INTERVIEWEE: DR. WILLIAM H. STEWART (Tape #1)

INTERVIEWER: DAVID G. McCOMB

December 2, 1968

Mc: First of all to identify this tape, this is an interview with Dr. William H. Stewart. That's spelled S T E W A R T. He is the Surgeon General. The interview is in his office in the HEW Building in Washington, D.C. The date is December 2, 1968, and the time is 1:30 p.m.

First of all, Dr. Stewart, I'd like to know something about your background. Where were you born and when?

S: I was born in Minneapolis, Minnesota, on May 19, 1921, grew up in Minneapolis, went to high school there, went to the University of Minnesota in premedicine. My father was a physician, pediatrician. He also was the faculty member at the University of Minnesota that ran the out-patient clinic in pediatrics for years. Between my sophomore year and my junior year in undergraduate college, my father moved to New Orleans to become professor of pediatrics at Louisiana State University's School of Medicine.

So I went along with the family, finished my junior year at Baton Rouge campus of Louisiana State University and then entered medical school in July of 1942. Since this was the World War II period, we were on the accelerated program, and I completed medical school in June of 1945, a three-year program. I was a member of the ASTP during that period of time--the Army Student Training Program. After graduation from LSU I went to Philadelphia General Hospital for my internship. We were still on war time footing. It was a nine-month internship. Then I entered the Army Medical Corps. I

spent most of that period of time, slightly under two years, at Ft. Sam Houston--Brooke General Hopsital in San Antonio, Texas.

I left the Army about December 1947, and went to Minneapolis where I worked for the Veterans Administration for six months, and then I returned to New Orleans to take up a residency in pediatrics at Charity Hospital in New Orleans on the Louisiana State University service. Completed that in July of 1950 and entered practice in Alexandria, Louisiana.

When the Korean War broke out there was a ruling made that those who had been in the ASTP during medical school and had served less than 21 months in World War II were subject 1-A to the draft in the Korean War as a physician. I had 20 months and 25 days, so I was 1-A and was preparing to go back into the Army.

I heard through some friends that the Communicable Disease Center was forming an Epidemic Intelligence Service and they particularly wanted pediatricians because we had more training in infectious disease than other specialists. So I wrote the Communicable Disease Center and I was admitted to the first class of the Epidemic Intelligence Center--that's how I entered the Public Health Service--in June of 1951.

M: Well, that satisfied the draft people then?

S: That satisfied the draft people.

I spent my first two years in the field station in Thomasville, Georgia, doing studies on salmonella and shigella organisms, on typhus fever, rabies, and a few other diseases.

After my two years in Thomasville, a decision had to be made whether to return to practice or continue in the Public Health Service. Under the influence of Dr. James Watt, who had just been made head of

the National Heart Institute, I decided to stay in the Public Health Service and moved then to Bethesda to become part of the Grants Branch of the Heart Institute. I served in various capacities over the next three years in the National Heart Institute, becoming assistant director in 1957. The Surgeon General, Dr. [Leroy] Burney, wanted some staff assistance in his office at that time and I was selected to work in Dr. Burney's office, which I did for the next 18 months.

M: The National Heart Institute, that's part of the Public Health Service?

S: Part of the Public Health Service. It's one of the national institutes of health.

I then assumed the head of a division in the Surgeon General's office, called the Division of Public Health Methods. This was the planning and study division for the future development of legislation or program of the Public Health Service. Most of my time in that division was spent in working on the growing interest of the federal government in medical care and in the shortage of manpower. I was Executive Secretary of the Bane Committee, which developed the document "Physicians for a Growing America," which formed the base of the final passage in 1963 of the Health Manpower Professions Act.

M: Who was Bane?

S: Mr. Bane, who was chairman of the committee, is Mr. Frank Bane, who at that time had just retired as Executive Secretary--I may have the wrong title--of the Council of State Governments. He has been recently the Intergovernmental Relations Commission chairman.

M: This Bane Committee was appointed when?

S: It was appointed by the Surgeon General and I believe it was very early

in 1959.

M: Under Eisenhower?

S: That's correct.

M: And then it worked on into the Kennedy Administration?

S: No, the Bane Committee actually reported before the Eisenhower Administration was finished. Actually, there were two, if not more, bills on physician manpower in the Eisenhower Administration which never got anywhere. The significance of the Bane Committee Report, I think, was that one of the Board of Trustees of the American Medical Association was a member and the chairman of their Council on Medical Education was a member. So their endorsement of this report was the first recognition of the American Medical Association that there was a shortage of physicians.

M: Is it true that there had been some interest in federal aid to doctors and medical facilities on back into the early 1950's?

S: That's correct. Dr. Parrin made a speech on the post-war shortage of physicians in about 1948, for which he was severely criticized. And there was a great debate through the 40's and early 50's between the Public Health Service and the American Medical Association, as to whether there was or was not a shortage.

M: Did the AMA take the position there was not?

S: They have always taken that position and only last year was it made explicit that they had changed their position in testimony before the Congress.

M: Was their position based on self-interest? Were they trying to protect the profession, the union, so to speak?

S: It's difficult to pin that down. It seems that it was a basis of

self-interest, of protecting the market place of the physician, of trying to hold down the production of physicians. Some of this was a hold-over I think in the sense that people didn't have any money to demand it. There was considerable cutback in the production of physicians at the insistence of the AMA during that 1930 period--and then a complete inability to realize that times were different after World War II, that the market demand was increasing rapidly and that there was no recovery and growth in the out-put of physicians. I would say they were running 15 years behind times in their vision of what was happening.

M: Then, was the Bane Report a breakthrough in this?

S: Yes, I think it was a great breakthrough. It was the first report which was recognized by this group of experts from around the country in which it was clearly stated that we had to have the federal program in order to increase the out-put of physicians in the country. This is where the goal, 20 new medical schools, started.

M: Then this report led, at least in part, to the passage of this Medical Assistance Bill.

S: Yes. It was followed the next year by a Surgeon General's report on nursing, in which I played a role--when I wasn't the executive Secretary of it. I worked with Lucille Leon who was the Chief Nurse of the Public Health Service in developing this report. The reason I bring that up was that from the Bane Report we had the Health Professions Education Assistance Act in '63 during the Kennedy Administration, and from the Surgeon General's Report on nursing we had the Nurse Training Act which followed the next year in 1964 in the Johnson Administration.

The breakthroughs were occurring during this period of time in all of federal assistance to education. I really feel that not only was it the recognition of the AMA to the problem, although reluctantly, but it was also the passage of the Elementary and Secondary Education Act that changed the attitude of Congress toward the federal aid to education that paved the way for this legislation.

M: So it's all part of the same thing?

S: It's all part I think of the whole same movement.

M: Can you say now whether or not the Health Professional Education Assistance Act has been a success?

S: I think it's been a great success so far. It's put into being some 15 new medical schools, some 8 or 9 new dental schools. Of course, it now extends over schools of podiatry, optometry, and other types of schools in the health field. It now has scholarships; it has student loans; it has aid to the educational process itself. We're well on the way towards the goal that was originally set and may exceed it.

M: Is this the first major federal assistance to medical students?

S: Yes it is.

M: They didn't get in on the National Defense Education Act?

S: Yes, they could have been covered under the National Defense Education Act. But since medical school usually comes after four years of college, most of the students had exhausted their NDEA loan ability before they got to medical school. And, second, medical school costs a great deal more than undergraduate education and the loan limitations on NDEA wouldn't reach the cost that was true in medical school.

M: So for the medical student, then, this was a great aid.

S: This was a great aid.

M: Now are these grants, or are they loans of money that the medical student gets?

S: These are loans, and actually it's structured just like the NDEA program. There is very little difference between them except the amount that can be borrowed, and the pay-back period is a little different. But otherwise it's identical with NDEA.

M: Has there been an increase in the number of medical students?

S: The amount of increase of medical students has been substantial. There's been roughly a 15% increase in the medical students in the last 5 or 6 years. The thing you must remember that from the point of deciding to make the capital expenditure to expand a medical school to the time you have out put is a period of 10 or 15 years.

M: Right. And of course the population is growing too.

S: This is ture.

M: Will the 15% increase keep up with the population?

S: Yes, it keeps up with population. In fact it's a little bit more than population growth.

M: Which of course is what you need if you're behind to begin with.

S: This is correct. We also recognize that just numbers isn't going to solve all the problems, but you have to have the supply to start with.

M: Is quality of education a problem here?

S: No, except in some schools. The quality of education, if anything, has been extremely boosted by the research grants from the National Institutes of Health. While the Health Professions Education Assistance Act supplies mainly capital for construction, or student aid, the flow of money into faculty salaries and the running of the school has

been mainly through the research grant route from the National Institutes of Health. And while it's considered to be research, the man who's doing research in the physiology department is also doing some teaching.

M: These funds would flow to a private school as well as a public?

S: That's right. There wasn't any restriction on it. But, you see, with the money that was flowing from research, and the initiative to get a research grant being the scientist in the school, the schools that were short on scientists to start with, or who could not attract good ones, were starved for this type of money. So we had not an even distribution of this money, but money flowing to a few large schools and others being neglected.

If you look at it as a support of science, this was quite right. It goes where the best science is. It was never intended to support education. The amendment we had for the Health Professions Education Assistance Act in 1968 begins to put in a formula money to the education process and will even out some of this maldistribution that had been going from the research money. We're now supporting the institution's educational process as well as its research process.

M: I see. Now this was first initiated, or first passed, under Kennedy. Did you have anything to do with the passage of the bill? Did you have to contact people on the Hill?

S: I'll have to go back to my history. You remember you had me in the Division of Public Health Methods. I then went to form a new division in a bureau called the Division of Community Health Services. I stayed there one year and then Mr. Boisfeuillet Jones, who was the special assistant to the Secretary for Health and Medical Affairs,

the predecessor to the present position of Assistant Secretary for Health and Scientific Affairs, asked me to come and be his staff man.

M: He has an unusual first name.

S: Boisfeuillet.

M: How do you spell that?

S: I'll have to get it for you. I don't know how to spell that.

M: our guess will be as good as yours then.

S: Therefore I was working in the Secretary's immediate office from 1963 on with Mr. Jones and then later with his successor, Dr. Dempsey. In such a position I worked very closely with the legislative process. I worked very closely with Secretary Cohen, who was then Assistant Secretary for Legislation and did much of the staff work related to the mental retardation legislation, the mental health legislation, the Health Professions Assistance Act, Nurse Training Act, and so on down the line.

M: Did this bring you into contact with people from the Hill?

S: Yes, it did in a staff capacity. I was the one who went up and answered the technical questions from time to time. I was also the one who sat behind the Secretary and passed him pieces of paper when he was testifying, if he was asked a statistical question or something like that. I wrote a great deal of the testimoney, or I should say I participated in writing it. It's always a group project.

M: Was there any person in particular who gave you trouble on the Hill, or did it depend on the issue?

S: It depends on the issue. Since I was really providing technical information wherever I went on the Hill, I was usually very well

welcomed because most everybody on the Hill wants information to make the decisions they have to make. So this relationship is always a very good one. You have something they need, they want, and I think since I never was an advocate of a piece of legislation--this was always the Secretary's job or the Assistant Secretary's.

M: Did you have any trouble with lobbying groups, such as the AMA?

S: Not in relationship to education. We did have some trouble with--we would present a series of facts and the American Medical Association would present a series of fact to the committee members and we would be rebutting one another through this process, the normal legislative process. Where we had the greatest difficulty, this was during the era of Krebiozin (?). It was at the time when the Food and Drug Administration was being pressured to approve Krebiozin for interstate shipment and there was great effort to try to stop this from being approved. This landed in Mr. Jones' lap and since I was part of his lap we carried this together. This was a very difficult era.

M: Okay, let me ask you some questions about that. First of all, what is your relationship--the Public Health Service--with the Food and Drug Administration?

S: They were two separate agencies on equal footing according to the Secretary at that time.

M: But you did cooperate?

S: At that time I was in the Secretary's office, so I was working both with the Food and Drug Administration and the Social Security Administration on Medicare, and with the Public Health Service on their areas. I was working across the board.

M: Now who was it that was trying to push the sale of this drug?

S: There were two brothers in Illinois who were manufacturing it and sending it to doctors as experimental drugs. They had the support of Professor Ivey, University of Illinois, which gave it an aura of scientific acceptance since Dr. Ivey had always been considered an outstanding research worker in physiology.

M: Excuse me, does he spell his name I V E Y ?

S: Yes.

The champion on the government side was Senator Paul Douglas, who was pushing us very hard from the Hill. I can't believe, and never have believed, that Senator Douglas was doing anything more than feeling that here was a bunch of small people being pushed around by federal bureaucrats and he was going to see that they got a fair hearing--although it's difficult to say. I am suspicious and have been suspicious that one of the staff men that Senator Douglas had was mixed up in this process--

M: Had some personal interest?

S: Had some personal interest, but I could not prove that at all. We had great difficulty with this because it had been used on famous people--on Senator Taft, had been used on some high staff person with Adlai Stevenson, and so on. The difficulty with the whole field of cancer quackery is the fact that there are misdiagnoses, so you have a cancer case that gets well by itself. There are some spontaneous cures of cancer. And there's nothing more devastating, when you're trying to prove something is worthless, than a person to stand up and say, "My doctor said I had cancer and I got well." And they used this very effectively as a weapon. We were unable to ever get any of the material from them to find out what it was.

M: You mean the drug itself?

S: The actual drug itself. This was a requirement to approve it, obviously.

M: They wouldn't even give you a sample to analyze?

S: Would not give us a sample. Finally through a whole series of maneuvers, Mr. Jones made it impossible for them to go on unless they did produce some material. They produced 4 milligrams, which you could barely see in the bottom of a little ampule. And the Food and Drug Administration through some beautiful analytical chemistry found out that it was a worthless chemical. Then there was also some indication through Internal Revenue that money was flowing out of the country from the brothers, as if they were getting ready to flee and a few other things. Then they went to court and the process went on from there. A very difficult situation, very hard to handle. We had sit-down strikers in the Secretary's office--

M: Where did these people come from?

S: They had an organization, a citizens group was organized.

M: Did the brothers organize this?

S: No, I think it was organized mainly around a woman in New York and around a National Nutrition Foundation, I believe was the name, which has always been a supporter of all kinds of odd things like anti-fluoridation and other efforts.

So this was a very difficult time that we worked through. I think we were able, through our efforts, to keep this from welling up to the President. I'm not aware that the President was in on this at all. We did have some input from the Office of Science and Technology that helped us, but we kept it mainly within the Department. Other than, I think, getting rid of a cancer-quack cure

in the country, I think we were successful in carrying out what I think one of our functions was to handle everything we can instead of having it well up to the President's sub-heads.

M: It never then became a crucial political issue, one that would divide the parties? Or did it?

S: Well, a crucial political issue in the sense that Senator Douglas was a rather important man for everybody, and it could have been a very difficult situation.

Anyway, most of our effort, while I was in that office, was spent in the early days of the Medicare legislation hearings. My role was only tangential to the Medicare hearings since most of the effort here was carried by Mr. Cohen and Mr. Ball--Mr. Ball, the Commissioner of Social Security. I did participate over a whole series of years in the development of the Medicare. One has difficulty deciding just what stage it was decided to have a certain benefit or some things else. But most of my effort was around "how do we protect quality, how do we get standards into it, and how do we get more benefits than just hospital benefits." I did participate in the development of sections that set standards, did some of the staff studies, or my staff did some of the staff studies on it.

M: Did you have much contact with hospitals in that work?

S: We had contacts with the American Hospital Association, mainly through their Washington office, sometimes with the Chicago office.

M: There was a great deal of criticism that this would cause burdensome red-tape in the hospitals at the time.

S: This is the payment mechanism and I haven't had anything to do with that at all. What I was working on was which hospital could participate,

which one met a standard that could participate in the Medicare programs, and how would you determine this. This is in the law now. The same thing was true with extended care facilities, home health agencies, and out-patient diagnostic clinics.

M: Also, about this time the famous Surgeon General's Report on Smoking came out.

S: Yes, it came out in 1964, early part of the year.

M: Did you have anything to do with that?

S: I had very little to do with it before it came out. I knew it was underway and that it was coming out. As soon as it came out we had negotiations, rather delicate negotiations, within the Executive Branch as to "what are you going to do about it?" It particularly related to the Department of Commerce as far as possibly taxing cigarettes as a way of controlling it, and the Department of Agriculture subsidy to tobacco, and this department and what it was going to do. There were written several staff papers on this and certain negotiations. What finally turned out, I think, was a kind of "We'll go about our business, you go about your business" attitude. From then on I was the major professional input into the Secretary's office on how we should answer letters, staff papers, this sort of thing.

M: Is it correct to say the position of the Surgeon General on this was more one of education of the public than anything else?

S: I think the Surgeon General took the position that the only way one could stop people from smoking cigareetes or stop them from smoking if they already smoked, is to motivate them not to, to educate, that prohibition wouldn't work, and that there weren't any other ways of handling it. This led to the Labeling Act which was a FTC Act. It

put the label on the cigarette packages but it also put a prohibition on FTC for using any other of their regulatory powers until July 1, 1969. There was great controversy around this, where with some effort in this Department to develop this as part of the Hazardous Substance Act of the Food and Drug Administration, somewhere it was decided, "no, this would be FTC." I'm sure the lawyers for the tobacco industry wrote the label because it relieves liability and this is as much as we could get. Since we had already decided that education was going to be the process, that was the way to go. Our job was to see that the message got out just as much as possible.

M: This may be jumping ahead a little bit, but it's on the same subject. Apparently, in 1967 you did a follow up report on smoking, is that correct?

S: That's right, yes.

M: This is after your appointment.

S: That's correct. When the Labeling Act passed there was required a report to the Congress every year from the Public Health Service on updating all the scientific evidence, and from the Federal Trade Commission on the effect of the label. In 1967 was the real first roundup of this data in which we had broader evidence but mostly confirming evidence of what had been used in 1964. With the proper use of dissemination one gets this message across much more.

M: Apparently this '67 report confirmed--

S: Confirmed very strongly. The thing we had at that time was prospective studies which we had not had before. We'd had before retrospective studies on mainly veterans population and some British studies on physician population. But in England they had gone ahead and did a

prospective study on all physicians who had stopped smoking who had predicted what would happen, and the predictions came out. This added great weight to the retrospective studies. So it made so much confirmation that I don't think there was any question in our minds that as far as lung cancer goes, this is a real problem.

M: What about the label?

S: The FTC doesn't think it does any good, and I don't think so either. It's not in a place where people would read it. It doesn't have much meaning. I have a hunch that if that label had to show up every time a cigarette package showed up on a television screen it would have more effect, which we have recommended this year.

M: Have the number of cigarette smokers declined?

S: The consumption has declined this year for the first time since the report came out in '64.

M: Can you credit the report for this?

S: We think that the effort we've made in the last year has had some effect. What we find is that two groups have declined in smoking cigarettes. One is the young people which we're most enthusiastic about and the other is physicians. You see very few cigarettes smoked in the medical meetings anymore. We hope we can make more effort in the future. We think the attitude is beginning to change.

M: All right, what's changed this? The report came out in '64--

S: I don't think the report, per se, has that effect. The report gives you a base to give factual evidence, but I think it's the constant attention to all information channels. In particular, I think it was the Surgeon General on television. I personally feel that television is the modern way of communicating with the people, and I did everything

I could to get on television just as much as I could for this purpose. I think this had some effect. I don't think it's the sole effect, but I think it had some effect. I don't think writing in newspapers or magazines--or any kind of written word--really hits people as much as television does now.

M: Of course, if the physicians themselves give it out, they communicate this to their patients.

S: Oh this is true.

M: So this ought to be effective.

This may be an unfair sort of comment, but I notice you're smoking a pipe. How does this fit in with the Surgeon General's report about smoking?

S: The Surgeon General's report is related to cigarette smoking. The evidence in pipes does not come through. It's quite different.

M: So pipe smoking seems to be safer then?

S: Oh, there's no question that it's much safer than cigarette smoking as far as lung cancer goes, and any other related diseases. There is very little evidence of anything with pipe smoking or with cigar smoking.

M: Cigar smoking, too.

S: That's right. Now we don't have any idea why. But there's a distinct difference. So if you can stand these pipes, you can smoke your pipe.

M: Maybe you should try to educate poeple to smoke pipes and cigars rather than cigarettes?

S: We've said this in most of our literature, if you can't stop smoking shift to a pipe or cigar. Most people who like cigarettes don't like pipes or cigars. I've always smoked pipes.

M: Now to go back then. Kennedy was assassinated late in '63 and Johnson took over. President Johnson then appointed a number of task forces to review problems there. Were you in on any of these task forces?

S: Yes, I was the Executive Secretary of the Task Force on Health. Dr. George James, who was Commissioner of Health in New York City at that time, was chairman. I did most of the writing of the report for that task force.

M: This was a general survey of health in America, or what?

S: No, it was a program for the future, and mainly aimed around--when Mr. Johnson was elected and then--the program for '65 really, January '65. We met through the summer of '64 and had our report in, I think it was a few days after election day in '64 that was the target date, but most of that has been enacted into law.

M: What all was recommended in that report? You say November 10, 1964 was the reporting date on it?

S: Yes, it was the reporting date to the President. We reviewed in part and very briefly the health problems of the nation.

M: Let me ask this first. Did President Johnson talk to you about this before you started?

S: I believe we did meet with the President before we started. He gave us our charge and then we met with him at the end of it.

M: Do you recall what he said to you the first time?

S: No, I don't recall.

M: But your general task was to map a program for the future on health?

S: In Dr. James' transmittal letter, "We have been mindful of your request that we advise you of our nation's needs in the field of

health." If I remember rightly it was a general charge, "What's needed in this nation in the health field?"

M: How many people were in on this task force?

S: Oh, there must have been 8 or 10.

M: All of them doctors, physicians?

S: No. Herman Summers was a member. He's an economist. Rashey(?) Fine was a member. He's an economist. I think the rest were physicians, if I remember rightly. We recommended in the manpower field, which have now been added to the Health Professions Assistance Act, also the Allied Health Professions Act has been added since then for technician training. We recommended Medicare in this respect. We recommended a child health program, which has now come into being in part and was embodied the rest of the way in the Child Health Act that Mr. Johnson submitted last year which did not pass the Congress. We recommended a development of planning at the state and local area. We recommended project grants for community health programs which I think have now been manifested in the Partnership for Health Act which passed in 1965. So most of what we recommended has been passed into legislation. There are one or two places where it's a little different than what we visualized, but the essence is there.

M: Are you favorably impressed with the use of the task force as a means for forming future policy?

S: I am in the way this was done. I think that the task force effort which has enough time--we had three or four months during the summertime--before a new administration is going to introduce things, and internal working guidelines, so you don't get the debate started

over the document--rather it's over the substance submitted to Congress--is a very effective tool. The President can call on all of the talent in the country and I think gets the best results this way. I don't know anything about the other task force reports that were produced. I assume that there were some he didn't think were so good and others he thought were better.

M: Now has this task force served as a springboard for most of the legislation that has come out of the Administration in your area?

S: Yes, it's served as a springboard. Of course, one of my problems with this is since I was the executive secretary writing this, and Mr. Jones and Dr. Dempsey knew I was writing it and what was in it, we were in a sense writing the way we saw it. And we continued after that producing the proposed legislation of the White House. There also, I think, was a great consensus in the country on what needed to be done at this particular point in time too. So I don't know, I can't tell whether it was because I was all mixed up in it all the time and others who were going to be the continuity or not.

M: Now at this point in time, were you involved in anything else? This is right before your appointment.

S: No, most of the effort was in legislation and here.

Now there's one other piece that I'd like to mention. President Johnson had a Commission on Heart Disease, Cancer and Stroke, which reported in December of 1964, I guess it was. I was not mixed up with the Commission but I had a young staff man who was working with me by the name of Dr. William L. Kissick who was working with the Commission staff. Then Dr. Dempsey, who was then my boss, as the Special Assistant for Health and Scientific Affairs, had been a

member of the Commission when he was appointed as special assistant. So he'd kept up his interest.

The report was made and was put on my desk and said the President would like to have legislation before the Congress in two weeks. The report had 34 recommendations. I read the report many times. So did Dr. Dempsey and so did Dr. Kissick. We came to the conclusion that the first three or four recommendations were the real new meat in the report. We said this report is telling us that science is developing new diagnostic and treatment techniques in the medical centers which are not being translated out to hospitals. It's not been translated because it usually requires technicians, equipment; you can't write it up in a medical journal; and any doctor that reads it can automatically do it. What you needed was a system for this.

So we wrote a piece of legislation which was introduced in the Congress in about 19 days and in 9 months was law, called the Regional Medical Programs. It was changed in part in the Congress--much of it around words, semantics. But I have never been in on a piece of legislation that went from a commission report to passage and signing into law in a period of time like that--very interesting.

I spent some of my time out trying to convince the medical schools this was a good piece of legislation, a good idea, but they were rather hostile to it at first. I had one meeting with the Association of American Medical Colleges in Chicago where I spent three hours defending it and I don't think a single dean there supported it.

M: This is in a room filled with--

S: All the deans in the country, the vice-presidents.

The significance of this is that they are now the great defenders

of the Regional Medical Programs.

M: Once it went into law they--

S: And the money started to flow. And I think this is to me has been one of the two--I kind of include that in my term as Surgeon General, because it was just before. And actually there were two pieces of legislation born in ideas that day that we were sitting at the blackboard trying to figure out what to do. One of them was the Regional Medical Programs. The other was the Partnership for Health Act. We didn't know what to hang the Partnership for Health Act around and since this was on knowledge and quality of care in getting techniques out we thought the university axis was a proper one. The other area was in planning and control of flow of capital and this sort of thing. We didn't see how that could be hung into this. Well, the Partnership for Health Act occurred after I became Surgeon General. I found a vehicle to hang it on and so these two pieces to me are very important.

M: Okay, what was your vehicle to hang it on?

S: It was interesting. There had been a great debate around here on federal-state relations for four or five years. The federal grants in health were on a formula basis or project basis, but they were all categorized around certain diseases--cancer, heart disease, tuberculosis, venereal disease. I think we had fourteen categories, each small, each completely inflexible, and some of them not authorized by law but by appropriations language--a great dissatisfaction among the states on this inflexibility and dissatisfaction on the part of the Public Health Service. There had been two study groups but [they were] unable to solve the problem. In the meantime legislation was expiring; we were expanding it one year. When I became Surgeon General about the

first week, I found that Dr. Terry had turned down the last report of the study group on this. And yet the legislation had to be prepared for the next year on what to do with these formula grants and these project grants to state health departments. I think he was right in turning it down because it really said, "Let's go on like we've been doing."

So we conceived of the idea of forming a pool of money of these kinds of grants to give flexibility and to give more authority to the states and localities to use the money as they saw priorities. And that was our vehicle to hang the planning portion on of the Partnership for Health Bill. That's beside the point but it was an interesting concept.

I think this fitted in very well with the Johnson Administration at that time, which helped, because the President was talking about creative federalism. His concept of creative federalism was this, not federal-to-state-to-local, but a kind of partnership arrangement where you get together to handle a problem and for more flexibility at state and local level. It fitted right into the whole concept I think of creative federalism.

M: This must have pleased the President.

S: I don't know whether it pleased the President or not, but I think that his efforts of speaking of it and working on it and Secretary Gardner's efforts created an atmosphere of making this piece go. We met with most of the governors in the country and they liked it. There was great support for it, so I feel that it was just a thing that arrived at the right moment.

Anyway, when Dr. Dempsey left the special assistant job in--I

think it was March or April of 1965--I have always had in mind I would like to leave the Public Health Service by the time I got to be 50 years of age or thereabouts because I've always had sort of a rule of thumb that if one wants a second career he'd better do it before he's fifty. I was three or four years away from that. I was looking for a base where I could create a second career and in the meantime have some fun while I was still in the Public Health Service. Dr. Shannon had asked me several times if I was interested in being a director of one of the institutes. I finally told him, "Yes, I would" at this point because I thought an institute director's job would be a good place to relate to universities and the scientific community--which is where I wanted to go for my second career. So he offered me the directorship of the National Heart Institute, which I accepted. I went out there on July 1, 1965, and started to work as Director of the Heart Institute. Late in September, Secretary Gardner called me to come down to his office where he told me I was his choice for Surgeon General, "would I take it?" One doesn't say no to a thing like that.

M: This was a surprise to you?

S: It was a surprise to me, because I really didn't think I was a candidate for Surgeon General. In the first place Dr. Terry had just been reappointed 6 or 8 months before; I didn't know he was leaving.

M: So you were brought into Gardner's office--

S: There's a little irony to this. President Johnson came out to the National Institute of Health along in June to sign some bills in front of the Clinical Center and I was appointed--no, it must have been a little later than July because I was Director of the Heart

Institute at that time. But since I knew everybody I was asked to introduce all the Institute directors to him. It was on that stage that he announced that Dr. Terry was resigning and he was going to search the country for a new Surgeon General. I was convinced that they were going to try to find somebody from outside the Public Health Service. Anyway, Secretary Gardner didn't know when the President would make the announcement, but he knew it would be soon so I had to sort of stay hidden in a room around here for a day.

M: Gardner, then, did he call you on the phone?

S: He called me on the phone and asked me to come down--

M: So you went to his office and he told you this, he told you of course to be quiet about it.

S: He said that I'd better remain incognito somewhere. So I worked back here in an office until the next morning when I was asked to go to the White House to see the President with Secretary Gardner. We had about a half-hour discussion in which Mr. Johnson did most of the talking.

M: What did he talk about?

S: It was very interesting. He talked, I would think, 99% of the time. What he was really saying, I think, was "I expect you, Surgeon General, to pull together all this federal health enterprise into something that's good, best in the nation" and so on. "That it's too scattered, too fragmented; the quality is not good in our hospitals," and so on but the central theme was "How do you pull it together into a central organization?" Now that's the way I read it. What it came out was, statements about how lousy this hospital is and how bad that one is, and why can't you get the doctors to do this and all that. But in essence what he was saying I think was, "How do we

get a federal health enterprise that makes sense." He also turned to his television sets back in his office there and said, "and I'll be watching you," which made me shrink a little lower in the chair It was rather interesting.

Then he said, "Come on," and Secretary Gardner and I walked out the side door and just outside the door here was this sea of reporters and microphones and the President and I and the Secretary stood there and the President said a few remarks, "I've just appointed Dr. Stewart Surgeon General," and then he left.

M: He left you with the reporters.

S: Me to say something. That was the way I became Surgeon General.

M: It certainly was--it took place in what--less than 24 hours?

S: 24 hours. It was quite a process I'll tell you. I got back here and there was no Deputy Surgeon General. There was only one Assistant Surgeon General. There was no Executive Officer. Most of them had drifted off. And--

M: Did this happen between the time of your appointment and the affirmation by the Senate?

S: No, it happened at the time Terry announced that he was leaving.

M: Then everybody else left?

S: Yeah.

M: Tell me about the Senate confirmation.

S: The President appointed me September 25, and I went up for confirmation a few days later. Usually the Surgeon General doesn't go, or it's just perfunctory, but for some reason or other that committee wanted to sit in session that morning. They didn't want to break up and go somewhere else. So for three hours I sat there and answered questions

--on population, family planning.. The first question I got was from Senator Javits, "Did I consider my job political or professional?"

One of the amusing incidents was Senator Pell from Rhode Island, who is a Coast Guard Reserve officer, asked me how come I was being made Surgeon General when I had never served with the Coast Guard? I told him I didn't know what they would do with a pediatrician on a Coast Guard ship. I got a laugh out of it. But it was a very interesting and a very thorough examination.

M: Why did they want to talk to you, did you ever figure that out?

S: It had nothing to do with my confirmation. That's as much as I was told. When I left there was one of the Senators, and I can't remember which one it was, grabbed me by the arm and said, "Do you know what's going on up here?"

I said, "No, I'm surprised that I was examined so thoroughly." And he said, "Oh well for some reason or other they don't want to have any meeting so some other subcommittee can't have an excuse about this meeting going on." That's why I was examined so thoroughly. But I was perspiring under the collar, I can tell you.

M: Then your confirmation went through?

S: Yes, no problem. I took over the office.

M: And you had to find assistants to help you.

S: Had to find assistants and establish an organization that would move. Then it was quite apparent from a few conversations with Secretary Gardner what his grand strategy was. It was a very interesting grand strategy because it involved me agreeing to his grand strategy at the same time it involved breaking up the Public Health Service that I was head of. But our process was as follows.

The Secretary had decided shortly after he came on duty that it would be wrong to break up the Department of Health, Education, and Welfare as some of his predecessors had suggested; that health, education, and welfare were interrelated with one another; that people were it's targets; that it was the only department of the people. In fact, he even toyed with changing the name to the Department of Human Resources, or something like that. But his conclusion was that you don't break it up, and since you have all these interrelation problems between health and education and welfare, if you break it into three departments the coordinator is no longer a secretary but the President, and the President's got plenty to do without having that. That was one thing.

The second thing was that he recognized that we are becoming a society of very large complex institutions. And the one way you don't handle large complex institutions is to break them up into smaller parts, that we have to learn how to live with very large complex institutions.

So on those two premises we planned. Now this wasn't any sitting down session where we said this is the plan and strategy, but in conversations with him it was quite apparent that his strategy was to break up the three organizations in this structure that were the most traditionalist, themost likely to resist change. By break up, I don't mean destroy, but break into pieces so that lines and hierarchies and traditions are different than they were before. These three organizations were the Office of Education, the Welfare Administration and the Public Health Service. Now in dealing with the Public Health Service he had a peculiar problem. All the authority

was in the Surgeon General.

M: Let me interrupt you a minute here. Now, the Department of Health, Education and Welfare, before Gardner especially, had been characterized as being practically ungovernable.

S: That's correct.

M: There were too many agencies involved that were practically independent. Is this what he's striking at?

S: It was considered to be the king of a whole series of baronies, and fiefdums, independent agencies. The three most powerful were the Office of Education, the Welfare Administration and the Public Health Service.

M: In this reorganization that you're talking about, Gardner tried to bring these under his control.

S: He's trying to make a unity of HEW, as a large complex organization. His feeling is he has to break up these powerful baronies before he can then make the unity.

M: In breaking up, does that mean merely changing personnel or does that actually mean--

S: Personnel, lines of authority, etc.

M: The actual authority of the agency involved?

S: Yes. Now, I knew in the fall of 1965 that this was his strategy. With the Public Health Service he had one peculiar problem, and that is, the authority was in the Surgeon General not in the Secretary. They had no question, no problem justifying having the authority transferred from the Surgeon General to the Secretary. The Hoover Commission Report in '48 recommended this and there had been 14 agencies that had moved that way in the past. It still--almost sounds silly

to say it--was that any Secretary ought to have the authority to run a department the way he should be able to--the Chief Executive should.

So we had to seek a way of getting the authority transferred from the Surgeon General to the Secretary. In order to do this, you could do it through legislation or through a reorganization plan, which was sort of a backward legislation. He chose to go by a reorganization plan. That means he had to have something to reorganize. So we came up with a reorganization which, I think, helped group some things in a little better way. But the essence of it was the transferal of authority from the Surgeon General to the Secretary, who then turned right around and delegated it back to the Surgeon General. Quite a different kettle of fish than it was before.

Even before we implemented that reorganization we were already on the next steps. I wrote the Secretary a memorandum in November of 1966 which was two months before we implemented the reorganization on what the structure should be after this. He got this from other people too. He asked each of us to write our ideas on it. He also then was going to proceed with the next steps in the health reorganization, but for reasons I don't know he decided to move on the Welfare Administration first and put the health one on the back burner. He did; the Welfare Administration disappeared; a new thing called the Social Rehabilitation Service appeared; and a realignment, in fact a stretching out of the functions on a line were developed.

Then he was beginning to move. That was all during the summer of '67. And he promised me as soon as he got through with the SRS

--because I was getting worried we were losing our momentum--that he would move it as soon as he got through with the Welfare Administration organization. In October of '67 he said, "Let's go," so we started the ball rolling again. But before we got all the way Mr. Gardner had resigned.

Then it took us from then until April to finally get it evolved to where we are now. What we have now is health all broken up into units, and in the Public Health Service we moved the Food and Drug Administration into it. We have three large organizational units. But we don't have any unity.

M: In other words, right now you're in the process of reorganization.

S: We've gone through the reorganization but the reorganization, in my opinion, is an interim. We're not there yet. What we've done is that first stage. We've broken up the old tradition. We've got ourselves out in these independent units held together by three things we call Administrations and loosely held together by an Assistant Secretary. But as yet we haven't accomplished that unity that I thought President Johnson was instructing us to do from the very beginning--yet.

M: All right, now how do you get that unity?

S: That's the next steps.

M: I mean, time is short. You're going to have a change in Administration.

S: I think it'll take four or five years.

M: But what has to be done to get that unity that you're talking about?

S: If you're going to have one Health Agency, or principally one Health Agency, the next step in my opinion is to transfer the Child Health

Services and the Neighborhood Health Centers of the OEO into this Health Agency. That would help a great deal.

The next step after that is to decide whether the experiment on the way we're running this at the top is right or not right. In the reorganization a part, which I believe came from Dr. Gardner himself, was that we could not build the usual superstructure of the man in charge. We do not have any budget office, personnel office, or management office in this office. We use the secretaries. We're kind of ruling by a committee of three, the Secretary, the Assistant Secretary and the Surgeon General. We share each others authorities and staffs. Now this was an experiment in how you lead large complex corporations. It means the next echelon has to have the real power to direct and we haven't accomplished that yet. Maybe we will.

M: It would seem difficult for three men to share staffs, and to work together.

S: I think the crux of the experiment is when Mr. Cohen, Dr. Lee, and I leave, because we know each other and have worked with each other well enough that you can't tell whether it's working because we work together so well--and have for years--or whether it would work if three strangers came in. That's going to be the real crux.

M: What you're suggesting then, that this may be working now because of your personalities--the fact that you know each other well.

S: But you see the idea that Secretary Gardner had was that the Office of the Secretary, if it captures the budget planning and the legislative planning and the management information systems, it then can allow any unit to direct, as it has the powers of control. He was trying to build the control of the policy development planning group here

with the information systems in the direction here. We haven't been able to pull this off yet, although in part we have. I think we do a much better job of budget and legislation than we did before. It's planning--long-range planning--we haven't built up yet, and management control systems. When you figure an organization that's--and Health is about 11 billion dollars and we've got 55 thousand people. It's a rather complex organization, and we have about 80 people to run this here.

M: In general then what you say, the problems of the Department of Health, Education, and Welfare as an organization for control under the Secretary, are not solved yet.

S: Not yet. And I think what we have given to the next secretary and the next president is a lot more flexible, malleable package than he would have had if he'd come in prior to the Johnson Administration or the Gardner era. What we've got is something now that he can mold and shape whereas before you couldn't. You couldn't get your hands on it.

M: Is it correct then to say that you have accomplished a breakup of the fiefdums?

S: I think this is true.

M: Although the next step is not yet clear.

S: Not quite. I'm not sure--well I am sure that it would be possible for a new Secretary to allow it to slip back. It's not quite consolidated yet. But I believe that no one could have taken the next steps of molding this if we hadn't gone through those steps we'd gone through the last three years.

M: You must have had some resistance from the personnel below you?

S: Oh, there's been great resistance. Many people classify me as the Surgeon General who sold the Public Health Service down the river. This is ture.

M: How do you overcome such resistance? You just can't fire these people that are hindering you.

S: No, some left; some changed; some considered their opinions said and let it go at that. Actually, I think that there had been enough concern about, "things weren't going the way they should be going" that there was a recognition that change was necessary. But I don't think any of them expected the change to be quite as drastic as it has been. You see it's not only complicated by the fact that you had an organization called the Public Health Service, but you also had an organization where 12% of the personnel were in a different personnel system than the rest of the personnel--the commissioned corps. And the commissioned corps was mainly built around the professionals, the physicians, doctors, dentists and nurses, and had since 1870 run the Public Health Service.

M: These people, the commissioned corps, did they have special status, or is this informal status?

S: No, their personnel system is quasi-military. It's part of the uniformed services and has equivalency ranks to the military. The pay system is the military pay system, being quite different from the Civil Service System. It's a rank-on-man system. Up until I appointed Dr. Fininger(?) as one of our Bureau Chiefs there had never been a non-commissioned officer as a Bureau Chief before in the history of the Public Health Service.

So you're breaking up an old line tradition, which was gradually

breaking down itself, and while people in the commissioned officers system and others recognized change was necessary, it was always the other fellow should change, not us. Part of the reorganization plan was to create a new special personnel system in the Department for professionals and scientific people. And we did develop a personnel bill which was introduced into Congress last year and never got anywhere. It was fought very bitterly by the Commissioned Officers Association of the Public Health Service. Whether that will go on or not, I don't know.

M: Is there any justification now for a commissioned corps?

S: No, there is justification for a uniform and some kind of military discipline in certain parts of the Public Health Service. The Coast Guard--you need it; for the care of merchant seamen in hospitals you need some kind of military type discipline, and in the federal prisons. But that 20 years ago was the major function of the Public Health Service. Now it's 100 million dollars out of 3 billion, so it's a minor part. And that's what's been happening.

All of these changes I'm sure were dictated by the massive amount of federal health legislation that was passed in the last 8 years. There's been more than anytime in the history of the country. The Public Health Service operated on 3 basic laws: they operated on the Interstate Commerce Law, which was the protection against communicable diseases, foreign quarantine; they operated on the subsidy of Merchant Marine as part of the seafaring country, started in John Adams' time; and operated on grants to states to assist them with health programs started with the Social Security Act in 1935.

What's happened in the last 5 to 8 years is the Federal Government

has emerged as the major force in health, not as an assister, a major partner I hope. And we were not ready to handle it, so we had to change. There wasn't any question in my mind that we had to change. It's a little traumatic to be right in the middle of it, but I think it's turned out reasonably well so far. I think it'll take another four years.

M: This is a rather intriguing development since in certain areas where there has been a need for a change or need for a new program and an expansion of a program there have been new organizations set up such as OEO, and yet here the change has come within the organization. Is there any explanation for this?

S: Yes, I think so. I think that if one wants to move fast with a new concept outside of traditional lines, you set up a new organization. OEO wanted to deal directly with the people and with the cities. They didn't want to have any lines in between. They wanted to deal with a certain group of people called the poor. They wanted to try a lot of things, completely flexible, not down into "well we tried that last year, that won't work," this type of thing--no history, no tradition whatsoever. And this is great. It is the only way you can do it. Conceptually one could say,""Well you could have put OEO right in this department." I don't think it would have gotten to first base. Now, as OEO moves, it becomes more traditional or into it. As soon as it loses its flexibility and ability to experiment then I think it ought to be consolidated into these departments.

M: Why couldn't you put something like OEO in here?

S: I think it's because you build a history and tradition and you don't want to get in on that history and tradition. We have a tradition

of some 4 billion dollars of this Department's money that goes to states. They don't want to deal with states. We're so used to dealing with states that it's hard to conceive of dealing with a city without dealing with a state. It's not a matter of resistance, it's the way it's always been done. It's like asking somebody to suddenly put the fork on the right side of the plate instead of the left side of the plate. You know, we've always done it this way. But if you go to another country that's never had forks, it wouldn't make a bit of difference. It's that kind of thing.

M: And yet, you've had massive changes here.

S: We've had massive changes, and my feeling is that by the array we now have, the breaking up of the old baronies, we are now more receptive to receiving the Neighborhood Health Center Program of OEO than we would have been before. We now have a home for it that will just let it go right on, because we've been making massive changes in the same direction of OEO. With the Partnership for Health Act we were able to change our priorities from a whole laundry list of diseases, many of which were put into effect by pressure groups, not by problem, into a pool of money that we could shape towards Neighborhood Health Centers. And we are now jointly funding some of those with OEO.

M: Now, if a new idea came along with the scope of something like OEO, except perhaps more in your field, could the Public Health Service absorb this now?

S: Not yet.

M: It would still have to be an outside organization. You still haven't got the flexibility to allow for an innovation of this nature.

S: I don't think so. Well, I'm not sure that's the right answer. I

think organizationally we could. We don't know about our emerging leadership yet. That's why I hesitate. There's more to administering a program here than just administering it. Most of the people run it as an orderly house and get it done. What you're looking for is that fellow who goes a little beyond that into some kind of "yes, we ought to be doing that two years from now"--the leadership role. They're hard to find. You almost have to build on one that comes along.

M: What role has President Johnson had in this change you've been going through? Where does he fit into all of this? Is he just a product of this time, or has he been an innovator in this?

S: No, I think that Mr. Johnson's acceptance, or creating, or taking on the idea of creative federalism was a major step. I know those words have kind of become a banality now, but if you really read that Michigan speech that he gave and the concept that was trying to be put forward I think this was a major policy step, trying to straighten out some of the inter-governmental relations that we have. We still have a long ways to go but I think we've made some progress.

And actually there is quite an effort now going on in the government to model many more of the federal-state local programs around the Partnership for Health methodology. In the education programs, in health, it fits in with some of the--well bloc-grant is too far, but broader categories in a sense.

Also, I think that Mr. Johnson was very interested personally, although I've never spoken to him on this. I got this from Secretary Gardner--personally interested in the archaic nature of the Executive Branch to modern times, the need to modernize it. I think his proposal

to combine the Labor Department and Commerce Department is part of this recognition. I always got the impression that he was giving full support to Secretary Gardner in all these maneuvers we were doing here and several other things that were going on. This was my feeling anyway. And it's very difficult for a politician to take on reorganization because it is my feeling that in reorganization those who carry it out pay a lot and gain nothing from a political standpoint. You can't win in a reorganization.

M: You mean by that you get known as the hatchet-man?

S: That's right.

M: You sold the Public Health Service down the river.

S: Maybe the next fellow takes some of the credit for it, but you don't win in a reorganization--no matter what it is, a little tiny thing or a big thing.

M: But you are impressed that the President had some interest in what you were doing?

S: Very much so.

M: Were you impressed with his insistence on the quick passage of laws in which you have experience?

S: Yes, very much so. You got the impression that the President sensed that he had the ability to get laws passed through the Congress and that this door wasn't going to stay open forever, and therefore let's go. Get it going, just as fast as you can. Now, I don't know whether it's true or not, but that's the impression one had.

Also, the period of time was such, with the difficulties in the budget area, that one can make more political mileage out of the legislative process than you could out of any other process that might

be available to a politician.

M: What does he do to be sure that these laws are pushed through quickly? Does he phone you? Does he keep in contact with you?

S: Oh no, I don't have anything to do with that. I help in developing the legislation, help in developing the health message that is then sent to the Congress. We work on the testimonies of the Secretary, participate with him in testimonies, sometimes testify. There's a lot of negotiating around the back rooms. But if it's on the President's list, he obviously is asserting some kind of pressure to get his program through.

M: Speaking now of your administrative lines, your contact with the White House would be through the Secretary, is that correct?

S: Yes or sometimes we go direct, Doug Cater--

M: To his staff.

S: Yes, Joe Califano, Jim Gaither.

M: Does this cause any problems with the Secretary?

S: No, because we know pretty well if anything's going to come up that he should know about--and they know too. After all, they're speaking in a sense for the President. They're not about to give us an inch that they think the President should have decided--and likewise with the Secretary. So it's a staff-to-staff relationship.

M: Have you ever gotten the feeling that the White House staff was overstepping its bounds, telling you what to do?

S: Yeah, to a certain extent. When you're developing a legislative program they seem to have their own ideas once in awhile that they want to insert and sometimes you're able to persuade them not and sometimes you're not. Whether those are personal ideas of developments

from somewhere else we don't know. But in general it works pretty smoothly.

M: Have you ever gotten the feeling that an idea you had was being blocked by the White House staff, that you might want to go on to the President? There was no blockage or hindrance?

S: The Secretary can always go to the President. If we finally felt that it was absolutely necessary for something to get to the President, and if the Secretary agreed, it went right to him.

M: So there would be no blockage of ideas going up from you.

S: None at all.

M: You mentioned earlier that the President had a reputation for being rough and tough at times. He does have that reputation in the books, at least, that are written about him. Do you have any comment about that?

S: Well I've never felt this wrath, but when Medicare was being implemented in July of '66--several months before that I was responsible for certification of the hospitals as to the requirements of Title VI of the Civil Rights Act, which meant I was running around the South and battling with all kinds of groups. It was a very tense and very hard time, which I look on as one of the most satisfactory things I did. The President obviously was very interested in all of this business about getting Medicare so that it started on July 1 very efficiently and effectively. We were worried about how many hospitals wouldn't be certified so there'd be people who were eligible who wouldn't have any place to go.

We had a meeting in the White House in the Fish Room. It must have been three or four weeks before Medicare was to go into effect,

and it was on the problem of discrimination and hospitals. The Attorney General was there, Mr. Cohen, Mr. Gardner. I don't remember who else was there. There was a small group. That may have been all.

The President started out by saying to Mr. Cohen, "Who in the hell is Jim Kelly?" Mr. Cohen explained to him that he was our comptroller, and apparently Mr. Kelly had underestimated some expenditures in this Department--or something had happened. The President was approaching the end of the fiscal year and this made the difference in hitting some target or not, and he was very upset. In fact, he told him to get that straightened out or get rid of Mr. Kelly. But he was an example and I think he was right in his pick.

But he also could be very good to you too. You know, I don't think he knows too much about who I am, but I was over at a ceremony where he was getting something from some group and he was going around shaking hands like he always does with everybody. He stopped with me and he said, "You're doing a good job," and he turns to the next guy and says, "You know what I like about him, he isn't out there trying to wave a flag all the time." And so on and so forth. That makes you feel great, something like that. So he's a very interesting person.

M: A few general questions that you might have some opinion on. Since you're a pediatrician by training, do you have an explanation of why the United States should have such a high infant mortality rate as compared to other countries that supposedly have a lower standard of living and less facilities?

S: Because we have this range of income. We have a broader range than

most countries do. We have much poorer poor people, as a developed nation, than Sweden, Denmark. We have many more rich people, but with pockets of poverty.

M: Can this be counted as a fault in, say, our Public Health Service? Is it not broad enough?

S: No, I don't think it's a fault of the Public Health Service. I think it's the fault of our society. Part of it's discrimination--discrimination towards the Negro, the Indian, the way they are housed, educated, the job discrimination so that they're kept on a very low level. They were the last to leave the rural areas and move to the cities. They're the last of the rural poor to have opportunity. They really didn't emerge from the problems of the '30's until the last few years and they all moved into New York and Chicago and the other cities. Mechanization of farming didn't hit the South until the 50's when you remember all the Negroes moved into the airfield down there. I think the real problem is this wide gap between the "haves" and "have-nots". Until we've solved the problem of the "have-nots" we won't do much.

M: Recently Walter Reuther proposed a national health insurance program to solve this problem, among others. Would you agree to something like that?

S: I'm not sure what it is in form, I think that the great national health debate over the next decade is whether you will or will not have national health insurance and what form it will take. I think there will be some kind of national health insurance. There are no answers to Medicaid's problems, to the problems of rising costs, to the problems of maldistribution of services, without some mechanism

like this. This is why I was saying, I don't think the organization can be talked about as complete yet because I think the federal role is still unfolding, and I think we'll roll with it for awhile. My guess is the next 8 years will be spent debating this.

M: Do you foresee an expansion of the Public Health Service, say into control of water and air pollution?

S: I think the Public Health Service will grow in size. I think its responsibilities in the environmental area will grow, although it could very well leave the Public Health Service. We don't really have enunciated yet a national policy in the environment, and I think when that is put together it's quite conceivable we'll have a new agency for natural resources or environmental protection or something like this. It may take a new agency for the same reasons we were talking about for OEO. But you need to get one into some non-traditional basis to get it started, or it could grow within the Department. I don't think we'll know for awhile. I don't think we'll know whether we will have national health insurance or what form it will take or whether we'll do it piecemeal, build it up to finally having it--for a few years. And I don't think we have really completely unfolded the role of this Department in higher education yet and its health and scientific relationships. So as these unfold in the federal government, we'll see what kind of structure we have. Finally, if you do away with money payments under welfare through some other scheme--income guarantee or negative income tax or whatever these are--what's left in public assistance is the health programs. They just don't make any sense unless there's some form of free payment and insurance principal.

INTERVIEWEE: DR. WILLIAM STEWART (Tape #2)

INTERVIEWER: DAVID G. McCOMB

December 2, 1968

M: You wanted to say something about the international relationships?

S: Yes, I thought I'd mention some of the activities in the international health field. I was asked by the President to accompany Secretary Gardner to Viet Nam in the spring of 1966, ostensibly to develop a health program for the people as part of the program to build up the society itself rather than the military operations.

M: Is this something new? Usually you think of Public Health Service as a domestic agency.

S: This is true. The Surgeon General of the Public Health Service has always been the chief delegate of the United States to the World Health Assembly, and we ran four hospitals for civilians in Viet Nam. In 1961 when there was guerilla fighting, but not organized fighting, it was obvious they needed some help, and we were asked by AID to take over four civilian hospitals in Viet Nam. Later on as the fighting got so great it was too insecure for non-military people to be there. It was getting harder and harder to recruit for these positions and they were finally taken over by the military, although we still at this time have a surgical team in Da Nang, which we've had from 1961.

But I was sent over to develop on the civilian side of Viet Nam what might be the future after the war was over, during the war--what should you do? Secretary Gardner and Mr. Keppel, Commissioner of Education, went with us. There was a whole team of people.

It was quite apparent that the effort that one could put into this was practically nil. Security was so much of a problem that you couldn't do anything outside of an institution that wasn't secure --that the war effort had so depleted Viet Nam that there wasn't any resource there which one could begin to train or build towards the future, and that there was little one could do except support the care of sick civilians or casualties. The casualties were running pretty high among civilians at that time. You also got the impression that, while there seemed to be a spirit and a desire on the part of AID to develop the Pacification Program, the military so dominated the situation, particularly communications, supplies, transport, that there was little one could do unless it had a military function. And therefore the priority on paper looked like pacification was pretty high, but in actuality it was down around zero. Now this was my own personal impression and the impression of those who went with us on this mission, who were the health people.

In education they had done a little better, but it had been mainly around the development of schools, self-help by the villagers. This was something that was put by the people themselves and therefore was sacrosanct from destruction by the Viet Cong. You were destroying something the people had put there. But if AID had built one themselves it was immediately torn down.

With medical areas, what you were really talking about was schools for health professionals, nurses, technicians, a public health program which is completely dependent upon communications. And these were nonexistent since everything had been absorbed into the army of Viet Nam. So you got the impression that while the spirit of pacification

seemed to be there, the possibilities were very, very low. I also went with President Johnson to the Honolulu Conference, the first time I'd ever been to a conference like this.

M: Why were you selected to go?

S: I was to meet with the Minister of Health to discuss health programs in Viet Nam. General Humphries who was head of the health mission of the AID in Saigon was present, also. He'd developed a program which was mainly support for the civilian hospitals, as care of casualties and illness, which was about all you could do because all you could get was military supplies and military people to work in the hospitals. So we discussed this as our side issue.

But, I again, from just sitting on the sidelines got the impression that this Honolulu Conference was more a display of relationships than it was to solve anything in substance. Now I may be entirely wrong, because I wasn't in on the inner circles, but I just had that impression from sitting in meetings when Mr. Johnson made his speech, Mr. Ky made his speech, and the various side meetings that were going on and from the fact that the communique was written before the meeting occurred--at least the first draft I saw before the meeting occurred. A few other things--it was a display, an outward display of perhaps something that had been going on inner all the time anyway. And perhaps this is the only use that a meeting like that can be for. I don't know. But it was an interesting observation for me.

M: From your experiences then, did you come away feeling that there was little that we could do in the way of health in Viet Nam?

S: That's correct. At that time about half the provincial hospitals had

no physicians whatsoever. So we took as our prime target to get medical teams into those hospitals and supplies, and they had to come from the military, which means that once the military leaves there's nothing. So you're not building anything new--very little one could do beyond that though, because the South Vietnamese Army was taking in everything that came along off the pipeline. So my feeling was that even though the fighting stops in Viet Nam, there will be a period of rebuilding which we will have to invest funds into, until they are on their own.

Finally, I have represented the United States at the World Health Assembly now for 3 years. We have been in a posture for 3 years now of trying to cut the budget, to get control of the budget, to get in a sense a veto over the organization. It has really been the reflection I think, of the attitude in this country, both public and within the Congress of pull-back on foreign aid, both multilateral and bilateral; a decline in the importance of foreign aid, the efforts of AID; and it's use as an instrument of foreign policy.

We have then been forced into a position in every World Health Assembly meeting of the "haves" versus the "have-not" nations. Since the "haves" represent some 14 or 15 nations and the "have-nots" 100 nations, this generally puts us with a few nations voting against the majority--a vast majority--with the Soviets playing it back and forth and no real way of handling this tyranny of the majority, in a sense, except to try to develop some kind of Security Council veto arrangement--which we have condemned so much within the UN. So we're really in a dilemma in our outward appearance in

the health field to underdeveloped countries. We, in a sense, are saying they should develop themselves, and on the other hand we're saying "but don't spend very much money."

M: At least not our money.

S: Not our money. Now I don't think that the health field is that important in foreign areas. It's important from the psychological and social acceptance standpoint, but I don't see where we're going to be able to do anything in the health field of any consequence until the whole attitude of this country to underdeveloped countries changes.

M: Would you say that this is one of the faults of our attitude toward health--world health, in this case?

S: No, I don't think the problem is any consideration to health. I think if health had been able to stand by itself it would have gotten along better. But the way the budget for the specialized agencies of the United Nations is presented to Congress, this is one lump --all of them. The argument then gets over the level, not what it's doing.

But I do feel myself that the Viet Nam war and the diversion of so much of AID, foreign assistance money, into Viet Nam acted as a major deterrent to our developing foreign aid through the multilateral-bilateral pass to other areas.

M: Then would you classify the Viet Nam war, that we find ourselves in, as a major hindrance to our world programs?

S: Yes, I think so. I think it has been the major block. I think the price of the Viet Nam war is high--much higher than the actual dollars spent. How much of this is reparable over time if peace should be declared I don't know. Whether it was worth the price or

not, I don't know either. I don't know enough about it, but it was quite apparent that everytime we moved in on the budget of the World Health Assembly, the argument was, "Well, you just want that money for bombs, not for food, not for trained people."

M: This proved embarrassing to you.

S: Very embarrassing.

M: Was there anyway you could answer this?

S: No.

M: You just had to take it.

S: That's right. But it's not a--you know--the U.S. contribution to World Health Assembly is peanuts compared to our total budget. It means very little as far as the world goes, but from a world opinion standpoint, I think it has great bearing. It was just a reflection of the difficulties the Johnson Administration had with this Viet Nam War and how it reflected out into other areas that you think are rather remote from it, and the prices you pay for this sort of thing.

M: Is there anything else you'd like to say?

S: No.

M: Well then, thank you very much for the interview.

S: You're quite welcome.

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