Testimony on the

Confirmation of Surgeon General Nominee C. Everett Koop, M.D.

presented to the

Committee on Labor & Human Resources

United States Senate

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on behalf of the

American Public Health Association

by

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Introduction

Chairman Hatch, and members of this distinguished Committee. My name is William H. McBeath. I am a public health physician currently serving as Executive Director of the American Public Health Association. I am authorized to appear before you today on behalf of that organization.

APHA is the oldest and largest professional public health society in the world, having begun in 1872, and now having over 50,000 national and affiliate members across the country. We are a science-based, action-oriented, multi-disciplinary organization with an envied tradition and significant potential as a force in the movement toward valid national health policy and effective community health programming at federal, state, and local levels.

We appreciate this opportunity to present our views on the important subject before you for consideration today.

The issue:
What public health qualifications does the USPHS Surgeon General need?

The American Public Health Association firmly believes that the health interests of the nation are best served only when the United States Public Health Service is headed by a Surgeon General who is a clearly qualified, specially trained, broadly experienced community health professional of demonstrated expertise and recognized ability.

Long-standing tradition and provisions of federal law have helped assure such leadership by requiring that the Surgeon General be appointed for fixed terms from the commissioned corps of career USPHS professional officers. Recent changes in the law permit the designation of a Surgeon General from outside the career corps, but only if that individual shall "have specialized training or significant experience in public health programs."

This Committee now has before it for consideration the nomination for Surgeon General of an individual who has not served in the USPHS career corps, who has no specialized training in public health, who has no significant experience in public health programs, and who is therefore clearly unqualified for this important office.

Accordingly, for the first time in over a century of collegial co-existence with the Public Health Service, we in the American Public Health Association are constrained to speak out

against the appointment of a specific candidate being designated as Surgeon General. We strongly oppose the confirmation of Dr. C. Everett Koop as Surgeon General on the grounds that he is without the requisite qualifications for that position.

There is ample evidence that Dr. Koop is a distinguished pediatric surgeon. He is much honored, doubtless deservedly, as a practitioner and teacher in his chosen medical specialty. It is not our intention to cast the slightest shadow upon his reputation as highly skilled physician, exceptionally gifted in the art and science of surgery for infants and children. However, we must insist that these admirable qualities alone are wholly inadequate to equip one for national professional public health leadership; and Dr. Koop is otherwise almost uniquely unqualified.

We believe one aspiring to such national public health leadership must be well supplied with a familiar understanding of public health principles and a mastery of public health methods which together give an essential background for an effective approach to and solution of public health problems. The Congress, in its wisdom, has seen fit to include reference to such qualifications in the legislative language which now specifies the prerequisites of the Surgeon General. It is this expertise in public health which Dr. Koop is so utterly lacking, and which is clearly required by law of any Surgeon General candidate.

Why isn't any distinguished medical doctor considered a qualified public health practitioner?

Why do we say that being a specialized medical clinician is not sufficient qualification for Surgeon General? Are not the biomedical and clinical sciences at the core of medical education and practice, also importantly related to public health? Of course they are. But only the narrowest form of medical chauvinism would permit the view that any competent clinical physician is automatically equipped to direct organized community health endeavors.

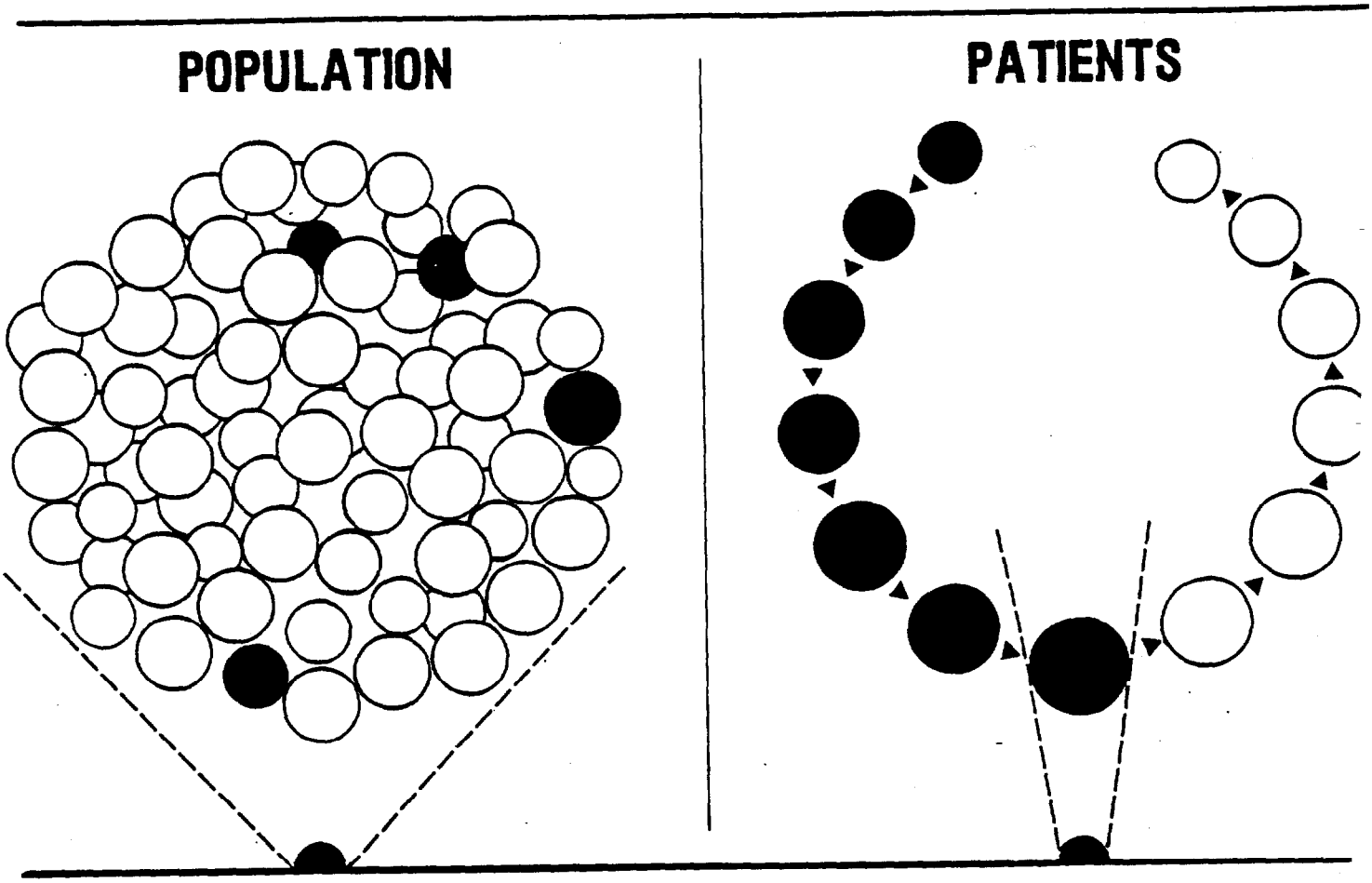
A recent national commission had defined "public health" as "the effort organized by society to protect, promote, and restore the people's health, involving programs, services, and institutions which emphasize the prevention of disease and the health needs of the population as a whole;" as distinguished from the "clinical sciences" (including medicine) "which operate through a one-to-one, practitioner-patient relationship, and emphasize the empirical application of these fields to individual health problems."

Thus, physicians are especially and exquisitely trained to deal with the pathology of disease in the individual, rather than the public health focus on the active promotion of health in population groups. Medical science and technology is largely that of the treatment of a diseased patient, not the public health knowledge and skills for the prevention of ill health in aggregates. Private medicine is focused on the care of patients

and the cure of their individual ailments, while public health is concerned with the varied causes of disease and their control in the community and its environment. (These concepts are presented graphically in the accompanying figure.)

The almost exclusive orientation for one-to-one, provider-patient relationships so advantageous for the clinician, can actually be a disadvantageous distortion for the community practitioner committed to the broader goal of equitable programming for a total population.

In contrasting the patient care clinician and the community health practitioner, we attribute no inherent superiority to either. It is the significance of their differences we seek to emphasize, reflecting the distinctive contribution each can best make to human well-being, and also justifying the distinctive public health qualifications specified for the Surgeon General in the Public Health Service Act.



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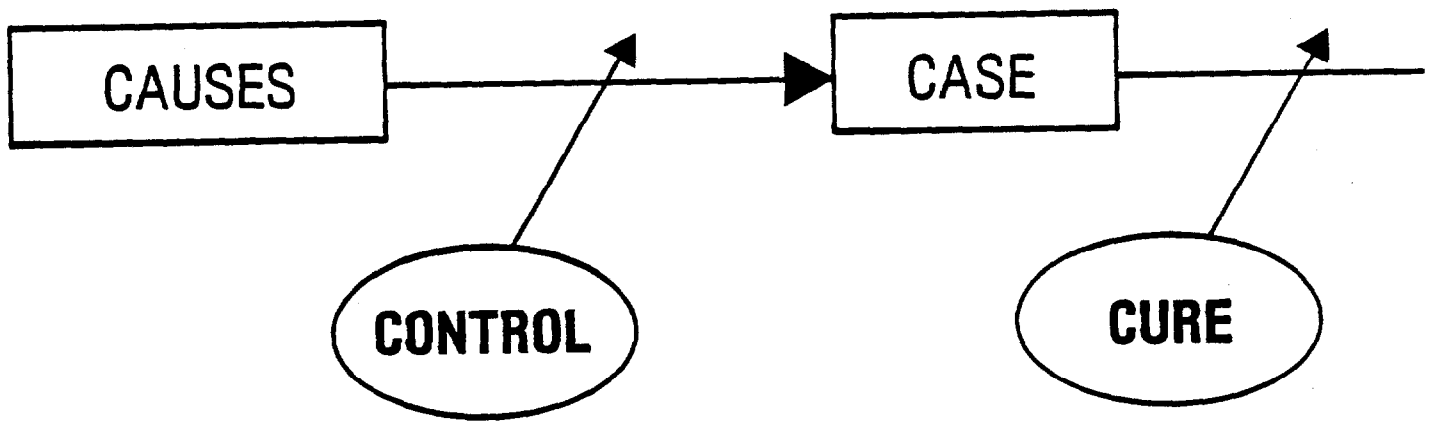

Training and experience in public health -- what important difference does it make?

What is it about training and experience in public health that provides the substantive difference so essential to the qualifications of community health professionals? How does such training and experience make an important difference in public health professionals?

First, through education and work experience they come to share a unique body of knowledge basic to the principles and practice of public health, including certain measurement sciences, environmental sciences, social sciences, and management sciences. Epidemiology is the core science of community health. Other important courses of study at the heart of public health include behavioral science, biostatistics, community dynamics, demography, educational change, environmental protection, human ecology, public administration, and social policy.

Second, through training and experience they come to possess special skills related to community health methods and procedures, including the conduct of community development activities, controlled field trials, environmental inventories, epidemiologic investigations, health program planning and evaluation, health survey research, legislative implementation, mass communication, regulatory enforcement, and sanitary/safety inspections.

Third, through experience in organized public health efforts

they come to comprise a characteristic working group of occupational disciplines in distinctive organizational settings. Community health educators, environmental health scientists, epidemiologists, health services administrators, health planners, industrial hygienists, nutritionists, public health dentists, public health nurses, public health physicians, sanitarians, statisticians, and others publicly identify themselves as career community health workers, and are employed jointly with others of these related community health disciplines, in formally organized program efforts set predominantly in governmental public health agencies and voluntary community health service organizations.

Thus, three distinctive characteristics generally shared by public health professionals as a result of their training and experience are: unique knowledge base, special skills ability, and work group identity. In contrasting these characteristics of public health professionals to those of the clinical physician, one notes that the clinical physician does not ordinarily master the areas of scientific study unique to community health service, does not usually develop the special skills and techniques common to community health practice and research, and does not customarily work in the same organized settings with community health disciplines.

What constitutes "specialized training" or "significant experience in public health?

There are several real-world examples which clearly identify the essential form and content elements of public health training and experience.

For U.S. physicians, the definitive testimony to attainment of specialization within medicine is formal certification by an American specialty board recognized by the American Board of Medical Specialities. In 1948, the American Board of Preventive Medicine and Public Health was recognized to award specialty certification to qualifying public health physicians. To date, some 4,000 physicians have been certified by this Board as qualified medical specialists in public health and its related preventive medicine fields. (Dr. Koop is not among these 4,000. He, having chosen formal preparation for and active practice within the entirely different medical specialty of pediatric surgery, has been certified by the American Board of Surgery.) In addition to the M.D. degree, a medical license, one year of postgraduate clinical training, and successful completion of a comprehensive, two-part, specialty examination, the training and experience requirements for board certification in public health include: (1) graduate course of academic study, including biostatistics, epidemiology, health services administration, and environmental health, leading to a master's degree in preventive medicine or public health, (2) one year residency of supervised preventive medicine practice experience,

including planned instruction, observation, and active participation in comprehensive, organized, preventive medicine programs, and (3) an additional year engaged in specialized public health activity (training, research, teaching, or practice). It is true that federal law does not require the Surgeon General to be a board-certified physician specialist in public health; but it does require that the Surgeon General have "specialized training" or "significant experience" in public health. Isn't it reasonable to demand that the type of public health training or experience to be possessed by a physician candidate for Surgeon General, should be the same type (but not the same amount) of training and experience defined by the recognized medical specialty board as appropriate for any physician seeking to qualify in public health? (With regard to the nominee before you for consideration, our point is not that Dr. Koop hasn't yet completed all of the training and experience required of public health diplomates; our point is rather that Dr. Koop hasn't even started any of the type training or experience specified as appropriate.)

Successful completion of graduate training at the master's level (only one of the requirements included above) has increasingly become the recognized norm for professional public health training within many health-related disciplines, including medicine, nursing, dentistry, environmental science, health services administration, etc. Beginning in 1956, the Congress has affirmed the value of such education by authorizing public health traineeships to support "professional health

personnel" in "graduate or specialized training in public health." Since then, Congress has provided a variety of grant programs to support public health training in public and private non-profit graduate schools of public health, and other educational institutions. Since 1930, about 50,000 health professionals have received graduate public health degrees (usually the M.P.H.) from the nation's twenty-one, fully accredited, university-based, graduate schools of public health alone. It is estimated that over 35,000 of these are still professionally active, along with at least an equal number who hold equivalent graduate degrees from a variety of community health/preventive medicine/environmental health/health services administration programs in other degree-granting institutions. This cadre of graduate-trained professional public/community health personnel, educated with federal support, are additional evidence of the level and character of training Congress intends by the phrase "specialized training in public health." (Dr. Koop has had no graduate education or specialized training in public health.)

Where do we look for practical examples of what constitutes "significant experience in public health programs?" Where else than in the daily work experience of public/community health professionals? In a recent report to the Congress, the Secretary of Health, Education, and Welfare reported that this country has a core group of about 150,000 qualified professional and technical personnel with distinct public health competence who work exclusively in public health settings. In addition to

this large core of professional public health workers, the report goes on to enumerate supporting personnel in public health agencies and programs, and others whose primary work requires the performance of significant public health functions. This total public health workforce is over a half million personnel.

It is this community of public health workers -- professional, technical, executive, operational, and supporting -- which must be understood, motivated, and guided by expert leaders of recognized ability and demonstrated dedication, beginning with the Surgeon General. And it is the work experience of this group which must be shared by any Surgeon General candidate deemed to have "significant experience in public health programs." It is almost inconceivable that any Surgeon General candidate deemed to have that requisite "significant experience in public health programs" would not be part of this total public health workforce. Dr. Koop is not.

What makes for "significant" experience in public health programs?

It should be patently obvious that simple knowledge of, occasional exposure to, or even sympathetic interest in community health programs does not constitute "significant experience" in the present context. As revised, Section 204 of the Public Health Service Act is stating the job qualifications for Surgeon General. As with any job qualifications statement, the experience requirement refers to valid work experience of the candidate, demonstrated by prior substantial commitment of time and effort to a responsible occupational involvement (usually employment).

In the case of the Surgeon General, the experience is explicitly required to be in "public health programs;" but what quantity and quality of experience is "significant?" Logically, the requirement for public health programs experience is intended to provide and/or assure the capabilities (i.e., the knowledge, the skills, and the values) needed for public health programs leadership. Experience is therefore "significant" only if it is adequate to provide the needed capabilities. It is ludicrous to treat the USPHS Surgeon General as an entry-level public health career position. Particularly in the absence of any specialized training, only an extended and commendable career of professional public health program leadership would meet the "significant experience" test for Surgeon General.

What are the purported public health qualifications of Dr. C. Everett Koop?

In the openness of today's "information society", anyone with access to a good public library can freely examine the important public aspects of the personal and professional life of prominent individuals. Standard reference works such as Who's Who in America and the Directory of Medical Specialists are recognized as authoritative, readily available stores of biographical data and career information on many noteworthy persons in the world of health affairs.

By coincidence, page 1824 of the 40th edition of Who's Who in America lists only two physicians. Appearing almost side by side in adjacent columns, their life sketchs reveal some interesting parallels between the two men, but also some clear career contrasts. They were both born in New York state less than a year apart, and eventually both graduated from medical school there in the 1940's. After a period of residency training (one in internal medicine, one in surgery) they began their practice careers in different states (one in North Carolina, one in Pennsylvania). Both became members of their local medical society and the American Medical Association, and each has engaged in private medical practice. However, as it turned out, each was to spend almost his entire professional career with a single institution, both men having now retired from the top jobs at each. Both have been active in civic affairs, and each has received awards and honors from his

professional peers. Both record one marriage with four children; both are Presbyterian.

So much for the parallels; what of the career contrasts?

In 1946, the North Carolina internist began as assistant epidemiologist with the state board of health and, after periodic advancements, became state health director in 1966. During this time he had an interim two-year period of service with the U.S. Public Health Service; and obtained a graduate degree (M.P.H.) from the University of North Carolina School of Public Health, on which faculty he subsequently served, eventually attaining the rank of adjunct professor. His professional memberships include American Public Health Association, Association of State and Territorial Health Officials, Conference of State and Provincial Health Authorities, and Delta Omega -- all public health groups.

In 1948, the Pennsylvania surgeon became surgeon-in-chief of Childrens' Hospital of Philadelphia, continuing in that post during 33 years of institutional growth. He served concurrently on the active faculty of the University of Pennsylvania School of Medicine, eventually becoming full professor of pediatric surgery and pediatrics. He became founding editor-in-chief of the Journal of Pediatric Surgery. His professional memberships include American College of Surgeons, American Surgical Association, Society of University Surgeons, International Society of Surgery, Surgical Section of the American Academy of Pediatrics, and the American Pediatric Surgical Association -- all pediatric surgery groups.

Surely these eminently gifted physicians can both be cited as noteworthy for their contributions to human well-being resulting from distinguished careers, each in his own respective area of special competence. The question we raise here is this: Which one of these physicians has "specialized training and significant experience in public health programs" and which one is being nominated as USPHS Surgeon General?

Early this year, soon after Dr. Koop was named Deputy Assistant Secretary for Health, we requested and received a copy of his four-page curriculum vitae from the Department of Health and Human Services. We wanted to identify any public health experience in Dr. Koop's background in order to assess his qualifications for Surgeon General. Of course, his curriculum vitae elaborated considerably (and appropriately) upon the details of his distinguished professional career. It listed three earned, and seven honorary degrees. It cited six years of postgraduate training and fellowship appointments. It mentions medical licensure in two states, and two certifications by a specialty board. It specified eleven faculty appointments in 36 years of active teaching at two institutions. It told of appointments to four hospital staffs. It named eleven awards and honors: professional, civic, and religious. It reported his membership in seventeen local, national, and international professional/scientific societies, plus several important offices and committee assignments therein. It gave four specialty journals he has edited. It included personal and family information. <u>But, at no point in the curriculum vitae is</u>

there direct or indirect reference to anything that could reasonably be called "specialized training or significant experience in public health programs." None of the education or training was public health focused. None of the faculty or hospital appointments were in preventive or community medicine. None of the society memberships were in public health organizations. None of the edited journals were community health periodicals. (A separate review of over 150 scientific papers authored by Dr. Koop revealed none on public health subjects, or in journals devoted to community health or preventive medicine.)

(For the record, we wish to add that more recently, our request to the General Counsel of the Department of Health and Human Services for a copy of specific documentation of Dr. Koop's presumed public health qualifications was denied, although the possession of such documentation was admitted. To say the least, we were anxious as to the justification for such "confidentiality.")

Within the past few days, administration representatives have distributed "background information" materials on Dr. Koop's Surgeon General nomination to members of this Committee, and some of you have shared these with APHA. We sincerely appreciate even this brief opportunity to review and analyze therein the administration's claims of public health qualifications for their nominee.

Perhaps understandably, the materials never quote the legal qualifications for Surgeon General as defined by Congress and

given in the Public Health Service Act: "specialized training or significant experience in public health programs." The administration apparently concedes that Dr. Koop has no specialized training in public health, since no reference is made in the materials to such training. Its apparent tactic is to dress up events in the nominee's clinical career which can hopefully be sold to this Committee and the Senate as "significant experience in public health programs." We urge you not to buy this thinly veiled attempt to disguise "examples" which, as we shall see, are usually not "public health", often not "programs", sometimes dubious as personal "experience", and never "significant."

The centerpiece of these materials is a four-page document entitled "background information" (which is attached hereto, and which we request be included as part of the record). After beginning with references to Dr. Koop's internationally known accomplishments in pediatric surgery, it goes on to quote a definition of "public health" previously cited in this testimony. Thereafter, under three headings taken from the definition, purported "examples of Dr. Koop's experience" are introduced which supposedly "attest to his extensive background in both clinical and public health services delivery." Each so-called example is presented as a brief "bulleted" paragraph under one of the three headings.

The paragraphs are peppered with "buzz words" and jargon, frequently underlined, but usually without direct relevance to the substance of the paragraph. Careful examination also

reveals that the "example" paragraphs are assigned almost randomly to the three headings, with the paragraph subject actually bearing no significant relation to the heading it's placed under.

Some may lightly pass off these aberrations as simply a masterpiece of the publicist's art. More likely they are the deliberate attempt to mislead this Committee as to the public health qualifications of Dr. Koop.

Almost all of the fourteen "examples" refer to clinical patient care activities, not to "public health services" as alledged. Earlier in this testimony we sought to carefully distinguish between clinical patient care on the one hand, and public health programs on the other. To review, a quick rule of thumb (which can readily be applied by each of you to the "examples" cited here) is this: If the effort described is directed primarily at <u>patients</u> who are <u>ill</u>, it is <u>clinical patient care</u>. If the effort described is directed primarily at a <u>group</u> of relatively <u>healthy</u> people, it is <u>public health services</u>. Try that simple test on the core subject of each "example" paragraph (ignoring the "buzz" words and "puff" phrases) and you will quickly see that most of them do not relate to public health at all.

A few of the paragraphs admittedly do describe (or at least mention) public health type activities. However, the obvious attempt throughout this "background information" document to exaggerate to the point of distortion justifiably raises questions concerning the validity of even these as "<u>significant</u>

experience in public health programs."

Neither can it be ignored that all these "examples" are here undocumented. Particularly, they almost never give us information on (and therefore leave room for legitimate doubt as to) the nominee's specific role vis a vis others, his degree of personal responsibility, the precise nature of his contribution, the extent and duration of his involvement, and his time and effort commitment.

Even assuming the most favorable verdict that available facts will permit, we are forced to conclude that all these "examples" in aggregate still fall far short of affording Dr. Koop the "specialized training or significant experience in public health programs" required by law.

Is it really imperative that the Surgeon General be a qualified public health practitioner?

We urge this Committee and the Senate not to minimize the importance of these mandated public health qualifications in the case of any Surgeon General nomination.

The Surgeon General is widely and appropriately viewed as a symbolic leader of the nation's public health movement. His role can be critical to stimulating the mobilization of the nation's total public health community, including a total work force of over a half million.

As the senior career public health professional in federal service, the Surgeon General is looked to for national public health leadership by professional counterparts serving as state health directors, county health commissioners, and city health officers across the nation. In a time of much heralded decentralization of public health responsibilities, there must be the maintenance of mutual respect and confidence at every intergovernmental facet.

Secretary Schweiker and Assistant Secretary Brandt have been eloquent in their language supporting health promotion and disease prevention. If this initiative is to continue and thrive, it must have committed expert public health leadership in the highest USPHS office.

In recent years, the Surgeon General has regained considerable traditional stature as a primary professional public health spokesperson for the nation, with a hard-earned

reputation for authoritatively presenting scientifically objective positions on important matters of national public health policy, e.g., smoking, nutrition, influenza, and prevention. Public confidence in the quality and reliability of our official public health leadership should not be permitted to unnecessarily erode.

The U.S. Public Health Service, as a qualified career professional service, is the legislatively established, permanent, internal locus for technical expertise and professional public health competence within the federal government. Its community health staff leadership is an essential continuing national resource to be both used now, and strengthened for even greater future use.

Conclusion

This is not just another battle in the abortion war.

Throughout our APHA effort to bring Dr. Koop's lack of public health qualifications to the attention of the President, the Congress, and the public, there has been a tendency for some media coverage to focus instead on Dr. Koop's controversial public statements on abortion, infanticide, and euthanasia. We regret this, because it tends to overshadow the less emotional issue of his public health qualifications. It is undeniable that APHA has long held that safe medical abortion should be available as an essential personal health service on a basis of need as defined by the choice of any woman and her physician. Some of Dr. Koop's supporters have suggested the abortion issue is the real reason for APHA's unprecedented opposition to his nomination. This is flatly untrue. APHA has not opposed the selection of other high ranking federal officials in both parties who have disagreed with the Association's position on abortion. The real issue is one of individual qualifications. We are joined in that view by other national groups that have no policy position on abortion, e.g., U.S. Conference of City Health Officers, and Association of Teachers of Preventive Medicine and the United Mineworkers. Dr. Koop's supporters sincerely feel that his extreme opinions should not disqualify him from appointive public office. We would also defend Dr. Koop's right to his position on the issues; but no views or opinions on issues, however dramatically presented, can be

accepted as valid substitute for basic qualifications. That is the real issue which the administration and the nominee wish would go away.

This is not just a matter of President Reagan getting his choice. As a Presidential appointee, Dr. Koop is actually now already serving in the position of Deputy Assistant Secretary for Health. We have not objected to this distinguished pediatric surgeon thereby becoming one of President Reagan's top medical advisors; but the Surgeon General post is distinctive. It is clearly intended to be the top federal public health professional in career service, and this traditional office should not be capriciously prostituted to the cause of either political patronage or personal presumption.

This is not simply a guild issue involving territorial imperative. The public interest validity of our position is attested by: (1) a long history of national health policy positions which emphasize public needs and avoid narrow professional interest, and (2) an impressive list of newspapers which have joined us in editorial opposition to Dr. Koop's nomination on the basis he is not qualified:

Detroit Free Press

Louisville Times

Los Angeles Times

Miami Herald

New York Times

Philadelphia Bulletin

Philadelphia Inquirer

St. Louis Post-Dispatch

Washington Star

Copies of these editorials are attached for inclusion in the record.

In conclusion, we earnestly urge the Committee on Labor & Human Resources to recommend the Senate reject the nomination of Dr. C. Everett Koop as Surgeon General of the USPHS on the grounds the nominee does not possess the statutory requirement of "specialized training or significant experience in public health programs."

Thank you.