PROJECT HOPE

Health Affairs

Interview with C. Everett Koop, M.D.

May 24, 2004

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P R O C E E D I N G S

INTERVIEWER: The date is the 24th of May, 2004. We're in the office of Dr. C. Everett Koop, at Dartmouth, in Hanover, New Hampshire. Let me just take a sound level here. Would you tell me your name, and spell it?

DR. KOOP: I am C. Everett Koop, C, period, E-v-e-r-e-t-t, capital K-o-o-p.

INTERVIEWER: All right. Good. What I'd like to do is start by talking about children's health, as I mentioned, since this is primarily a child health issue of Health Affairs that we're going into. And maybe talk most specifically first about pediatric surgery which, of course, is where you got your start in medicine. Just a word about how you've seen the development of that as a discipline, and how you feel about it looking back on it.

DR. KOOP: Well, I've always been delighted to have been associated with pediatric surgery. It was really a passion of mine, and I wish I could say that I had thought years ago that there ought to be such a

thing as pediatric surgery, but that's not the case. But I did know that children did not get a fair shake in surgery, and when I had the opportunity to be part of a new developing specialty, I seized it.

One of the things that I think made that experience so remarkable is that it was a new specialty. I was associated with the founding of the two societies that represent pediatric surgery. One was the Surgical Section of the Academy of Pediatrics, and the other was the American Pediatric Surgical Association. In addition to that, I had founded, with Stephen Gaines, the Journal of Pediatric Surgery, and had the great privilege of being the surgeon chief of the Children's Hospital of Philadelphia from 1946 until I went to be Mr. Reagan's surgeon general in 1981. So I entered on the ground floor, and what I like to say is true, and that is pediatric surgery really replicated the growth of general surgery in America, but whereas it took general surgery about 200 years to evolve, pediatric surgery started from scratch and achieved about as much as a specialty in 35 years.

INTERVIEWER: Where does it sit today? Are

you pleased with its developments, even after your active role in it?

DR. KOOP: I am pleased with part of it, and very frightened about another part. The part that I'm pleased with is that we have developed a group of young surgeons who are not just clinical surgeons and people who understand how to do good surgical procedures, but their bench research is contributing to other fields of surgery, as well, and I think that's one of the ways that a new specialty not only grows but retains the respect of its competitive --

INTERVIEWER: Their "venture search"?

DR. KOOP: Their what?

INTERVIEWER: Their -- oh, their "bench research."

DR. KOOP: Bench research.

INTERVIEWER: Bench research.

DR. KOOP: Yes, I'm sorry. The thing that worries me about the future of pediatric surgery, I give you the bottom line first. I don't think that the surgical care of my great-grandchildren will be as good as the surgical care was of my grandchildren. And let

me explain that to you.

I remember a day when I was the only pediatric surgeon south of Boston and east of the Mississippi. When we started, we were a very small group. I was the fifth person in America who called himself a child surgeon; "pediatric surgeon" wasn't invented until somewhat later. But I was the first person in America who did children's surgery exclusively. And that was as recently as 1946, so you can see we are relatively young.

The specialty grew in numbers. There was not, in the beginning, an international society of pediatric surgery, but the British Association of Pediatric Surgeons served in that capacity, and it was sort of the mother organization of other national pediatric surgical societies.

What happened to pediatric surgery is part of what happened to medicine itself. It slowly evolved from being a pure profession to being a professional business, and in business money is the bottom line, and that means that hospitals, medical centers, and even medical schools are competing against each other for

supremacy, and it got to the point, about 20 years ago, when if a small hospital didn't have a pediatric surgeon, parents knew enough about pediatric surgery that they wanted their child to be seen by someone who'd had experience with their child's problem. A reasonable and sensible request. That meant that small hospitals with no pediatric surgeon had to send from their institution, elsewhere, patients who were considered high risk pediatric surgical patients.

The resulting change in the business of pediatric surgery was that more and more hospitals advertised for a pediatric surgeon, the enticements were great, "We'll build you an ICU, we'll do this and do that for you," and the best way I can describe it is that when you have the number of pediatric surgeons multiplying the way they were, the gravy gets so thin it's not nutritious. And I am convinced, especially in a specialty like pediatric surgery where the technical prowess of the surgeon is very important to the initial success of the patient's outcome, I'm convinced that nothing succeeds like experience on experience. And today, there are so many pediatric surgeons that some of

them see very few of what we call "index cases," such esophageal atresia, diaphragmatic hernia, intestinal obstruction of the newborn, things of that particular nature, which were real technical challenges as well as physiologic challenges post-operatively, and there were times in the Children's Hospital of Philadelphia when we would have a dozen patients with esophageal atresia that came through in a single month. And in the last 20 years, when I have occasionally made rounds in other children's hospitals, the first question that I ask is, "How many esophageal atresias did you see last year?" And I get the astonishing answer, "Was that the year we had two, or was that the year we had three?"

INTERVIEWER: How many pediatric surgeons are there in the United States today?

DR. KOOP: I don't think I can answer that question for you.

INTERVIEWER: But the numbers have proliferated.

DR. KOOP: The numbers are great. Somebody told me that there are something like 800 certified pediatric surgeons, not all practicing in the United

States. That includes Canada, some from South America, but that are certified by the American Board of Surgery as pediatric surgeons.

And with the esophageal statistics, for example, my group and I did 272 esophageal atresias -- that's not right. We did 472 esophageal atresias between 1946 and 1981. And the results speak for themselves. In my own personal practice, for the last eight years that I was a surgeon, we didn't lose a patient with esophageal atresia. And our survival rate for premature babies was 88 percent. And I don't think that you can achieve that for the tough anatomical and physiologic challenges unless you have the experience that warrants your ability to meet the unexpected and to take care of it.

INTERVIEWER: Both as a pediatric surgeon and then in your role as Surgeon General, you had an extraordinary opportunity to observe the health of children or developments in the health care and health of children. How have you seen that over the last half century, and where do you feel we're headed?

DR. KOOP: Well, children occupy a very

special place in medicine. We always talk about the children being our future, and therefore they deserve our best, but I'm afraid we don't always deliver that way, and I have to admit that the older I get, the more I understand the relationship of poverty in a child and poor outcomes in everything else. And I think that I'm not beating a socialist kind of drum here, but I think, as we look to the future, unless we take into account what a severe role poverty plays in the future of children, we will never be able to attack its base causes.

Now, we have accomplished a good many things. One of the things I'm proudest of is that during my tenure as Surgeon General, working with Finch Hutchins and Norma Cursett (phonetics) of the Bureau of Maternal and Child Health, we were able to actually amend the Social Security Act, Title V thereof, so that it became the right of every special needs child in this country to have coordinated, comprehensive, family-centered, community-based care. And that was a tremendous advance, because it said the child will have the support of the family, which is so essential to developing kids

emotionally, but it also said you won't have to travel across the country to get it.

INTERVIEWER: What does that mean in terms of clinical or social support? What did that mean? What did kids get as a benefit of that they weren't before?

DR. KOOP: What they get is the ability to -- let me explain it with somebody like Katie Beckett, that is known to many people. Katie Beckett was a child who was respirator-dependent and lived in Iowa, but she was hospitalized as a Medicaid patient 30 miles from her family, and that was a great burden for the family to provide the emotional support that they needed. And Mrs. Beckett wondered why, when we had gotten children out of hospitals into their home, on a respirator, at ever so much cheaper rates per week than the hospital could do it, why that wasn't possible.

And out of that came the Katie Beckett Waivers, and that meant that Katie Beckett was transferred from a hospital to her home. That meant that it was community-based and not at a distant place. She had the emotional support of her family, so it became family-centered. It was comprehensive in that

all of the necessary specialists and those who provided social support were part of the team, and --

INTERVIEWER: And Medicaid continued to cover it.

DR. KOOP: Medicaid continued to cover it, but it was ever so much cheaper for them to do it at home. And it's interesting that just the day before we're speaking now, I noticed in the newspaper, warning that there would be tampering with the Katie Beckett Waiver System. So after all these years, we may have to fight that battle again.

INTERVIEWER: It's K-a-t-i-e?

DR. KOOP: Yeah.

INTERVIEWER: B-e-c-k-e-t-t?

DR. KOOP: Right.

INTERVIEWER: There is social criticism or political or policy criticism from time to time about the income transfer between youth and the elderly, with Medicare in particular commanding such a huge portion of our public budget, and relatively less going to children. Is that a concern you subscribe to in terms of public policy?

DR. KOOP: It's a concern that I have, because all the time that I was a pediatric surgeon, I was aware of the fact that our chief competitor was really not in the pediatric field at all, it was geriatrics. And just as --

INTERVIEWER: "Chief competitor" in the sense of?

DR. KOOP: Demand for services and the fact that people were living longer, living better, and you can't do either of those things without spending more money. And so I would say that it can be summarized by saying pediatric social and medical interests were vying with geriatric social and medical interests for an ever-increasing slice of a shrinking pie. And that doesn't make for good social service, it doesn't make for good family support, and it doesn't make for good medical outcomes.

But I would say that on balance, except for a few major things that stick out like sore thumbs, children do get a better shake. They certainly do, surgically. One of the changes --

INTERVIEWER: Than they did previously?

DR. KOOP: Than the did previously. I think one of the changes that should be noted is pediatric surgery started in a strange way, and the people who called themselves pediatric surgeons in the early days were really surgeons of the skin and all of its contents. I mean, I used to do subdural hematomas, and I'd work in the neck. I avoided the eye and the ear, but the rest of it was my domain. And it didn't mean that I kept out of the chest or the belly or the pelvis or the extremities, and for a surgeon who loves surgery the way I did, that was a wonderful system.

But if one looked at the development of general surgery in America after World War II, the great spurt in surgery, what I call "the golden era of surgery" in America, came about because of specialization. The war made specialization easy, and made it almost necessary.

INTERVIEWER: "Easy" in the sense?

DR. KOOP: Well, if you were in military situation and you suddenly had a huge bunch of burns, you've got to develop a kind of specialist that can take care of big burns. And the same is true with trauma,

and then people began to say, "Well, look, I've had so much experience in the chest, why do you abdominal surgeons keep stepping in my territory," and on it goes.

The long and short of that is that with the burgeoning of surgical specialties, I don't think there's any doubt about the fact that patients got better care and their outcomes were better. Largely on the basis of the fact that I mentioned before about pediatric surgery, study after study shows that the best outcomes are in the places that have the most experience. And surgeons did not like to see the log of general surgery cut into any more splinters, and one of the reasons that pediatric surgery faltered a little bit in getting it started in American surgical circles was that it was seen as not only the competition of another specialty, but here were a group of people who came along and said, "We can do what you do better at a certain age," and that made the competition even more telling. It wasn't just technical skills, it was understanding the physiology of a newborn and a small child.

INTERVIEWER: What do you think of the

prospects for child health as you look at the situation now, and look to the future? Is the aging of the population going to continue to create competition that kids won't be able to keep up with?

DR. KOOP: I think it depends, in the long run, _____ about advocacy. There are people who have always been child advocates, and they've done a tremendous job to advance the understanding of the public to garner public and private funds, and to, in general, move pediatrics along. But children are not able to have their own lobby, and I think there's no doubt about the fact that the geriatric lobby -- and that's not a specific group of people, it's just a tremendous variety of people who have interest in the aging population because that's where their business interests lie --

INTERVIEWER: And the aging population is not quiet group themselves.

DR. KOOP: No, they're not quite, and they vote. And I think that one of the major reasons why groups of people like handicapped children have never made the same kind of progress that elderly population

has in gaining services that they need, is that they don't have the ability to fight for themselves. And when you're fighting for yourself, I think you're fighting a different battle than when you're fighting for a class of people, like children, that you have sort of a nebulous connection to.

The one thing that I think stands out as -- I said like a sore thumb a minute ago -- and that is that the pediatric world did not recognize the fact that obesity, which is becoming a national problem, was also affecting children. And they didn't seem to understand that fat bouncing babies became fat children, and fat children became fat adolescents, and fat adolescents became fat adults. And we now have a problem that is going to be very difficult to reverse, and it has very serious implications about diseases in the long run and in later years that are associated with obesity, like Type 2 diabetes, breast cancer, colorectal cancer; that sort of thing.

INTERVIEWER: So this, in terms of the vigilance within the child health community, that's an area that perhaps might have been attended to better?

DR. KOOP: I think it could have been attended to better if, for example, I'd had another four years as Surgeon General, even though people weren't talking much about obesity in 1989, I would have made that one of the pillars of a next term.

The government were very slow, I think, to recognize what was happening with obesity and overweight, and you may recall that in the private sector I founded, with the aid of Hillary Clinton and the White House, a thing called "Shape Up America." Which was designed for the private sector working with private entrepreneurs to provide a way for people to become educated and aware of the dangers of obesity.

INTERVIEWER: Let's switch to your years as Surgeon General. As you look back on those eight years, what sort of reflections do you have about the job, about the experience, and about the outcome?

DR. KOOP: Well, no one ever tells you what the job description is of Surgeon General. And I think it's entirely possible, the way that job was organized when I arrived in Washington, to almost make it what you will. And I found that at the end of Mr. Reagan's first

term, as his early appointees began to leave government and go back to the private sector, that there were many vacuums in the government, a lot of them in public health and HHS. And waiting for somebody else to fill those vacuums, I stepped in and tried to do those jobs. I think it was appreciated by people who were leaderless, but it provided the opportunity to get several major things done.

One is, I don't think there ever has been -- had never before that been the same type of assault, not just on the problems of smoking and the health consequences thereof, but on the nefarious activities of tobacco industry and their deceitful processes, which were designed to obfuscate the public's understanding of what the government was trying to teach them. And fortunately(?), the momentum of that work has never really subsided. And I think we -- I have a terrible prospect of global expansion of smoking by the tobacco industry with the University of Cambridge statisticians predicting that by 2025 there will be an additional 500 million deaths of people now alive on this planet, due to smoking causes alone.

But the other thing that was a huge problem during my tenure was AIDS. And as I have made it abundantly clear in my writings about the subject, no one ever asked me to be the spokesperson of the government for AIDS, but it's a job that I assumed because nobody else was doing it and because, frankly, the people who advised Mr. Reagan were doing such a poor job of it. And I think the people -- and when I say "the people," I mean the public -- appreciated honest answers about a difficult disease to understand, and I think that both AIDS and smoking are the two huge problems that our global society faces in reference to health in the future. The problems have expanded, and they will not go away.

Smoking is a lot different than AIDS. Smoking involves an addictive substance, and that changes the whole aspect of the growth and development of an industry that has to replace those it kills, with new recruits on a constant basis, and the various settlements that the tobacco company has fallen heir to make it necessary for them to find new and outrageous sources of income. And they can pay the huge bill that

they established with this attorneys-general of the several states only because they had plans afoot even then to smother the rest of the world where men smoke but women didn't, and to turn their financial returns in such a way that they could pay what they had indebted themselves to do.

INTERVIEWER: Yet to these -- I do want to pursue the tobacco theme, but staying on the PHS for a moment and staying on AIDS, you described to me previously the vacuum that existed and how back of the hand or how informal your invitation to step up to the AIDS issue and develop the first AIDS report had been. Run that by me again, I mean how that happened, because I think that's an important part of history.

DR. KOOP: Well, for reasons that were never made clear to me, when AIDS was established as a disease and we knew we had an epidemic on our hands, I was told that AIDS did not come under my purview and that that would be handled by other people in the department, and I was reminded of that any time I made a public appearance or went on television or gave a lecture, that I was not to get into the subject of AIDS.

And yet, when that day came that I just mentioned a moment ago, when the original Reagan appointees began to go home to their points of origin, there were fewer and fewer people who really knew what was going on with AIDS, and it was easy to step in and by that time I had secured, I think, a sufficient confidence in the people of America that they could expect me to handle the situation with integrity, that the efforts that had been made to silence me before sort of disappeared. And I did become the spokesperson, and one of the things that aided and abetted that was that we changed secretaries of HHS, from Margaret Heckler to Otis Bowen.

Otis Bowen was a remarkable gentleman and a physician, a man with tremendous political experience, had been the governor several times of Indiana, and we struck it off as medical and political colleagues right from the start. And he made it very clear to me that it was not his intent at any time to step on my toes or get in my way, because he was very pleased with what I was doing, and he gave me every support that I could have.

The next thing that came along that was

fortuitous was that President Reagan asked me to write a report for the American people on acquired immuno-deficiency syndrome. And I don't think I've worked harder in my life on anything, and we published that, and except for treatment modalities, everything about the epidemiology of that disease and so on that was stated then is still true.

INTERVIEWER: And that report you got through with very little clearance, as I recall you and perhaps Secretary Bowen?

DR. KOOP: Secretary Bowen and I were the only people in HHS, except for two people appointed by me to be my associates, that knew what was going on. And I had agreed with Otis Bowen that if we passed this through the usual channels, of one being the Secretariat of the HHS, it would never have seen the light of day, because there were too many people, especially those surrounding the president at that time, who felt that who had AIDS after all, weren't they prostitutes, homosexuals and drug abusers and, after all, didn't they deserve what they had?

And the thing that I published had as its

theme, along those lines, we were fighting a disease, and not the people who had it. And I think that was a turning point --

(End of Tape 1, Side A)

INTERVIEWER: This is Dr. Koop, Side 2.

DR. KOOP: I do think that -- I forgot what I was saying.

INTERVIEWER: I'm sorry. The question was the clearance process and who -- and your position --

DR. KOOP: Yes. I did think that the major mistake that was made by government and the public was to treat AIDS as a political disease and not as a public health disease. I think we would not be in the terrible global situation we are right now if we had treated this the way we would have treated typhoid fever. Or syphilis. Or gonorrhea. And instead, we had special rules about privacy and special thoughts about protecting people, and as a result now we have a pandemic that is out of control in Asia and in Africa, and so --

INTERVIEWER: So you think if we'd been more incisive and more traditional in our infectious disease

approach, the epidemic would have been better contained?

DR. KOOP: I think the epidemic would have been far better contained if we had treated it according to public health principles as an infectious disease that was containable. I mean, the thing that stands out about AIDS more than anything else is its preventability. And as long as you had no way of knowing who contacts were and no way of understanding the reasons for testing and not testing, we just were in a quagmire for years.

INTERVIEWER: A word on being the Surgeon General. The metaphor, the cliché is, "bully pulpit." And you certainly used it as a bully pulpit. But beyond that, how did you feel about your prosecution of the job and what would you say about it as a position in general?

DR. KOOP: Well, I have tried to intimate that it is a job that you can make into really what you'd like to make it.

INTERVIEWER: Or, I presume, not? Should you not have the vision --

DR. KOOP: If you decided to sit and read the

New York Times, that would be also acceptable. Nobody would say, "Hey, do your job a little better."

I think the present situation, which I don't know whether you want to get into or not, but --

INTERVIEWER: Sure.

DR. KOOP: But we have a Surgeon General now whose qualifications seem to be perfectly satisfactory for the job at hand, but you don't hear much about him because he doesn't have the freedom that I was afforded by the Department of HHS; in this case, being strongly overshadowed by the White House. And so I describe Dr. Carmona as being a capable Surgeon General who is unfortunately wearing a straitjacket.

And I think that in this era where most people are a little concerned and some people greatly concerned about our preparedness for a possible biochemical terrorist attack, that this is a magnificent time for a Surgeon General with a bully pulpit to educate the people of the country, and, by moral suasion, to improve the preparedness of the public health service to deal with the problem.

INTERVIEWER: But that isn't being afforded

him, in your judgment.

DR. KOOP: In my judgment, we are not very well prepared at all. And the things that I've seen by people -- not necessarily medical people, but people on inside of government, who have been prompted to speak in the last few months of the Iraqi war, they confirm everything that I fear about the lack of preparedness of the country for biochemical response.

INTERVIEWER: On the Surgeon Generalship, others have come to town with, I'm sure, ambitions for the job and have not succeeded as well as you did --and as you bring your own persona and your own level of charisma and energy to the job, but how much is it the person and how much is it the political circumstances they work within?

DR. KOOP: Well, I don't think you can say it's either one to the exclusion of the other. There have been a lot of people who have discussed my performance as Surgeon General with me, and if they were people that I recognized as having experience in government I have asked them, "Why do you think I was successful?" And I would say the consensus of those

people has been something like this. That in Washington, you will find people who are remarkable diagnosticians of the problem, others who have wonderful therapy to change a situation, and a third group of people who do it. And I've been told that I have all three of those characteristics, and my work style is to diagnose, plan the treatment, and then do it myself.

INTERVIEWER: In doing what you did, you arguably changed constituencies in terms of your support virtually a hundred percent, or -- and several times. How did that come about? Did you change? Did they change? Was it the time?

DR. KOOP: I think there's no doubt about the fact that the people behind Mr. Reagan -- and in all the things I say about Mr. Reagan's administration, I separate Reagan the man from Reagan's advisers, because I found Ronald Reagan to be a straightforward person. If it hadn't been for the real conspiracy to keep me from the president about AIDS, I think that Reagan and I would have gotten along very, very well. And I think he would have seen the concerns that I had early on, and would have avoided for himself and his administration a

lot of the criticism that he had.

I tried to blunt the criticism that Reagan had by saying, "The president doesn't usually assume the public air waves to talk about the health problems of the nation. That's why I'm here. And no one could have tried harder to give you an absolutely clear understanding of what we face with the problems we do face in health, especially with smoking and AIDS."

And -- you had another question there.

INTERVIEWER: Yeah, well the question about the constituency.

DR. KOOP: Yeah, my constituency. I think the people who advised Mr. Reagan saw me as an ultra-conservative who would do their bidding and who would fit very nicely into their preconceived notion of the way things would go. Of course, they didn't know about AIDS.

INTERVIEWER: This was when they appointed you or they nominated you.

DR. KOOP: That's right. And I was nominated by the president on Valentine's Day, 1981, but I had been discussing this with people who were searching for

Mr. Reagan's cabinet and so forth, from the day he was nominated by the Republican Convention. So this went on all during the fall, between Election Day and Valentine's Day.

I think one of the problems with Washington in general is that people are labeled, first of all by the press; secondly, they're labeled by the supporters or the detractors of prospective members of the government; and those are three separate assessments of an individual, and none of them are necessarily true. And so I came with a label that I really didn't fit. I mean, my reaction to smoking, my reaction to big tobacco, was not the reaction of a Republican to big business. It was fury at the deception of an industry masquerading as a legitimate business, but really exuding evil in the attraction of children, especially, to an addictive drug that ruined their lives and killed them early. And so when I began to say things that I felt had to be said, there was never anybody who stopped me.

Now, I don't understand the anatomy of what I just said completely. The advice that Reagan got from

his close advisers was to dump me and to get rid of me as soon as he could. He never did that. He never reprimanded me for anything that my critics criticized me for. When I left office, in 1989, one of the surprises I had at the celebration of the end of my term in California was a very long and highly complimentary video of Ronald Reagan talking to me, of course on the screen. One of my happiest possessions, because although it's absolutely true he never criticized me and never called me to stop me doing anything, but on the other hand he never said, "Good for you!" And so I didn't really know, until he had gone back to California, what he really thought about my performance, but I think he thought it was satisfactory.

INTERVIEWER: Well, it sort of was a social conservative, the "Right to Life" groups, that touted you as their candidate.

DR. KOOP: They touted me as their candidate, and you know, one of the interesting things to me about government that most people don't know, I gave a tremendous number of talks in the old Executive Office Building, usually up in the Entreaty(?) Room, to groups

of constituents that really admired Ronald Reagan, and that he sometimes invited to the White House. And I'd get a call in the morning that the president's entertaining some people this afternoon, he's going to speak to them from 1:00 to 1:05, could you take over until 2:00 o'clock? And so it would be on all sorts of things that had nothing to do with my job, really, and I had one big collection of talking points. And I used them many, many times, but never gave them a title, because the title shifted all the time. And so my staff, to file it someplace had to give it a name, so they called it, "A Really Good Sermon."

(Laughter)

And I gave that really good sermon for Ronald Reagan many, many times, and --

INTERVIEWER: Did it have a political or social agenda, or --?

DR. KOOP: It was his political social agenda. Really. It was his pro-life position, it was a conservative view of life in general, but never cramping my style. And no, it's -- I worked much more closely with Mr. Clinton than I did with Mr. Reagan. Strange

circumstance, but he would never have let me get away with the things Mr. Reagan did.

And I had a secret way of communicating with the president. You must remember that the people who were most opposed to the things I did and said, like Gary Bauer, had made it almost impossible for me to communicate with the president. But I had a way of slipping a note to him at the end of each day, if I wished to --

INTERVIEWER: "Him," being the president?

DR. KOOP: The president. And --

INTERVIEWER: Through a back channel? Through someone?

DR. KOOP: One of the routines of the day for Mr. Reagan was before he left the Oval Office and went up to his private quarters, is that the director of the mail service would drop by with about ten to twelve letters that she thought were the pulse of the nation that day in the letters that came to the president. And he'd dutifully sign them, but he added a little note to each one, "So sorry to hear about your husband's osteoarthritis," and that sort of stuff.

Well, sometimes between two of those would be a note from me. And --

INTERVIEWER: And then she saw to it he got them?

DR. KOOP: He got it. And I'll give you one example.

INTERVIEWER: But she was your contact? Or she was your --

DR. KOOP: She was my contact. And Mr. Reagan was very, very upset about the fact that there were children who were born with no bile ducts in the liver and who faced certain death, and the only possible chance for survival was a liver transplant. And so I did three Surgeon General's workshops on transplantation. I founded, for the people who used it, the American Council on Transplantation; got some funds from the public health service to pay for the legal fees to set that up and so forth and so on.

But the -- where was I going with this?

INTERVIEWER: You were talking about Reagan's interest in liver --

DR. KOOP: Oh. So he went on television one

afternoon, sat in his -- you know, he spoke on radio every Saturday afternoon. And his whole program was a plea to the American people, "There must be somebody out there who has someone who just died in the family or might die between now and the time tomorrow comes. We need a liver for this little girl."

And he was, I heard from my White House contacts, crushed that nobody came through with a liver. As far as he knew. And so the little note that I put in his mail was, "Don't be upset about no liver for your patient. We actually had 40 livers offered to us. None of them were suitable, but the most important thing which, Mr. President, you do not know, is that no liver transplanter in this country is willing to put this little girl at the top of his list, which is the only way her parents will deal with a medical professional."

And he called me about -- he flew to California that week, called me about five times, because he didn't know about the change in time, but anyway, and we had a great talk about liver transplant on the telephone.

But those were the kind of opportunities I

used, and I think he appreciated the fact that I protected him and informed him about things like that. Which I would much rather prefer to do eyeball-to-eyeball, but his minions would not permit that.

INTERVIEWER: Tell me about your relationship with the Clintons and how you moved, in your own political persona, in your latter Surgeon General years and post-Surgeon General years, to what, in simplistic political terms, would be from having been a conservative Republican to at least a moderate to liberal Democrat.

DR. KOOP: I didn't ever really change my point of view, but what happened is my constituents felt that I did, or understood where I stood in the first place. That was what most of them didn't know.

Mr. Clinton had campaigned on a platform that had to do with health care reform. And I was speaking as often as I could to the American public about health care reform, and I had some good ideas about it, and I received a sort of relatively secret message from the president by word of mouth --

INTERVIEWER: This being now President

Clinton?

DR. KOOP: Clinton, that he would like me to be the salesperson for his health plan.

INTERVIEWER: So during the campaign or prior to that, you had not worked with him.

DR. KOOP: I had talked with him nine different times during the campaign about health care reform.

INTERVIEWER: He had sought you out, or --?

DR. KOOP: He had sought me out, and thereafter I would call him or he would call me, and we had a good understanding about our differences of opinion and what I thought were important things and what I thought could be accomplished and what I thought couldn't be accomplished. And that was interrupted by -- he had a medical student from Harvard who was advising him, down in Little Rock --

INTERVIEWER: Atua Gwandi (phonetic)?

DR. KOOP: Atua Gwandi. And Atua Gwandi told me that I would no longer have the opportunity to talk to the president, and any message I had I would give to him and he would give to the president. And I never

passed any word to the president through Atua Gwandi, but --

INTERVIEWER: He's become a pretty good surgeon.

DR. KOOP: Yeah, so I've heard.

INTERVIEWER: Yeah. He's an excellent writer, too.

DR. KOOP: Yeah.

INTERVIEWER: Yeah. But that was a little presumptuous, I have to agree.

DR. KOOP: I thought at the time, yeah, even for a Harvard medical student.

(Laughter)

So I said that I could not support any program as a sales person unless I knew what it was all about, and I had to confess that some of the things that I had read in the press were disturbing to me. So the president sent for me, and we had our first meeting, and he said -- he was very gracious. He said --

INTERVIEWER: This is in Washington or this is in Little Rock?

DR. KOOP: Washington. It was in the Oval

Office. He said, "I know you can't be my salesperson," and he said, "I realize that we have differences on opinion about some things and what I'd like to reform," he said, "but what I'd like to ask you, would you be willing to be the moderator of a conversation between the medical profession and me and/or the First Lady?"

I said I could not possibly turn that down. And so that gave me the opportunity to travel with Hillary and I truly believe -- something you can't disprove but neither can I prove it --but I truly believe if she and I could have done what we did for a whole year, instead of for three months, we could have come up with a compromise with the medical profession and we might have avoided the horrible transition to managed care. We just didn't have time to get it done.

INTERVIEWER: "Horrible," in that you would have been able to craft or develop legislation that would have been passed, that would have been a reform?

DR. KOOP: The thing that impressed me about this dialogue that I had been asked to moderate was how flexible both parties were. I would go to a meeting with medical profession, anywhere from 40 to 400 people,

with the First Lady. We'd stand on opposite sides of a platform, behind lecterns. And there was no bitterness. There was no accusation of carrying too much baggage with you and that sort of stuff. But she understood their point of view, and when she didn't I explained it to her then or later, and vice versa. And I don't remember leaving a single one of those things, those dialogues, when she didn't have a broader view of the medical profession and when they didn't have a more accepting view of her.

INTERVIEWER: She credits you in her book as selling health care reform with her in a very effective way.

DR. KOOP: Yeah. Well, she --

INTERVIEWER: She doesn't limit it to the medical profession.

DR. KOOP: No.

INTERVIEWER: You talked to other audiences, as well?

DR. KOOP: Well, the medical -- I think in the medical profession you have all the people who worry about insurance, health care and administration of

hospitals and the sale of goods and pharmaceuticals, and that sort of stuff. So they're all --

INTERVIEWER: And your coverage went everywhere, I'm sure.

DR. KOOP: Yeah. But she --

INTERVIEWER: So you spent three months on the road --

DR. KOOP: Yeah.

INTERVIEWER: -- on and off, with her?

DR. KOOP: Uh-huh. And we would come home from someplace, Atlanta, and I'd sit with her and her chief assistant in the plane, and we'd just outline -- I'd say, "This is what you learned today. This is what you found is going to be hard to push the medical profession on," and so forth. And we'd get back to the White House late in the day, and her devoted staff would be waiting, at 12:00 midnight or 1:00 o'clock, and she'd say, "You do this, and you do this, and you do that," and they'd get report back to me in three or four days and say, "We were able to accomplish this, this and that, but we can't do this."

And it was a heady time, because I felt that

we were -- I never came away from any of those meetings saying, "They don't understand each other." Because they did understand each other. And I would be elated sometimes at the concessions the medical people would make once they heard her say it. Very charming person, one to one, with a doctor. And no sign, ever, of any arrogance, "I've got a reform plan and you're going to take it," you know. And it was really great to see. And I do think we could have done it.

INTERVIEWER: As you look back on health care reform and your work with the Clintons, what do you conclude? What might have -- was it doomed, ultimately?

DR. KOOP: Toward the end of those days, I was sort of acting as a courier between the Senate and the White House, and it demonstrated to me the one thing about politics that is, I guess, insurmountable. I'd spend all day talking to three Senators, and I'd get them to join the eleven that were already agreeing with what we wanted to do, but in getting those three I lost five others.

And the person that was trying to shepherd this -- you remember that it got so complicated that the

House threw up its hands and went home. They didn't even bother to continue to discuss health care reform. And it was the Senator from Maine -- what's his name?

INTERVIEWER: Mitchell, George Mitchell.

DR. KOOP: George Mitchell was trying to act for the Clintons in getting this stuff through Congress, and it just -- we'd gain three and we'd lose four; we'd gain five, and we'd lose six; we'd gain six and we'd lose two; and we just never got to the point we could pass it.

But see what -- I think we were watching history in the making, because I think essentially what medical politics said at the failure of the Clinton plan, is "The pundits have always told us if we let market forces run health care, we'd have lower costs and higher quality, and let's give it a try." And I don't know anything that works that way. You get lower cost, and you don't get higher quality; it's usually the other way around.

And even at this late date, my feeling is that if we'd had a better chance to educate the medical profession and the public -- and we were doing a good

job, but you can't do it all in three months. If we could have spent a year doing that, and had postponed health care, say, until maybe the third year of his first term, I really think we could have avoided managed care. And we would have had a better health care plan than we lived through with managed care.

INTERVIEWER: And that what we have now, you're saying.

DR. KOOP: Oh, yeah, I don't even know what to call it now.

INTERVIEWER: We'll come back to that. Is Hillary going to be president?

DR. KOOP: You're not going to put this in the Journal.

INTERVIEWER: I won't if you don't want.

DR. KOOP: No, uh -- I think Hillary would like to be president. I think that there are a lot of barriers in the way. I think if Giuliani runs against her for the Senate, for example, and she loses, which is a likely thing to happen, then I think it's all over.

But I think that it will take several more years of history to fully assess the importance of the

Clintons to the things that are going on right now in the Democratic party. Because I -- you've got to ask yourself about Howard Dean's meteoric rise and meteoric fall, how'd that come about? Not for publication, please, but I don't think it would have suited the Clintons to have another leader in the Democratic party.

INTERVIEWER: As Howard Dean.

DR. KOOP: And he was on the way to being that. I mean, you know, up here, which you didn't have a chance to see, this place was pulsing for Dean. It was really -- it was like when Reagan came to Washington. People who weren't even interested in politics were thinking, "This is pretty good."

INTERVIEWER: Do you think she would be a good president from her executive ability, her vision and wisdom?

DR. KOOP: She's one of the most talented people I've ever worked with, and I think she has all the necessary things to do the right thing. I think whenever you talk about what will a politician do, you just don't know because politics is so important.

INTERVIEWER: Yeah. Do you want to take a

break?

DR. KOOP: No, I'm okay. Well, maybe I -- no, I changed my mind. I'm fine. I'm _____ my legs so they don't clot anyway.

INTERVIEWER: Okay, good. Let's go back and pick up on tobacco. And you certainly got your feet and more of your anatomy wet with tobacco, as Surgeon General, but then there was the battles after that and there was the ultimate tobacco settlement. Tell me a bit about that, and how you feel about the settlement and the aftermath of settlement.

DR. KOOP: Well, I think the first thing that should be said about tobacco at any time, but especially right now in history, is that tobacco is always a good news/bad news story. Tobacco at this moment is, at once, one of our greatest triumphs and one of our greatest defeats. It's a horrible defeat, after all the effort we've made, to know we have 49 million nicotine addicts in America. On the other hand, we have fewer than half the number of people smoking than we had in 1964.

INTERVIEWER: Percent-wise in the population?

DR. KOOP: Yeah. Yeah. So we are, you know, we've done very well, but it hasn't been good enough. And I think that efforts at tobacco control have been rather magnificently done, and I think in the past decade we've seen all the things fall in place that make it possible to control tobacco, and the reason I say that is that --

(End of Tape 1, Side B.)

INTERVIEWER: Koop, Tape 2, Side 1. You were saying about tobacco just in the last week?

DR. KOOP: Just last week, both the House and the Senate gave approval to that, which should lead to the regulation of tobacco by the FDA, and then the thing that I think will make it happen is that Phillip Morris supported it. And so when you have the House, the Senate and Phillip Morris, you've got a majority, as far as that is concerned.

I think one of the things that differed in my approach to the tobacco problem was that I did what my predecessors had done, and I talked about the health effects of smoking. And we did that very well through the Surgeon General's reports, and we had things nailed

down, chapter and verse. I think that the two major things that I accomplished along those lines was making clear the dangers of passive smoking, because what that did was to turn nonsmokers from neutral folks into activists against smoking. And I think the most important thing that I accomplished in the Surgeon General's role with the Congress was the 1988 report on addiction.

INTERVIEWER: When was passive smoke? That was earlier?

DR. KOOP: It was earlier, yeah.

INTERVIEWER: But during -- there was a report on passive smoking?

DR. KOOP: Yeah. I think there five public --

INTERVIEWER: But the addiction one was '88?

DR. KOOP: '88. And I consider that to be progress in the following way. If I had gone to a meeting any place in this country or Canada, say in 1987, where I was in a room full of smokers and I asked, "How many of you are addicted to nicotine?" you might have seen one or two hands gone up. You ask that same audience today, and you get 80 percent of the people

saying, "I'm addicted." And I think that is a huge change. It's a sea change in the way people think about themselves, and if you think of yourselves as somebody who has a tough habit to break, "But I can do it tomorrow," it's an entirely different problem than if you say, "I am truly addicted to an addictive drug." And I think that the ground rules change, and it's, in a sense, harder to sell a cure, but it's also, for some people, easier to sell a cure.

The other thing that I did a little differently than my predecessors was to attack the tobacco industry. And I -- see, I came on the tobacco scene as an anti-smoker. I came on the tobacco scene with very little political understanding of what went on behind the scenes. And I was absolutely infuriated that when we would make -- spend a whole year getting a report together and present it, and two weeks after that the tobacco industry would spend tearing down the science and saying it wasn't true, and so forth and so on. And I decided not to take that as just things that happen to the Surgeon General's report, but to continue to hammer away until the next time something happened

that they were a deceitful group of people.

And I used to talk about the fact that although it couldn't be used in a court of law, that I had many communications from tobacco industry workers telling me about the nefarious things that were going on in their company, but everything was protected by attorney/client privilege. Which was a pretty clever maneuver on the part of tobacco, that any research was never reported to management without being reported to legal counsel first. So everything became attorney/client privilege.

And that was the biggest, the biggest aspect and the biggest sea change in the tobacco settlement, was the tremendous efforts of Skip Humphrey, the attorney general of Minnesota, Hubert Humphrey's son, in getting the courts to remove that attorney/client privilege because it was not necessary and it was spuriously obtained. And now, not only do we have repositories here and in England of all of the documents, something like 30 million pages, but they're catalogued, and there still is a treasure trove we haven't turned up, of the things that were deceitfully,

knowingly and deceitfully said by the tobacco industry that's perjury.

And one of the things that I find very difficult to understand is why there isn't more outrage on the part of the public on the way the tobacco companies duped them, to the point that their mothers and fathers died of tobacco, and their kids are hooked, and they are too. I think they would be furious.

INTERVIEWER: Yeah. The run-up to the ultimate settlement was a fairly rough and tumble period, as I recall.

DR. KOOP: It was a rough and tumble period. I've got to be very careful what I say, because I don't want it to be the wrong way. I think that the tobacco industry sort of rigged it the way they wanted to. I had two secret meetings with people from the tobacco industry, with great secrecy, in places I didn't usually frequent, go in the back door, go up the backstairs, this sort of stuff. Really seeing if, I would say, I could be bought, but seeing whether in my position of righteousness about tobacco, I couldn't say things that would be favorable to the settlement, the way they

wanted it to go.

The thing that was frustrating is that there were lawyers, lawyers, lawyers, lawyers. And there was nobody from public health. And when they sat around the table and discussed things, it was lawyers there discussing with other lawyers in reference to their clients; their clients were the tobacco companies, their clients were other people in society, their clients were the attorneys-general who got their own lawyers from outside their offices, and we had just one person representing our side. Now, he is a very zealous and a very efficient guy, Matt Myers, who now runs the campaign for Tobacco-Free Kids. But I do think if he had said --

INTERVIEWER: "Our side" in this case? You said Matt Myers was representing our side.

DR. KOOP: He was the person that was opposed to smoking and opposed to the tobacco industry's influence on children, advertising and everything else.

INTERVIEWER: But that was different than the attorneys-general?

DR. KOOP: He had a passion that was closer

to --

INTERVIEWER: He was a pure advocate.

DR. KOOP: He was a pure advocate, but I think he should have protected himself by saying, "I want seven people from public health on this committee to be my advisers and to work with me." And a lot of us tried to talk with him, and I was talking to both sides, back and forth, all the time, and the settlement itself was a tremendous thing, huge amount of money, over 25 years, but it were the things that happened apart from that that made me leave Washington and move up here.

And when Trent Lott behaved the way he did and said that this subject will not come up again as long as I am president of the Senate, and when we took a vote in the Senate and won, and we discarded the vote. It just seemed to be such highhanded --

INTERVIEWER: He discarded the vote? Explain more, because I'm not familiar with this.

DR. KOOP: I don't understand it either. But the Senate vote was in favor of tobacco -- well, let me interrupt and say that an ad hoc committee of Senators and Congressmen asked me if I would be co-chair of a

committee, and David Kessler would be my other co-chair, and that we would prepare, with the help of anybody we wanted to get, the gold standard for tobacco legislation, to control tobacco in the United States. And I think it's one of the better things that we did, and we presented that gold standard. And essentially, that gold standard was sort of what we were voting on, although it wasn't in the words that we used, and my recollection is that we had six more votes than we needed, and essentially won that battle, and then Trent Lott said that he was withdrawing the, what I would think would be a completed act, he was withdrawing it from the Senate and -- .

This was an interesting time, because we had some stalwarts from both sides of the aisle in both Houses of Congress who were really hopeful -- Ted Kennedy being one of them -- that we would finally come to something that would pin the ears of the tobacco industry back where they belonged. And when all those things happened, in a matter of a couple of days, I said, "If working as hard as I can with a very efficient volunteer group helping me, and with the reputation that

I have in Washington about tobacco and about integrity, if working two years like this, it comes to nothing more than we have seen, there's no point in my staying here." So I left and came here.

INTERVIEWER: And this would have been legislation that would have been far more regulatory and far more --

DR. KOOP: Yeah.

INTERVIEWER: -- and would have controlled the tobacco industry and tobacco sales and advertising?

DR. KOOP: But you remember -- yeah, but you remember, it was a little more complicated than that, because there actually was a court case that came up in the south that we lost, in trying to assure the role of the FDA in the regulation of tobacco. So it wasn't as open and shut as I like to think it was. It's a funny way to say it, but there were so many things going on at the same time, that I think even legislators were confused.

INTERVIEWER: And the settlement was a separate track.

DR. KOOP: Separate, indeed.

INTERVIEWER: And when that came down and was finally legislated and accepted, were you satisfied with that? Were you satisfied --

DR. KOOP: No, I was not satisfied with it because although the sum of money was exorbitant and I think fitting and proper, the thing that bothered me was that there were so many little things that were just ignored, and when the questions came up about them, the answers were all, "Well, we understood that that was to be this way," you know. They pretty well ran roughshod over things that weren't settled by individual articles in the law.

INTERVIEWER: The size of the settlement. Do you recall what that was?

DR. KOOP: The what?

INTERVIEWER: The size of the settlement?

DR. KOOP: 270 billion, I think.

INTERVIEWER: Over 25 years? And since that time there has, of course, been highly variable use of the money on a state-by-state basis. Your thoughts about that?

DR. KOOP: Only one state has used the money

for its intended purpose completely, and that's Mississippi. And that's because Michael Moore was one of the major protagonists in the group of attorneys-general who were bringing the suit. But --

INTERVIEWER: And that purpose was tobacco reduction?

DR. KOOP: There were two major issues. One was to prevent children from starting to smoke, and the other was to make treatment available and worthwhile for adults. So (inaudible) still a problem.

INTERVIEWER: But other than that, states have used it in a variety of ways?

DR. KOOP: Well, it came at a difficult time when, because of an awful lot of problems in the economic world, practically ever state in the union was running a deficit budget. And they saw this as sort of having won the lottery. And nobody had any qualms about taking that money and using it to fill potholes or fix bridges or pay schoolteachers or maternal and child health, or -- very, very little of the money went to health, even if it was tobacco health.

And states like California and Massachusetts,

which had the best programs for their own citizens, the money that was available was in such short supply that they lost a lot of their people, a lot of their programs. New Hampshire, exactly the same way. Everything up here was jeopardized. I knew 24 people that were very active in the state, working with us here periodically, and they all were without funds all of a sudden because the money was not used for its intended purpose.

INTERVIEWER: What will happen to tobacco in America? What's your prognostication? Will we better the situation now in terms of percent of the population? Well, it's down, it's 20-some-odd --

DR. KOOP: Five.

INTERVIEWER: Twenty-five percent?

DR. KOOP: I think -- I don't think you can talk about the United States separately. The United States is 9 percent of the global economics of tobacco. And to make that payment of $200-and-some billion, and other things that have happened, and no one knows what's going to happen with the huge suit that's been brought by the government against the tobacco industry, but

that's a lot bigger than the settlement is, if they were to win that, and it means that there's going to have to be some very innovative financing, and I don't see the one thing that could be a deterrent, and that is a global public health effort to fight big tobacco.

INTERVIEWER: It's not there.

DR. KOOP: It's not there. And the thing is, you can't expect Zimbabwe to fight it by itself, or the Philippines to fight it by itself. The American Cancer Society has done as much as anybody, by bringing over to this country selected individuals from developing nations to teach them how we have handled the politics of big tobacco, and to teach them the ways that we have used our political muscle, the way we've used public education, the way we've used gimmicks here and there. And it just -- it's a nice effort, and it's well thought out and very well-meaning, but it's just too little recognize _____ size of the problem.

INTERVIEWER: So I gather from that you think that the United States' efforts over reduction will remain where they are, but a great deal of the commercial and promotional effort's been moved globally?

And will remain so?

DR. KOOP: I think so. And you know, again it fits into -- it's a politically bad time to worry about tobacco, when you try to get the attention of a concerned citizen who is worrying about the war in Iraq, the economics at home, and people dying tobacco deaths in Indonesia, you know what takes third place. And I don't know any way to overcome that.

Everybody talks about the shrinking globe and the fact that our problems are everybody else's problems, and there's no such thing as a disease which is somebody else's problem alone, and yet we're not doing the things that should come from that understanding and working together to try to fight what's happening.

When you think about the fact that 500 million people now alive and well on this planet will be dead by 2025, you know, I can't take that number in. I tried to work it out. That's the same number of deaths as if you had all the Vietnam War deaths every day for 25 years. It's the same as if the Bhopal incident in India recurred every four hours for 25 years. It's the

Titanic sinking every 47 minutes for 25 years. If you wanted to build a Vietnam-type memorial to these people that were going to die by 2025, you'd use the same kind of set-up. It would start in Washington and go westward over six countries, and end in Kansas City. A pretty big monument.

INTERVIEWER: Well, I think that puts tobacco in perspective.

Would you like to take a break and --

DR. KOOP: I'll walk about a bit.

(Recording interruption.)

INTERVIEWER: I'd like to pick up with looking at public health in America. We can talk global later, but talking United States in particular. Post-9/11? I mean, that certainly was a seminal event for the nation, but also for public health. It's not clear to me whether it started public health on a new route and, of course, 9/11 is overlaid with anthrax and events of that period. Do you -- I mean, how do you feel about the direction of public health? Do you think it's gotten new life? Or do you think it's been diverted into wacky bioterror concerns?

DR. KOOP: I think that public health in the United States began to slip in the Clinton administration, and I think that we began to lose some of the people in the commission corps that I thought were real stalwarts and people who understood the permanence of such a group and what its contribution could be to the nation. And since that time, everything that I have seen or been able to understand that was happening to the public health service of the United States in that group, and especially to the commission corps, has been downhill.

And I actually got to the point where I stopped going to meetings of the commission officers that were social events and I sometimes could attend, just because I'd come home so depressed by everybody's cornering me and telling me how awful things were and how they were going downhill and getting worse. And I think that a lot of little things -- there were some changes in pay for -- of the uniformed services, but they weren't passed on to the public health service, and at every turn it seemed that something was happening that wasn't good, and then when I was asked to testify

about the public health service and about the commission corps before Shays' committee, I really felt that the public health service and the commission corps were being exposed to scrutiny from people who really didn't understand much about either, and when you got finished hearing all the complaints it sounded like things just couldn't be very good in the future.

INTERVIEWER: This Representative Shays -- Chris Shays?

DR. KOOP: Chris Shays.

INTERVIEWER: Of Connecticut.

DR. KOOP: Bioterrorism didn't start with 9/11, and we've had ample discussions about bioterrorism in the confines of the public health service and in the commission corps, and it seems to me that we never took very much of an effort to do anything about it, and yet I believe that the public health service, as it was constituted when I was there, and the commission corps particularly, was very well suited to running a program that would be as good as you would expect.

You can't prevent terrorism, and so your effort has to be on ready response. And rapid

deployment of your resources to prevent things from going from bad to worse. And I don't see that.

And I think the manner in which the anthrax, for example, was handled was five cases -- suppose it had been 50? Suppose it had been 5,000? Suppose it had been 50,000? I mean, what would we have done? I think we wouldn't be over the panic yet.

And I don't know enough about the new department except that it's the biggest we have to have in government --

INTERVIEWER: Homeland Security?

DR. KOOP: Homeland Security, to know how well that's going to go. I think Governor Ridge was given a very tough assignment, because, I mean, people such as you and I know that Washington and your ability to function there depends an awful lot on old-boy networks and people you know and can call on in time of need, and Ridge came into Washington with a huge task to perform, and no connections at all. And I think that with that in mind, he has done an admirable job with what he had to face. But as far as being able to show me or anybody else, "This is what we would do if somebody blew up this

bridge and attacked us at the same time," and so and so forth, and that's what worries me.

INTERVIEWER: In the real 9/11 and the post-9/11 period there was a lot of money put into the system in and around public health, including very specific and rather wooden items, like vaccine procurement. I don't mean that disrespectfully, but "wooden" in the sense you've bought that, that's just a flat purchase starter pile. Do you get any sense that this new money, new attention, has invigorated American public health in general _____ public health service, or not?

DR. KOOP: If you ask me a yes or no question, I'd say not. And I realize that in organizations such as the size of which we're talking, a lot of things can be good that are going on that you don't hear about, but you hear about the bad things. And I don't want to badmouth the official representatives of public health in this country. But I do have the feeling that the people who know the most, those who are responsible -- not medically, but line officers for the defense of this country -- are as concerned as I am about the lack of

preparedness, and that worries me. It worries me at the level of communication. And it seems to me that the public health service, going back to the NIMNIS (phonetic) days, has had --

INTERVIEWER: "NIMNIS"?

DR. KOOP: You must know what --

INTERVIEWER: Shame on me.

DR. KOOP: It's the thing that -- about 1986 or so, the military made a decision that they would not try to have a chain of health command like they had in the Korean War, with MASH units and base hospitals and up, but that the transportation was sufficiently good for the entire globe that we'd have the hospitals here, use the benching(?) system, and transport our wounded to there. And there were a lot of people who had -- public health service who had obligations to NIMNIS, and some were people who would be called up immediately if there were a military conflict and so on. And the only reason I raise it is that the thing that always appealed to me about NIMNIS, it was a system that was working in a time of peace, in a civilian authority, but it was transferable to a military need just by saying, "Hey,

we're using you."

And we have a group up here that's working on some of the problems with terrorism, that's an official DARPA thing, and then there's another group of us that have published five papers on terrorism so far, all asking the same thing: that in this day and age, terrorism is going to best be fought in cyberspace because we have a communications system, and if we're going to use our heads we want a system when we finish using it for the military, we can use it for civilians, and it works just as well.

And whatever we have should be able to handle the Oklahoma bombing of a government building or a tornado or hurricane or a flooding, as well as it could handle anthrax in Trenton or with the post office. And that's what we've been trying to focus our attention on is a system that is not either military or civilian, but it can serve both at any time by a switch of the --.

And I know that's not answering your question, because it's very hard to get your hand on what's going on, and I would be hard put to make you a list of the things that ought to be changed right now.

INTERVIEWER: Yeah. I don't have a sense that, say, the profession of public health has received a bump up in public esteem. I don't have a sense that more physicians are choosing public health or public health careers. I don't have a sense -- I know actually I'm not as well read on this, that might be admitted, but post-9/11 CDC published an evaluation of state health capabilities, connectivity being a big one, that was just an embarrassment.

DR. KOOP: Right.

INTERVIEWER: I mean --

DR. KOOP: Well, that's what I mean about it's got to be fought in cyberspace. The number of local first responders that don't even have a computer and can't go on the Internet, can't send e-mail -- it's astonishing, really.

And the other thing that you mentioned, I don't find people dedicated to public health as much as I find them feeling they ought to have a little background because it's good on their resume. I mean, a lot of students come through here and ask me if they shouldn't go someplace where they can take an MBA -- I

mean, a --

INTERVIEWER: MPH.

DR. KOOP: -- MPH along the time they're getting their medical degree.

I always say, "Yeah, it's a great idea."

And I have actually turned a couple of people toward public health alone and forget the medical school business, because I think we need the kind of people that go into medicine to go into public health.

The other big shock to me was that I was with one of a group of six people who, about six years ago now, decided that the spread of public health from medicine was not to the benefit of either profession, and there were things that we could do together, we could fight together for principles, we could fight together for money, we could fight together for research budgets, and we could work in each other's labs and bring that together, and you know the old joke they tell about Baltimore, that the widest street in Baltimore is Wolf Street, because public health's on one side and the medical school's on the other.

But old joking aside, that group of six grew

to a group of 70, grew to a group of 240, who wanted to see public health integrated. We even got so far in the planning as to think if Dartmouth couldn't be a virtual school of public health for all the medical schools in New York and New England who didn't have a school of public health associate with a university where they were. And Roy Shores (phonetic) was very prominent in this, Stan Reiser -- do you know Reiser? He's got an interesting title, he's Professor of Humanities, the Department of Medicine, at Baylor in Houston.

And we had a meeting of the 240 invited guests, and I gave a keynote, Reiser gave a keynote, Bozher (phonetic) gave a keynote, and we went away from that meeting with the feeling, at last places like the Providence Rhode Island Department of Public Health is talking to people in Connecticut about how they can work together on problems, and terrorism wasn't even a big thought at the moment. And it is dead. It is totally dead.

And you call anybody who was part of the planning committee or something, say, "When is the next meeting?" they want to know, "What meeting?" And I

think we muffed a tremendous opportunity to bring medicine and public health together, and to stress our ways that we could cooperate. And, you know, somebody asked me one time, "If you could do something about public health and medicine, what would it be?"

And I gave an answer off the top of my head which, in retrospect, isn't too bad. I said, "The first thing I would like the people in (inaudible) in medicine to realize is that there are more doctors than medical doctors, and that they shouldn't look down their noses at people who spend their years getting a doctor in public health."

And the person who asked me the question, "Well, what about the other side?"

I said, "Ben," I said, "I think that the contribution that medicine has to make to public health in this regard is that we've got to teach all those people with MPHs that the numbers the computers spew out all the time are real honest-to-goodness people with blood, who are hurting, and they're hurting because of poverty or they're hurting because of disease or they're hurting because of both of them, or they're hurting

because our systems don't jibe right where public health interfaces with medicine." And I think it's one of the biggest challenges that we have for the future, and one of the great missed opportunities, that we can't pull together medicine and public health in such a way that we help each other instead of be detrimental to each other.

INTERVIEWER: The status of medicine. Had health care reform attempted, and you've described eloquently your role in trying to make that happen, and then as you indicated, we had a market solution that was brought upon us, managed care, which is still with us in various morphed forms.

What do you see as the lot of medicine today, and where is it headed?

DR. KOOP: Well, I think the major thing that's happened to medicine, I alluded to in reference to pediatric surgery, it's all part of the same big ball of wax, and that is the gradual evolution from a pure profession to a profession that relies on businessmen to make it work.

Take the American Medical Association. There

was a day when the infrastructure of the AMA -- that is, the people who worked out in Chicago in the AMA building -- were retired physicians or sometimes impaired physicians who couldn't do the job they did before. As those men have died and retired, they have been replaced by MBAs. They're not health-oriented, they're not medicine-oriented; they're business-oriented. And that is to the detriment of our profession.

And the second thing that I find has changed tremendously is the doctor/patient relationship. And that is, to me, the most precious thing about the practice of medicine. Medicine's appeal is not its independence financially or its ability to be your own man and your own boss, it's the fact that you interdigitate or you cooperate with the public at the interface between the patient and the doctor. And the thing that has changed that has been the things that came in with managed care, and have stayed. Even when managed care seems to have disappeared, the bad things about it stayed behind, such as 14 minutes per patient and that sort of stuff.

I ran a program with the help of John a couple

of years ago, called "Take Time to Talk." And I went around the country talking to doctors and to patients about taking time to talk with each other, and about what the benefits would be to both the profession and _____.

Secondly, we are reaching this crisis in the doctor/patient relationship just at a time when I would have predicted just the opposite, with the use of the Internet to provide information for patients, we have the opportunity to have a much more knowledgeable set of patients than their parents were. And everybody knows, I think, that a physician loves to talk to an intelligent patient, and the opportunity now exists to be able to, instead of meeting a patient and starting with a kindergarten and work him on up to college, he can ask you to do that the night before. Suppose somebody calls up and says, "I'm having pain in my chest, Doc, and I get it mostly when I'm tense or trying to be active at the same time, and I think I have an angina."

Well, the doctor doesn't say, "Well, come on in and I'll talk to you about it." He says, "I'll see

tomorrow morning, but before you come I want you to look upon the Internet the following. I want you to know what angina is, I want you to know what GERD is, I want you to know the difference between those two, and when we get here together, instead of taking 20 minutes to get to the point we are when you walk in the door tomorrow we'll have it all behind us. And I can talk about angiograms, you know what I'm talking about."

And that is not working as well as I thought it would.

The other thing that I think is a tremendous boon, and that is doctors and patients using e-mail for types of communication. We do it very well in this institution because we were the first school in America where everybody had to have a computer, and we had something called "blitzmail." And people don't use telephones in this town. They just don't use them. They use fax machines. They use e-mail. Three kids will occupy a room in a dormitory, they don't know each other very well but they know each other best by e-mail, in spite of the fact that they can reach out and touch the guy they sent an e-mail.

But the intimacy that has been lost between doctor and patient can be partially regained by the Internet, and it can be an additional boon to a patient. Mrs. McCarthy comes in and has her time with the doctor and it turns out to be 11 minutes and she's out in the parking lot before she knows it, and she gets home and says, "I never asked him about so and so."

So she sends him an e-mail. And instead of playing telephone tag for three days, he answers her, but he has the opportunity, with no effort at all, to lift her spirits and put her on a whole different level of healing, by saying, "By the way, I should have told you, I never saw you look better." And it regains some of that intimacy that even doctors say, "I've lost with my patients."

And one of the things that I look back on, I've been in medicine now since 1934. I've been having something to do with medical students _____ 1934, and what do I look back on now and see that we've lost? We've lost role models. Used to be that people my age were not uncommon in medical schools. They didn't want to give up, and they had an awful lot to tell students,

and a students had a lot to learn by just watching what they did and the way they thought. It's not so popular any more. And I think that if medicine continues on the path that it seems to be taking about being a business, we are heading ourselves into a future that I don't think we're going to like as well as we liked the past.

Do you remember when Mr. Clinton campaigned, he was talking about 34 million people who were uninsured or under-insured. When he was talking about his health care reform, as president, that had gone up to 43 million. And it's someplace above that now. I think there's a day ahead of us when the critical mass of people who are uninsured will be so heavy that they can't stand it, nor can we who are insured stand by and see them deprived. And I think when that day comes, there will be a real sea change in the way we practice medicine in this country, and that's when I see us moving into a single-payer system that we will do at a time when every other country that's used it has weighed it in the balances and found it wanting. It's kind of the wrong time to go. But I think it is almost inevitable, and it will happen because people say,

"Well, we've tried everything else."

We really haven't tried anything else. Both the Democrats and the Republicans, ever since Mr. Clinton's health care plan failed, are afraid to talk about a big plan. If you look back on the history since 1993, there are no big plans that are discussed about medicine and health, and yet the problems are bigger than they ever were before. Talk about this little thing down here, we'll fix that and nobody will notice it and they won't get mad at us, and then we'll fix this little thing over here. Well, by the time you fix the third thing, the first one's broken down again, and you know, you're going around in a circle.

And I think that there is a way out of our troubles that nobody has ever tried and nobody talks about, and that is to have the care of patients managed in a public/private partnership. I think public/private partnerships have a great advantage of a private sector keeping down fraud, waste and abuse, and the public sector being able, by regulation and legislation, to set the parameters within which they think medicine ought to function. But, there's one thing missing. And I think

that we could take a page from the book of the economists and we need, in medicine, what the economists have in the way of the Federal Reserve Board. And --

INTERVIEWER: Let me just flip the tape over.

(End Tape 2, Side A)

INTERVIEWER: Tape 2, Side 2. The Federal Reserve Board.

DR. KOOP: I think it's possible to have a medical board that sits between the government and the public/private partnership, that takes care of the health of America. And I am sure that there are enough men left in medicine who don't have overpowering financial connections to some clinic or some legal enterprise, I think there are enough people who are not seeking personal aggrandizement, I think there are enough people who are not trying to squeeze the last dime out of medicine, who would welcome the opportunity to act in an advisory capacity, just like the Federal Reserve Board does. It has an understanding of economics and that's why it can make its decisions. This board would have an understanding of medicine, where it's been, where it could go, and can guide its

direction that way, and can respond to the things that happen in medicine that bother people.

I mean, if you talk to the average patient today, he doesn't have much to say about what a wonderful experience he had. It's all the problems he had. And when I talk to a stranger about my medical problems, they say, "Wow! If that's happening to you, what do you think is happening to me?" And it's a really serious question to ask.

And I think we need that kind of thinking and not -- it seems to me that we're stymied in sort of a quagmire of lack of innovative creativity as far as what medicine could be. If we look at the things that made medicine great, and we had a board and a private/public partnership that tried to guarantee that those things were sacred and sacrosanct, and would never vary for future generations of patients, I think we could restore medicine to what it once was.

One of the things that is of greatest concern to me is that when I was a young man, no matter whether it was in a Reader's Digest or Vanity Fair or Fortune magazine, any poll put the medical profession at the

very top of everyone's list for respect and awe. Now we're number 17. And we should have nipped that in the bud when we got to be number two and three. But it's pretty hard to come back from 17.

But the pride that an individual has that he is responsible for the way his profession is accepted, I think is gone. And when I talk about doing something in medicine now, with a medical reserve board and public/private partnership, then I think I could go back and I would think about the medical student who hasn't yet become a medical student. But he is up to his neck, trying to find a way to get in medical school. He wants this more than anything else in the world, and so he spends four years in college worrying about that and preparing himself intellectually to be that. But nobody in our profession says, "Welcome to the guild. Let me tell you some of the things you're going to love about medicine."

We could build into college students who are heading for medical school a loyalty to the profession, a disgust with people who abuse the profession, and we could turn it around to be what it was in the days of

our parents, when they really had tremendous respect for doctors, and doctors in turn respected them. We don't have that now.

INTERVIEWER: The amount of malaise and complaint that you hear within the profession today is quite profound. I mean, for a long time I wrote it off as disgruntled people getting more press than others, but the more I travel and talk, the more folks I hear are unhappy. And I'm sure you hear the same thing.

Is this failed expectations? Is this greed not being satisfied? Or is this that the ground really has shifted, and people who went in with reasonable and noble expectations have been poorly dealt with by the profession. What do you think is going on?

DR. KOOP: Well, I think the first thing that's wrong is that a young person that goes into medicine doesn't feel that the day he steps over the line and joins the guild, and he has responsibilities to that profession and to himself and to his patients, and there's a code of ethics and there's a code of behavior. Doesn't realize that any more, and that we have to get back to. I've already covered what I think the

governance should be in the way of a medical board and a public/private partnership.

And then I think we have to work on the individual and his profession, and you can't get into medicine very far without doing something about malpractice. And I mean, the things that have happened in the practice of medicine, I mean, they should have been nipped in the bud in the beginning. I mean, how can a physician do his bet for a patient if, on the first occasion when he sees that patient, his patient brings a lawyer with him, to be sure that everything is done in such a way that they can sue at the right time if it doesn't go right.

And there is a way -- I practiced medicine -- actually practiced medicine after all my training was finished, from 1945 until 1981. And I had all kinds of problems. I was in a brand-new specialty, and I did things that nobody ever did before. And I never got sued. Now, why didn't I get sued? Because I made the patients' parents allies with me against the problem their child had, and we fought it out together. But that takes an effort, and it takes an understanding of

what makes people unhappy about their doctors. But it's a teachable thing. I mean, you can't teach some virtues, but you can teach the practicality of getting on the right side of your patient so he doesn't sue you when things go wrong.

INTERVIEWER: Is the changing demographics -- more women, and the changing environment, where professions in America perhaps are not what they once were, that leisure time has become a more important phenomenon, is that impacting the profession?

DR. KOOP: Yeah, I think it is. When I was young, we were looking for training jobs, we wanted to know what their autopsy record is. Now what people want to know is how many nights you have off. And how much money you get paid, and so forth and so on. And so there has been a shift in that. Some of those things are inevitable over the passage of time and the growth in the complexity of the profession.

But I think we have to be more frank about our problems, and we have to address them as problems and find solutions to them. If some large international corporation, like Sony, were having relationship

problems between the people who worked for Sony and the people who bought Sony products, they would either have to fix it or they'd be out of business. And we've got to take that attitude, and that's why I say you have to start in college, you even could start in high school.

You know, if you study the guild system in Britain, didn't matter whether you were a chimney sweep or a butcher or you were a doorman, you were proud to be that, and you wore a uniform that showed that you were, and you knew what was expected of you and you knew what was a line you didn't step over. We don't raise people to feel that way any more.

INTERVIEWER: Your theme about business and medicine, theme since it impacts many of your diagnoses, is there a way back from this? I mean, once upon a time there was a belief that medicine was a profession relatively untainted by business concerns. You didn't advertise, for instance. You allegedly saw the poor and charged them what they could pay, or didn't charge. You taught for free or little recompense. And those traditions have largely fallen by the wayside. And business has roared into medicine.

Is there a way back out of that?

DR. KOOP: There's not an easy way, and there's not a quick way, I don't believe, out of that. But it's going to take a generation to change it, but I think that well-meaning in planning that generation and keeping tabs on the way it works can bring it about. But you know, the attention span of people is very short. And to tell the people who are critical of medicine, "We can change it, but it won't be until this college student has gotten to the age of 40, when he's practicing medicine, and he's only 16 now," well, that's a long time to wait.

But I think if you don't change it, you're going to lose it all.

INTERVIEWER: I mean, I do see the ground shifting in ways that it's hard to imagine it shifting back, not only in medicine but around medicine. I mean, the first person whose story I tell in "Big Doctoring," which you probably heard, I think I read a quote from him, Eugene McGregor, who practices up here in a little town -- or Lebanon, "All is life," was sort of the classic old-model GP, and he referred to younger doctors

who came and had practice and moved, as "gypsy doctors." "We were gypsy doctors in my day." Of course, he practiced in one place for 40 years. But it's kind of a gypsy society, at least compared to the rather more staid society. And I find it hard to envision, I mean, the values that you describe make a lot of sense to me, appeal to me, but I don't see how teachable that is, I guess is the question I'm asking. I mean, you can teach a higher level of awareness, but the society is a different society.

DR. KOOP: Well, you can't teach a society not to be mobile. But you can teach a doctor, who is taking care of a member of that mobile society, how to approach the patient on a new arrangement. Guy used to live in Des Moines, Iowa, his business changed and how he lives in Brooklyn, New York, and the culture is different and the climate's different and the pay is different and everything is different, but here's a doctor who still feels the same way toward him. I think that's doable.

INTERVIEWER: And I must say, I see in young people in medicine, and clinically I work with medical students and pediatric residents, there is an awful lot

of idealism in those folks, to be cultivated, cultured, nurtured. I mean, that's, to me, the most sustaining thing, the people who go into it are good people.

DR. KOOP: You're absolutely right. The thing that impresses me most about medical students today is that you never hear them talk, as you used to hear them talk, about the accumulation of wealth. They are not ashamed to say, "I'm going back to Bridgeport to practice because that's where I was born and that's where they need me."

And the thing that proves to me that they mean what they say is that the average student that comes to this medical school has had two years minimum between the time he left college and the time he went to medical school. And in that period of time, he has almost always spent that time doing some beneficial service to society. And it's because he wanted to, not because he wanted it on his resume so it would get him into medical school.

INTERVIEWER: Tell me more about your view now of specialism and generalism. We talked about specialism in surgery. And I know the Koop Institute

has been a pusher of primary care ideas over time. How have you seen that play out, and where do you see it going in medicine, in the division of labor.

DR. KOOP: Well, when I came to Dartmouth, 29 percent of medical practitioners were in primary care. And that got up almost to 45 or something --

INTERVIEWER: When you came to Dartmouth this time around?

DR. KOOP: Yeah. When I was 72.

INTERVIEWER: That would have been '94? '5?

DR. KOOP: I'm 87 now, you can figure it out.

INTERVIEWER: Well, when you left --

DR. KOOP: It was two years after I left the government, which was in '89.

INTERVIEWER: So 29 percent then. And as high as 49?

DR. KOOP: Got as high as about 45 percent in some parts of the country, and now it's drifting back again because the same things that led people away from primary care are at work in the whole business of medicine. The pay isn't as good, hours are worse, the leisure time doesn't exist, and there is still, on the

part of specialists, an unreasonable failure to understand the real contribution of the primary care doctor, who has to know a little bit about such a huge amount of stuff. And there's nothing that makes me madder than to see a professor of medicine humiliate a medical student on grand rounds, because he says, "What do you expect to do with your life?"

He says, "I'm going to join my father in the family practice."

It's as though he committed a sin and went into prostitution.

INTERVIEWER: That does happen.

DR. KOOP: Yeah. And, you know, I am surprised at the way it's happened. I'm surprised that -- I'm not surprised at the change in gender. I think women are kinder, gentler people, and I think they're good for medicine. And I think there's no reason why they can't do specialties that people used to think were only for men. Surgery, for one. A lot of very good female surgeons around.

But I do see the pull in every way -- economics, leisure time, prestige, importance, self-

esteem -- that goes with specialization, as compared to primary care. And the primary care doctor has to have his feet on the ground. He has to know himself well enough to know that he's making a contribution that a specialist can never make to medicine. And he has to know that that's what brings him satisfaction and not envy.

INTERVIEWER: One scenario for the future is that medicine will become increasingly the domain of specialism. And that nurses and others will inhabit the realm of primary care as, to some extent, they've done already. Is that a plausible outcome or a plausible possibility? And if so, would that be good or bad?

DR. KOOP: Well, with the caveat that all people aren't the same, I think that it makes good sense to share the burden of primary care with people who can handle certain things, but I think it is a mistake to say that because a nurse has taken two years of training to be a nurse-practitioner, that that makes her equivalent to a primary care doctor. And I think that is a tendency that you hear criticized by primary care physicians, and it's a tendency that nurse-practitioners

aid and abet by believing it.

INTERVIEWER: My concern is that if medicine does not take a firm stand for primary care, beyond the rhetoric -- that is, structuring payment so there's some pay equity, structuring values so that primary care is valued and supported in terms of research, in terms of training, we will have a profession that, because of the inevitable lure of technology and money, will become largely balkanized into specialties, with no base.

DR. KOOP: Right.

INTERVIEWER: And I think the nurses and others will -- because primary care is necessary. Society says it needs it. Others will migrate in and populate it, but medicine will essentially have become a domain of specialists, which to me would be a great loss. But I think is a possible outcome. I mean, that's the doomsday outcome, from my perspective. Hope not.

DR. KOOP: No, I've spent a lot of my time in the U.K., watching that system work, and there isn't the same split that there is -- they have more primary care doctors. And they have fewer specialists. They

should go together, but they don't always. And I think that the differences in income are not as exaggerated as they are in this country.

And one of the things, while we're on that subject, might be settled by having the federal medical board that I was talking about a bit ago, but what's disturbing to me is that the knowledge that a primary care physician has is not appreciated and is not compensated, but if he has a gadget that he can use on a patient, he does a technical procedure, and he suddenly can become a quote, "specialist," by buying the gadget.

And I think that there are some other things in medicine that we have talked about that are affecting the future. One of them is something that nobody talks about much -- I do, all the time -- and that is the great advances in medicine and surgery have made a lot of acute diseases chronic. We can't afford that. We can't afford it as a society, and we can't afford it financially.

One of the other things that bothers me is if you were to ask the question to a totally honest audience, unable to give you a false answer, why has it

taken us so long to do some of the things that we do? For example, as the treatment of the cancer program becomes such big business that there are forces at work that don't want to see cancer moved toward cure because that would change the balance of economic power. Very difficult questions to ask, and even more difficult questions to answer.

INTERVIEWER: I mean, I've heard those charges often from what I'll call the "Rodale Community." I mean, the kind of health food fringe.

DR. KOOP: Oh, yes.

INTERVIEWER: That -- _____ cancer, but about other -- about disease in general. Do you think there's credibility at all that there are physicians or clinicians or clinical specialties that don't want to see progress because it would be bad for business?

DR. KOOP: I think the more that our profession becomes a business, the more you'll see that sort of thing.

There was a certain purity that professionalism delivered to medicine, and when it is contaminated by greed. . . . The average guy that went

into medicine, even now, he does it for entirely different reasons than the average guy that goes into business. Has to make money, to be sure. But that's not the end-all and be-all. And that is one of the things that I most enthusiastic about in the future, is that the medical student of today seems to have lost that greedy outlook for the future that his predecessors had 25 years ago.

INTERVIEWER: Speaking of idealism, global health. Where do you see the role for the United States in global health? Where have we been? Where are we going? Is it something we have done well with or not?

DR. KOOP: Well, global anything is kind of frightening.

When you treat a problem globally -- let me start it a different way.

The only thing that I am absolutely certain that we have globalized is the spread of disease. We have really done that very well.

INTERVIEWER: "We," United States, or --

DR. KOOP: We, all of us, because of transportation, communication, and reliance on quick

treatments, quick fixes, rather than prevention. So that that's a fact of life, I think, today. And if we have globalized disease, we certainly have the obligation to globalize health.

And it seems to me that there was always a huge barrier to the globalization of health, and that was it would take so long and so much money to build the infrastructure in, say, a developing country, that you might lose sight of your goals before you ever achieved them. But two things have happened that have changed that.

One is the invention of the cell phone, and the other is the Internet.

And with the Internet and the cell phone, you don't have to build that infrastructure any more Because instead of having to go through all the stuff that's down here that used to be called infrastructure, now you can go from here to here, and here to there. And therefore I have real hope for globalization, if it doesn't destroy the little man in the process. What I mean by that is, if you globalize everything, then you're going to have Wal-Marts and K-Marts instead of

individual shopkeepers. And I don't know how you're going to manage the economic side of the change to globalization if you deprive people of their livelihood. So I think that that's something that has to be an economic arm that has to be discussed whenever any of these things are talked about that are global.

I think that one of the things that I always wanted to do when I was Surgeon General, was to have an international health corps, the way we had a national health corps, because I didn't mean to have people leaving these shores and going and doing hands-on care in underdeveloped countries, but I saw a corps of capable trained people transmitting the know-how to other people, so that they could do it on their own. And I think that's the real challenge of globalization of health care, is that you don't just import the treatment but you import the understanding so that they can develop their own system.

And I think that's all the more important when you try to recognize the cultural differences that we have -- we have them in this country and we don't _____ them. It's a totally different cultural

challenge to talk against smoking in Utah and California, than it is in Kentucky or Virginia. Totally different. We have the same people, we speak the same language, but it's totally different. It's increased in complexity when you're talking about a sub-Saharan African country and something that's attached to India. And that is going to be the hardest thing, I think, to learn because you can't treat different cultures with the same, as I said, the accoutrements of medicine. It takes more than just the pill.

INTERVIEWER: Any likelihood of an international health corps, or -- one more question. Outside of the missionary community, it's argued, and perhaps outside of the CDC with some of its targeted efforts, we haven't done a lot to promote, certainly at a government level, large numbers of teachers, clinicians, going abroad. Any prospects that we'll be doing that?

DR. KOOP: I think there are theoretical reasons why it should work now better than any time that I've been alive, because you have more disgruntled physicians leaving medicine because of the things we've

been talking about, than ever before.

INTERVIEWER: Who might be recruitable?

DR. KOOP: They're recruitable. And you know, the thing that I have seen, you take somebody who's never been off on an altruistic mission to help somebody in another country, the first time he does it it's like a new world to him. He just can't believe how great it is. And they go back.

(Interruption)

If you think about how the Peace Corps came about, that didn't take a lot. It took one man talking about it, it took another man writing about it -- Kennedy, Sargeant Shriver, and it took a lot of people who, once they went, they became the advertisers. And I think there's so much to be learned, so much to bring satisfaction with some kind of a thing like an international health service corps, that it would be worth some major foundation really attempting to try it.

INTERVIEWER: Yeah. Switching gears. I want to get at least something on the record about the National Health Museum. I know it's something you've been involved with for a number of years, been one of

the leaders and thinkers about it. What would the role of a National Health Museum be in American life?

DR. KOOP: Well, what a National Health Museum should not be is just a curio shop. There is a real place in education to have some illustrations from the past about how things were successfully or unsuccessfully managed, but the challenge of a so-called museum today is that it becomes a health education center primarily to inspire the new generation about what is possible to be accomplished.

My reason in the beginning for being interested in a museum in Washington that had to do with health, was that I used to stand in my office up on the top floor of the Humphrey Building and see all these kids standing by one of the reflecting pools, getting their pictures taken, when they came on their senior trip to Washington, and I kept thinking about the wonderful opportunities that they had, and then it occurred to me that they could be stimulated to be almost anything in the world by what they saw in Washington, except something in medicine and health. Because there's no place to see it.

And I think that still should be the major educational effort to get young people to commit early to a life of health and medicine and science that leads to the betterment of the human condition, but there are so many things that you can tack on to that to make it interesting, that I think it's a great idea.

INTERVIEWER: Good. The Bushes. We talked a little bit about George Herbert Walker and a kind of transition, but you've seen the Bushes as presidents and worked to some extent with them and their people. Any thoughts about either or both, and their health policies?

DR. KOOP: I don't think -- as far as I know, there's only one person in health that has the ear of the president. I don't think one person is enough.

INTERVIEWER: This being the current president? George W.

DR. KOOP: Yeah. And that person is Tony Boucher(?). And great respect for Tony Boucher in many ways, but I think one person can't do it.

The thing that I see different about this administration from the other three that I was

associated with is that it is hard to get an answer to a health question in the White House. And I don't think that this administration really thinks it needs any guidance in the health field. And I think that that's wrong, because nobody can guide in health except somebody who is trained in health.

And off the record, this is a pretty hard group to infiltrate. Just twixt thee and me, I sat with Barbara Bush for eight hours one day, and I filled her in on a lot of things that I wanted her son to know. And I said, "I've met him socially and I've met him when he was governor, but I would like to talk to him about his presidency because, one, I know where there are a lot of minefields that he shouldn't step on, but also I know that there are opportunities for him to make an absolutely lasting contribution to the health of this nation. And I'd like to be able to talk to him about it."

She wrote it all down and she said, "Chick, I will see that he gets this the first time I see him."

And I know Barbara well enough to know that she did, but I never have been to see him.

And I think the war on terrorism has taken a lot of attention, but I think if there weren't a war on terrorism, it would still be about the same because I don't think they have the capacity to understand what we need to do.

INTERVIEWER: Being a senior statesman is a role you played well. Personally and business-wise, I know it's been a tough role. Dr. Koop dot com, in particular. If you were coming out of the surgeon generalship into your senior statesman role on the personal side, would you -- business side, would you have done it differently?

DR. KOOP: With the hindsight I have --

INTERVIEWER: Time Life Books, too, I guess.

DR. KOOP: Something that is not known by the public and I don't mind if they do know it, I think the Time Life venture is one of the best things I ever did, and I think that what remains and hasn't become antiquated by the passage of time is still state-of-the-art.

The reason that that company went bankrupt had nothing to do with that company. It had to do with the

fact that my plans were a threat to the tobacco industry, and they went to Time Life, Time-Warner, and said if I were permitted to go the direction I was going, that they would cease to advertise in People, Time, Life, Sports Illustrated. We were in business at 4:00 o'clock, and bankrupt at 4:20.

So that was an engineered thing by the greed of tobacco companies. I think I got caught up in something that a lot smarter businessmen than I got caught up in, and that is the dot.com craze --

INTERVIEWER: Yes, on that, the Time Life Books, which was supporting the videotapes and the -- what was the whole enterprise called?

DR. KOOP: Well, we called it Time Life, Inc., and we had the privilege to do that as a franchise.

INTERVIEWER: Right, but the health information video program, did it have a --

DR. KOOP: Yeah, well, that was called --

INTERVIEWER: Did it have your name on it?

DR. KOOP: No, it didn't have my name on it. No. Media Information --

INTERVIEWER: There was a program of

informational materials, videotapes in particular --

DR. KOOP: There were 34 videotapes. That was Time --

INTERVIEWER: State-of-the-art commentaries on different diseases for the layman.

DR. KOOP: Right.

INTERVIEWER: And the legs were cut out from under it financially because the company went bankrupt?

DR. KOOP: They refused -- Time and Life took their franchise away from us because they were threatened with no advertising by tobacco industry.

INTERVIEWER: Is that something you're willing to -- if I include that in the new --

DR. KOOP: I've said it publicly before.

INTERVIEWER: Okay, good. And drkoop.com.?

DR. KOOP: drkoop.com, we -- you know, the first year we got every prize that you could get in the world of the Internet for what we did with that thing. We really kept the data up-to-date, so forth and so on. But competition was just too tough. There were too many people in the business, and I don't want to say this, but I'll tell you, one of our competitors was

Med -

INTERVIEWER: MedScape? Web, M.D.?

DR. KOOP: Web, M.D. And you know how they're financed? Any time they need any money, they just call Bill Gates and he gives it to them. Can't fight that. And Web, M.D., has not been for the benefit of the public since that time. It's for the benefit of the doctors saving money by having electronic ways of handling their business.

(Recording interruption)

INTERVIEWER: We were talking of drkoop.com. Anything else -- I mean, I know it was an awful episode for you, to sort of take the thing public and have as much attention to it, and then have it fail.

DR. KOOP: Yeah.

INTERVIEWER: Is that --

DR. KOOP: It was a very disappointing thing, and fortunately I had lots of other interests, and so it -- I seldom think about it now. I'm not sure that if I did it again and that I could weather the storm any better. Because it was just -- just thousands of health sites failed.

INTERVIEWER: Yeah. I mean, certainly, with your interest in communication and the explosion of the Internet, the two seemed destined to work together, and that they came together and then it didn't work is just -- I mean, a disappointment to you, a disappointment to me.

HIV and the world. A problem. You were there when it started. Where do you see it today?

DR. KOOP: Oh, HIV and the world is a disaster. There are countries with 38 to 40 percent HIV positivity, in sub-Saharan Africa. The people that I talk to who know what's going on in China say that the future there is grim, because there has been such a population shift from central China to coastal China, which is where the business opportunities are today, that by being introduced in coastal China also introduces a naïve population to the sexually oriented population, and there is very little understanding about the transmission of the disease by these country folks who come in to town. And so public health people in China are looking forward to a disaster they don't know how to handle.

I think that the obligation of the United States in all global health problems is to share our knowledge and to share our know-how and, where possible, to put in seed money, and I think that the fact that Mr. Bush has included that in his plans is very good. I think it's a good sign that some of the pharmaceutical houses have changed their pricing structure for places like Africa. But when a country like South Africa still refuses to believe that HIV is the cause of AIDS, we have a very serious problem.

And we do know, by the way Uganda has changed its educational program and has changed its culture, to some degree, that AIDS is not an insurmountable problem even in a culture like that. So I think that it needs organization, there ought to be some kind of African-Asian consortium that worries about this.

Compared to the United States, the rest of the world is in terrible shape. The United States, because it's an affluent country and because we know about giving AZT to pregnant women and because we know about fancy therapeutic cocktails, it's possible now to be diagnosed with AIDS and to live out your life expectancy

and die of something else. But that's at the cost of $20,000.00 a year per person.

INTERVIEWER: A final question. As you look back on your career, thoughts about it?

DR. KOOP: I've had a very, very interesting life, and I really feel that I was born at a good time, because I lived through what I think is the golden age of surgery, tremendous technical advances, but in the midst of it was very much a part of the development of pediatric surgery, which was a special privilege.

My time as Surgeon General was one of the happiest and I think most productive times of my life. And the fact that I'm 87 and still active and still lecturing and still teaching here, is -- it's enough to raise your eyebrows.

(Laughter)

INTERVIEWER: That's a good place to end.

DR. KOOP: Good.

(End of proceedings as recorded.)