INTERVIEW II

DATE: May 16, 1990

INTERVIEWEE: EUGENE GUTHRIE

INTERVIEWER: Michael L. Gillette

PLACE: Dr. Guthrie's residence, St. Michaels, Maryland

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G: Let's begin this afternoon with a discussion first of the mental retardation legislation. The original bill was in 1963, is that correct?

EG: That's correct.

G: Did you have any role in the initial legislation?

EG: Well, to the extent that the [Public Health] Service had had activities in the retardation area of the National Institutes of Health, primarily concerned with some research out of the Institute for Neurological Diseases and Blindness. For instance, support of the development of a test for newborns for a genetic disability called phenylketonuria, so-called PKU. The institute coordinated the research and development of that test. So there was interest within the Public Health Service primarily in research dealing with entities that either were the etiology of defects causing retardation, or in diseases that as a result left the patient retarded. But there was no activity dealing with ongoing services to individuals who were retarded. Most of what was being done was being done through voluntary organizations around the country. There was a stimulation of interest that was begun by some members of the Kennedy family to see if something could be developed, from a federal agency point of view, dealing with a national focus on the problem of

mental retardation. From that came the beginnings for legislation for a program that would deal with direct services to people suffering from mental retardation.

That focus in the Public Health Service came to my Division of Chronic Diseases, and when it looked like there was an opportunity for support in the Congress for such legislation, we began to gather in the manpower who were expert in that field. And that ultimately led to the passage of the Mental Retardation Act, which gave us roughly seven million dollars of new money to support--I think my recollection of the funds is correct--a variety of activities around the country. And those activities ran the gamut of grants to organizations and institutions to launch programs where there would be first of all, identifying the retarded, because as you may recall, mental retardation was a type of problem, a defect that people were taught to be ashamed of. So many of the retarded were closeted within homes and families and no one knew about them.

There was an attempt to provide public education and information to enlighten people that to be retarded was not a shameful affair, that there was much that could be done for the retarded to make them capable of self-care, for those who were profoundly retarded; to education and training of those who were minimally retarded, who could in effect be so-called mainstreamed.

So there were a number of things proposed under that legislation, to include public education, improve diagnosis, to accurately identify the level of retardation; to establish community resources for rehabilitation, training, education and, where appropriate, treatment.

What we did in our program was essentially concentrate on the states, and through the states to cultivate interest in their medical institutions to look to this component of concern; not to detract from research but to add on for community services. So we targeted grants--the program consisted of primarily grants to institutions and organizations to develop programs. We created at the national level several [study sections], akin to the National Institutes of Health study sections, to review these applications so that they were competitive, and [they] were reviewed by peers to determine which were the most likely to succeed; and then they were rated and priority sets given, and then the grants awarded on that basis.

The staff that I accumulated went around the country promoting the development of these grants, [and] seeking out individuals and organizations who had expertise and interest and so forth. And it was, I think, a very successful enterprise. Where there really hadn't been anything like that, there was a great deal of interest throughout the country, as you might imagine. And we were able, in spite of the fact that there were very few "experts" in this, to locate them and accumulate a very creditable staff of individuals who I think spent that money very well. Now that grew, that budget grew--I wouldn't say exponentially, but gradually and probably appropriately in accord with our ability to spend it wisely. And it did a great deal around the country to bring up the level of awareness about retardation, and brought a lot of people out of the closet, and that program has continued to thrive.

G: Was there a reasonably accurate notion of how many mentally retarded citizens there were?

EG: In the early days, of course, there was an awful lot of guesstimation that had to take place, because it was very difficult to get any sort of an accurate count; no such thing had been attempted. As money became available, of course, people began to be interested in finding out who were the retarded, and what was the magnitude of their problem, and how would they spend it? Gradually the states were able to better come up with estimates of the numbers of retarded individuals they had within their states, but I don't think at any time we could really say we had an "accurate count." I think as the years unfolded we were much better able to give reasonable estimates of the magnitude of the problem.

G: Was it necessary initially to educate the members of Congress with regard to the need for this legislation?

EG: I don't think it was too difficult because with the attention that the First Family brought to the problem it was not difficult for the members of Congress to recognize that this was a seriously disabling birth defect, and that there was very little that anyone could say was being done in any substantial way to deal with it. It was definitely a neglected field and I don't think it was very hard to demonstrate that.

The fact [was] that it was not difficult to demonstrate that a great deal could be done for a relatively small amount of money, of course that's appealing to anyone. And the effects were relatively near at hand, as opposed to some of the research effort that was extremely difficult to show how soon benefits could be derived, because we were, and to some degree still are, at the very early stages of our ability to determine the cause of a lot of these defects. And yet we had already found two or three of them with respect to mental retardation.

It was also rather startling to demonstrate how much improvement could be brought about to a given retarded individual who had had no opportunity for any professional rehabilitation; to bring those people from what would almost be a vegetative state to an individual who was capable of self-sufficiency--with support. And as I say, those were very appealing opportunities and I think the Congress saw that, and it wasn't difficult to get those funds.

The difficulty came in finding capability out there to immediately utilize that much money. I was always happy to receive fresh money in operating programs, but I had to say at the close of that first year [that] I didn't want to ever have to spend seven million dollars in one year like that again. It was very difficult to organize that system and be able to say we spent that money wisely.

G: Did you encourage the development or expansion of state programs then in the process?

EG: Yes. We really knocked on a variety of doors. We went to state health departments to encourage them to consider mental retardation as a public health priority program. We encouraged the voluntary organizations to support their official health agencies in taking on that responsibility, and in so doing, were looking forward to the states developing their own programs and their own dollars to compliment federal so-called "start-up" monies to follow up. Because as is typical with a federal grant, we liked to provide start-up money and then suggest that in the third year or the fourth year they begin to develop local or state methods of support, and gradually phase out the federal support and let that go on to some other place. So that was one target, the state official health agency.

The other target was the medical centers that traditionally would take on programs of that sort, and to encourage them to--many of whom were already in research--but to encourage them to take on the community services side and to provide leadership. And in the medical profession, the medical and related professional groups--physical therapy, rehabilitation medicine, groups like that--to take on retarded individuals as a clientele that they wanted to serve. Those were target groups and that's where our staff put their energies, and then encouraged them to go on into their communities and seek out the next further level of that. So you began to get a ripple effect.

G: Were there any states that had no program or no facility at all for dealing with this problem, where you just had to start from scratch?

EG: As you might expect, it was somewhat dependent upon who had had experience with the problem and how prominent they were. The squeaky wheel gets the oil, so to speak. Where a particular state had a prominent individual, either politically or through some other avenue of fame, had a retarded individual in their family, that frequently was where the impetus came to do something about it. Or a particular chapter of the National Association for Retarded Children, who happen to be a very strong organization, strong in the sense of aggressive in their lobbying, aggressive in their hanging in there to get their share of the pie when the funds were doled out. Where they were very strong and very aggressive, you'd frequently find a very good program. But it was spotty. There was not a pattern and, as I say, our intent with the federal legislation was to try to bring about at least a basic level of service available throughout the United States, and then look to certain

areas that obviously would have more capability, more expertise to continue to provide leadership.

G: Did the administration's support for this initiative change after President Kennedy's assassination?

EG: It kept on going. Once it was established I think the administration stayed with it. It was a popular program. I'm trying to think now when--I don't have the dates in my head so it may have been that some of the initiation of this began in the Kennedy Administration, but it was in the Johnson Administration where the follow-up took place.

G: Was it a relatively bipartisan initiative in terms of the Congress? Did you get significant support from both Republicans and Democrats?

EG: Right.

G: There was a series of amendments in 1967 that extended the 1963 law, and in addition provided funds for the first time for initiating services and facilities for the mentally retarded and the extension of the program for the training of teachers of handicapped children; and a new program also that would provide training for physical education and recreational personnel for the mentally retarded and other handicapped children. Do you recall those 1967 amendments?

EG: I don't recall the detail, but I do recall that--and I think it was pretty much as a direct result of the initial legislation. The education system--I don't know whether compelled is the proper word--was made responsible for the education and training of the handicapped. I think that became a broad definition, but I think that the initiation of that concept came through what was done with the retarded, the so-called mentally retarded. Now of course that's a rather global term that covers a

lot of specific entities. But when that was begun and the concept was put forward and accepted that it was the responsibility of the state educational institutions--that is, basic education--to provide the education and training for those individuals; if they didn't do it within their own facilities they had to provide it to the individuals. So a number of special programs were developed that took care of these kids, but they were financed by the state and local boards of education. As I say, that has now reached out to encompass all handicapped children.

Now whether it was those specific amendments or amendments not only there, but perhaps in some of the office of education legislation--but I know now that much of that support for those services comes from the boards of education. In fact, I know in my own community that the health department had a joint responsibility with the board of education in providing some of the health services to those people, and we helped them in the evaluation of those youngsters for the kind of treatment they received, because the board of education didn't have the health competence within their staff to do that. I think that's a common practice all over the country.

Whereas prior to that, just to show you the reason for it, a lot of these children simply had no access to education opportunity. The school couldn't handle them. They were denied entry on the basis that schools said, "We just can't handle that kind of kid in our facilities," and they were able to shake it off and were not required to make any commitment to it. They can't do that now. If you come in with a severely handicapped youngster and present that youngster to the local

school people, they have to provide the highest level of education opportunity that that child can utilize, which practically means that the school has to write a blank check. With some of those individuals it's an extremely costly process to provide the kind of help they need. It's just a very intense kind of program.

There was obviously in some areas a considerable resistance to that because the costs were--although early on there was a lot of federal money, that federal money gradually has shrunk down. Schools have had to absorb more and more of that locally. But of course once the public was given the fact that this was their due; this was an entitlement, you can't turn that off. It's very difficult to turn that off.

G: Was HEW largely one of the motivating forces behind getting this initiative going?

EG: My recollection is no. The impetus came from outside. It came from the groups who were supporting these individual groups.

G: Do you want to talk about the air pollution legislation during this period and your involvement with that?

EG: At that time I was in the Surgeon General's office as associate surgeon general, and I had been one of those responsible in one of the reorganizations of the Public Health Service. At the time I was both the assistant surgeon general for operations and then subsequent[ly] the associate surgeon general. The environmental programs were amalgamated and elevated into a bureau status, and in those days the bureau status was the top organizational entity of major program operations of the service. There was a Bureau of Community Service which incorporated a lot of health and medical categorical programs. There was a Bureau of

Hospitals and Indian Affairs which covered most of the direct operational entities of the service; the Bureau of Environmental Health which brought together all of the environmental programs of the Public Health Service, and then the NIH was considered a bureau. So that roughly we had four or five bureaus within the Public Health Service, and that reorganization brought together the environmental programs.

Now most of those programs at that point were so-called demonstration-type programs. Their funds were used to support state and local environmental activities, mostly in the form of grants. Some were formula grants to the states, others were project grants; I don't know whether you know the difference in those.

G: Why don't you explain that?

EG: There's a long history in the Public Health Service of giving grants to states and institutions, organizations, to do this, that and the other thing. Many of those were in the form of what we called project grants. In other words, an individual project. An example of that might be a given institution--we'll say, looking back on retardation--starting a diagnostic and referral program for the mentally retarded. They would be given X amount of dollars to develop a program for which they had given us specifications, and it was in that type of entity. And the grant might support the entire thing; staff, operating expenses, the whole thing. Or it could be a grant in part, in which the grant was matched by some local funds or institutional funds, and that would be called a project grant.

A formula grant, where--there had been a long history of the Public Health Service providing grants to the states and principally to the

state health agency to conduct a variety of categorical programs. And the derivation of the formula came from the circumstance where states were not co-equal in their ability to launch those programs. To oversimplify it: the more wealthy and more technically capable states were given less money and the less wealthy, less capable states were given more money, based on some type of formula that was developed. And there were scads of different formulas that covered everything from such things as the population, the relative status of wealth of those individuals, some means of estimating their technical capability, and so forth and so on. Those formulas were developed. If we talk later about the Partnership for Health we'll talk about what happened to some of those grants.

Anyway, the Bureau of Environmental Health, most of their money at that time was in project grants or in formula grants to the states. For instance, the states would be given water quality grants to maintain or improve and try to reach federal standards of water quality within the states. They would be given a certain amount of money, based on a formula. Grants covered a number of areas like that, and that's how air pollution [grants] got started, was on a formula grant basis to the states. Part of that legislation covered formula grants--it's my recollection--and part of it covered these so-called project grants. If a given community had a certain type of special air pollution problem--let's say for instance, Los Angeles with its smog could apply for a project grant to deal specifically with the L.A. smog problem, which might be an inspection of automobile exhaust systems, in the early days. That would be a project grant. Whereas the state health department might

receive a formula grant to provide air pollution technical consultation to industry, that type of thing. Those were the manners in which they did them.

Now one thing that the Bureau of Environmental Health did not have was research money. We undertook a review of the National Institutes of Health research grants dealing with subjects in the environment, and indeed we found there was a substantial amount of money--and my recollection is something in the neighborhood of fifteen to twenty million dollars--of the NIH funds were going to support grants that could be assembled under the rubric of environmental health. That fifteen to twenty million was spread across all of the institutes, some more heavily involved than others. And a good example of that would be in the Cancer Institute, where they would be studying industrial solvents, for instance, and the ability of those solvents to cause cancer among industrial workers, so forth and so on.

Anyway, we entered into a discussion with the NIH about bringing that core of grants from within the NIH, and transferring it to the new Bureau of Environmental Health and creating a research arm of that bureau. Now as you might imagine, there was a certain amount of possessiveness on the part of the individual institutes to maintain that research in their own area, and their argument was it would be an artificial separation to take that research out. If, let's say, the Cancer Institute was studying hydrocarbons and they were studying the whole span of hydrocarbons, industrial hydrocarbons might just be one aspect and they would not look kindly upon pulling that out. Well, we felt the time had come for a concentration on the environment as a

subject of its own. In spite of the arguments put up by the NIH, it held, and of course we had to convince the supporting committees in Congress that this was a bona fide thing to do. In order to create a sum of money without looking to that magnitude of new money, we would start with a core of money from those grants and then build upon that in the name of environmental research. And with a awful lot of gee and haw going on between the National Institutes of Health and this new Bureau of Environmental Health, we were able to pull that off.

I forget now what the final negotiation on that basic amount of money was, that came over from the NIH. But what we did was essentially establish a mirror image of the mechanism by which the NIH handled its grants, in the new Bureau of Environmental Health, and that did a great deal. The academic institutions around the country--both their environmental interests as well as their medical interests--found that here was a new focus of attention in environmental research, and many of the research individuals sought to get in on that popularity and growth of interest in environmental research, and [that] served as a major stimulus to many of the institutions around the country that today now pride themselves on having a very capable research arm in the problems of environmental health.

G: Was it a question of lobbying for this arrangement on the one hand, and the NIH lobbying for the status quo on the other on Capitol Hill?

EG: Yes.

G: How were you successful? Was it a question of just getting the committee chairs on your side for the House and Senate?

EG: As with many things, it was a combination of events. The NIH people were very cognizant of the increasing interest in the environment, and

the medical community, which of course they were mostly allied with, was beginning to recognize the importance of the environment in terms of hazards to human health. However, with so many things there's a natural built-in resistance to change, and the institutes had a tough time making a convincing argument that they could create enough interest in the existing research entities to adequately address the environmental health issues. They couldn't muster the argument to sustain that. And the counter forces who were arguing for a different focus, to create more environmental research interests, were able to marshal an argument that removing that from the NIH would in no way reduce the importance of the NIH and what they were doing, nor really even threaten their concern for the environment as it relates to human health. But history provided more evidence that a different focus and a focus more oriented to environmental interests would in the long run produce a better quality of research effort.

So part of the negotiations developed a compromise, in that instead of locating these research interests in Washington as the NIH already had, a new physical location would be established at the research triangle in North Carolina, down there between the Raleigh-Durham area, which was at that time a new research development on the part of North Carolina and the greater universities of North Carolina. They became sensitive to the growing attention to the environment and made a sort of gentlemen's pledge that they would establish a national focus of environmental research, if the Public Health Service would locate its research center there for the new bureau. Well, that was a very attractive deal, and the University of North Carolina, Duke and

many other institutions that were closely allied with the NIH sort of lobbied the NIH to go along with that idea, that everybody would benefit from this.

So it was finally sold, I believe, as a good idea for everybody concerned. I think Jim Shannon hated to part with any number of millions of dollars, but I think he saw that that was a game that ultimately he couldn't win, and he'd better go along and support it for the benefit he'd get out of being a good guy in going along with it. The net result was a very small dent in his operation.

G: Were there any key, critical players on Capitol Hill whose support you had to get in order to make it happen?

EG: I'm not sure of that. I'm trying to think if both [John E.] Fogarty and [Lister] Hill were still in their positions, because obviously you couldn't do anything without their approval.

G: Hill retired in 1968.

EG: Did he? Okay. That happened then prior to his leaving, so obviously he had to be for it. And I don't recall--I think at that stage in time with Lister Hill, he was really not that sharp. And when we were able to present--we now being the Public Health Service--an agreed-upon solution, he would be pretty apt to accept it. If he felt there was not unanimity among the minds of the PHS then he might want to hold off.

With Fogarty it was a different thing. Fogarty, coming from his background, as I recall was for this proposition from the very beginning. He prided himself on his bricklayer's union card that he carried, and he was very much for the blue-collar worker and that sort of thing. As I recall I think he was for that from the very beginning although he

was a very strong supporter of NIH. But I think he saw early on that this would not hurt NIH and it would strengthen this new environmental entity.

G: Was there any significant opposition from industry?

EG: Not to my knowledge. I think industry essentially was on the side of the new bureau.

G: Did the White House take one side or another?

EG: Now on that score, I'm not sure. Again, I think the White House position was, "If you all present a united front, it's a subject we're interested in and we'll support it, but you get your ducks in line." Certainly the center went off the ground very well. We were able to recruit good people. It was a program that was really coming on, so it was a successful enterprise.

And I guess air pollution in all of this was probably the newest kid on the block in the programs. Radiological health, water had already been going and air was somewhat the new kid on the block.

G: How about the Water Quality Act, did you have any role in that at all?

EG: Not too much. The major issues at that time, it seems to me, were the debates over the amount of exposure that human beings should be limited to in a variety of these pollutants. There was great debate both within the Public Health Service, within the Congress over the so-called zero tolerance issue. Should we prohibit any amount of certain pollutants? As I recall, it took a lot of thrashing to come to a position whereby these pieces of legislation would be acceptable unless they contained some "realistic levels of exposure," and that was a compromise circumstance. Whereas the proponents of as little exposure as possible--

because we knew so little about many of these, and we were beginning then to develop the concept that the public was exposed to multiple exposures, it was very difficult to say in water you will limit it to thus; in air you will limit it to thus, unless somebody took a look at the whole exposure that the individual got. Of course you had many organizations who were concerned about discussion of this issue, period, because the more you get into it, it becomes a little more frightening.

So I think a lot of what went on behind the scenes, there was not so much the difficulty that these pieces of legislation were not appropriate and important and timely, but the real issue was how much tolerance are we going to accept and what level is going to be established as a national standard; and in what direction is it going to go? And some concern on the part of some that even to discuss this and let it get out into the public domain was a rather fearsome thought, and to some extent I feel that that basic circumstance prevails today, and has ever since those kinds of legislative issues came out. It's very difficult to get hold of what is the proper answer on a question like this.

G: Difficult from a medical standpoint or difficult from a political standpoint?

EG: All of them. All of the above. At the time the EPA [Environmental Protection Agency] was created I know many--

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EG: At the time the EPA was created and the environmental programs were taken out of HEW or whatever that was called at that time, there were many of us who felt concern that once the EPA, or rather once the environmental issues had to stand on their own and compete in the

marketplace of everything--outdoor enthusiasts, industrial interests, sports interests, health interests, all of those--that human health was very apt to come out pretty low on the totem pole. If you put the key national environmental--federal, I'll say--concerns in a health agency, you were in a sense saying that the human factors relating to the environment were of primary importance and the other factors were second to that. Now maybe not as clean-cut as that, but that assumption could be made.

By the same token, if you put the environmental concerns in the Department of the Interior, then you could be pretty sure that the assumption would be that the effects on the physical environment were of primary concern, and human health, sports interests, and industrial interests were of a secondary nature. So a lot of us felt that concern when the EPA was formed, and I think that concern has been borne out up until now, that the effects on the human being are not the most important concern. Now occasionally--I won't say occasionally--sometimes it does become the key concern and federal legislation and federal action is based on that primary issue, and the others have to take second choice. But I think many specialists in this area have been and are continuing to be concerned that the total spectrum of the environment in which we live, and what happens in that environment and the consequences of that on human health are not very well dealt with. And the consequences for human health are still very iffy, and in some ways getting more iffy at the federal level. Consequently that reflects all the way down the line, because what happens at the federal level this year was going to happen at the state level X years down the road.

And I can go on and say a lot of the disruption and decay of federal health operations have begun to take place at the state level and are beginning to take place at the local level, because I don't think today we have a very strong federal health organization either in terms of dollars or capability. That begins to reflect at the state level and at the local level as time goes on. I also will venture to predict that we will find that that is a deficit that the nation cannot afford to have happen, and we will rebuild it at some time and at a great cost, I might add. But that's rather a typical way we deal with things.

Reflecting a little bit more on the environmental legislation, air pollution and the rest--it was in a time of great change in our environmental interest in the United States, and it was extremely interesting to see the developments take place. Health was just one piece of it. The whole environmental field was being affected at that time and health was just one part of it. And the players, as compared to some of our long-time ventures in traditional health business in the Public Health Service and the Congress and in the White House, [were] a rather traditional array of players, but when the environmental interests took off that brought a whole new cast of characters and a whole different ball game. And the health people had to learn to play in that ball game. Many of us were strangers--everybody in there were strangers so there was a lot of feeling out: Who are you? Where do you come from? You talk a different language; all of that.

So a lot of things that happened in those days and to some degree I think all that hasn't jelled yet--are a result of different professional groups, different voluntary groups, different interests in the

Congress getting together and working out and working in as to who plays what role and what part. It's a very interesting phenomenon, and I should think to many people an interesting study.

G: Was Mrs. Johnson an ally in this whole environmental initiative?

EG: I think her interest in the environment--in a way I think she had a comprehension of the importance of the whole development, and I think the way she manifested her own direct interests and her own personal involvement was in some of the physical things that she was the spark behind in the city of Washington. Her interest in beautification--I think it was called a beautification program--was, I felt and my colleagues felt, a reflection of her concern for some of the environmental degradation that was taking place, and a way of bringing public attention to the care of the environment in a very tangible, understandable way. I think she did a great deal in that regard, and it's lasted.

G: Any recollections of auto emission controls and the effort to get the auto industry, for example, to manufacture cars that contributed less to air pollution?

EG: Most of my recollection is [of] a very stubborn industry who didn't want to deal with that, who resisted everything. I know in some of the studies we tried to develop in Cincinnati where we had environmental laboratories--in fact, the Public Health Service's own direct research activities were carried out in Cincinnati; I forget the name of the--oh, it was [the] Robert A. Taft Engineering Center--were to study auto emissions and try to establish standards and therefore build those standards into legislation, and the auto industry didn't want that. I don't recall the specifics. I was not involved in the details of negotiations

with the auto industry, but I do know the guys who were doing that and reporting back in. You weren't going to expect to see them in support of much of consequence, or if they did support it they didn't want it to take effect until as far down the road as they could get it.

G; How about the Water Quality Act? Was this another measure in which the Public health Service became involved?

EG: Yes, because the Public Health Service had been in water quality control, so to speak, for a long time primarily through setting standards for interstate travel--railroads, airplanes. Any interstate water had to meet Public Health Service specifications. Therefore, since there were so many things involved in where you got your water supply for that, it essentially was the mechanism by which the Public Health Service controlled the national water supply quality. So any time you manipulated the standards for interstate water, everybody pricked up their ears because that meant they were going to have to conform. Although the program itself was not all that large, the ramifications of it were such that it in effect set the water quality standards all over the United States.

Of course, that brought out the pro and the con groups always. Frequently the operators of water systems would always see any change in standards as a cost factor to them because they would have to change equipment, or they'd have to purchase more chemicals or different kinds of things. Usually whenever these standards were updated or amendments were made to the legislation it required some change of that nature, so you could almost always expect the industry to, if not oppose it, question the accuracy, and what is the basis of this and so forth and so on.

You usually had to start out your preparation for selling that quite a ways in advance of the actual legislation coming up, to be able to get out there and educate people to understand why the changes were necessary.

I think that debate that I told you about earlier, on this business of how much are you going to--that always prevailed in all of these negotiations. I think now perhaps hindsight is telling us that we didn't pay enough attention to the status of the system itself. We were so concerned with the quality of the product, which I guess blinded us to the fact that the system itself should maintain its capability if it's going to produce a quality that meets what your endpoint is. But I think what we're finding today is that many of the water systems in this country are in a dreadful state of--disrepair isn't the right word--bad condition, where replacement is probably the only answer. We were not paying enough attention to maintenance and upgrading those systems. Now many of them are ancient and coming unglued so that major population concentrations are depending on a water supply that is being delivered to them through a system that is loaded with problems of breakdown, of inability to maintain itself. Where we used to think that anywhere you'd open a tap in America and take a drink of water you're perfectly safe; you're not. Now you're not going to die from it like you would if you went to Afghanistan and drank tap water, but your chances of getting sick because the water is contaminated, the potential for that is getting greater all the time. So to me there's a deficiency in our attention to that, to let it get to the stage where it is now. We talk now about rebuilding the infrastructure of America; that's one piece of it,

is the water system.

(Interruption)

EG: --had little jurisdiction or authority in waters that weren't to be fit for human consumption. And I mentioned the fact of interstate transportation--buses, trains and airplanes--where you get a drink of water, drinking water had to meet Public Health Service standards. If you were on a boat the water you drank had to meet those standards, but the water the boat was in was not our jurisdiction.

So the only time we really got concerned about major bodies of water were things like the Mississippi River, where people downstream two hundred miles from Chicago were drinking water that had been through the sewer systems of about ten cities. And was it possible to purify that water sufficiently to protect the health of those people after it had been urinated up to a dozen times upstream? You can recall the signs that people used to put in the hotels in Chicago and other places about how to avoid polluting the people downstream. But in those instances we began to become concerned about the quality of water in those rivers and requiring that--or trying to get legislation that would require municipal treatment programs to return the water to the stream in the same condition they got it, and that was a very controversial concept. And it related to some of those circumstances such as you described, that those lakes up there were being used for so many waste treatment purposes or waste disposal purposes that, as you say, it almost became a dead body of water. In fact, I guess it did become a dead body of water.

But that responsibility was never given to the Public Health Service, and I don't think until EPA came into existence did there then

begin to be a concern for the whole aspect of a body of water, that that had to be looked at not only as a place for fish to survive and sportsmen to have activity and recreation, but it also had to be considered for human consumption and a lot of other things.

G: Let's move to the Partnership for Health. This was a comprehensive health planning and public services program, is that right?

EG: Yes, right. And one aspect of that--now that had, I think, two very important implications for public health in the United States. One was that for the first time a planning concern about the health services in the United States was dealt with in legislation. It was recognized that the health industry as we know it today in the United States was built not by plan, but by gosh and by golly, without much attention to things beyond the next year or two. When a hospital was built or when a major piece of equipment was installed, even though they cost many millions and millions of dollars, nobody was really concerned with whether or not this was a duplication of something a half a block away, and yet our costs were escalating and everybody was hand-wringing because of the escalating costs of health care, and the construction of institutions and all the rest.

So that legislation was an attempt to put in place a mechanism to plan the further growth and development of the health care system in the United States on a semi-voluntary basis. I say semi because there were both carrots and sticks in that legislation. It was not ironclad that performance had to meet plans, but it was an attempt to place in the American health care system a mechanism to plan on the future based on a variety of criteria, some of which I just enumerated. And I must say

that--I will say that or its outcome was dubious as to whether it was successful or not.

Unfortunately because of the pressure of the cost to the federal government, the nature of the program was changed in midstream from a planning program to a cost control program. That occurred via amendments to the program. It took the emphasis off the planning and put the emphasis on cost control. Then when cost control became such a controversial factor at the federal level, it was pretty well destructed by further amendments. So that now it is pretty much a voluntary program mostly funded by the states and some large local communities.

Anyway, that was the purpose of that legislation, and the other major thing that was tied into it was a change from the method by which the federal government was funding health in the states and local communities.

I spoke earlier about formula grants and project grants. Over the years the number of grants in the health field had escalated to an almost mind-boggling number of categorical concerns. There was mental retardation; there was heart disease; there was cancer--you name it, we had everything but left toe wart disease grants--and they were a combination of project grants and formula grants. The Congress was very concerned that the growth of these had outstripped the ability of anybody to really know whether this was the most efficient way to use federal money. There was an attempt on the part of the Congress to turn that over into a single granting project, one grant. And this was the reason the so-called partnership in the title got in here.

The concept would be that the federal government would give so much money to a state, and since we were a union of fifty different

states with at least fifty different sets of problems, rather than the federal government and the Congress trying to determine what those priorities were, we'd let the states establish that. And they had so much money and how they doled it out among the categorical interests was their concern. Well, you can imagine what that provoked, a concept like that. There was a great hue and cry that came up from all the categorical concerns because they saw their baby going out with the wash water. So they amalgamated themselves to lobby against such an idea, and the states of course amalgamated all their friends to lobby for the idea, and a great battle ensued over that.

As with most things, a compromise was developed to have so-called block grants, and the concept was born of block grants; not one big grant but several--but not too many--block grants and the blocks would cover a broad area of concern. An example: environmental health. "We'll give the states a block grant in environmental health, and then they can determine whether half of it goes to air pollution, or all of it goes to air pollution, or none of it goes to air pollution. Now, wait a minute. Maybe we ought to say 5 per cent of it has to go to air pollution." So as you can see, in the compromise the block grants came out covering I think less than half a dozen areas, broad areas broadly defined, but some categorization within the blocks. And the categorization depended upon how strong the voice was for the category. If they had a lot of friends and were very strong they probably got a percentage of that grant earmarked for their program. Then after you took out the various percentages which, of course, the governors and mayors and the rest were fighting to prohibit, the remainder the state or the

municipality could then spread as they wished, with a few provisos thrown in there that at least they should cover such and such and so forth, but they didn't tell them how much. But when they reported back they had to say, we did spend some on maternity and child health, and we did spend some on XYZ disease, and that kind of thing. That did pass the Congress as a major innovation in the federal means of supporting public health and environmental programs. That plus the planning was called the Partnership for Health.

G: Did this then replace the funding formulas to the states?

EG: Yes. All the previous categorical grants and project grants had to fall into those blocks. To show you what a dumb idea that was, from a categorical interest that was a bad idea because they lost badly. As categorical and project grants the sums of money were not too large, but when you put those all into blocks, the sums of money were very large. And my experience with the Congress was, a very large sum of money presented a problem. They always looked at a big sum of money and they usually had problems with them. When those block grants came in and they were socked in the face with, "My God, we're giving the states X hundred million dollars in that block. That's a lot of money." When times got tough, they began to chop away at that, and because it did not reflect those categorical interests which had been able to muster such a beautiful lobbying system, they were pretty easy to cut. Consequently, those grants have gotten smaller and smaller and smaller so that the federal share, or the federal role, in those health programs has diminished and began to diminish from day one when those bills were first put together and the first authorization was established, they began to cut away at those programs.

G: Was this an intent at the time or was this just an unforeseen result?

EG: It was never acknowledged, of course, as an intent, but I think it was definitely an intent because as categorical programs the Congress pretty much had lost control of it. The vested interests in those categorical programs became so powerful, and particularly when they amalgamated themselves they became so powerful that the Congress just had to deal with it. By putting it into the block grant, they successfully wiped [out] or at least canceled out a great deal of the clout of the categorical interests.

G: Did the Partnership for Health have the effect of changing the balance from formula funding that supported more rural states to a replacement that was inclined to allocate more funds to urban states?

EG: You mean in the new block grants?

G: Right. Was there a rural versus urban tension there?

EG: I'm trying to think of how that was dealt with because I know it had to dealt with, but to tell you the truth I don't recall how that was dealt with. I do know a number of things happened with that. Certainly one was that the ability of the federal government to have a significant impact on happenings within states and local communities was considerably reduced on the basis of that change from categorical to block, because whereas on the one hand you had a happy constituency receiving that grant, you also had a benefit from the federal viewpoint of being able to set standards. And that was frequently the major purpose of the federal intervention, to provide a floor of standards which would be uniform across the country.

And as it got out of that and got into the block grant, they tried to simplify those. There was a great request for simplifications. You

can just imagine the governors' conference and what they were hammering for, "Don't tie our hands with all those bloody requirements and regulations that the agencies will put on us. Don't put any in there. Just give us the money and we'll do a hell of a job." But that isn't the way it happens. The states, although they promised with all their hearts crossed and everything else that they would solve the problems, without the standards, there was no mechanism to hold their feet to the fire. There were some attempts at it, but they just had no teeth and the states recognized that very quickly. I can't say that the states aren't trying to do a job because in most instances they are trying to do a job, but then they begin to set their own standards, and they become subject to their categorical interests, and the next thing you know you've got a hodgepodge of everything and nobody really knows what's going on. And your ability to get data is shot down at the same time, because frequently with all these categorical grants there was tied a reporting system. So you were able to get in most instances very good quality data on what was going on. I know I feel very concerned today that the quality of our data on what's going on out there isn't worth very much. That's of great concern because if you haven't got basic data, basic information, you really have lost a tremendous amount of ability to know what's going on.

I think that legislation had a major impact and I'm not sure--I know for a fact that we didn't realize the consequences of that legislation at the time. There were a lot of things going on that made the proponents win out on that legislation, even though there was concern. But the major factors coming to bear that no one really foresaw, because

they were coming from so many different angles, in my estimation did not serve the country well, the effects of that. For one thing, the planning legislation was so late in coming, we had gotten so far into the organization of a cottage industry, that to try at that late stage to force those people to do some really honest planning was just more than the system could handle. And the legislation was queasy enough that if you wanted to thwart it, it didn't take any major effort or any effort to do it; you could do it easily. And I know it because when I retired from the service I became the head of the first planning agency in the state of Maryland.

So I took that legislation which I had helped to get passed in Congress and I had to implement it in the state of Maryland. I had a bear by the tail, no question about it, as did every other state because when you start monkeying with--for instance, telling a hospital whether they can or can't do something, you've got one of the biggest bears that you can get hold of. That's really something.

G: Is that just because of the clout that is there, the influence?

EG: Yes. Every community wants a full-service hospital. That's where we start in America. Whether you have five thousand people or five million people, every community wants ready access to a first-class hospital. The idea that there may be duplication or whatever, or inefficiency, just is intolerable. Usually every physician, of course, wants his hospital to have the best of everything for his patients. That's a perfectly normal-sounding kind of thing. So if anybody thinks you're going to get in the way of that, you're going to come up against some pretty strong opposition. And that's exactly what happened. Most community

hospitals are, if not controlled, certainly influenced by the major decision-makers in that community. And when those major decision-makers feel that their baby is being tampered with, they're going to come out and want to know about it. That was really something.

G: It interesting to have seen it at the federal level and then on the state level.

EG: Yes, it was fascinating. Then I saw it even further down when I got all the way down to the county level. Fascinating.

G: In retrospect, would it have been better to have left the system in place as it was?

EG: It wasn't all bad. I think the results--a lot was learned from the planning legislation. I think a lot of eyes were opened locally that probably the legislation couldn't have opened unless it took on that issue. When I say eyes opened, I think a lot of the people in community--because what the legislation did, the good thing it did was to require that the local communities and the states put together advisory bodies comprised not only of the people operating health care, the so-called health care providers, but also the health care consumers. And by putting all those people in one room and making them discuss why do you need to build this? and why should you have this? everybody had to defend what they were doing, frequently for the very first time.

I can remember the chief of surgery over in a suburb of Washington having to come before a group of people, some of them--he might say, "These ignorant blacks, what the hell do they know about my operating suite? I need a whole new wing on this hospital just to house the operating suites." This guy had to come in and defend this, explain it

and defend it before a whole bunch of people that didn't know beans about the health care system. Now that guy a year later I met, and he confessed to me how much he learned from that experience, and most surgeons have a pretty good ego as you are probably aware, and for that man whom I had not known at all prior to that engagement, that set-up, coming to me and confessing that he learned a lot and had become--I would not say a humble man, but had a great appreciation for the need to justify what had to be done in the growth and development of a health care institution.

I think a lot of people learned from that and are willing to go through some of that thinking. Unfortunately, there are still a lot of people who don't want to be put through that discipline and who want to do as they damn please. Of course that costs a hell of a lot of money and wastes a lot of resources.

We've got an extremely complex health care system and to attempt to put in some type of nationally uniform system is almost impossible. So we lost a lot in that program but we also gained a lot. And then, to the harm of planning, the program was converted into a cost containment program, and that made a policeman out of it to stop people or tell people how they could and couldn't spend their money. Of course that was the death knell of the program. That was simply intolerable. It couldn't do the job and it was allied with planning; therefore, planning's bad because this thing is bad. I think that was an unfortunate turn of events and it was in part, if not wholly, brought about by the federal--absolute almost panic in being unable to control hospital and medical costs. They're looking for anything. They've tried now I guess

half a dozen gimmicks here in the last five or six years, none of which are working, obviously. That was just one attempt at trying to grab on to something and try to make it work.

Tape 2 of 2, Side 1

G: You were going to talk about the heart, cancer, stroke legislation.

EG: Heart, cancer and stroke. I was saying that that was very timely legislation, very popular legislation in that it came at a time when we had accumulated, in a variety of major centers around the country, a lot of technical capability in the diagnosis, the treatment and the identification of problems in the heart, cancer and stroke field. [It was] also timely because of course the three major killers were in those three categories. So it was very difficult not to be a hundred per cent in favor of that legislation, and in the manner by which it was implemented it provided a source of grant money throughout the United States via a mechanism involving the major medical centers in the country. They were invited to establish a central program concerned with the implementation of that act, and frequently it meant bringing more than one university into cooperation with another.

An example right here would be Johns Hopkins University and the University of Maryland. The grants were a single grant in each state so it meant if they had multiple sources of capability, they had to figure out a way to bring them together. I know in Florida, for instance, it was a joint endeavor of the three centers in Tampa, Gainesville and Miami. Three major university centers went together and provided staff and a coordination of programs whereby they would translate these latest research findings of capability in diagnosis and treatment into the

average community. That was their mission, to take that from the university center and get it out into the general practice of medicine. [That] was a simple way to say it.

They used a lot of methods of doing that. One of course is public information and education. They had money to do a very creditable job of informing the public of what they could expect if a member of their family was stricken with any of those three problems. The medical profession was given a very intensive continuing education program on subject matter so that the average physician in the average community would be more knowledgeable in how to treat his stroke victims, and treat his heart attack victims, and his cancer patients; with first-class seminars, you name it, the methods of teaching and continuing education were applied first-class. Top quality people were recruited to deliver these messages out in the hinterland. In the past it often would be quite difficult for you to expect that a general community hospital in Podunk would get the chief cardiac surgeon from the top state university to come down and talk to their little bitty medical staff, but that's exactly what happened.

Many institutions were encouraged to establish coronary care centers, for instance, which was a very concentrated method of treating people who had had coronaries, by setting aside some special beds in their intensive care units, things of that nature. Very specific, very realistic and very capable of getting prompt immediate results. That happened all over the country. So to the extent that those funds were available, I think they got a lot of mileage from that.

G: The emphasis then was not so much on research as it was disseminating the results of research.

EG: Exactly. Some of those monies were used for a type of what you might call applied research, rather than basic research, in finding out such things as what happens to, [in the] first instance, stroke victims after the stroke has occurred; how many of them go on to rehabilitation, what kinds of rehabilitation; to help the states and the communities identify the problem and where they could best apply their money. They might find that the initial treatment was excellent, but that patients were being sent home after three weeks in the hospital, [having] regained a lot of their ability, we'll say from a stroke with certain partial paralysis, [then] sent home with no follow-up and three months later they're back where they started. So they learned that what they need to do--the initial treatment was fine, but they've got to plug in a follow-up for the first year or two to make sure that individual continues to do their exercises or wear their brace, or whatever they're supposed to do to maintain the benefit that they achieved while they were in the institution.

So it was very practically oriented and the attempts were made, and I think in most instances were quite successful, in obtaining crackerjack individuals who knew how to do that kind of thing. And they didn't let that money fall back in to the so-called basic research and not obtain the objective that the legislation intended. It really did a good job.

There was a national body that kept an eye on how it was going nationally, that kept up a very high visibility of top quality individuals in the various fields. It was a well run program, very well accepted.

G: Was this the result of Mary Lasker's lobbying and that of others like her?

EG: Yes.

G: Any specific recollections of how they got the legislation through?

EG: I think they had a pretty good pipeline in making known their ideas, and there was some concern that I think had developed around the country that a heck of a lot of money was being invested in national institutes of health that undoubtedly was doing great good in research, but there was difficulty in showing how this research was benefiting the average citizen. I think through that concern was born the idea of, "Look, we have a lot of good technical knowledge but unfortunately it's not getting disseminated." And there had been a few pilot projects--in fact, in my own program in chronic disease we had established several pilot coronary care units. We already had the data that these things could save lives in a remarkable fashion, but we had no real mechanism to extend those beyond the demonstration. In the traditional method of doing business it would be years and years and years before we'd get that word around. Now we could write articles and they'd appear in journals, but there are lots of journals and it takes time to read them and so forth and so on. Moving through that process is a slow, laborious task. So the idea of this commission and bringing in a national spotlight and giving substantial publicity to it, and then giving it sufficient funds to make it attractive so that an institution would free up its top people, was a very bright idea and very timely. I think in the orchestration of the support for that it was not difficult to enlist the support of academia to the need for this, because traditionally, I

think, academic institutions come under periodic criticism for staying home too much and not getting out in the hinterland. I think it's a very valid criticism. So a stimulant every so often to kick them out of the ivory tower and get them out into the hinterland, and tell the general public what they know, is worthwhile. This essentially was that kind of endeavor.

It was timely and there was plenty to put on the plate. It was readily acceptable out in the communities so it was a very successful program.

G: Was the AMA opposed to it initially?

EG: Not to my knowledge. The only opposition that I was aware of came from some concern that the academic people might try to put some kind of imprimatur on the way things were being done out in the community. And the local physicians, there's always that town and gown situation where they were happy to receive the information and happy to receive equipment and all the rest, but they didn't want to be necessarily strapped down to certain methods of using all those things. Obviously, certain of the experts felt that there was only one way to do things and it was their way. That had to be carefully tended to to make sure that that didn't occur, and to my knowledge it didn't occur enough to cause any damage.

End of Tape 2 of 2 and Interview II

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