INTERVIEW I

DATE: April 18, 1969

INTERVIEWEE: DR. ROBERT QUARLES MARSTON

INTERVIEWER: STEPHEN GOODELL

PLACE: His office, National Institutes of Health, Bethesda, Maryland

Tape 1 of 1

G: This is an interview with Dr. Robert Q. Marston, presently the director of the National Institutes of Health, and today's date is April 18, 1969.

Dr. Marston, I would like to ask you to begin this interview by providing for the record your own background, which would involve I guess some of your appointments, your professional training, how you got into the area, and how you got to be director of NIH.

M: I was born in Toano, Virginia, in 1923. I went to college at Virginia Military Institute and to medical school at the Medical College of Virginia. While there I applied for and won a Rhodes Scholarship and spent the years 1947 to 1949 in Lord Florey, then Sir Howard Florey's, Laboratories at the Sir William Dunn[?] School of Pathology in Oxford. And [I earned] a research degree, a Bachelor of Science degree there. I came back to Johns Hopkins and subsequently to Vanderbilt and the Medical College of Virginia for training in clinical medicine, in internal medicine. This was interrupted by two years when I was in the army and was stationed at the National Institutes of Health, on loan here actually to carry on work in the role of infection in whole body irradiation. This was my first

contact with NIH, and I had two delightful years, 1951 to 1953. Subsequently after going back to Richmond I did consult with NIH, in concluding some of the work that we had carried on, over the next five years or so.

I was at the University of Minnesota in the department of microbiology and immunology, was associate professor of medicine at the Medical College of Virginia, and then assistant dean and then became dean of the new school of medicine in Jackson, Mississippi, in 1961. During the time I was there I continued to have contact with NIH and was chairman of the postdoctoral fellowship review committee over a period of some years then. During my period of time immediately after completion of my training I was a Markle Scholar, and I have kept close contact with the Markle Foundation and its interest in medical education over the years. I've been active in the three areas of medicine--research, education, and the care of patients.

Among the various organizations and activities, I think I would probably pick out the Association of American Medical Colleges as one that I gave considerable amount of time to. I served on the editorial board of the Journal of Medical Education, and then was elected to the executive council of the AMC during a period of time when it was seeking a direction in terms of its role in medical education and the very major changes that medical education seemed to be undergoing in this country. I have been a member of honorary societies, AOA, and received an honorary degree recently near my home town, at the College

of William & Mary.

In 1966 I came to the National Institutes as associate director of NIH and as director of the Division of Regional Medical Programs.

G: Could you describe what brought you here?

M: Yes. I had been talked to off and on over the previous years with Dr. Shannon and Dr. Sessoms about the possibility of coming to NIH, either in the role of an institute director or on his immediate staff. I had felt two things really: that a dean of a medical school has a responsibility for continuity of effort over some period of time, and that this really required a commitment of four or five years as a minimum. Secondly, I was very much involved in Mississippi and the problems of a new medical school and the problems of being a focal point for the major integration activities of the country, and actually the transition over that brief period of time from what was essentially a segregated to a fully integrated institution while one continued to carry out the responsibilities of a medical school and teaching hospital, which I think we did quite successfully. So I had not been interested, actually, in making a change, and indeed had not been interested in leaving academic medicine. But I had said if there were an opportunity to play a major role in the broad area of the relationship of academic medicine to the problems of society, that I would be interested in having a call and discussing it further.

So I think within days after the passage of the heart, cancer and stroke amendments I got a call, first from Doctor Sessoms, asking

me if I would come up and discuss the possibility of being the director of the Division of Regional Medical Programs, which would have the primary focus of relating, in a cooperative fashion, the academic and other strong institutions to the actual practice of medicine. So it was a challenge of this opportunity rather than any desire to cease being a dean or an academician that brought me [here]. Well, perhaps we'll want to come back to Regional Medical Programs later, but I was the first director that brought together the staff and was responsible, with the help of many people, for launching the program.

I remained in that position until April 1, 1968, at which time Secretary Gardner asked me to become the first administrator of the Health Services and Mental Health Administration. I took on that post the first of April and remained in that position until September 1, 1968, at which time I became the director of the National Institutes of Health.

G: Okay. Could you describe what kind of a process there was back in 1966 when you came to NIH in terms of confirmation? Was that strictly under the authority of the director of NIH?

M: Well, normally [with] the higher level appointments at NIH, the appointment authority is and was then the director of NIH, but it has always been customary to check these with the surgeon general and with the secretary's office. There was considerable interest in this program. As you may recall, it was the outgrowth of the President's Commission on Heart Disease, Cancer and Stroke. Copies of this had been sent to every physician in the nation. There had been a vigorous

discussion in Congress and much clarification of the type of program that this should be. It also carried the imprint of the President's personal interest in this program.

What happened was, Dr. Shannon asked me to accept the position, and with full understanding that the necessary paperwork would have to be done and that no firm commitment, as is always the case, in government could be made until all the security clearances and job qualifications had been checked out through Civil Service. In the midst of that I got a call that said that something new had been added, that the White House had asked that all senior appointments actually go through an interview process at the White House. I was the first experience as far as NIH was concerned, and they didn't know quite how this would work, but they would let me know. Finally I was asked to fly out and was asked to go to the White House and did meet with Mr. Marvin Watson, who said, "We all know you and we all like you. We just wanted to meet you." That was the extent of the meeting. The process went on for a few months more and then was dropped, but it was an interesting [experience].

G: That was the extent of the interview?

M: Only words of encouragement and a statement that, "You do have a contact with the White House. If you need any help, then you should feel free to call me. The President is interested in this program, and he's interested in you."

G: What was your mandate at that time? What were you charged to do?

M: To start a new program that many felt had little broad support at

that time because of some confusion and fears as to the nature of the program. There was a misconception and early fear that what the President's commission had recommended was the establishment of a federal network of centers for heart, cancer and stroke treatment which would siphon off from the mainstream of medical practice those patients with these diseases. This had emerged as a major concern during the congressional hearings and was still present in the fall of 1965, with some suspicion, misunderstanding on all sides. Another concern was as each group looked at this program there was a tendency to say, "What will it do for the medical schools? What will it do for the hospitals? What will it do for the practicing profession? What will it do for nurses?" The concept of regionalization, that is of sharing resources and focusing on the needs of the region rather than the needs of the institution, was part of the job.

Dr. Shannon, I remember in talking with him early, had expressed his opinion that this would be a difficult problem, to move into a complex area where the stakes were high and where the difficulties were great. I probably should add that there had been considerable discussion concerning the location of the Division of Regional Medical Programs. Some had felt that it should be sort of an autonomous unit, some had felt that it should be in one of the other bureaus, and there had been vigorous debate. I was told when I first came that the division would be set up so that it could be moved at some subsequent date. This was one of the reasons for having direct access to the office of the director, to have the associate director

title, and to have my whole structure in a way that it could be moved in toto. Although at that time I think Dr. Shannon and others really felt that it was going to become a bureau in its own sense, not anticipating at that time the type of reorganizations that we have had subsequently.

But the main reason for its being put at NIH was the fact that if it were to have the opportunity to relate the findings of research and the conditions under which the most sophisticated, complicated and difficult medicine could be practiced, a relationship of those institutions and organizations to the community at large, it was essential that it start with a firm foothold in the academic institutions and the groups that had worked so closely with NIH over the years.

G: In your experiences in directing this program, in terms of some of the problems that you faced at the beginning, could you make an assessment at this point as to how they were overcome, whether some of those problems may still exist?

M: I think the biggest single problem which does still exist is the experiment of whether one can achieve a purpose that everyone can agree to; that is, to have the best of health care available to all the people in an area, whether one can do this through a voluntary, cooperative type of arrangement in which the inducement is sort of self evident benefits and federal dollars as opposed to a regulatory type of approach. The second question, and [one] related to this, had to do with the question of whether one can do this without an established power source. In other words, what we set up was what I

called a "power probe," in which we said, "All right, let the local region come to grips with how it can best fit its needs; subject this to a national peer judgement but don't start out with the assumption that the basis will be municipal government, a state government, or some pre-existing area." I think the goals of Regional Medical Programs have always had to be looked on as being limited in the sense that it could not do all things to all people.

One of the areas of misunderstanding, in addition to those that we have talked about earlier, is some looked on this as being purely a continuing education program for physicians. So part of the job was and is to say that the purpose is to benefit the patient using whatever mechanism one can, continuing education, the purchase of equipment, working together of two or more institutions to save scarce resources, scarce manpower, rational planning, anything that it took to improve the care of the patients rather than any one mechanism. I think the problems--first let me say that the program moved more rapidly than any of us expected under these types of constraints. The problem that it ran into was the constraint of dollars, and this I think has been a major problem.

We made the decision, perhaps in error, that we would put the emphasis on establishing a sound program, not on spending the dollars in the early years. Well, one example, there were twenty-five million dollars voted in supplemental appropriation in October. The division was not established until February, and I think it would have been somewhat foolish to have spent all of that twenty-five million dollars

between February and July in a new program with guidelines that were still being worked out. So there was some carry-over. There was two year authority, and there was some carry-over in the early years. When the program reached the point, as it has now, of needing sizable dollars for operational activities, then the dollar constraints have come on and have been difficult.

A second major problem has been the concern about all of the various planning mechanisms that have emerged. While the planning in Regional Medical Programs was to develop a program, not planning for planning purposes, there was confusion between that and the partnership of health legislation, the Hill-Burton planning activities and various other programs, which has continued to be a problem for those running the program.

G: You mentioned there was subsequent reorganization that affected this program. Could you elaborate on that a little?

M: With the reorganization, which was stimulated by Secretary Gardner and actually put into effect by, I guess it was Acting Secretary Cohen at that time--and then he subsequently become secretary--a new organization, the Health Services and Mental Health Administration, which was to have the responsibility for the federal government's role in the organization and delivery of health services broadly, as well as having the research responsibility in mental health itself, was established. It was proposed that the Division of Regional Medical Programs would be a part of that administration. There was concern by those who had been interested in Regional Medical Programs about

its separation from NIH, and I think there still is some concern of that type.

G: What was your own feeling at the time?

M: I had been asked in the fall of 1967 to comment on some of the plans for reorganization, and my recommendation had been against reorganization because I thought it had not been worked out, and specifically against moving Regional Medical Programs. I had an ample opportunity to display with charts my concerns about this, and I had an opportunity to talk with Secretary Gardner and to tell him that I felt that he should not reorganize at that time. And it was that night that he asked me to become the administrator. So my feeling was that there was ample opportunity for discussion. The problem was whether it would ever be possible in a rational fashion to think out a reorganization of the health function, or whether it was indeed going to be necessary to make some moves and then to work out some of the details subsequently. I could see the logic of both sides of this. My own feeling has been that we should not do it, but once the decision was made, I felt that I had ample opportunity to make my views known and was able to move enthusiastically into it.

Once having made the decision then that there would be an agency of the department that would have the responsibility for research and education and the Library of Medicine, an agency that would have responsibility for the regulatory activities in consumer protection, and an agency that would have the responsibility for the organization and delivery of health services, it seemed to me there was indeed a

logical rationale for having Regional Medical Programs in the Health Services and Mental Health Administration. This was where the new Center for Health Services Research and Development was to be established, it was where Comprehensive Health would be, it was where the broad responsibility for the support and federal determination of the building of construction, the capitalization activities would be, and I thought rationally that it did make sense for Regional Medical Programs. Rationally it could [also] have stayed at NIH.

G: What was the rationale for putting this regional program in NIH to begin with? It is an operating program as well as a research organization.

M: As I say, there was long debate about this. I think a number of things, and I sort of hate to put this one first, but I think the environment of NIH has been one in which it has been possible for new important programs to move rapidly. It has the confidence of the academic community. There was some greater ease in recruiting people into it. [That is] one pragmatic reason. Conceptually this was a program that was to span the activities of NIH and the practice, and so you could say that it was equal logic to put it in the NIH as to put it in, say, at that time the Bureau of Health Services, which would have been another place that one could have made the case. But I think more important, in terms of a rationale from my own standpoint, would be that the assumption was that we had made reasonable forward strides in the support of biomedical research. Predictably in the future, as this investment continued, the problem

of relating this advance--and I just don't mean new findings, I mean the whole ability of our best institutions to do things that are not available to the community at large--would be an increasing problem, and how did one, if you will, bridge the potential gaps of the future?

I think another thing that was probably important was to be sure that this was not set up as something in competition with research support, but rather as a part of it. Because there was concern at one time that this would be at the cost of research, and I always said at the beginning of all of my talks that one could justify a regional medical program only if the nation could continue to expand its support for research. If it had to choose one or the other then one should not have a regional medical program until such time as the country could do both. But as I say there were vigorous debates, and I guess it was Surgeon General Terry who made the final decision to place it at NIH. He had strong advocates on various sides.

G: Did those advocates continue their advocacy at the time of the subsequent reorganization?

M: There was some discussion of concern, both by the individuals in the field with responsibility in Regional Medical Programs, by members of the council, by members of the President's commission. I don't know how many names you want out into this.

G: Feel free to--

M: Dr. DeBakey and Dr. Farber I know were contacted specifically by Secretary Cohen to see the degree to which they would object to its being moved out. They both talked to me, and they both said that as

long as I was going to be the administrator of Health Services and Mental Health Administration that they would not fight it, the move. They agreed, as I did, that looking at it only from the standpoint of Regional Medical Programs that it would do better as a part of NIH. About this same time, and I guess we better spread everything on this that we can, there was a strong movement from the mental health group to keep mental health from being a part of Health Services and Mental Health. This had an adverse reaction in the Secretary's office, and it seemed to me and to others that as long as we had the opportunity to make our case we should not go out then and start a campaign to sort of fight the movement.

So I think there was concern. There was one meeting of program coordinators, in which I was asked my advice, in which I said essentially what I've said here, and there was no outcry or real fight to either keep it in or to move it out. In part, I think the concept of the rationale [was] having it in an agency that had similar activities, and at that time . . . The biggest concern I think that all of us had was that it was being moved out too soon. I think that perhaps Dr. Olson has had that feeling since he has been director, that it may be in the right place but it would have been better if it had stayed here for another year or two.

G: I gather that this was Cohen's decision, the reorganization.

M: As I say, my first discussion was with Gardner, and the request that I take over the job came from Gardner. So I think the most accurate statement would be that Cohen decided to implement the decision that

had been made by Secretary Gardner in consultation with Mr. Cohen, Kelly, Lee and the others in the department. Now when Mr. Gardner did leave none of us knew what was going to happen. Subsequently Secretary Cohen did--I remember this--call me out of my hearings on the continuation on the legislation for Regional Medical Programs when I was testifying and say, "I've got to see you immediately. I've just left the President, and I've told him that we've all got to go forward with the reorganization and that you are my choice for the administrator of Health Services and Mental Health Administration." The President asked me if it was sure that I would accept it, because at that time I think there was some concern in the--this must have been about the time he had announced or was about to announce that he would not be running.

G: That was March 31.

M: Well, he probably knew it, but he wanted to be sure that he wasn't in the position of offering a job to somebody and then having it not taken. So Wilbur Cohen called me and said, "Would you take it?" He said, "You know that we had talked about it in the parking lot, and I've assumed that you would. But when he [Johnson] said, 'Have you actually asked him?' I had to say, 'No.' And so, 'will you?'" I said, "As I told Gardner, I think that I'm in the spot that I should be [in], but if you want me to, then I will."

G: As long as we are talking about Gardner and Cohen, could you for the purposes of the tape indulge in some sort of a statement about each man?

M: I worked much more closely with Cohen, because at the time that Gardner was secretary I was several echelons down: there was the Surgeon General and Dr. Shannon and me. Whereas with Cohen, as an agency head this meant that I had weekly staff meetings with him and worked more closely. Then particularly when, again against my recommendation, he recommended me for the directorship of NIH, we had discussions, and I worked with him more closely. So let me just say, as far as Secretary Gardner was concerned I know he created tremendous respect among the people in the department. We all had considerable concern when it was obvious that he was going through these problems of deciding whether he was going to stay or not, particularly I guess it was after his trip back from the Ranch, when even those of us fairly far down felt that something was amiss.

I've talked to him recently, and I've got an appointment to talk to him to, among other things, let him know how he changed my life a little over a year ago. His statements, I remember when he was out at NIH, and his written word--everybody in the world is impressed with these. I think there was a sense of change, in that clearly Wilbur Cohen had ready access to the President and a type of support which, again I gather from a distance, it seemed that Secretary Gardner did not have in the latter part there. I don't know whether this is the type of thing [you want]. You have more accurate information on this.

G: Surely. From the point of view of having served in various capacities under both Secretaries, [although] the approximate relationship would

have been closer on the one hand than on the other--was there any indication of a change of direction or any indication of an interest in certain kinds of programs than [there] had been previously, and along these lines?

M: I think, as you probably gathered from talking with Dr. Shannon, he felt that he did have very close relationships with Secretary Gardner. I know in sitting around the table here that we discussed this. So the relationship of NIH, the sense that Gardner was deeply immersed in the whole problem of higher education in the country, was knowledgeable in this area, had an appreciation of the value and necessity of research, was clear. In contrast, it is interesting that Gardner chose to go into the societal problems subsequently. So the sense of sort of community an easy communication in terms of common interest, I think, was apparent from the background and from the expressed interest of Secretary Gardner. The concern is always of how one translates these into operational programs, but there was no question about the sense of support for NIH. He made one trip out here specifically to put the academic community at rest, in which we had all of the scientist advisory group in the auditorium to hear a talk by Secretary Gardner.

Now by background, and by contrast I think, Wilbur Cohen's contributions over the last thirty years have been in the welfare/social area. His strengths have been as a professional in the department who knew the department in depth and who knew the Congress in depth and who is a very, very skilled person in the broad political scene

and had been for a number of years. So the question was raised in many people's minds as to, first, whether Wilbur Cohen would become a lame duck with essentially a caretaker role until after the election; and secondly, whether his interest would be so deeply in the areas of his past interest, his actions would be so restrained to his interest and contributions of the past years, that perhaps some of the other things would not attract his interest.

Well I think neither of these concerns eventuated. First, he did move in an amazingly short time, and I think to his great credit took a department which is important, large and complex and created a sense of action and a sense of motion that was probably very important at that time. At no stage was he ever a lame duck secretary, which he told me he told the President he would not be. [There was] just a flurry of activity right up until the time that he left. In addition, as far as NIH was concerned, despite the fact that things were very, very tough, I think that he did have during that period of time as a very high priority not doing things to hurt the academic base. The dollar constraints were becoming quite keen, and it was not and is not an easy time for anyone in this area. Perhaps that answers your question.

G: Yes, thank you. You've mentioned the dollar constraint twice. When did you first begin to feel the pinch, approximately?

M: I think when we were going up for the Regional Medical Programs extension. Here was a program that had been conceived and indeed authorized in the multimillion dollar level. We had spent a year in

preparation of the report to the President, which had been required by the law, and had anticipated that we would be talking in terms of four and five hundred million dollars. And it was chopped down while people at the same time were saying, "The program's a great success. It has attracted talented people throughout the nation to work in it. The progress is uneven, but there's no question but that it's moved from a program that was one of suspicion to one that has the support across the field." So I think that was my first realization that we were running into dollar problems. Then of course the most difficult period was the period in NIH when we had to go out last year and renegotiate the so-called moral commitment grants, the ones that had been sacrosanct. Investigators, you know, would get a grant with dollars allocated for the first year but with a commitment for the second, third, fourth, and fifth year. We had to go back on those the second year and renegotiate down on an average of about 15 per cent, and this was a very, very serious awakening, both inside and outside of the seriousness of the contraints.

G: Who did the chopping? Were you or others in HEW in these various divisions and various programs in the year-to-year appropriations, if not authorizations, if you didn't need to go for another authorization, [doing it]? You had a two year, I believe it was, on the health.

M: I don't know how much time we have spent in talking about the NIH situation, but the research part of NIH has not had to go back for authorization. It's had an open-ended authorization for the most

part, there are some exceptions to that--construction for instance does require recurring legislation. Thus, in contrast to the usual process of enabling legislation followed by specific yearly appropriations, for NIH both functions have been carried out by the appropriation committees. The appropriation committees have conducted unusually detailed NIH hearings with NIH in part because of this. I think that one has to say that the dollar constraints came first from about 1964-65, and the rate of increase of dollars did begin leveling off, I think as a policy determination as well as some constraints of dollars. But I think the fact that we have not increased the number of grants, either training grants or research grants, since about 1964 or maybe since 1963, despite the fact that the dollars did increase for a few years more, pointed up that we were not growing as we were previously. Of course, everyone recognized that the type of growth that we had between 1955 and 1961 was not going to be maintained indefinitely.

G: That was a pretty phenomenal growth.

M: Yes. It was a phenomenal growth, but there was growth in other areas involving investment in research and science. It was a period of growth in NIH more than in any other areas.

But then the real sort of vigorous awakening I think came in the duel between the President and the Congress; first with his attempt to constrain the budget sufficiently not to have additional congressional action, and then this was followed by the Expenditure Control Act and the fact that in a situation such as ours in order to get expenditure controls one has to start in the previous year. So [as to] your question as to where the cuts were made, the broad cuts were

made in the Executive-Bureau of the Budget-Congress axis. The method of implementing was determined by NIH with approval of the Department, and there was a difference in the method of implementing this between the National Science Foundation and the NIH. There were different situations. But I bring this out as an example that the decision of how to do this and how to implement it was one that we had choice in.

G: Has this hurt the program, do you think?

M: NIH?

G: Yes.

M: Oh, sure. When you take resources away from a program, then it hurts it, yes. But I think it's hurt in another way, too. I think the relationship between the federal government and the non-federal establishments has always had some degree of suspicion. I can remember the earlier days of NIH in which institutions would say, "You can't trust the federal government; therefore, we should not make commitments that require long-range investment on our part when the best we can get from the federal government is a one year bit of money and where this is a one-sided negotiation." This came up in recent years in two areas, one in which I think the institutions were at fault and in another in which I think the federal government had a problem.

The first one was the so-called clinical research centers reimbursement. This is sort of a technical thing, but the federal government said, "We want to get some clinical research programs going.

It's hard to get these started, so we will make a guess that about 85 per cent of the beds will be occupied. We will establish our estimates on that figure." There was some fuzziness in communication. The assumption was the institution would then have to come back and justify the use of the dollars. It would not be a gift for this purpose that they wouldn't have to pay back. But that led to a long debate and struggle and some academic institutions having to pay back sizable amounts of money.

Secondly though, at the time the Health Education Assistance Bill went through, there was a requirement that in order to participate, to receive the basic improvement grants, institutions would have to increase the numbers of students. The institutions increased the numbers of students, but the federal government did not come up with the dollars to carry out the basic improvement grant in full. Well, I give this as the type of background that always leads to a certain amount of tension between the meeting of individual needs in institutions, individuals, investigators, and the unpredictability of the federal government.

One thing that had stood at NIH as the starting point of our budget each year was the noncompeting continuations. That was where we started, and we either went up or down on that. When a year ago we had to go back and renege on this, then I think it reopened the whole problem of the unpredictability, or the difficulty, of having predictable support from the federal government. This has raised for a number of us the problem of how one designs the best system

that allows one to use the peer judgment of national quality standards, if you will--and this has the limitation of unpredictability, the possibility of going up and down in support at any one time--versus the sort of formula support, however it may be, per capita or what have you, which tends to have a greater stability in terms of administrative and congressional understanding of the difficulties of cutting into this and tends to stabilize institutions. But it also tends to homogenize institutions and make it more difficult to be able to put resources, either local or national, in a way that gets the best in achievement. Now I think the peer judgment in the research area has a higher priority than, say, the peer judgment in the support of an educational process. But one needs it in both of these areas. Well, this type of problem, I think, was created in addition to the dollar shortage.

One final thing that I am very concerned about [is that] in general there is a growing feeling that biomedical research, academic medicine is no longer a profitable field for young people to go into. I think we run the risk of losing talent at a time when there is a surplus of a million young eighteen to twenty-two year olds who are making career choices, and at a time when I think as one looks to the future, and I have just done a speech on this, probably the most important thing for the nation and for mankind is indeed to get a better understanding of the nature of life processes and the nature of man. I think it's hard to back off and look at that as a justification for an allocation of resources. I

didn't mention the President very much, but one of the things that came through very clearly was his strong dedication in the health field. This was a special and strong dedication, and it's one that all of us felt, I think.

G: Perhaps we can get into that now.

M: Am I talking too long?

G: No. No, not at all. When was your first contact with the President? You mentioned that you had been interviewed by Marvin Watson in 1966. At what point in time did you first meet Johnson?

M: That summer when he had the institute and division directors down to the White House to discuss what sounded to us as to how one can get the fruits of research out to the people. I was present at that meeting and spoke briefly about the Regional Medical Programs at that time.

G: Could you elaborate a little bit on that?

M: Then subsequently he came to the NIH and met with us at the clinical center, and then with a larger group as a follow-up really, and also at a time that Dr. Shannon presented him with report which had grown out of that meeting. I think you've covered that in other areas.

G: What did the President say? What were the kinds of interests that he expressed? You said that one point that came through was getting this to the people.

M: At the 1966 meeting in the White House there was, quite frankly, concern that the President was going to insist on a division of activities, from sort of the inquiry into the basic nature of life

processes to a premature emphasis on the application of research findings on targeted research. This is something that is always very much on our minds, because we are a mission-oriented agency which has the job of using research in our educational, biomedical communication to improve the health of the American people rather than being an agency to support basic research for its own purposes. So there was concern that the balance was being tipped, and with the prestige of the President's office that we would have problems. I think there was a concern that the balance was being tipped, and with the prestige of the President's office that we would have problems. I think there was a concern through the academic community at that time, too.

G: Is this to say that there was not perhaps the proper understanding of the nature of research and perhaps too much of an emphasis on the application of results, not so much instant application but a greater desire to have solutions, to have problems dealt with and solved?

M: I think so, yes.

G: It's the difference between pure research and the application of findings.

M: I think there were two concerns. I don't think anyone knows what goes on in another's mind in terms of the understanding of the nature of research, because at no time was there any suggestion that he was against research. It was coming from the President's office at that time what would sound like, you know, "Okay, we've done the job in research. Now the job is to go into either massive, targeted research areas or to find out how to get the research findings that are bottled up in the laboratory out into the field." Of several

examples of the types of problems that we constantly faced here, one was what was the state of the art in terms of an artificial heart? Should one have an artificial heart program as such, or should one recognize that the basic problems are the problems of understanding the physiology of the heart and have a broad myocardial infarction/ artificial heart program, one part of that being the artificial heart program.

Kidney was another one that was on our mind then and still is. Whether one puts all the emphasis on sort of building a miniaturized cheap kidney, or is really the long-range solution to kidney problems not more in the business of a better understanding of the causes of renal disease? It would be unfortunate if one built a gadget to serve a short time purpose at the expense of an understanding that may allow one to control streptococcal disease so that you don't have nephritis, or to get a better understanding of chronic polynephritis so that you can prevent it or, even in terms of treatment, get a better understanding of how one can modify the diet so that you in many instances perhaps don't need these complex and expensive and less than ideal substitutes for human functions. It seemed like an imbalance on this was possibly coming out.

G: These things you are describing are basic formulary problems in research and hypothesizing?

M: I think it's the ability to make the decisions on the best judgment of the state of the art; you know, not saying basic research versus applied research, but saying that one looks at the evidence and makes

the decision on the basis of the evidence, not on the basis of the assertion that one needs more in applied at the expense of basic research.

G: Could you continue on what you interpreted to be the President's interest or objections to what had been?

M: I think the sense was that, "Here we spent a lot of dollars for research. What's it done for me recently?" So I say, following up on that there was a meeting by Secretary Gardner to sort of clarify the record. It was viewed as an opportunity to produce the document which perhaps you talked to others about, a report.

G: Yes. Dr. Shannon describes it much the same way you do.

M: Obviously Dr. Shannon was in the key position, and I would suggest, in case you wanted to follow up on this further, that Mr. Murtaugh was another one. I would think that you would want to perhaps talk about this to people like Dr. Sherman, my deputy director, and Dr. Sessoms, who was the deputy director of NIH at that time. There were others, but these were the individuals who were carrying the actual responsibility at that time.

G: What about the report that finally emerged? Did you have anything to do with that?

M: No. Regional Medical Programs really was not involved in that for a couple of reasons. One, the purpose of the report was to display the role of increasing knowledge in benefiting the health of the American people, and the whole nature of RMP was to do this. Therefore, it was stated that there was a program and this was its purpose.

Secondly, we did have the requirement in law of producing a report to the President and Congress on the accomplishments of RMP.

G: In 1967 the President made a trip to NIH and I believe was briefed and was shown around and then made some remarks. Could you go into that a little bit?

M: Yes. I don't remember it in detail. The meeting with the institute and division directors was a relatively brief one in which he expressed pleasure at being there and the work that had been done. As I recall the whole visit was a pleasant one, and there was general approval of what he had said and a morale lift in terms of having the President drop in by helicopter and visit us.

G: Was there a perceptible difference in his attitude in that time span between the time when you first met in 1966, the report came out, and his visit in 1967?

M: I don't think I could have any judgment on this. I think the President constantly and right up until the time he left office was indeed interested in doing the things that would improve the health of people. I suspect at the time that he was out here he was more cautious perhaps, not to be misunderstood in terms of any concept of being against research, but I think he was, as the President perhaps should be, interested in the fruits of research, if you would. But I was not really in a position to make any judgment on this.

G: Could you continue this in terms of your personal contacts with him?

M: I think, actually, overall I had between six and eight contacts with the President, a couple of them simply being at signing ceremonies

such as the Regional Medical Programs extension. Then I was asked to come and meet with him concerning the directorship of NIH. . . This was last summer. I did go in, and I sat down and he turned to me and immediately said, "I'll tell you what I want you to do, I want you to be the director of NIH." He never asked me if I would. Of course I had already said to Dr. Lee and to Mr. Cohen that I thought it was unfortunate after only five months as administrator of Health Services and Mental Health Administration to move me to any other job. I felt that if there were any other alternative that this should not be done. I was assured that they had given serious consideration to this, but that they had recommended it to the President.

Then we did sit and talk some with the President, and he expressed his interest in NIH and in the work that was to be done and the fact that it was a tough job. As he said in a letter later: "It was a staggering job." [This was] evidence of his support and his interest. Then there was another meeting with him, on the occasion of his meeting with Dr. and Mrs. Nirenberg after Dr. Nirenberg was awarded the Nobel Prize. This again was a small group meeting with the President, and subsequently the press was invited in to take pictures of Dr. Nirenberg. Again he expressed his great interest and appreciation for the type of work in DNA that had been done. I guess the last contact, other than sort of signing and awards ceremonies, was a somewhat unusual decision to have a display commemorating the twentieth anniversay of the Heart Institute in the East Wing of the White House. There was a small program with an

exhibit, and the President and Mrs. Johnson came into that. He spoke at that time and then viewed the exhibits.

G: Was this one of his special concerns, heart research and the Heart Institute?

M: I think he was interested in heart research for several reasons. One, Dr. DeBakey was close to the President, and he was always interested in the work that Dr. DeBakey was doing and that others were doing as far as heart disease was concerned. There were times in which he talked about his own heart attack, and how he would not have been alive if he had not gotten the excellent care and the benefits of the best in medical science at the time of his own heart attack. And thirdly, I think he realized that heart disease among the various health problems of the nation ranks number one as a killer and is a major health problem. So I would say from these standpoints, yes, he did seem to have a special interest in heart.

G: Were there any others that you were aware of, that he made known to you?

M: He had been interested in the heart, cancer and stroke program as such. I've said a couple of times that he seemed to have a special interest in health, and I was thinking a few minutes ago as to what the reasons for this [were], what the evidence that I had [was]. I think I've already said some of the evidence, but I think in addition to that one should mention the large amount of health legislation that went in during the time that he was in which of necessity made him involved in the health problem, things such as the passage of Medicare. His

office did become directly involved, I understand, in the final negotiations and discussions of Medicare. Secretary Cohen towards the end of his time, and against the background of the type of financial constraints that we were all seeing, felt that the President had a special interest in health and that health would perhaps not have fared as well if the President had not been as interested as he was.

G: Given the nature of the constraints?

M: Given the nature of the constraints, yes.

G: What kind of relationship did you have with the White House other than the President? Were there other people who you talked to more than others, and if so what was the nature of that kind of a relationship?

M: I didn't have a great deal. I was down working some after the decision that I would be the director of NIH on the information to be made available. I met and talked to on several occasions Doug Cater and Califano, who were carrying responsibilities in the health areas, but no extensive contact with the White House over the time. I wasn't at that level.

G: Would these contacts have been because of congressional review or congressional actions on certain things?

M: Yes. This would be at times, or the appointments that I had.

G: Yes. Could you describe your relationships with Congress, the kinds of problems you had to face, the people that you felt were supportive of the kinds of programs that you were supportive of?

M: Well, Regional Medical Programs first. The first time I appeared before the Appropriations Committee there had been expression to the Surgeon General, when he had made his testimony, and to Dr. Shannon when he had made his, of interest and concern specifically by a Mr. Flood and a Mr. Laird concerning the direction and the pace of Regional Medical Programs. In both of their districts there had been rather slow movement, and both of them had made the point that, "If this is the exception then,fine, but if this is the way it is going over the country then nothing much is happening." Yet when I actually apppeared before them, then it was clear that this was more interest than it was hostility. I can remember on two occasions Mr. Flood saying this heart, cancer and stroke program was one of his special interests, and he thought it was the best thing since canned beer, which appeared in the Record. And at another time he said, "It looks so good, it is just like a trout about to pounce on a fly." So both of them, I think, had a real interest and were supportive of the program.

We had an intensive contact with the House Interstate and Foreign Commerce Committee at the time of the extension of the legislation, and then with Senator Hill's two committees, both the appropriation committee and then the legislative committee. I would say that with the exception of the dollar level in the authorization that the contacts with House Interstate were very good. There was concern expressed by some that the program, along with many others, had a much higher authorization ceiling than the administration had then

recommended as funding. They felt that this made them look ridiculous to their peers in Congress, and this came out in some of the hearings. But in general it was a friendly and supportive view, and the only real problem that emerged at that time--in contrast to the first time the bill went through when you may recall it went through by a one vote majority--was the dollar level. There was no question about extension of the program in Congress. I think it was unanimous, maybe it was with one vote, and there were some very good things that were said. The relationship with Senator Hill's committee was always cordial and friendly and supportive.

So, I would say that my experience with Congress there was a favorable one, with the concern the first time that we went up of why the program was not going along more rapidly. I had very little contact with Congress in the brief time in Health Services and Mental Health Administration, and of course this spring it has been under the Nixon Administration before the appropriation hearings.

G: What is your observation on the comparative role of Congress and the Executive vis-a-vis the programs that you've been involved with?

M: I think the President's office, through the establishment of the commission and then through its prestige, was the key point in initiating and carrying through the heart disease, cancer and stroke program. The implementation actually [was entrusted to] the special assistant to the Secretary, Dr. Dempsey, and Dr. Stewart, who was his deputy at that time, the present surgeon general. I have always had the feeling that in some of the other parts of the department there

was not the same strong support. In Congress, as far as Regional Medical Programs was concerned, I think this was essentially carrying out the administration's desires, although there were some crossings of party lines which were necessary to get the law through the first time. Subsequently I think Congress did become interested in it and perhaps more supportive in terms of dollar level, and the department was able to work under the types of constraints that it had.

As far as NIH is concerned, if I can go back and have my associate director hat on,too, it seems to me that increasingly in recent years the determination of the final level has been more within the administration than in previous years. In previous years, historically I think because the various administrations did not support biomedical research to the degree that the country and the Congress was willing to do it, Congress essentially grasped and maintained control of the funding level, and beyond that of the programmatic nature of the research activities. I think one sees a little bit of the possibility of the same type of thing occurring now as far as manpower is concerned. Congress is very interested in the support of the mechanisms of getting more physicians, dentists, nurses, allied health workers, and it is quite possible over the next few years one can see this type of interest emerging very strongly in Congress. I think this has been particularly true in the last couple of years. I think that probably answers your question.

G: In the Regional Medical Program, as well as NIH, do you coordinate with other executive departments, other agencies?

M: The Regional Medical Programs cross the field pretty widely. At our council meetings we used to have a grandstand of observers. Veterans Administration would have representatives there, as well as the Office of Education and many, many other areas. In addition to such obvious channels as the Bureau of the Budget and the sister agencies within HEW, the NIH has always had close relationships with the National Science Foundation, the National Academy of Science, the Office of Science and Technology--which previously had a deputy with particular interest in health areas, Dr. Ivan Bennett. There were also relationships with other areas of interest in science from the Department of Defense, NASA, AEC. So the answer is yes, there is coordination, as one would expect. I would also say that the same type of coordination exists with organizations outside the federal government in NIH's almost unique relationships with the academic societies, the scientific societies and the institutional associations throughout the nation.

G: Did the Regional Medical Program, or has it subsequent to its initiation worked with the Poverty Program? I'm thinking of the kinds of programs that were created in 1964--

M: Yes.

G: --and subsequent to that time the ones that have been added on to it and so forth.

M: I think there are a number of areas in which one can draw examples. One, we had a special meeting on the relationship of Regional Medical Programs to the urban problems. In Nashville we have supported several programs jointly with OEO. When I was still director of

the Regional Medical Programs, I had a visit from some people in Los Angeles concerning the problems of Watts following the riots when there was no hospital in the whole Watts area. The county made the determination to build a hospital, and the problem was, "How can you staff this?" from the standpoint of getting the type of competent staff on board before the building is actually completed. Following completion, the staff would be paid by the county. RMP was asked to participate, and Dr. Mitchell Spellman, supported by RMP, has gone from Washington to be the dean of the postgraduate faculty there. More important than the dollars was the mechanism to bring together UCLA and USC in a combined working relationship with the Watts Postgraduate Center and the Drew Medical Society, which is the medical society in that area. One could go on with other examples, but I think this is the type of answer you are seeking.

G: Yes. I wanted to ask also whether NIH and some of the research areas that it does take on had ever prior, let's say, to 1964, worked in the area of child development? Actually I'm sort of using diverse routes to get to my final question, and that is, to what extent is the applicability of research the result of something external to NIH? I'm thinking for example of public opinion, the whole emphasis on nutritional problems right now. With the inception of the War on Poverty, there were areas it would seem logical that NIH would be involved in.

M: [It] depends on how far one goes back. If you go back far enough, the Mental Health Institute was once a part of NIH. Because of that, it has emerged from our other institutes in that it has full responsibility, from research to actually setting up neighborhood mental health centers. There are two other examples: one, the Child Health and Human Development Institute was established to be involved in the whole problem, from research on mental retardation to being one of the best reservoirs of knowledge and opinion needed to make decisions in problems of children, behavioral and otherwise. Two, the Arthritis and Metabolic Disease Institute for years has had major programs in this country and throughout the world on problems of nutrition. It has been called on, along with the Child Health and Human Development Institute, for information and expert advice on nutrition.

I think the role of NIH is to focus on research and to examine with some degree of flexibility the relationship of the research activity to the societal needs. NIH, however, should not, at the expense of research, go out and pick up the totality of a problem. Joint responsibility for programs is the desirable goal.

G: Does NIH fulfill the role of sketching out or perhaps presenting to the people who can do something about it the areas of critical need?

M: Senator Hill each year criticized Dr. Shannon that NIH was not doing enough to make its accomplishments known to people at large and specifically to Congress. Whether NIH is doing enough now, I don't know.

This is a very tricky area in the health field. One is constantly walking the tightrope between the possibility of overpromise to sick people with heart-rending, deleterious results and reticence to publicize an issue until one is sure all of the facts are in. The whole history of quackery and charlatanism is that it is not hard to sell a concept of health. I think one has to take a longer-range view and carefully plan an information program in a fashion that doesn't make the ends so costly. Ideally, one would have an increasingly sophisticated Congress, an increasingly sophisticated population, and then he can work in a logical and rational fashion and not oversell. I think there is a real danger in misusing the promise of health in order to get money. Is this part of what you are talking about?

G: Yes.

M: Two points are worth further comment, now that Fogarty, Hill and Laird are no longer there to exercise strong leadership. First, the base of support must be much broader. No longer is it possible to focus only on a handful of people in Congress who had the knowledge of the problems in the health field, and who, in addition, had the confidence of their peers and the legislative skill to make decisions that were meaningful. Secondly, there's far greater interest in Congress. One has hardly been able to pick up a paper in recent years without seeing that Senator Yarborough is planning hearings in health areas, Senator Kennedy has had a series of articles on health, Javits has become interested in it, and more and more people in the House are developing health interests.

Across the board a political reason--in the best sense of politics--is developing for one to be interested in health. People may soon be elected on the basis of their health policy in cities and districts, and this was not true ten or fifteen years ago.

G: So this has been an evolutionary thing?

M: Yes. There are a couple of reasons that I think there will be a lot more interest in it. One, people are more knowledgeable about health; thus they are more concerned about their own health, particularly as they get older. Secondly, as we move towards third-party payment mechanisms, whether it be Medicare, Medicaid, Blue Cross/Blue Shield, what have you, I think we will have something of the phenomenon that one sees in car buying. If everybody had to pay five thousand in cash to get a car, there would be far fewer cars on the road, but the fact that you can do this in a reasonably painless fashion through installment payments means that the cost deterrent becomes less effective and perhaps relatively ineffective. It is a certainty that many more dollars will be going into the health care field generally. One of the problems this will create is that as you look at a fifty billion dollar health care bill going towards a hundred somehow you wonder if you can solve that problem by taking some of the dollars away from a research program, even when the research program may cost only one billion. This is a real threat to the nation's health problems.

G: Is there anything that you would like to add to this tape?

M: No. My personal contacts with the President were always pleasant ones. They were infrequent, and with the exception of the appointment

to NIH, I really didn't have any sort of close relationships with the White House.

G: I would like to thank you very, very much.

M: Thank you.

[End of Tape 1 of 1 and Interview I]

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