nash in terms of enforcing compliance. Let me ask you to evaluate that criticism.

LG: I don't recall all of the specifics but I do know that this is something that was raised I think in that vein and had been raised otherwise on occasion. My assessment is this: I knew Bob Nash. I worked very closely--he did head our civil rights compliance office. I found him, in my judgment, to be a very practical and devoted to the basic thrust of the act. When you get into some of these judgmental decisions that you have to make on the basis of available evidence in areas where there is some real tugging and pulling, I think the good Lord himself would have had difficulty being approved by everybody.

We had, and he arranged and worked with, quite a number of consultants who were black and were not people who were, if you will, Uncle Toms in any sense of the word. My feeling--and I guess I'd have to be faced with more of the specifics, but I know they had some objections. As I recall their objections ran very significantly to the matter of staff privilege. I never saw Bob Nash shaving perceptively any decision. He had to make some tough ones and I would expect he may have made some that weren't that good, but I would say, by and large, he made excellent decisions.

G: Was there ever a situation where you had to choose between the social imperative of enforcing compliance and a medical or another social imperative of delivering the medical service?

LG: A basic concern to me in some areas, if significant change didn't occur, was that there may be a limitation of available service. It didn't occur in a lot of places. I would say that it was not an overriding concern. We did have the authority for the emergency admission of a Medicare patient to a hospital that otherwise was not approved for Medicare patients. Thus urgent health issues could be dealt with. So I don't think we felt, in a lot of circumstances, that we had to come to a decision because we needed a facility here. I really don't know of any time that we knowingly made an approval decision that was motivated solely or primarily for this reason.

Now coming into compliance is a matter of where they were and how far they go. It seems to me here there's always room for an argument, but if you have a substantial picture of 1) they've changed their pattern of admission and they're taking what appear to be a significant

number of all races; and [2)] that they're assigning them without any predestination concerning their race or any other factor. If there is no other obvious discrimination, you make a judgment. Now, someone might say, "That's not enough. The average level of people in this community who are"--and I keep saying black, but that's not the only basis--"black is 15 per cent and therefore 15 per cent of their admissions should be that."

This is where you get into an argument of what's real and I guess one could say, "Well, you accepted 11 per cent instead of 15." That sort of thing is arguable on occasion. I think that sort of thing did raise--but we had an equally difficult problem that is still difficult to resolve, and that is one that few think of: the fact that we do have "hospitals that have treated the blacks." The difficulty of getting a mix in that hospital is a whole different type of problem but it has the same discriminatory appearance if you look at an admission rate. I don't know how that one has ever really been resolved. That's been an exceedingly difficult one to induce whites to go to a hospital that had cared traditionally for only the colored.

G: What sort of standard did you exact?

LG: I'm not sure now. It seems to me the availability of the resource had to be a kind of a guiding issue. In other words, they weren't discriminating but we can't by the same criteria--the government can't tell somebody you must go here to be treated.

G: Let me ask you about the whole question of medical costs under Medicare early on, particularly the rise in doctors' fees. Were you involved in efforts to control--?

LG: No, I was not. The funding aspect of Medicare being under the Social Security Act, the defense and the administration of that program was not within the area of my purview. Being in the department, however, and as a matter of fact working very closely with Social Security even in the compliance activity, because we used the Social Security computer system, et cetera to manage this, early on--and I'm saying by early on, the first two years or so--the dollar cost it seems to me really didn't rise to be the issue that we saw in the seventies. For example, the efforts to establish reimbursement caps. So I really didn't see it in that role. I saw this in a totally separate role as a senior vice president for the American Hospital Association because I retired in 1970 and for the next decade I was in that program, essentially managing their office here as well as being their senior vice president. Here I did see from quite a different perspective, in the sense of the problem and concerns that we had, with regard to costs going up, and continues to this day.

G: Did that reflect, do you think, the shortcoming of the original legislation?

LG: No, I don't think so because you're dealing with an issue [for which] we still haven't been able to find a solution. We've got a much broader experience and we've gone to a number of things. If you take a look at the methodology--now I'm talking about hospitals primarily--but it is true that the original picture as established suggested essentially what we did in some of our war efforts, and that was cost-plus contracting. Now, that's changed completely because, if you're familiar with the method of reimbursement, hospitals are paid not on a cost-plus [basis]

but on a methodology that adopts a certain level of payment for each type of condition as well as type of stay and so on. In this sense it puts the hospital at risk because if you don't meet what is the current and apparent average that is established by Social Security, you just aren't paid the additional. So this is the evolution that we've seen and it will continue to evolve into something, forever trying to pin it more specifically to a high level of performance quality care. But we're faced with other things that nobody's been able to solve. Being a free society as we are, medical research has continued to hand down methods of treatment that are inordinately costly. One of the basic arguments is, should you really be doing this? The extension by Congress for coverage of some very key medical conditions--one of the things, I remember was renal dialysis.

G: Dialysis?

LG: The dialysis program at the University of Washington in Seattle was one of the first in the country. And at that time, Social Security did not cover the cost of dialysis. Communities would raise funds for some poor individual and get a fund that kept him going on dialysis for a year or so. But it was at that time that I remember the statement that, "As a government program this is going to go cost a billion dollars if we establish a pattern of acceptance of this for treatment." That has been accepted under Medicare for many years now. The buying-in to those patterns and the advances of medicine are not the only reasons for cost increase, but are examples of some of the reasons why cost is going up. At the same time not with our activity but the activity the government accepts, like with the Joint Commission on Accreditation of Hospitals,

the requirement of a certain patient coverage and the qualifications of people who work in hospitals, and the whole change from an eleemosynary institute into one in which everybody there works certain hours, gets paid so much, whereas in the past a lot of good people--the nurses were a great example and held up for many years--really didn't get paid what they were worth but that was good because they were giving of themselves. That whole pattern of life has changed in our country. All of these have had real impact on rising costs and the rising expectation of the public.

Now the efficiency of the hospital has got to be good and that is a problem. Here we've seen real changes and I think the reimbursement scheme has been a really good one in terms of letting everybody know they are at risk. Now the government has continued to try to get a handle on what do you do about physicians fees? There again, the establishment of usual and customary fees and so on have been some of the efforts. To the extent they're adequate, that's another story.

G: Any specific recollections about the role of the White House in either supporting or not supporting your initiative in Medicare compliance?

LG: Oh, I'll very definitely comment. Not only supportive, but we were reporting to Marvin Watson at the White House regularly with regard to the progress of the program. Tremendous concern--and rightfully; we all had it--of the fact that we would be in a position to act definitively and nationally in a very short period. The data with regard to the progress we were making was something of great concern. So I would say the White House supported and demanded a high priority to this of the

Secretary, and through him those of us in the Public Health Service as well as the Social Security Administration.

G: Let me ask you about the effort during the 1960s to expand and improve hospital facilities; the renovation of urban--

LG: Hill-Burton activity?

G: Yes.

LG: I think to me the sixties were but a continuum of what we saw--I've forgotten it but I believe the Hill-Burton act was passed about 1948.

G: 1946.

LG: As you well know, this provided grant funding to institutions who were private, non-profit institutions who were complying in terms of providing care to a community without necessarily knowledge of payment. Hospitals entered into that and it did provide a support and it had particular emphasis--and this was the result of Lister Hill especially in terms of his interest in the small rural hospital. We saw hospitals spring up across the country in many areas where there were none existent before, and the improvement of facilities throughout. So it, in the early days, was a very large program even though dollar-wise now it would look small. But at that time it was truly a big effort and it did a great deal to provide, not necessarily full funding, but would provide the seed money necessary to move ahead and modernize.

We saw in the sixties developing a contra-concern and that is for comprehensive health planning, which didn't permit institutions necessarily to expand willy-nilly. I testified in this area, and I felt very strongly that comprehensive health planning had the sort of view of the problem that was most necessary. In other words, an institution added

an expensive service or a new institution was built only if there was reasonably proved planning requirements for such. Because in hindsight now, we've seen during the last decade significant closures or diminishing-sized hospitals where overbuilding did occur. When you mention the improvement of hospitals in the sixties, to me, yes, there was significant [improvement] and a lot of it, because hospitals had resources available through Hill-Burton and also through tax-free bonding activity. There was real effort and there were a lot of advances made, it seems to me, in delivery of services and types of delivery of services. An individual who hadn't been in a hospital for ten years and went into one in 1970 was abashed in terms of just how much changed in facilities. And as we went on, the computerization of activities in the hospital, in development of intensive-care units, dialysis being more or less routine, and now when we look at [magnetic] resonance imaging in a hospital and lithotripter activity--things that require big capital investments--it's a night and day proposition if you look at them now versus a decade ago.

G: You mentioned earlier the growth of the National Institute of Health.

LG: Here it seemed to me, the period of the sixties was a very key one, and the entire National Institutes of Health, programs like heart disease, cancer and stroke got great emphasis and the President and the administration had tremendous interest in it. We saw the development of the national medical library. I should say the National Library of Medicine. Certainly the whole area of mental health had a big shot in the arm at that time, developing both structurally as well as dollar-wise for the

support of mental health and later, in a smaller way, mental retardation.

G: Any insights on, for want of a better term, what we'll call the health lobby, the Mary Lasker/Florence Mahoney types and their advocacy on the one hand versus James Shannon's on the other in terms of where to channel the resources for--?

LG: Speaking very frankly, it seemed to me from the offices of the surgeon general, you almost thought--and no negative reaction to this, in my judgment--but you think of Mary Lasker and you think of Jim Shannon in the same breath. Although one having a great deal of Hill connection and the other one had good Hill connections in his way, but that was a team. It worked during that period particularly well.

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LG: Further, when you think of the dedication in one sense of John Fogarty of Rhode Island and Lister Hill of Alabama--both leaders in their relative areas of Congress in the health area--the net result was the development of the world's greatest research institution.

But I must say that certainly this is thanks to a lot of people, and names like Mahoney and Lasker are certainly among the tops of that group.

G: People have often alluded to Mary Lasker's ties to Capitol Hill, I guess Lister Hill and John Fogarty. Tell me about Jim Shannon's.

LG: I'm not sure I'm in a position of knowing anything in detail other than it seemed to me [that] Shannon represented NIH very exquisitely with them. Generally I think he had good personal rapport and follow-through

with the congressional members that were key in support of the activity. And I don't know of anything else.

G: Was it largely an issue between them of applied research versus pure medical research?

LG: I think there were always strains and I didn't see really any strain between these congressional members and Shannon on the issue.

G: I meant between Mary Lasker.

LG: If there was I didn't recognize that, although there was always an undercurrent by some pragmatists that what they wanted out of NIH were things you could apply to people, versus what Jim would defend as basic research which leads to that thing which can be applied to people. It seemed to me--at least I always felt there were enough demonstrations that neither was exclusive, practical application or basic research, and both happened. I don't know of any institution that has claim to more prize-winners of the Nobel Prizes than the National Institutes of Health, many of which are for what I consider to be basic [research], but developments that have important applications.

G: Did the White House get involved in this balance between the basic research and applied research in tipping the scale one way or another?

LG: I don't think so. And here I guess I run out of knowledge. My feeling is that I'm sure the White House had some things that it wanted to see of a very practical nature--it's the kind of thing the constituents are going to argue for--so that in that sense may have expressed it. But I never saw any overwhelming hand there. As a matter of fact, I thought generally the administration as well as Congress were very supportive of

Shannon's basic thrust of [a] top-flight research institution that obviously focused on basic research.

G: So at NIH Mary Lasker was seen as an ally rather than an adversary.

LG: From my point of view, the answer to that is yes. Now I suspect that may not be true for others; I really don't know. But my feeling was I thought that they were so fortunate in having the support of somebody of her ilk because it seems to me while she may have had some axes she wanted ground, she really supported the thrust of that institution.

G: One particular interest of hers was the Heart, Cancer, Stroke Amendment of 1965; they had the commission in and--tell me about that and any special role you played in the implementation here.

LG: I remember well the program and certainly the emphasis that both the administration and the Congress put on it in terms of dollars. The Surgeon General, Bill Stewart, really had a very real interest in this area and an epidemiological background of concern with regard to it, so that I would say Bill really knows the ins and outs of that and I do not. I really don't think I can shed much light on this subject except the general thrust, and the concern of the Surgeon General in support of that activity.

G: I want to move to one topic that is more environmental but with health implications, the Clean Air Act.

LG: Here again, my knowledge of this program is very limited. To me, not being an engineer, my only thought was that it was monumental in its scope and importance, and certainly the administration put emphasis on it. My knowledge of it was only of the very early period during the formation of the legislation, so that I really can't add.

Another area of activity in environmental programs was testifying before the Atomic Energy Commission on the problems of radon exposure of hard-rock miners and cancer of the lung. Our efforts with the Secretary of Labor to get established improved standards for ventilation of mines were supported by studies by our Division of Radiological Health. We had a study, a cohort study of some twenty-five thousand hard-rock miners over a long period of time looking at the incidence of carcinoma of the lung that arose. The incidence of cancer of the lung was many multiples of other cohort groups.

This study was excellent and over time has proved to be very valuable. While this did not involve as such, legislation, at that point in time, it was an important area in the regulatory program for the Department of Labor.

G: The anti-smoking initiatives or at least hazard warnings, did you have an involvement here?

LG: Limited. Really the major initial thrust, as you know, occurred during Surgeon General Terry's period, and while aware of it, I was not intimately involved. There have been annual reports given, and we had problems with regard to the impact it was having on the tobacco industry, et cetera. But the real fight had long before been waged and the warning on the packages and all that continued. It seems to me the changes that have occurred in the warning and the more popular acceptance has been a matter of public education over time. I think everybody looks with pride that at this point so much has been accomplished, but I don't recall anything terribly unusual except--and again here's an

area the surgeon general is very intimately involved in--the continuing evaluation and the annual reporting.

G: The Community Mental Health Centers Act in 1965--well, the amendments at least. Any specific recollections there of the implementation of this program?

LG: I was not all that close [to it], although I was reasonably knowledgeable and it was a high-priority type of activity. Certainly the whole Community Mental Health Act and, like you said, the amendments to it were important.

G: How about the health professions legislation?

LG: Educational?

G: Yes.

LG: This was a period of, I think, considerable effort in the whole Health Professions Act, both for the training of physicians at that time, but also a nurse training act and the Allied Health Professions. The latter I believe was essentially a new thrust. There was emphasis placed in all of these areas. We've seen over time in each instance--the nurses early seemed to develop a plethora of people and there was a cutback on this activity with a voluntary limitation of hospital schools of nursing in the seventies. Now we're into another phase again where we're too short and looking for more. The physician situation, which at that time needed attention was given attention by the government, seemed to overrun its mark too in succeeding years where we began to develop more than would seem feasible. This kind of goes back to the cost of medical care. Medical care is an expansive sort of thing, just like dental care. If you've got more physicians, they're going to cost more money

because more things are going to be treated. So that overproduction of physicians is a problem in a variety of ways, one of which is the financial impact on the system.

There is one area that occurred to me that I mentioned earlier that I would just as soon put on tape, because I thought it was a real thrust in what might not be considered a health area but we were very much involved, and I was with Secretary Celebrezze when we went up and testified. That was on the--for lack of a better word--reconditioning of the Immigration Act. As the Immigration and Naturalization Act had been essentially unchanged in terms of quota systems for a period of thirty years plus--I think 1921 being the last time of change--there was a real interest. Because if you looked at the immigration of Northern Europe and so on, this had decreased considerably and yet the walls were being pushed for access in a whole different area of the world, like the Middle East and South East Asia.

The President certainly supported it. As a matter of fact he signed the passed Immigration and Naturalization Act in front of the Statue of Liberty in New York Harbor. I was so impressed because we had important immigration responsibilities in the health area. We maintained posts overseas and used to staff Ellis Island when it was functioning.

G: Did the change in the immigration law have a medical impact?

LG: It has a medical impact in the sense of the original law, and that is that all immigrants went through what we called quarantine and quarantine examinations. And over the years, whereas in the original period I believe all of them were primarily done at Ellis Island or points of

entry--Ellis Island being the best example on the East Coast--we had developed a chain of either private or contract stations in Europe and the Far East where we did the examinations. We tried to do away with the problem of someone arriving here with tuberculosis or some other excludable disease, which is first discovered on an x-ray in the United States, and then having to send them back. In the Public Health Service, we are still responsible for the quarantine activities of this country, and in that process the examination of aliens prior to admission.

G: In terms of, let's say the number of doctors, did it bring in more health personnel that might otherwise have--?

LG: We've always been conscious of brain drain. It does bring some physicians from particularly disadvantaged countries. The ones you worry about are the doctors who are trained and are desperately needed in their home country. For example, I knew a Togolais physician from West Africa who was trained in our country and started to work here. Now if he had remained here that would have been an unfortunate brain drain. He happened to be a very patriotic person, and I worked with him when I was in the Peace Corps in Togo and here he was earning little money as a trained orthopedist, top-flight physician and the only physician in the country from that country. He since has been made ambassador to the United States, the United Nations and Canada, [and is] living in Washington, which is unfortunate.

But the thing that you mentioned--not off the track--but brain drain has always been a concern. Now the Immigration Act does have certain requirements with regard to the acceptance of somebody based on

an occupation in which we have a need. To that extent I guess, in the earlier period, that could have been a ticket. We are concerned about taking specialized personnel from countries that really needed them. We want them to remain where needed.

End of Tape 1 of 1 and Interview I

INTERVIEW I

DATE: February 13, 1990

INTERVIEWEE: LEO GEHRIG

INTERVIEWER: Michael L. Gillette

PLACE: Dr. Gehrig's office, Washington, D.C.

Tape 1 of 1, Side 1

G: Let's begin with a brief discussion of your background and how you became involved in the administration of health policies during the 1960s. You're from Minnesota originally?

LG: Yes. I'm Leo J. Gehrig. I am a physician from Minnesota, educated at the University of Minnesota. I joined the U.S. Public Health Service during my internship at the University of Utah and served a full career with them. I have been trained and have my boards in general and thoracic surgery. After being chief of thoracic surgery in both our hospitals in New York and Seattle, I was brought into Washington at that time largely in an administrative role as an assistant chief of our division of hospitals across the country. Over the years my position moved up in that area, finally as assistant surgeon general, chief of the Bureau of Medical Services. I had been assigned by the Public Health Service, and then-Surgeon General Luther Terry to be the first medical officer of the U.S. Peace Corps when Sargent Shriver asked the service to assume responsibility for the health area of that program.

G: How did you happen to get that assignment, do you recall the background?

LG: I had been on a development program for the service in which I served in each of the major areas of the U.S. Public Health Service: National Institutes of Health, Bureau of State Services, and then Bureau of

Medical Services. I was a fairly loose individual at that time, having had several years in Washington, and because suddenly the Surgeon General was hit with a request for someone to plan the medical program for the Peace Corps, he advised me that that was my next assignment. So I went there without a great deal of past experience in the area, but a basic interest. While I went over ostensibly for one month of planning, it wound up that before I was through planning I was operating and I stayed on and was there for the first two years.

Later, after I returned to the service as the chief of the Bureau of Medical Services, I was selected by then-Surgeon General William Stewart for the post of deputy surgeon general, and it was in that position that I remained until my retirement.

G: As a practical matter, what did your functions include as deputy surgeon general?

LG: I guess the easiest way to describe that [is to say that I] was to be available for such duties as a surgeon general needed on a regular basis and representing him in some areas where it was impossible for him to go. I guess that boils down [to] that there were relatively few definitive responsibilities, over the period, that I had as part of my job description. On the other hand, a very significant part of my time involved some of the legislative activities of the Public Health Service and, very particularly, the implementation of the Medicare Act and the compliance of providers with the Civil Rights Act of 1964, particularly Title VI.

G: There was some controversy over the withholding of Medicare funds from hospitals that were not in compliance. Describe that whole issue.

LG: To me--and now, at least in my judgment, President Johnson's fingers get into it, really. The passage under his push, if you will, of the Civil Rights Act of 1964 in, it seems to me, all areas of social concern was a major milestone and obviously in Title VI there was a provision that no one could discriminate on the basis of race, et cetera.

At any rate, the passage of the Medicare Bill, in which the government formally became a contractor potentially very widely with hospitals in the country and physicians, provided the first closure of the loop, if you will. In other words, such a contract brings in to bear in a legal fashion the compliance of the institution. So after the Medicare Bill passed, one of the first programs that the surgeon general was faced with implementing was an inspection activity of all the hospitals in the United States for their compliance with the requirements of the Civil Rights Act, as well, obviously, as their capabilities to fill a contract in health care and support for the federal government.

This was one of my delegated duties early in office. The Surgeon General said, "I can't keep my hand on this every minute, but the priorities that have been established in the department and the White House with regard to it make it a significant job for us that I want you to be responsible for, even though I will continue to be involved in it." Thus I think at least for the next year to eighteen months, roughly, we were involved. At that level I had at my disposal health manpower rather broadly-based in all of our institutions, both direct-care facilities as well as others, and we were able to mobilize and, if you will, train individuals very rapidly for these inspectional requirements. It was our intent that people who evaluated institutions with

this area in mind have sufficient training to make not only a medical judgment but a basic judgment based on the requirements of the Civil Rights Act.

G: Did you have people with legal backgrounds as well as medical backgrounds?

LG: Absolutely, yes. The area of involvement was certainly legal and medical, and a number of basic social areas of expertise. The hands-on, if you will, inspection of a hospital to see whether it was in compliance required all of that, but the ongoing one for the evaluation of medical activities and their role was largely in the hands of people who had backgrounds primarily in the health field.

G: What did your examiners look at to determine compliance?

LG: This is a broad one and there were developed evaluation sheets by individuals who had been primarily involved in the social side of this. For example, one of the very important areas, obvious areas of discrimination, the separation of facilities--by that I mean restrooms, restaurants. One of the key ones was the assignment of patients without regard to race, because in some areas of the country it had been long a pattern where there were "the separate but equal" so-called facilities, but they were definitely segregated.

These easy areas of obvious discrimination were important right off, but there are many other factors that were looked at that tended to be less obvious. Yet there were patterns that described such--in other words, even the referral patterns of patients in a city area, certain hospitals getting largely the colored and et cetera. So it was a fairly broad look at the operation of a hospital facility, looking again for essentially patterns of discrimination.

G: Were there problems with black doctors not being allowed to practice at some of the hospitals?

LG: Yes. One of the issues that was faced was the matter of staff privileges and the availability. There are a host of problems within this. For example, certain hospitals, particularly your teaching hospitals, will have requirements that only board-certified individuals may be on it. There was a separation of, was this a requirement that medically was important and necessary or was it a pattern of denying someone access that would otherwise get it? Certainly a lot of hospitals with the requirement for board certification could justify very well what their position was. On the other hand, those that were found for that or other reasons to be discriminating in staff privileges were off base. So it was but one of a variety of areas of discrimination that had to be dealt with.

I think overall for my purposes, having been in the Department of Health, Education and Welfare, although not necessarily all that knowledgeable of the activities of other departments, I could only appreciate that in the area of health, while we had our problems, resolution of the problems was fantastic, and fantastic over a fairly short period of time. I think, if I recall correctly, by July or so of 1966 a piece of data was that about 92 per cent of the facilities available in this country had been considered adequately meeting the requirements of Title VI and eligible for participation. The big concern, and it seemed to me a very prominent one of President Johnson's, was the fact that everything was moving very fast and--I think it was in July of 1966 that Medicare was implemented as an available resource to the elderly. But

his concern was that once implemented there would be available the resources to treat people everywhere. The National Institutes of Health, as that date approached, were heartened of course by the rate at which things changed among those institutions where change was necessary. But to insure--

G: When you say things changed, do you mean doctors' or hospitals' acceptance of Medicare or the change in, let's say discriminatory practices?

LG: I think, putting it broadly, the rate at which institutions could be considered in compliance and available. The reason for that may be a variety of issues but a very important one was Title VI.

But in order to further assure that the government was doing everything possible, the President--and I believe his name was Watson; you would know better than I who was at the White House in the health area for the President.

G: Marvin Watson?

LG: Marvin Watson, I think that's it. There were weekly meetings over there with regard to where we stood. They established at the National Institutes of Health an emergency switchboard with calling available at no cost to individuals across the country to that board, should they be unable to reach a hospital or find a hospital that was certified for Medicare, so that the government could take other actions to authorize treatment or tell them where to go. Well, it wasn't needed.

G: Was there a fear that doctors would not be sufficiently receptive to Medicare itself to make the program work?

LG: I think there was a concern that health resources generally--by that I mean doctors and hospitals--that there might be in some areas resistance

to the point of denying available care at government cost. This did not prove so and, as you know, it seems to me the evaluation of institutions was a key concern because discrimination by--it seems to me, many physicians treated individuals regardless of their race even though the modus operandi for their treatment may have been appearing discriminatory. For example, a guy who treats someone but he keeps him in a different area is [committing] a discriminatory act. Now, whether you can say that's the hospital only or that's the doctor only I think is open to a degree of question. It can be either. But when the feet are held to the fire, the hospital has got to assure indiscriminate assignment of rooms which was a very, very key issue.

My only thought was--I had started on a thought before that--in the education area we saw this long period that really hasn't ended yet of accommodations to the problems, the busing continues, et cetera. At any rate, in the health area, while it was a very important activity for the period of a year or so, while there were pockets of problems that continued, [there was] not much and not in many places as it related to the hospital.

G: Do you think it was money that was the factor?

LG: I think this was the club that gave the government a chance to insist on it. There's no question without Medicare there wasn't anything you could with the Civil Rights Act particularly. But here a major purchaser of care in the federal government made an insistence on the terms of its contract and that obviously had to be a factor. Plus the fact that there's another element that is terribly important in all of these actions: as you well know, the hospitals of this country, with the

exception of the public hospitals run by local government, are by and large private facilities, non-profit private hospitals. There [was] an element at that time of certainly the proprietary hospital, but very small at that time. The fact that you have public hospitals of voluntary nature [means] they do have boards of directors who represent the community. Many of the individuals who are board members are very conscious of the role and responsibility of the institution. So it seems to me [that] when this became very evident and the press came, there was a lot of action by people who weren't necessarily working in the hospital but were really running the show, as a board of directors does.

G: Was there any pattern to the hospitals that did not comply? Were they in one geographic sector, or rural versus urban, or one state in particular?

LG: I'm afraid it's hard to be terribly particular about it. I think the more obvious discrimination was more frequently seen in what we consider the South, and it posed a little more obvious problem in several cities that I think better not be mentioned, necessarily. But we saw motion in those areas and these things resolved themselves very quickly.

One of the more perplexing problems was a subtle discrimination in some northern cities where you couldn't really put your finger on it without an awful lot of data and you were, if you will, circumstantially proving your case. Now it's one thing to walk down and see a sign over a door, "Toilet for Whites Only" or something, versus something or a pattern where it seems that most of one group of people are not getting in this institution, or something like that. So all I'll say is that

one can't say it was all in any [one] area of the country, although I would be inclined to say that some of the very obvious and some of the [more] difficult did occur in the South, but it also occurred in the North in a different way.

G: Were there any cities that were exceptionally bad, in either the North or the South?

LG: I think those of us working with it at the time could identify a few cities that were for us at that time a very difficult problem, where we even went to the extent of mapping all the admissions in a major metropolitan area to see how hospitals fell out in it, and that becomes a very detailed thing. But I don't--

G: Which state was this?

LG: I won't say that I don't remember, but I really think looking back, because changes were dramatic, that I would rather think of it as not a specific problem, but there were some.

G: What was the role of Congress when you were pursuing this initiative? Did you meet resistance from Capitol Hill or--?

LG: This was an amazingly difficult problem, as you can readily picture, for some of the congressman and senators depending on from whence they came, but I will say this: there may have been, but in my judgment there was practically no one on the Hill that stood up and said, as was said by one governor in the South, "Nobody is going to get in this institution." And I think a number of them really took a leadership role in difficult circumstances in being very supportive.

G: Who, for instance?

LG: I can't be very obvious but it just seems to me there wasn't--the big part of congressional action in this matter occurred in the 1964 period

of the passage of the legislation, a period in which the masterful legislative hand of the President was very significant. I think getting that through--voting rights and all that went into the act--was the significant Hill fight, if you will, and solution. I'm sure that if you really had a violently opposed Congress there could have been problems with funding for activities that went to implement it, like our own involvement, because it was not without cost although we never funded it. All of our programs in the Public Health Service contributed manpower and activities to this effort essentially as a part of their ongoing activity.

G: So you didn't have to get a direct--

LG: Now I don't remember our ever defending--now we did set up a separate office for this activity, but the assignees who worked in the field were largely temporarily assigned. We used people on temporary assignments across the country.

(Interruption)

In this area of implementation of Medicare I was so personally involved that it looms big in my mind, but it certainly only represented one of the pieces of the area that were so important in this whole period. To mention a few, and here I was a more distant--in some case I was close to it--during this period the growth of the National Institutes of Health was fabulous, in terms of funding support, where many other programs were much less assisted in terms of funding. It seems to me, and here you'll know better from others' direct role, certainly as I saw things from a distance, the activities of first the Vice President and then the President in the development of the Peace Corps was a very

significant one. He, I believe, headed our board of directors or whatever they called the advisory council for the Peace Corps. Other ones that strike me, of course very distantly, [are] the knowledge of his role and the whole development of NASA and his support to the space program.

I'll always remember the day that Sarg Shriver called me and said, "I'd like to invite you over to the White House because I'm being sworn in." In the East Room, the President swore him in as chief of the Job Corps.

G: Of the War on Poverty?

LG: The War on Poverty. I must say I was always so impressed, and I told Sarg Shriver later I couldn't accept a charge like that; I don't see how any man could. But with a President who was so positive and [who] said, "We are going to remove poverty from this country," and very strong statements, and [who] certainly supported that program, even though it became more difficult when it ran down the road in terms of the congressional support--it was a fabulous effort.

The other things that I saw, [from] his whole support to the area of mental health, mental retardation, to the training of health manpower--as a matter of fact, I'd like to show you some of the pens I have with which he signed key legislation. The one that I have, with a picture of his handing it to me, as everybody got in those situations, was the Clean Air Act. I got the Allied Health Professions, Mental Retardation, are some that I know are downstairs. His hand across the board in many of the activities of the Public Health Service was so very evident and he was such a masterful pusher of legislative authority that it couldn't be [inaudible].

G: Going back for a moment to the question of compliance, Lister Hill, I guess of all the members of the Senate, had a special responsibility and interest in health legislation and yet he was from a southern state. Tell me how he faced this problem of--?

LG: I'm not sure I know the whole answer. But I do recall, number one, he was in charge of two things. He was in charge both of the legislative authority for programs in health in the Senate but he also had his hands on the appropriation. So this is what's known as having both hands on the throttle. I can recall his comment on the difficulty of satisfying some constituents, but feeling a very strong point of view that this was what had to be done and what was right.

G: So he didn't flinch from--?

LG: I don't think he ever stood back. Now there may be some better examples where he initiated, necessarily, but I will say in terms of vocal reaction, it was a very supportive one. And to my knowledge, he stood that way all the way through. This was kind of like a number of other people who were under real pressures but nonetheless stood up and said, "This is the way it's going to be."

G: In the Senate?

LG: I think both in the Senate and in the House. I just can't remember a leader on any of our relevant committees that wasn't somewhat of that posture. What you see publicly and what you see privately may be in some instances two different things.

G: I wondered about Dick Russell in particular. I know he was not on--

LG: He was not on the health committees but he was such a strong member of the Senate. You know these people, even if they're not on the committee,

this sort of trading that has to be involved makes them a leading hand. I just don't know. I don't have any recall of any actions that he took. I guess there's nothing else about that area that I can add.

G: One other thing on the compliance. The National Medical Association in 1966 was critical of Robert Nash in terms of enforcing compliance. Let me ask you to evaluate that criticism.

LG: I don't recall all of the specifics but I do know that this is something that was raised I think in that vein and had been raised otherwise on occasion. My assessment is this: I knew Bob Nash. I worked very closely--he did head our civil rights compliance office. I found him, in my judgment, to be a very practical and a relatively devoted individual to the basic thrust of the act. When you get into some of these judgmental decisions that you have to make on the basis of available and in a sense--obvious isn't the word--real evidence one way or the other and into areas where there is some real tugging and pulling, I think the good Lord himself would have had difficulty being approved by everybody.

We had, and he arranged and worked with, quite a number of consultants who were black and were not people who were, if you will, Uncle Toms in any sense of the word. My feeling--and I guess I'd have to be faced with more of the specifics, but I know they had some objections. As I recall their objections ran very significantly to the matter of staff privilege. I never saw Bob Nash shaving perceptively any decision. He had to make some tough ones and I would expect he made some that weren't that good, but I would say, by and large, he made excellent decisions.

G: Was there ever a situation where you had to choose between the social imperative of enforcing compliance and a medical or another social imperative of delivering the medical service?

LG: A basic concern to me in some areas, if significant change didn't occur, was that there may be a limitation of available service. It didn't occur in a lot of places. I would say that it was not an overriding concern. And we did have--a person in Medicare has the authority of what is called an emergency admission to a hospital that otherwise is not acceptable for care. We had that much to go on. So I don't think we felt in a lot of circumstances that we had to come to a decision, not so much on the fact that they met the requirements but rather that we need a facility here. I really don't know in my recall of any time that we knowingly made a decision that was motivated on the latter aspect.

Now coming into compliance is a matter of where they were and how far they go. It seems to me here there's always room for an argument, but if you have a substantial picture of 1) they've changed their pattern of admission and they're taking what appear to be a significant number of all races; and [2)] that they're assigning them without any predestination concerning their race or any other factor. If there is no other obvious discrimination, you make a judgment. Now, someone might say, "That's not enough. The average level of people in this community who are"--and I keep saying black, but that's not the only basis--"black is 15 per cent and therefore 15 per cent of their admissions should be that."

This is where you get into an argument of what's real and I guess one could say, "Well, you accepted 11 per cent instead of 15." That

sort of thing is arguable on occasion. I think that sort of thing did raise--but we had an equally difficult problem that is still difficult to resolve, and that is one that few think of: the fact that we do have "hospitals that have treated the colored." The difficulty of getting a mix in that hospital is a whole different type of problem but it has the same discriminatory appearance if you look at an admission rate. I don't know how that one has ever really been resolved. That's been an exceedingly difficult one to induce, if you will, whites to go to a hospital that had been traditionally for the colored.

G: What sort of standard did you exact?

LG: I'm not sure now. It seems to me the availability of the resource had to be a kind of a guiding issue. In other words, they weren't discriminating but we can't by the same criteria--the government can't tell somebody you must go here to be treated.

G: Let me ask you about the whole question of medical costs under Medicare early on, particularly the rise in doctors' fees. Were you involved in efforts to control--?

LG: No, I was not. The funding aspect of Medicare being under the Social Security Act, the defense and the administration of that program was not within the area of my purview; so that we weren't. Being in the department, however, and as a matter of fact working very closely with Social Security even in the compliance activity, because we used the Social Security computer system, et cetera to manage this, early on--and I'm saying by early on, the first two years or so--the dollar cost it seems to me really didn't rise to the issue that we saw in the seventies, for example, with the beginning of efforts to establish caps and continuing

efforts to try to get a hold on cost. So I really didn't see it in that role. I saw this in a totally separate role as a senior vice president for the American Hospital Association because I retired in 1970 and for the next decade I was in that program, essentially managing their office here as well as being their senior vice president in Chicago. Here I did see from quite a different perspective, in the sense of the problem and concerns that we had, with regard to costs going up, and continues to this day.

G: Did that reflect, do you think, the shortcoming of the original legislation?

LG: No, I don't think so because you're dealing with an issue [for which] we still haven't been able to find a solution. We've got a much broader experience and we've gone to a number of things. If you take a look at the methodology--now I'm talking about hospitals primarily--but it is true that the original picture as established suggested essentially what we did in some of our war efforts, and that was cost-plus contracting. Now, that's changed completely because, if you're familiar with the method of reimbursement, hospitals are paid not on a cost-plus [basis] but on a methodology that adopts a certain level of payment for each type of condition as well as type of stay and so on. In this sense it puts the hospital at risk because if you don't meet what is the current and apparent average that is established by Social Security, you just aren't paid the additional. So this is the evolution that we've seen and it will continue to evolve into something, forever trying to pin it more specifically to a high level of performance quality care. But we're faced with other things that nobody's been able to solve. Being a

free society as we are, medical research has continued to hand down methods of treatment that are inordinately costly. One of the basic arguments is, should you really be doing this? And the extension by Congress for coverage of some very key things--one of the things, I remember when Surgeon General Terry was in, he and I had gone to the West Coast and we faced, in my experience, the first real cost problem when we went to Seattle, which had developed the first . . . kidney disease program which--

G: Dialysis?

LG: The dialysis program at the University of Washington was one of the first in the country. And at that time, Social Security did not cover the cost of dialysis. Communities would raise funds for some poor individual and get a fund that kept him going on dialysis for a year or so. But it was at that time that I remember the first time I said, "This is going to go cost a billion dollars if we establish a pattern of acceptance of this for treatment." That has been accepted under Medicare for many years now. But the buying-in to those patterns and the advances of medicine may not be the only reasons for cost increase, but are examples of some of the reasons why cost is going up. At the same time not with our activity but the activity the government accepts, like with the Joint Commission on Accreditation of Hospitals, the requirement of a certain patient coverage and the qualifications of people who work in hospitals, and the whole change from an eleemosynary institute into one in which everybody there works certain hours, gets paid so much, whereas in the past a lot of good people--the nurses were a great example and held up for many years--really didn't get paid what they were worth but

that was good because they were giving of themselves. That whole pattern of life has changed in our country. All of these have had real impact on rising costs and the rising expectation of the public.

Now the efficiency of the hospital has got to be good and that is a problem. Here we've seen real changes and I think the reimbursement scheme has been a really good one in terms of letting everybody know they are at risk. Now the government has continued to try to get a handle on what do you do about physicians fees? There again, the establishment of usual and customary fees and so on have been some of the efforts now. To the extent they're adequate, that's another story.

G: Any specific recollections about the role of the White House in either supporting or not supporting your initiative in Medicare compliance?

LG: Oh, I'll very definitely comment. Not only supportive, but we were reporting to Marvin Watson at the White House regularly with regard to the progress of the program. Tremendous concern--and rightfully; we all had it--of the fact that we would be in a position to act definitively and nationally in a very short period. The data with regard to the progress we were making was something of great concern. So I would say the White House supported and demanded a high priority to this of the secretary, and through him those of us in the Public Health Service as well as the Social Security Administration.

G: Let me ask you about the effort during the 1960s to expand and improve hospital facilities; the renovation of urban--

LG: Hill-Burton activity?

G: Yes.

LG: I think to me the sixties were but a continuum of what we saw--I've forgotten it but I believe the Hill-Burton act was passed about 1948.

G: 1946.

LG: It could be then. As you well know, this provided grant funding to institutions who were private, non-profit institutions who were complying in terms of providing care to a community without necessarily knowledge of payment. Hospitals entered into that and it did provide a support and it had particular emphasis--and this was Lister Hill in no small amount, in terms of his interest in the small rural hospital. We saw hospitals spring up across the country in many areas where there were none existent before, and the improvement of facilities throughout. So it, in the early days, was a very large program even though dollar-wise now it would look small. But at that time it was truly a big effort and it did a great deal to provide, not necessarily full funding, but would provide the seed money necessary to move ahead and modernize.

We saw in the sixties developing a contra-concern and that is for comprehensive health planning, which didn't permit institutions necessarily to expand willy-nilly. I testified in this area, and I felt very strongly that comprehensive health planning had the sort of view of the problem that was most necessary. In other words, an institution added an expensive service or a new institution was built only if there was reasonably proved planning requirements for such. Because in hindsight now, we've seen during the last decade significant closures or diminishing-sized hospitals where overbuilding did occur. When you mention the improvement of hospitals in the sixties, to me, yes, there was significant [improvement] and a lot of it, because hospitals had resources available through Hill-Burton and also through tax-free bonding activity. There was real effort and there were a lot of advances made, it

seems to me, in delivery of services and types of delivery of services. That attitude, an individual who hadn't been in a hospital for ten years--had been in 1960 and went into it in 1970--could be abashed in terms of just how much changed in facilities. And as you went on, the computerization of activities in the hospital, in development of intensive-care sorts of things, dialysis being more or less routine, and now when we look at [magnetic] resonance imaging in a hospital or lithotripter activity--these things that are costing big capital investments--it's a night and day proposition if you look at them now versus a decade or a little more ago.

G: You mentioned earlier the growth of the National Institute of Health.

LG: Here it seemed to me, the period of the sixties was a very key one, and the entire National Institutes of Health, programs like heart disease, cancer and stroke got great emphasis and the President and the administration had tremendous interest in it. We saw the development of the medical museum--I should say the National Medical Library. Certainly the whole area of mental health had a big shot in the arm at that time, developing both structurally as well as dollar-wise for the support of mental health and later, in a smaller way, mental retardation throughout the country.

G: Any insights on, for want of a better term, what we'll call the health lobby, the Mary Lasker/Florence Mahoney types and their advocacy on the one hand versus James Shannon's on the other in terms of where to channel the resources for--?

LG: Speaking very frankly, it seemed to me from the offices of the surgeon general, you almost thought--and no negative reaction to this, in my

judgment--but you think of Mary Lasker and you think of Jim Shannon in the same breath. Although one having a great deal of Hill connection and the other one had good Hill connections in his way, but that was a team. It worked during that period particularly well because I think it in many--

Tape 1 of 1, Side 2

LG: Further, when you think of the dedication in one sense of John Fogarty of Rhode Island and Lister Hill of Alabama--both leaders in their relative houses of Congress in the health area--the net result was the development of the world's greatest research institution.

But I must say that certainly this is thanks to a lot of people, and names like Mahoney and Lasker are certainly among the tops of that group.

G: People have often alluded to Mary Lasker's ties to Capitol Hill, I guess Lister Hill and John Fogarty. Tell me about Jim Shannon's.

LG: I'm not sure I'm in a position of knowing anything in detail other than it seemed to me [that] Shannon represented NIH very exquisitely with them. Generally I think he had good personal rapport and follow-through with the congressional members that were key in support of the activity. And I don't know of anything else.

G: Was it largely an issue between them of applied research versus pure medical research?

LG: I think there were always strains and I didn't see really any strain between these congressional members and Shannon on the issue.

G: I meant between Mary Lasker.

LG: If there was I didn't recognize that, although there was always an undercurrent by some pragmatists that what they wanted out of NIH were

things you could apply to people, versus what Jim would defend as basic research which leads to that thing which can be applied to people. It seemed to me--at least I always felt there were enough demonstrations that neither was exclusive, and fundamental to practical application is basic research and both happened. You certainly see a Nobel Prize--I don't know of any institution that has more claim to more prize-winners of the Nobel Prizes than that institution, many of which are for what I consider to be basic [research], but at the same time have such extreme and important applications.

G: Did the White House get involved in this balance between the basic research and applied research in tipping the scale one way or another?

LG: I don't think so. And here I guess I run out of knowledge. My feeling is that I'm sure the White House had some things that it wanted to see of a very practical nature--it's the kind of thing the constituents are going to argue for--so that in that sense may have expressed it. But I never saw any overwhelming hand there. As a matter of fact, I thought generally the administration as well as Congress were very supportive of Shannon's basic thrust of [a] top-flight research institution that obviously focused on basic research.

G: So at NIH Mary Lasker was seen as an ally rather than an adversary.

LG: From my point of view, the answer to that is yes. Now I suspect that may not be true for others; I really don't know. But my feeling was I thought that they were so fortunate in having somebody of her ilk because it seems to me while she may have had some axes she wanted ground, she really supported the thrust of that institution.

G: One particular interest of hers was the Heart, Cancer, Stroke Amendment of 1965; they had the commission in and--tell me about that and any special role you played in the implementation here.

LG: I remember well the program and certainly the emphasis that both the administration and the Congress put on it in terms of dollars. The Surgeon General, Bill Stewart, really had a very real interest in this area and an epidemiological background of concern with regard to it, so that I would say Bill really knows the ins and outs of that and I do not. I can't think of the first--Bob, and I can't think of Bob's last name, who headed the program first off, a very capable individual [who] went on to become assistant secretary at a later date. But I really don't think I can shed much light on it except the general thrust, and the concern of the Surgeon General in support of that activity.

G: I want to move to one topic that is more environmental but with health implications, the Clean Air Act.

LG: Here again, I run out of gas. As a matter of fact, it's the act that I have on the wall downstairs. To me, not being an engineer, my only thought was that it was monumental in its scope and importance, and certainly the administration put emphasis on it and pushed this one through. My knowledge of it was only of the very early period during the formation of the legislation, so that I really can't add much to that.

The concern of the Clean Air Act--while I don't have direct knowledge of it, I was closely involved in another aspect of environmental activity which probably doesn't look important to anyone but was so close to my feelings. And this was the testifying that we had to do

before the Atomic Energy Commission on the problem of radon bodies in hard-rock miners, and our efforts with the Secretary of Labor to get established improved standards for ventilation, et cetera, of mines that had high levels. We had had a very unique study in the world--I think a cohort study of some twenty-five thousand hard-rock miners over a long period of time looking at the incidence of carcinoma of the lung that arose. The incidence there was many multiples of any other reasonable cohort group you want to draw. We were faced with a lot of problems because, of course, the ventilation and that sort of thing is an expensive part.

This cohort study was excellent and I think over time has proved to have been a very real one. While this did not involve as such legislation at that point in time, it was an important area in the regulatory program for the Department of Labor.

G: The anti-smoking initiatives or at least hazard warnings, did you have an involvement here?

LG: Limited. Really the major initial thrust, as you know, occurred during Surgeon General Terry's period, and while aware of it, I was not intimately involved. During the course of [inaudible] there were annual reports given, and we had the usual problems with regard to the impact it was having on the tobacco industry, et cetera. But the real fight had long before been waged and the warning on the packages and all that continued. It seems to me the changes that have occurred in the warning and the more popular acceptance has been a matter of public education over time. I think everybody looks with pride that at this point so much had been accomplished, but I don't recall anything terribly unusual

except--and again here's an area the surgeon general is very intimately involved in--the continuing evaluation and the annual reporting, which had been a requirement, continued through this period with the usual back and forth fight.

G: The Community Mental Health Centers Act in 1965--well, the amendments at least. Any specific recollections there of the implementation of this program?

LG: I was not all that close [to it], although I was reasonably knowledgeable and it was a high-priority type of activity. Certainly the whole Community Mental Health Act and, like you said, the amendments to it were important. I'm trying to think of what I can say as standing out and I'm not sure, except for the fact that it was given high priority by the SG and it seemed to be well-supported. That was another example of the interest of the President in an area.

G: How about the health professions legislation?

LG: Educational?

G: Yes.

LG: This was a period of, I think, considerable effort in the whole Health Professions Act, both for the training of physicians at that time, but also a nurse training act and the Allied Health Professions. The latter I believe was essentially a new thrust. There was emphasis placed in all of these areas. We've seen over time in each instance--the nurses early seemed to develop a plethora of people and there was a cutback on this activity with a voluntary limitation of hospital schools of nursing--non-profit--in the seventies. Now we're into another phase again where we're too short and looking for more. The physician

situation, which at that time needed attention was given attention by the government, seemed to overrun its mark too in succeeding years where we began to develop more than would seem feasible. This kind of goes back to the cost of medical care. Medical care is an expansive sort of thing, just like dental care. If you've got more physicians, they're going to cost more money because more things are going to be treated. So that overproduction of physicians is a problem in a variety of ways, one of which is the financial impact on the system.

I don't know whether you're familiar with this, but I was always impressed--and it's easier to see in the dental activity, [and] there are data, and I don't have access to it now or haven't looked at it--which estimates that the meeting of dental requirements of the population is only a percentage of what it really is. Again that is because of two things, dollars and people. And the more dentists you have, the more treatment you're going to have so the dental bill will go up and it means more people are getting care. Now in medicine it's a little harder; a lot of people say, "Well, yes, but they're just getting unnecessary care." Well, that's not totally true either. There may be some unnecessary care but there is also care that isn't given for these same reasons if you're short of personnel.

There is one area that occurred to me that I mentioned earlier that I would just as soon put on tape, because I thought it was a real thrust in what might not be considered a health area but we were very much involved, and I was with Secretary Celebrezze when we went up and testified. That was on the--for lack of a better word--reconditioning of the Immigration Act. As the Immigration and Naturalization Act had

been essentially unchanged in terms of quota systems for a period of thirty years plus--I think 1921 being the last time of change--there was a real interest. Because if you looked at the immigration of Northern Europe and so on, this had decreased considerably and yet the walls were being pushed in a whole different area of the world, like the Middle East, et cetera, for access. The President certainly supported it. As a matter of fact I went to the signing on Bedloe's [Liberty] Island when he signed the passed Immigration and Naturalization Act. I was so impressed because we had, in usual public health service activity, important immigration responsibilities in the health area, and maintained posts in this country and overseas. We used to staff Ellis Island when it was in function. I had the chance to go and listen to Celebrezze who, himself an immigrant, told one of the most impressive pieces of testimony one could think of, because the committee just got behind him two thousand per cent.

G: Did the change in the immigration law have a medical impact?

LG: It has a medical impact in the sense of the original law, and that is that all immigrants went through what we called quarantine and quarantine examinations. And over the years, whereas in the original period I believe all of them were primarily done at Ellis Island or points of entry--Ellis Island being the best example on the East Coast--we had developed then a chain of either private or contract stations in Europe where we did the examination there, trying to do away with the problem of someone arriving here with tuberculosis, which is first discovered on an x-ray in the United States, and then all the pain of essentially repatriating them. In the Public Health Service, we are

still responsible for the quarantine activities of this country, and in that process the examination of aliens prior to admission. So that's the health aspect.

G: In terms of, let's say the number of doctors, did it bring in more health personnel that might otherwise have--?

LG: We've always been conscious--and it does bring [some] from particularly disadvantaged countries, but certainly England has been a big contributor over a time as well as many others. The ones you worry about are the doctors who are trained--for example, I knew--I think the only trained Togolais from West Africa was trained in our country and started to work here. Now if he had remained here that would have been an absolutely horrible brain drain. He happened to be a very patriotic person, and I worked with him when I was in the Peace Corps in Togo and here he was hardly making a living and he was a trained orthopedist, top-flight physician and the only physician in the country from that country. He since has been made ambassador to the United States, the United Nations and Canada, [and] living in Washington. (Laughter) Which is unfortunate.

But the thing that you mentioned--not off the track--but brain drain has always been a concern. Now the Immigration Act does have certain requirements with regard to the acceptance of somebody based on an occupation in which we have a need. To that extent I guess, in the earlier period, that could have been a ticket in that someone could use. There's no way of blocking the same thing--and we are concerned that taking specialized personnel from countries that really needed them and while we said we were short, we didn't want them here. We wanted them

to go home. It was a bit of a problem and I don't know that that factor has changed. As a matter of fact, the implementation of--I think in the nursing area it has become more restrictive. Institutions in this country used to recruit a lot of Filipina and other nurses for the lack of nurses here and now this is beginning to be, I think, a problem again.

G: Tell us about the efforts during the 1960s to control drug abuse.

LG: Here I have little recall except for a fracas that Jim [James L.] Goddard got into where there was some talk about the use of marijuana, I think. For reasons that were maybe well-founded Jim said that he would prefer to have his daughter, I think, smoke a cigarette of marijuana than to take a martini or something of this variety. Otherwise, I don't really recall.

The bigger area that I was involved in was the efforts of the Public Health Service to run the two research centers on addiction. These are the addiction centers which were in Fort Worth and in Lexington, Kentucky, and the National Addiction Research Group remains, I think, in Lexington, Kentucky. Here the Public Health Service manned and operated these two large mental institutions--I should say, narcotic addiction centers. Its patients were primarily federal and state, I think, convicted people that were referred there.

G: Criminal.

LG: Criminal. Yes. I've forgotten the details of it but our efforts in Fort Worth were phased out--and I've forgotten the date of it. The research center--and this was very much a part of the Bureau of Mental Health, and that program as a research program and an extension really

of their resources of NIH, was out in Lexington and continued to be. It was rather discouraging at that time because of the recidivism rate.

G: There was in 1967 an effort to expand, I guess it was the McClellan Bill to allow for federal treatment of non-criminal addicts, which was opposed. I guess the administration viewed this as a local and state responsibility rather than federal.

LG: I would assume so because that would be a wide-open gate if we were going to assume the responsibility for the care. At that time, it seems to me, the resources that existed for the care of addicts were largely these two low-risk, or whatever you call it, institutions in Fort Worth. NIH, while it had a research program out there, had hardly a facility for any kind of an active treatment program.

G: Was there a sense in the Public Health Service that drug abuse was going to become a much larger problem?

LG: I suspect there may well have been. I must confess that it never was an issue with which I had any direct involvement. I would imagine Stan Yolles--that was another person I was thinking of. I don't know whether you have him. Stan Yolles was the director of the National Institute of Mental Health for years. The original guy there, Bob--I can't think of his last name--had retired and died. But Stan Yolles, who last I knew was professor of psychiatry at Stoney Brook in New York, [is] very knowledgeable about that whole period with regard to the development of mental health and drug addiction.

G: Was birth control a political as well as a medical issue in 1966?

LG: I was trying to think. I think, again, I have to confess that I really wasn't involved and it doesn't stand out in my mind as a big issue. But

when you're not tied into it--it's all a matter of relative knowledge and activity in the area. And I had little or none with regard to birth control, so I really don't know.

End of Tape 1 of 1 and Interview I

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