Dr. C. Everett Koop, the 16th Surgeon General of the United States, is a formidable man.

First, there is his appearance. At 6' 1" and 210 pounds, the bearded, Lincolnesque Koop would absolutely dominate any room he was in were it not for the softening effect of his gentle speech patterns and his unfailing sense of humor. He looks more like a grandfatherly, understanding psychiatrist than the world-famous pediatric surgeon that he is.

Then, there are his achievements.

He was the sixth surgeon in the United States to devote his full surgical practice to children only.

He created the first neonatal surgical intensive care unit in this country.

He is known throughout the world not only for the extraordinary surgical procedures he has performed — such as separating Siamese twins and reconstructing parts of the body that did not turn out just right in the first place — but for the ordinary operations he has done that have guaranteed a better quality of life, or even life itself, for thousands of babies.

He has written 135 articles and four books, one of which was dictated to a secretary in a single day.

He is a man who has the absolute courage of his convictions. An ardent anti-abortionist, Dr. Koop was an active anti-abortion campaigner and proponent of preserving the sanctity of life prior to his appointment as Surgeon General. He has said that he will not use his job "as a pulpit for ideology."

During an hour-long interview with Mimi Craig, Noreen McHugh, and June Shibe, members of the TODAY'S OR NURSE editorial board, and Ann Caputo, managing editor of this publication, Dr. Koop spoke freely and favorably about the operating room nurses with whom he has worked. All four women were influenced by the simple impressiveness of the man and by his forthright views on the nursing profession and, specifically, on operating room nurses. The conversation among Dr. Koop and the representatives of TODAY'S OR NURSE follows.

I set myself the task, in 1946, of building the most comprehensive group of pediatric surgeons anyplace in the world, and I think I succeeded before I left Philadelphia.

Q

What made you decide to specialize in pediatric surgery?

A

I have to be very honest and tell you that there was an opportunity, which I seized, and I seized it because I didn't think the children got a fair shake in surgery. They had to compete with adults for everything they had. So I set myself the task, in 1946, of building the most comprehensive group of pediatric surgeons anyplace in the world, and I think I succeeded before I left Philadelphia.

Q

How did you go about setting up the first neonatal surgical intensive care unit?

A

I actually did that with a grant from the Children's Bureau, which was not a funding agency in the usual sense of the word. But through the good offices of Dr. Ivy, the plastic surgeon of Philadelphia fame, who had a lot of connections in the Children's Bureau, they finally listened to my plea. The Children's Bureau funded it for the first three years then the State of Pennsylvania took it over and eventually it was part of the categorical grant — half federal funds, half state funds.

Q

When you're dealing with surgery on a child, do you think that your thought process differs a little from how you would think if you were considering whether or not to do surgery on an adult?

A

No, I don't think so. I think the major difference is that you can't take the patient into the decision-making process about what you're going to do. Instead of that you have two parents and sometimes four grandparents, so it doesn't become any less complicated. I don't think that in making decisions about what to do, that it ever made any difference to me whether the patient was two pounds and two minutes old or whether he was 200 pounds and 50 years old. Decision-making is the same.

Q

You've operated on a lot of children. Do any of the children that you've operated on keep in touch with you?

A

Oh yes, especially at Christmas time and especially those who have gone into medicine or dentistry or some other paramedical group because they have become interested in this during the time they knew me. A lot of my patients know me for years and years, you know, and some of them get very concerned about health care and decide they want to go into nursing or something like that. So those groups particularly do keep in touch.

Q

Any pediatric surgeons among that group?

A

Not yet. But I can tell you that one of the most poignant moments of my life was when I made the film, "What Ever Happened to the Human Race." There was one scene in my living room and I had eight of my patients around me. These were all children I had operated on the first day they were born and they were now up to 34 years old. What I was trying to do was bring out to the audience that would be seeing the film the idea that these kids, no matter what they had been through, thought life was very special and very precious to them.

I asked this one gorgeous, brown-eyed, black-haired, Italian girl on whom I had done a colon transplant — I put her colon in the place of her esophagus — and I asked her what she thought about her life. I said, "There are people who said I tried too hard, I did too much to you, it cost too much money and so forth." She interrupted me and said, "No, I have a better quality of life than most people and besides, if this hadn't happened to me, how would I know I wanted to be a pediatric surgeon?"

Q

In our January issue we had an interview with an OR nurse in a children's hospital. She said that one of the things that pleases her most is that the children keep coming in to see her, and she's seen them grow up physically and found that they're not scarred either men-

I would like to be remembered as a person who recognized public health problems, addressed them, and handled the difficulties that had to arise with justice.

tally or emotionally, and that gives her a feeling that she has actually accomplished something.

A

I think that in pediatric surgery, more than in most brands of surgery, you get to play a very important part in the families of children that you operate on when they're born. So you grow up with their problems. If you have a child with an imperforate anus, that's going to be a patient for 12 years. You get to know the families very well and get in on their decision-making process — where they ought to go to school, what they ought to do for their hobbies, and so forth. It's a very satisfying kind of a life. I'm so sorry I left it.

Q

You said that you think the Surgeon General should be the family doctor to America...

A

I didn't say I thought he should be. I said in my confirmation hearings that many people regarded the Surgeon General as a family doctor in the sense that they expected him to give them competent and truthful advice about the prevention of disease and the promotion of health.

Q

Would you elaborate on another quote? You have said that you want to "reverse the tendency of the practice of medicine to be described as 'a health delivery system.' It sounds as if you're eating cereal or

delivering gasoline. I would like to see the personal aspects of medicine restored and say a patient is a patient and not a consumer, and a doctor is a doctor and not a health care provider."

A

Well, I think that's perfectly clear. When you talk about the health care delivery system, I think the consumer or the patient begins to think of this as some great big, monolithic structure from which perfection is to be expected. And when things don't go totally the way he'd like them to, he forgets that we aren't like carburetors and we can't be adjusted to a fine point. There are certain things that you can't always fix. I think it's a mistake in this big monolithic system that leads to so much malpractice litigation.

Then, I would hope that you, as a nurse, would share with me my concerns that I do a better job when I know I'm a doctor and you know you're a nurse, than when we are just providers giving somebody what they're entitled to. And I certainly, when I'm a patient, want to be a patient and not a consumer. I just think these terms take out the very thing that I went into medicine for, and that is the personal contact between physician and nurse and the patient.

Q

In the personal contact area, where do you see the nurse in the hospital, particularly the nurse in the OR, fitting into this kind of practice of medicine?

A

Well, I think she's a very important part of the team. I think that the care of the patient is a team effort, and I am perfectly willing to see the nurse do any aspect of that job that she is qualified to do, and that will vary in different places at different times. The only thing I think one has to be careful about is that there always has to be a captain of the ship. You can't have two different sets of people giving two different sets of instructions to families, two different prognoses, two different plans for treatment, and that sort of thing.

As far as the operating room is concerned, I think that it should not be just a technical exposure to an operative procedure. But, just the way a head nurse is someone who has had experience doing a variety of things, and therefore her various kinds of competencies are brought together in a supervisory job, I think that the nurse in the OR should have been a nurse taking care of patients. And particularly in reference to the OR, she should know about the preoperative preparation and the postoperative care, particularly in a recovery room or an intensive care unit, so that she just doesn't function as a technician doing just one little job, but sees herself as fitting into one segment of a continuum of care. I think that makes her far more intelligent, to see the things that are happening and to become part of that team rather than just a technician.

Q

Then you do see the need for an RN in the OR?

A

Oh definitely. Had we decided we didn't want them?

Q

Well, we have another question. What are your feelings about the proposed change in Medicaid, Medicare regulations that would permit technicians and licensed practical nurses to circulate in the OR?

A

Well, I think what I was just trying to say to you is that when you have a person who is an RN, she has broad vision, and she knows the patient from previous days and from different kinds of experience, and she's going to see the patient postoperatively. Whereas, if she is just a technician, then she's looking with gunbarrel vision at that patient as a technical project, and I don't think that's good.

Let me give you an analogy. I said that I wanted to develop the most comprehensive group of pediatric surgeons anyplace in the world and I think that I did. I could never have done that if I hadn't been, more or less, a surgeon of the skin and it's contents 35 years ago. Because I did cleft lips and cleft palates and club feet and fractures, and I did hydrocephalus and spina bifida. So when I tried to develop plastic surgery, urology, orthopedics, I knew the breadth and the depth of those fields and could provide for my colleagues the environment in which they could do their best work. I think that's what the RN does in the OR. She has depth and she has breadth and she has a perspective which you can't get elsewhere.

Q

Given the contributions of nurses, a lot of nurses are concerned about the "shortage of nurses." Some think there really is a shortage of

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nurses, some think they're just not distributed properly across the country, and the main problem seems to be that there are a lot of registered nurses who are simply not practicing. Would you have any suggestions on what could be done?

A

I would like to withhold any suggestions I have because right now, as you probably know better than I, Congress has asked for an investigation of this and has asked the Public Health Service to look into the so-called nursing shortage, and we have contracted this task to the Institute of Medicine. It is a two-year study. The first preliminary report has been submitted to Congress, and in about 18 months we will have a very comprehensive report that I think will answer just those questions you asked me — Is it a real shortage or an apparent shortage? Is it distribution or is there something about nursing which is not as satisfactory after you become a nurse as you expected it to be, and therefore you drift off into another profession? I think the study will address those things and then we'll have to do something to be sure that we can work it out so that whatever the problem is, we correct it.

Q

Having worked with nurses much of your life, why do you think there are so many nurses leaving or, more precisely, not practicing?

A

I don't think you can answer that question for everybody or for every hospital or for every nurse. I think things are different in different parts of the world. I think they're different at different times in a girl's life. I think they're different in different hospitals and under different kinds of circumstances.

I do think that we demand a tremendous amount of concentrated effort from certain nurses, and I would identify those as intensive care nurses, nurses who deal with cancer in children, for example, nurses who are involved in the operating room where you run just back-breaking schedules. I think they burn out because of the intensity of the concentration that they have without any relief. And, if indeed I'm right about that, then I think one of the things we have to think about is rotating them off so that they see another aspect of nursing and come back having learned something to further contribute to what they're doing and maybe prevent that burnout.

But that's just one little aspect of why nurses don't continue in the job, and I'm going to wait for the Institute of Medicine report before I tell you any more.

Q

I just want to verify something. Do you have any input into the legislation that would change the regulation and then would allow technicians to circulate and assume the responsibility in an OR?

A

Not specifically. The department does have a role in legislative packages that go up to the hill, but I have not been involved and I don't plan to be involved, as far as I know, in that particular legislation.

Q

Another problem that operating room nurses perceive is that many of the nursing schools across the

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country no longer include operating room nursing in the curriculum, which means that the students aren't exposed to it and there's a mystique about the OR. In short, they're afraid.

A

Yes, I think fear is a better word than mystique. If you could make it a mystique you could keep them, you could attract them. I have been opposed to this from the very beginning when the curriculum began to be changed in Philadelphia, and various places, and girls did not rotate through.

I don't think we ought to go back to the days when I was a medical student where you had one girl who just stood with her hands in warm water wringing out sponges and couldn't see what was going on. But I think unless you rotate a nurse through the operating room, she's never going to understand what role the operating room plays in the total care of the patient and it is going to be a frightening place for her. If you've never been in it, you look upon the people there as very special elitists, and it doesn't look like a friendly place at all.

And yet the operating room that I ran at the Children's Hospital of Philadelphia was, I think, the happiest part of the whole hospital. The five girls that had been with me the longest had 137 years experience with me together. We had a great feeling of camaraderie because we had one goal — we were trying to get as many unusual kids through very complicated surgery with as few complications as we possibly could. I think that they shared in the triumphs and successes that the surgeons had. I used to make it as much a part of my conversation with them as I could to bring them up to date on patients that I had seen last week, that they had seen the previous week, the previous month, the previous year. Sometimes when we had a teenager come back that some of those girls remembered as a newborn, I'd take her up to the operating room and strut her around so that they could see why this was worthwhile. If you can see something more than just an open abdomen on a premature and know that eventually becomes a functioning human being that's going to go out and get married pretty soon, then I think you realize that you've made a real contribution and you're not just a cog in a wheel but you're a member of a team.

When Florenz Ziegfeld had the Ziegfeld Follies, he had written over the door, along the lintel and over the top that went from the dressing room of the chorus girls onto the stage, the words, "Through these portals pass the most beautiful girls in the world." Every Christmas I used to put that on the door of the operating room in the Children's Hospital, "Through these portals pass the most beautiful girls in the world," because I told them many times, they were beautiful in their effort. They all would sign their communications to me, "The most beautiful girls in the world".

As a matter of fact, when I retired they gave me these two retractors that I must have used on about 17,000 hernias. The day I was confirmed, they sent me a balloon bouquet from "the most beautiful girls in the world."

Q

While we're talking about the OR nurses, what are the chief qualities you look for in nurses who are going to be working with you in the operating room?

A

Two very simple things — people that I get along with and people that are teachable. Everything else is secondary, I think.

continued

Q

Do you expect the nurses in the operating room to take independent action on their own?

A

I think they can take independent action on their own in certain ways. One way is to recognize that in a children's hospital, the patient needs a different kind of support than if it's an older person. The girls in the OR that I come from did that beautifully. They just stepped right in, made it a happy, joyful kind of occasion, played with the children, kidded with them, poked fun at me and that sort of thing for the benefit of the children.

I don't think there's anything more satisfying to a surgeon than to work with an operating room nurse and you don't have a single missed motion. I did so many hernias and undescended testicles that I used to say to the new girls — "You're going to feel strange in the beginning. It won't go as well as it will in the future. But let me tell you that the day I will feel that you and I are working as two pieces of one machine is the day that I never have to look at you, and we get to the end of it and say we didn't have a wasted motion."

I think that must bring satisfaction to a nurse as well. There aren't many opportunities for independent action on the part of nurses in reference to the specific patient. There are in reference to the management of the operating room, to the management of the children in the operating room, and to ways of cutting down on procedures that will save the patient time and will eliminate risk. I have always kept a very informal attitude in the operating room so that operating room nurses felt free to say, "Why don't we do this or that? Why do we have this many kinds of suture when we can do it with only half as many?"

I prefer to see nursing not get splintered into different kinds of nurses so that one cannot shift from field A to field B. I think that will further undermine the shortage situation.

Q

Nurses are now seeing themselves as patient advocates. How do you see that in the operating room?

A

Well, I hate the term because it sounds as if the rest of us were doing something to the patient so that the patient needed an advocate. I don't think that they do. I think the idea is all right. What I think this all started from was nurses seeking a role where they would be appreciated as the individual who saw the whole patient, saw the patient in the family, and acted in such a way that all those things were addressed, where there might be an opportunity for the physician to look at it more with gunbarrel vision. But I don't look on that so much as advocacy as I do on a nurse recognizing that the patient is a whole person and that there's more than just his wound to be taken care of.

Q

Would you encourage your daughter or your granddaughter to become a nurse?

A

I think it's always been thought of as probably one of the most satisfying professions. I have three granddaughters, and certainly if they had the slightest inclination to become a nurse, I would do everything I could to encourage them. I think in any profession that takes as much personal dedication as nursing, that you should not do it as a livelihood. Or to put it another way, it isn't something you should do unless you found you couldn't be happy doing anything else. I think it's a calling. I don't think it's just a job.

Q

Is the emotional climate any different in the operating room when the patient is a small baby, or even a child, as opposed a full-sized adult?

A

Again, I think it depends on how familar you are with what you're doing. When I was a resident and operating on large adults, just the thought of doing a baby scared me to death. Toward the end of my career, an adolescent was frightening to me. I preferred a five pounder.

Q

If the opportunity presented itself over this year, could you or would you operate on a child?

A

I don't think that I probably would. First of all, I haven't operated for almost nine months now and if I were to do an operation, it would be responding to someone who asked me to do a special favor. And I think if I wanted to do a special favor for that person, I would put him in the hands of someone who was operating every day.

Q

One of the things we all realize is that the general public doesn't understand what a nurse does, never mind in general but specifically in the operating room. What do you think nurses could do to get their image across to the general public, not only correctly, but to gain a little more respect?

A

I don't think that nurses are lacking in respect. I think the public respects nurses. I think that what has crept into the public's image of the nurse is the same thing that has crept into the rest of our lives, and that is that the media, particularly television, have distorted what a nurse is supposed to be. You seldom see a nurse that isn't depicted as a sex symbol or something like that. I just think that nurses have to work hard on their PR and demonstrate the kind of things that they do best.

Q

That's tough though, especially when you're an OR nurse.

I think that in a pluralistic society, someone who is opposed to something has just as much right to talk against it as someone who is in favor of it.

A

Sure it's tough. It's tough when you try to project any image that's become tarnished because of the way one might to treated on television. But I think you just have to be innovative and make clear what the true mission is. I have that problem right now with the Commission Corps of the Public Health Service. Many people don't know its mission, don't even know its exists, and are reading periodically in the newspapers how the OMB (Office of Management and the Budget) sees no reason for its existence. One of my jobs is going to be to try to change that image so that people out there in the world know what the Public Health Service does for them, and what they would be if they didn't have that aspect of the Public Health Service working for them.

Q

Would you tell us, briefly, how the Commission Corps fits into that?

A

The Commission Corps is one of the most remarkable things that this country has. There are about 6,000 commissioned officers — doctors, nurses, dentists, veterinarians, sanitary engineers, civil engineers, dieticians, physiotherapists, radiotherapists, and so forth — and this group of people is the only rapid deployment force for a national emergency that we have in this country. If there is a nuclear leak at Three Mile Island, or wastes that are noxious to people at Love Canal, or people are dying of heat strokes in Los Angeles, or there is an eruption of Mt. St. Helens, these are all public health problems and every public health commissioned officer is available on immediate notice to go any place in the world where he is sent. This is what protects you from exposure to some of these things that go on in our society.

If you count the reponses that the commissioned officers at the Centers for Disease Control in Atlanta respond to in the course of a year, we have over 1500 such emergencies. When the Cuban/Haitian refugees arrived in such large numbers on our shores earlier this year, we had 125 people down there in no time at all and we rotated them through so that about 450 of our doctors served down there. We also had some sanitation engineers and some dentists and some nurses and so forth to do the whole job. But that is the only way that this country is equipped, at this moment, to respond to such an emergency.

Q

You mentioned the Haitian refugees. I talked to some nurses in various parts of the country who are concerned about large groups of people from other countries coming in for medical care. They feel that they can't communicate with them, even if they know their language, because their health ideas are different from our American ideas. Included in your Commission Corps, do you have people who speak other languages and who are familiar

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with the strange ways some other countries may handle a health problem?

A

We don't always have people who can speak the various dialects that people arrive with, especially when they come from Indochina. But what we do have is a large group of people who have spent time with our Indian Health Service. They know a lot about folk medicine. They know a lot about the ways that medicine men treat patients and are sympathetic to that form of health care. I think that they are, for that reason, particularly understanding of people who come with a whole different system of health care, from say Haiti or Vietnam or someplace like that.

Q

Back to the nurses again. A lot of the nurses I've talked to are very concerned about other things that are happening in health care, for instance, paraprofessionals like physicians' aides. Now they have medication technicians in a hospital down in Houston whose job is simply to give medications to patients. And there are also a lot of LPNs. Nurses are afraid that they are being phased out of the system. I even read an article recently about a futuristic health care system that did not have nurses — it had medication technicians and IV technicians and you-name-it-hyphen technicians but no nurses. Would you have any suggestions to offer to nurses?

A

Well, I think one only has to look at history to see that this doesn't work very well. We never had medical manpower shortages during the last two wars — more than the last two wars. We didn't have them in Vietnam. We didn't have them in Korea. We didn't have them in World War I and World War II. But our enemies occasionally had a real shortage of manpower. When they turned over the care of patients to technicians that were neither doctors nor nurses, they might have been able to do certain things well, but they couldn't do the broad aspects of medical care that's necessary.

I think that's really the saving grace for nurses. As we said before, they have the breadth of understanding. They have the background and I think these people will always be a very important part of the delivery of any kind of health care in this country. If indeed it turns out that we do have true shortages of nurses, then it makes sense for these people who are RNs

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to be in a supervisory capacity and in a teaching capacity so that we stretch our resources to the limit in order to provide the care that we think a patient should receive.

Q

In other words, it behooves nurses, to let people know, often and loud, exactly what they can do in health care services. What do you think of the nurses who specialize — midwives, gerontological nurses, psychiatric nurse specialists?

A

I think there are true specialities and those that are just sort of a special interest. I think , for example, that urology is a true specialty. I think someone who gets very proficient at doing mastectomies has not created a new specialty. I think there is difference, therefore, between those two things.

I prefer, I think, to see nursing not get splintered into different kinds of nurses so that one cannot shift from field A to field B because I think that will further undermine the shortage situation and, incidentally, this is another aspect that's being addressed by the Institute of Medicine — nurse specialization. I think there's no doubt about the fact that there are some very critical shortages presently being addressed by nurses such as primary care nurses and nurse midwives.

Q

Nursing is a profession and a calling. How do you feel about unions in the nursing profession?

Every Christmas I used to put on the door of the operating room, "Through these portals pass the most beautiful girls in the world." I told them many times, they were beautiful in their effort.

A

I am not opposed to unions in general. I think there was a time in our country when unions were absolutely essential to bring about the changes that they did bring about. But I have to say that I still think you shouldn't mix up unions with a calling.

Q

Can you describe any experiences that you've had with nurses in the operating room where the professional quality of those nurses has been shown and saved the day?

A

I like to think again about treating the whole patient and being concerned about what goes on in the operating room and what effect that's going to have on the family later. The things that I remember are not the dramatic operations that we got through together, but the times where we would perhaps take a malignant tumor out of a small child. Then, when I would go to see the family on the ward, I might find that the girl who had assisted me with the operation was there with her arm around the mother, sympathizing with her about the unfavorable prognosis, and offering to be of any kind of help that she could be. That again is another example of not having gunbarrel vision about the technical procedure you just did. They recognized what a tremendous impact a child with cancer has not only on the family, but on the whole community.

Q

Day Surgery Units are popping up all over the country. I know my own staff is extremely excited about it because it's not only the technical skills that can be used but also the planning and implementing of those types of skills with discharge planning of the patient. Do you see this as definitely the wave of where everyone is going?

A

I don't think there's any question about it, and all the things that you said are true. You provide a better quality of care, but you also provide it more economically and that's the bottom line of everything these days. I think it is not far off when there will be certain procedures that third-party payers will not pay for unless they are done in outpatient surgical centers.

Now when it comes to children, I think one of the most difficult things in dealing with children with problems such as hernias, undescended testicles, or small lesions that bring a child into the hospital is that he is exposed to children who have other illnesses. He goes home the morning after his operation. He doesn't get his galloping diarrhea until the next day but he got that in the hospital. If you can totally segregate the outpatient facility from the inpatient facility, you have done children a tremendous service in eliminating the morbidity that comes from

respiratory and gastrointestinal infections. That was the whole reason why I went to outpatient surgery. I was moving my patients almost as fast as outpatient surgery but they were mingling with the patients in the hospital and that was not good.

Q

Children seem to bounce back easier than adults.

A

That's tradition. That's the way we were brought up. When I was a resident, on the rare occasion when we operated on a child with a hernia, he was in the hospital two weeks. He was sewed up like a thirty-nine-cent football. He was wrapped up in bandages to keep him from having a recurrence and we did him more harm than good.

Q

Day surgery didn't start with children, did it?

A

No, it didn't start with children, but because of the nosocomial infection problem they immediately became prime targets.

Q

Lets move into an entirely different field. Given their ability to sustain life or decide that death is inevitable, do you think physicians, and by extension nurses, are obligated to speak out about things that affect the human race, such as abortion and nuclear war?

Well, I hate the term patient advocate because it sounds as if the rest of us were doing something to the patient so that the patient needed an advocate.

A

I think they don't have to become proponents for a cause. But I think that in a pluralistic society, someone who is oposed to something has just as much right to talk against it as someone who is in favor of it. I would hope that our profession was broad enough so that they could permit certain latitude and freedom for people not to do things that they found repugnant.

Q

Do you have any advice for a nurse who might be requested to take part in an abortion or any situation that would be difficult for her?

A

I think, as I have always told nurses who have asked me this question, you don't wait until the occasion occurs as an emotional emergency, but you make up your mind where you stand on a given issue long before the issue arises. Then when it comes you say, "Well, I always planned that when this happened that I would do thus and so." I think this comes up more and more frequently as we have developed so many lifesaving techniques for newborns and we now have a situation where there are people who say, "Well, this youngster has a quality of life that's not worth living, and I don't think we ought to try to feed this one." Well that is very, very difficult for some nurses to tolerate and I don't think they should make that decision on the day they are told that, but before the situation ever comes up.

Q

Have you seen any evidence recently that society's respect for life has increased?

A

No, I can't say that I have. And I think we're going to have to be very vigilant about our concept of the sanctity of life because as we see an aging population being supported by a smaller and smaller group of young people, economics is going to be talked about more and more. I hate to see economics and the quality of life get mixed up in anybody's mind.

Q

To an extent, though, there's no getting away from it.

A

Well, I think we can always care for our patients. I think one has to be assured that you never get caring and killing mixed up.

continued

Q

If President Reagan, who is about the same age as you are, is reelected and asks you to continue serving, will you continue serving?

A

I don't think that's a question I could possibly answer now. And he is older than I am.

Q

Does that make you feel better?

A

Well, it did all the time people were saying I was too old for the job.

Q

How would you like history to remember you?

A

I would like to be remembered as a person who recognized public health problems, addressed them, and handled the difficulties that had to arise with justice.

BIOGRAPHY

Dr. C. Everett Koop has come a long way from Brooklyn, New York, where he was born in 1916. An only child, Koop attended Dartmouth College at the age of 16. While studying for his Bachelor of Arts degree there, he met Elizabeth Flanagan. Later they married and became the parents of three sons and one daughter.

After graduating from Dartmouth, Koop attended Cornell Medical College and received his medical degree. He was interned at Pennsylvania Hospital in Philadelphia.

In 1948, Dr. Koop joined the staff at Children's Hospital of Philadelphia (CHOP). At that time he was the hospital's only pediatric surgeon (Koop was among the first group of surgeons to devote a practice strictly to the treatment of children) and, in fact, the entire pediatric surgery department. This was also the time in Koop's life when he became a fervent, fundamentalist Christian who was willing to publically make his beliefs known.

By the time Dr. Koop "retired" from Children's Hospital at its mandatory age of 65, he supervised 26 full-time surgeons in eight specialties who worked in what was named the "Koop Surgical Center."

As Koop's career developed, he gained a reputation as a pioneer in the development of neonatal surgery. He was one of the founders of the *Journal of Pediatric Surgery* and served as its editor-in-chief. He also created the first neonatal surgical intensive care department and came to believe that, except in extraordinary circimstances, all measures possible should be taken to preserve the life of the newborn.

In 1979, noted medical writer Donald Drake wrote, in a profile of Koop called "Zealot for Life," that "he will not persist if the brain has been so severely damaged that there is no awareness of self, or if his efforts would only prolong a painful process of dying." Drake noted that in one case, Koop operated on the same child 22 times.

In 1974, Koop achieved national attention when he successfully separated Siamese twins who had been flown to the United States from the Dominican Republic. More than 5,000 newspaper and magazine articles were written about the extremely rare operation that was performed by a team of 20 surgeons. Subsequently one of the twins died in an accident unrelated to the complex surgery. One mother, whose son was being treated by Koop at the time of the twin's death, described him as "devastated" by the loss.

Koop also achieved national attention in 1975 when he was involved in successfully reconstructing the ribcage of a child who was born with his heart outside his body. The child, Christopher Wall, spent the first four years of his life at Children's Hospital. Christopher is now a happy 6-year-old. His successful development under difficult circumstances often has been credited to the nursing care he received while a patient at CHOP.

In 1977, Koop again was called upon to separate Siamese twin sisters who shared a six-chambered heart. The twins were daughters of Orthodox Jewish parents and the ethical debate surrounding the surgery was well-reported in the media. To save one of the twins, Dr. Koop was forced to sacrifice the other. The surviving twin died three months later.

In an ironic counterpoint to a career devoted to saving the lives of threatened newborns, Dr. Koop himself experienced the loss that is every parent's worst nightmare. In 1968, his 20-year-old son, David, died in a mountain-climbing accident. The death is said to have intensified Koop's religious studies and, 13 years later, he speaks of David with warm affection.

During an interview with representatives of TODAY'S OR NURSE, Dr. Koop described how David came to him in the third year of his pre-med studies at Dartmouth and asked how his father would feel if he changed his major to geology. "I told him that I couldn't think of anything worse than your going to medical school because you are doing it to please me and I'd be very happy to see you as a geologist if that's what you want to do," the Surgeon General said.

Dr. Koop's religious studies and his career have led him to become an ardent anti-aborionist. In 1979, he participated in a 20-city tour with a multimedia program designed to remind the public of the value of human life.

Explaining his viewpoint, Koop said in an interview, "One day when I was operating on newborn babies, I realized that less than 100 feet away in the Hospital of the University of Pennsylvania, they were destroying babies. Knowing what we can do with abnormal children, to know that we're destroying about one million normal babies a year just drives me crazy."

It was Koop's well-publicized and ardent fight against abortion, as well as his lack of experience in public health, that led many to oppose President Reagan's appointment of him as Surgeon General. In an editorial, the Philadelphia Inquirer said, "It would be unthinkable to expect a government bureaucrat to perform a rare operation to separate Siamese twins. By the same token, the man who so brilliantly performed it, Dr. Koop, simply does not have the knowledge, the background, or the temperament to perform as Surgeon General."

However, despite opposition, and the necessity of amending a federal law to raise the age of qualification for the post of Surgeon General from 64 years old to accommodate Koop's age, he finally was confirmed by the Senate in a 68-24 vote last November. Koop's supervisor, Dr. Edward N. Brandt, Jr., Assistant for Health, has said that "the Surgeon General is important for symbolic reasons." Brandt is the government's top policy-making health official.

Dr. Koop says he is writing his own job description as Surgeon General and history awaits the outcome of this writing. His stoic, unwavering viewpoints are supported by President Reagan and, whether agreeing or disagreeing with those viewpoints, many observers admit that Dr. Koop is a formidable man whose career, if not his stance, demands respect and admiration. He may prove to be the most interesting and active Surgeon General we have seen. ■