

THE SURGEON GENERAL AND THE BULLY PULPIT

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ABSTRACT

MIKE STOBBE: The Surgeon General and the Bully Pulpit

(Under the direction of Ned Brooks)

This project looks at the role of the U.S. Surgeon General in influencing public opinion and public health policy. I examined historical changes in the administrative powers of the Surgeon General, to explain what factors affect how a Surgeon General utilizes the office's "bully pulpit," and assess changes in the political environment and in who oversees the Surgeon General that may affect the Surgeon General's future ability to influence public opinion and health. This research involved collecting and analyzing the opinions of journalists and key informants such as current and former government health officials. I also studied public documents, transcripts of earlier interviews and other materials.

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CHAPTER 1

INTRODUCTION

This project looks at the role of the U.S. Surgeon General in influencing public opinion and public health policy. I examined historical changes in the administrative powers of the Surgeon General, to explain what factors affect how a Surgeon General utilizes the office's "bully pulpit," and assess changes in the political environment and in who oversees the Surgeon General that may affect the Surgeon General's future ability to influence public opinion and health. This research involved collecting and analyzing the opinions of journalists and key informants such as current and former government health officials. I also studied public documents, transcripts of earlier interviews and other materials.

BACKGROUND/OVERVIEW

U.S. President Theodore Roosevelt once told a friend; "Most of us enjoy preaching, and I've got such a bully pulpit." He was referring to the White House as being a splendid (or "bully") platform from which to persuade the public.

More properly defined, a bully pulpit is a public office of sufficiently high rank that it provides the office holder with an opportunity to speak out and be heard on any matter. The U.S. presidency is a bully pulpit, but there are similar offices in the world of public health. The U.S. Secretary of Health and Human Services has a bully pulpit, to a certain degree, as does the Director of the Centers for Disease Control and Prevention. The U.S. Surgeon General does also.

But there's a difference between the Surgeon General and these other offices, which is highlighted by another Roosevelt quote; "Speak softly and carry a big stick." The saying is an advisory to leaders to have the resources to enforce their will beyond persuasion.

President Bush, the chief executive of the nation, has such ability. U.S. Health and Human Services Secretary Mike Leavitt, who heads one of the largest divisions of the executive branch, commands significant resources as well. CDC Director Julie Gerberding has power, too, overseeing an agency with nearly 9,000 employees and a budget of \$8 billion. [1] When Bush, Leavitt and Gerberding speak, their words are backed not only by the prestige of an office but also by their control over significant public health resources.

That's also true of leaders in the business world, in the military and other leadership realms. In those settings, great leaders demonstrate the ability to communicate a mission to their followers and persuade them to accomplish a goal. But though skill at utilizing a bully pulpit is important, it is not absolutely necessary in those settings.

The Surgeon General is in a different position.

The office of the U.S. Surgeon General was created in 1870 to oversee the Marine Hospital Service, a national hospital system for sailors that is the ancestor of the U.S. Public Health Service. In 1889, the Surgeon General gained the additional responsibility of running the Commissioned Corps, a personnel system of doctors and other professionals that from the beginning was organized along military lines. [2] Commissioned Corps members staffed the hospital service and subsequent federal public health agencies that were created. As the National Institutes of Health, the Food and Drug Administration and the Centers for Disease Control and Prevention came into existence, the Surgeon General was placed in charge of them as well.

The Surgeon General was the head of the Public Health Service agencies, including the NIH, FDA and CDC, with control over the administrative and financial management. The Surgeon General, appointed by the President and confirmed by the Senate, reported directly to the U.S. Secretary of Health, Education and Welfare. But that changed in 1968, when those powers were transferred to the new position of Assistant Secretary for Health. The Surgeon General, stripped of control over staff and financial resources, became an advisor within Health, Education and Welfare (now known as the U.S. Department of Health and Human Services, part of the executive branch of the U.S. government).

Currently, the Surgeon General remains the titular head of the Commissioned Corps, but no longer has the ability to transfer or command Corps members aside from the dozen or so who report to him. Surgeons General cannot order implementation of a program, or enforce a law or anything of that sort. But the Surgeon General has continued to carry out one influential role – that of being a spokesman for the Public Health Service. The position still carries a historical prestige, which draws audiences and commands respect. In other words, their one real power remaining is that of the bully pulpit.

They face constraints in how they wield that power. Appointed by the President to four-year terms, they must deal with political pressures. If they speak too strongly in opposition to positions held by the Administration, they may be asked to resign, as Dr. Joycelyn Elders was in 1994, only a year after taking office. At what point in history they take office may also be a factor – if an individual takes office after a brash and controversial predecessor, he or she may face new constraints created by political leaders who felt stung by the previous Surgeon General.

U.S. Surgeons General seems uniquely poised to lead public health policy changes and improve the nation's general health. Indeed, some recent Surgeons General – most notably Dr. C. Everett Koop in the 1980s – were highly influential individuals who were perceived as having sway over public opinion and behavior.

My dissertation will focus on the seven Surgeons General who held office since the late 1960s, after the government restructured the position and stripped it of control over monetary and staff resources. I will explore the primary role of the position in that recent time, which has been use of the bully pulpit.

In case study analyses of each of the seven Surgeons General, I will briefly reflect on some of the four theories that key informants said might explain the performance of people who held the office. The ‘Great Man Theory’ suggests the genius, charisma or other personal attributes of a person explains his or her success. The ‘Long Leash Theory’ holds that each Surgeon General’s success in the bully pulpit was influenced by the political or administrative environment in which he or she worked. The ‘Great Issue Theory’ suggests that some Surgeons General benefited from an unusual event or set of circumstances that occurred during their watch. And finally, the ‘Chorus Theory’ posits that how well a Surgeon General stood out was influenced by how many other government official were speaking to the public at the time and whether what they were saying was similar or different from what the Surgeon General was stumping on.

The theories, and their applicability, are discussed in greater depth later in the dissertation, in Chapter 4.

RESEARCH HYPOTHESIS

That the Surgeon General matters – that individual leadership can make a difference in public health, but that the political environment and the characteristics of the individuals who oversee the Surgeon General may diminish or increase the Surgeon General's influence. My hypothesis will explore the commonly voiced observation that the Surgeon General's visibility and influence has declined in recent years, and the idea that the change is attributed to one or some or all of the following factors – the personal characteristics of the people who have held the office; the political interests and personality traits of others in the federal government who for various reasons may not want the Surgeon General to be visible and influential; and the public health circumstances of the nation at the time and the opportunities they present for a Surgeon General.

In the end, my work considers whether the office should be revived and whether it truly is important to the public health.

PROJECT COMPONENTS

The first part of this dissertation project involved a literature review, involved later in this chapter.

Next was a quantitative piece of work – a survey of health journalists, designed to ascertain the opinions of reporters about the newsworthiness and credibility of the Surgeon General as compared with five other prominent federal officials who also communicate important government health messages. The methodology for the survey is described in Chapter 2. The results are detailed in Chapter 4.

The largest part of this project involved qualitative research into how different Surgeons General used the bully pulpit, and the factors that influenced those performances. The

methodology for the qualitative work is described in Chapter 2. What I learned is woven into a historical narrative in Chapters 3. Thematic findings are summarized and analyzed in Chapter 4.

The last part of the project is a proposal, derived from the information and perspectives accumulated. That's contained in Chapter 5.

LITERATURE REVIEW

This literature review was designed to explore the influence of the Surgeon General and the office's use of the bully pulpit. Little has been written on those topics, so I expanded the search to more general questions about power, politics, influence and persuasive communication.

Some definitions used:

Power, as defined by organizational leadership scholar Gary Yukl, is "the capacity of one party (the *agent*) to influence another part (the *target*). It is a flexible concept that can be used in many different ways." [3] Webster's Dictionary offers a more common definition – "the ability to control others." [4]

Yukl notes the varying categories of power. Those include *legitimate power*, which stems from formal authority over work activities; *reward power*, in which a target believes the agent controls desired resources and rewards; *coercive power*, which stems from an agent's ability to punish a target; and *ecological power*, in which an agent controls a target's physical environment, technology and organization of work. [5]

Those definitions speak to an agent's ability to influence a target, but not to directly control them.

Control, according to Webster's, is the power to direct or regulate, and involves the reprisals and loss of rewards described in the Yukl categories of legitimate, reward, coercive and ecological power.

In contrast, *influence*, is defined here as the ability to produce effects indirectly, without necessarily having the authority or resources to control a target. The Surgeon General can have influence over the public and other government officials, and to varying degrees may enjoy what Yukl calls referent, expert and information power. But the Surgeon General cannot control them, and therefore does not have controlling power.

Persuasion, or *persuasive communication*, is a better descriptor of the type of influence power a Surgeon General has. The term is defined as the act of causing an agent to do something, by reasoning with them or through convincing or urging. The agent's ability to persuade may be helped if the target perceives the agent to have some degree of referent, expert or information power, as described above. However, if the agent has actual power (as described above), the act of influence is not persuasion, but a form of control.

Bully pulpit, as previously defined, is an office or position of sufficiently high rank that it provides the office holder with an opportunity to speak out and be listened to on any matter. The U.S. President has a bully pulpit, in part because he controls the nation's armed forces and the executive branch of the federal government. Legislators have a bully pulpit, because they have the ability to tax members of the public and provide or withhold government services. The Surgeon General is relatively unique in government for having a bully pulpit without controlling power.

Public opinion is the prevailing attitude or view within a specified society. Unless otherwise differentiated, this paper will refer to U.S. public opinion. This paper explores the extent to which someone without actual power can affect public opinion.

Politics is, in conventional terms, the science of government. But it is more broadly defined by political scientists as who gets what, when, how and why. I will look for the term's application to situations that describe how health policy decisions are made and influenced by the President, Congress and by top-ranking officials in the government agency now known as the U.S. Department of Health and Human Services.

Search Terms, and Databases

Multiple search terms were used in my literature review, including “power,” “influence,” “leadership,” “persuasive communication,” “politics,” and “public opinion.” All are MeSH terms. “Bully pulpit” and “Surgeon General” are not MeSH terms, but also were used.

The literature review involved a search of computerized databases available through the UNC online library system. Databases used include PubMed, CINAHL, Web of Science and CSA Sociological Abstracts. Outside the UNC system, searches were done using Google Scholar and the GAO electronic archives.

Inclusion/Exclusion Criteria

Only articles written in English were used. Peer-reviewed empirical studies were included. Commentaries and historical articles from peer-reviewed journals also were included.

Only studies done within the United States were included. Other countries do not have a direct equivalent to a Surgeon General, and the dynamics that affect the influence public

opinion (for example, the power of the media, and the form of government) are not easily compared from country to country.

There were no exclusion criteria for how old studies could be.

My search focused on the term “Surgeon General” as applied to the office of the U.S. Surgeon General, within the U.S. Public Health Service. Other types of surgeons general were excluded. The term ‘surgeon general’ apparently comes from the English Civil War, when the title first began to appear in reference to certain medical officers. [6] Today, branches of the U.S. military have surgeons general.

Even with a narrowed focus, not every article turned out to be relevant. That is, despite promising titles and/or some brief passages that seemed on point, they focused on topics other than the bully pulpit role of government officials and/or the interchange of politics and personalities in determining the role and accomplishments of the U.S. Surgeon General or other government health officials. Those articles that were deemed relevant – about 100 – were reviewed in a more thorough, later-stage analysis. They included empirical studies as well as theoretical articles and commentaries.

I also reviewed dozens of history and policy analysis books and biographies. Their titles are listed in the bibliography. Among them:

- *The Presidential Character: Predicting Performance in the White House* by James David Barber, 1992. Barber divided presidents into the categories based on their activism and personality.
- *Presidential Power and the Modern Presidents* by Richard Neustadt, 1990. Neustadt discusses how different presidents exercised the power to persuade.
- *The Politics Presidents Make* by Stephen Skowronek, 1997. Skowronek explores how presidents are agents of change. He finds some non-charismatic men have wielded great authority, and some men of great reputation and charisma failed.

- *On Deaf Ears: The Limits of the Bully Pulpit* by George C. Edwards III, 2003. This book looks at how presidents use the bully pulpit to try to sway public opinion.
- *The Bully Pulpit: The Politics of Protestant Clergy* by James L. Guth et al., 1997. This text analyzes political activism by protestant clergy, looking at ideology and church politics as influences on what clergy attempt to accomplish.
- *Influence: Science and Practice* by Robert B. Cialdini. The author is a social psychologist who explores methods of influence.
- *Speaking Truth To Power* by Aaron Wildavsky. An expert explored what public policy is and how societal changes have affected it.
- *For Your Own Good: The Anti-Smoking Crusade and the Tyranny of Public Health* by Jacob Sullum. The writer critiques public health messaging on the topic of smoking and cancer.
- *The Mediating Effect of Public Opinion on Public Policy* by Richard E. Chard. Focusing on the Health Security Act, the author develops a theory on how public opinion influences public policy outcomes.
- *Koop* by Dr. C. Everett Koop. This is Koop's autobiography.
- *Joycelyn Elders, M.D.* by Dr. Joycelyn Elders and David Chanoff. Another Surgeon General's autobiography.
- *Inside A Public and Private Life* by Joseph A. Califano, Jr. Autobiography of the activist HEW Secretary during the Carter administration, who personally lead anti-smoking and other crusades that formerly were handled by Surgeons General.
- *Quarantine!* by Howard Markel. A University of Michigan public health historian examines the role of the U.S. Surgeon General and other health officials in dealing with typhus and cholera epidemics that swept through New York City in 1892.
- *Emerging Illnesses and Society: Negotiating the Public Health Agenda*, edited by Randall M. Packard et al. Includes material on former Surgeons Generals roles in setting health policy.
- *Plagues and Politics* by Dr. Fitzhugh Mullan. A history of the U.S. Public Health Service which several sources recommended as an important first stop in researching my dissertation topic
- *Are We Ready? Public Health Since 9/11* by David Rosner and Gerald Markowitz. Includes discussion of botched HHS communications to the public during the 2001 anthrax crisis.

- *The Cutter Incident* by Dr. Paul A. Offit. Discusses the role the U.S. Surgeon General played in dealing with fear and controversy that erupted in 1995 when polio vaccine made by Cutter Laboratories inadvertently carries live, virulent virus.
- *Ashes to Ashes* by Richard M. Kluger. This Pulitzer-winning history of the public health campaign against tobacco includes great detail on Surgeon General Luther Terry's influential report on smoking.

Setting aside valuable historical detail, thematic literature review results that were useful can be grouped under three categories:

General studies of influence and public opinion:

Some of the literature looked at the general question of persuasive communication and influence. Papers include attempts by academicians to describe how agents use persuasive communication to influence targets. Some of the literature looked at the general question of persuasive communication and influence. Papers include attempts by academicians to describe how agents use persuasive communication to influence targets.

In a theoretical paper from 1963, Parsons posited that influence is based on “Gemeinschaft solidarity” – a sense of belong together in society. He states that people are influenced through appeal to loyalties and by the interpretation of norms, and the “honor” or reputation of an agent is a factor in the success of the influence. [7] This suggests to me that the title and historical prestige of the Office of the Surgeon General may be a factor in how the bully pulpit was established, and may lead to questions about the current amount of prestige accorded that office.

Cialdini highlighted characteristics of leaders adept at persuasion. He noted studies that show people like – and listen to – people who praised them and seemed to like them and be like them. He mentioned empirical research from 1963 that used data from insurance company records to show people were more likely to buy a policy from a salesman who was similar to them in age, religion, politics or even cigarette-smoking habits. [8]

Cialdini also noted research that shows people defer to those who are clearly defined as experts. Studies have shown that when an expert's opinion was published in a New York Times news story or aired on national television, public opinion shifted between 2 percent and 4 percent. [9] His conclusions prompt me to consider whether the Surgeon General is considered an expert, and how his expert status is established, and whether the Surgeon General's age, religion, politics or habits affects the public's receptiveness to his or her messages.

From the world of organizational behavior, Cable (a UNC business professor) and Judge took an empirical look at tactics managers use to influence others by reviewing longitudinal data from 140 organizations. They showed different personality types tended to employ different manners of persuasion. The researchers also found that the characteristics of a leader's superior were associated with the methods of persuasion that the leader used. When a supervisor was transformational, the leader was more likely to use coalition building, inspirational appeal and pressure tactics. When the supervisor was more laissez-faire, the leaders' approach tended to be more open with an appeal that was more rational than inspirational. [10]

That was echoed in an empirical study by Garko, who found that the way physician executives communicate is affected by the way their superiors communicate with them. [11] The Cable and Garko articles suggest to me that I should consider personalities and relationships within the U.S. Department of Health and Human Services, including the interactions between the Surgeon General and his or her supervisor.

Literature on influence, health and public opinion:

One subset of literature addressed influence of public opinion by Surgeons General and other agents in the world of health.

In a theoretical paper that drew on empirical data, Worden and Flynn noted the Surgeon General's 1964 report on smoking and disease, by itself, was not enough to change smokers' behavior. It had to be supplemented by a campaign of persuasive communication messages that addressed the targets' social needs and expectations. Information by itself is not sufficient, the authors conclude. [12]

They summarized earlier research they had done with school-age children that showed students in communities where anti-smoking messages were in the media and community were at least 35 percent less likely to be smokers than those only receiving the messages in schools. [13] Their work, and some of the research that is summarized below, suggests that I should research the manner and mediums in which Surgeons General try to communicate with the public.

DeJong assessed the role of mass media communications campaigns to promote public health. In a theoretical paper that summarized and drew from empirical data, he noted that much research before the 1980s concluded that mass communication campaigns could reinforce existing attitudes and behaviors, but it could not do much else, because the public generally chooses to only retain information that supports existing opinions. [14] Health promotion campaigns are not easily compared with advertising, because health promotion seeks to change behaviors and develop new attitudes, and not just influence selection of a brand. [15]

However, in the late 1970s and early 1980s, studies showed that long-term health communication campaigns targeting tobacco and alcohol did have some effect, particularly when they involved television. [16] Officials should be cautious when using a “celebrity” spokesman in a health campaign, and perceptions of the spokesman’s trustworthiness and credibility must be carefully assessed. [17]

DeJong’s conclusions suggest that using a Surgeon General as a spokesman makes more sense than an actor or musician, whose popularity or credibility may wane during the campaign.

Perea and Slater performed an empirical study that looked at responses by 73 Mexican American and Anglo American young adults to televised drinking-and-driving warnings. Latinos rated ads featuring the Surgeon General as the source of information as more believable than ads without the Surgeon General. For Anglo Americans, the opposite was true. [18]

A 1988 GAO report detailed government AIDS communications to the public in the late 1980s. The CDC abandoned plans for a 1987 household mailing of AIDS information because it could not obtain clearance from the White House. The CDC produced 38 public service announcements for television, but they were only aired on seven occasions in the first two months, and mostly after 11 p.m. after that. [19] In contrast, a Surgeon General’s report on AIDS was successfully sent to every U.S. household in the fall of 1986. The White House was not involved in that report’s printing and distribution, according to a different GAO report. [20]

In an empirical work, Guttman analyzed the extent to which people trust official sources of AIDS information and how it was reflected in personal health beliefs. More than 1,600

people were interviewed in 1991. About 94 percent had heard of the Surgeon General and 78 percent had heard of the CDC. But the CDC had the highest overall reliability rating, followed by the Surgeon General, then state health departments. People who had a poor understanding of HIV transmission tended to rank the CDC lower. [21]

In a theoretical work that drew on empirical data, Franke examined cigarette demand in the 1960s. The researcher found the Surgeon General's 1964 report on smoking and health was followed by a significant reduction in consumption, but that decline lasted only a few months. Changes in the price of cigarettes seemed to have a more long-lasting impact. [22]

The peer-reviewed literature is extremely limited on the media affects how the Surgeon General communicates with – and is perceived by – the general public. I found fewer than a dozen articles through PubMed and CINAHL. Most of the articles merely summarized a communications strategy involving the media rather than giving insights into analyzing the relationship. A few analyzed the resonance of articles quoting the Surgeon General with press coverage that used state health officials as the sources. Perhaps the best source on this topic is *Media Advocacy and Public Health* by Lawrence Wallack et al. It doesn't discuss the Surgeon General per se, but posits that the mass media "presents the perspective of the ruling class to their audience" and plays a large role in setting the public policy agenda. [23] I derived from Wallack's book the idea that if top Administration officials communicate a perception that the Surgeon General is not an important spokesman, then the media gradually may not seek him or her out, and his or her messages may fall by the wayside.

Lessons from influencers with power:

A large amount of literature involving search terms like "power," "influence" and "leadership" focuses on the U.S. presidency and how chief executives attempt to sway people

who cannot simply be ordered to do something. In the literature, the audiences presidents most seek to persuade tend to cluster in two groups. The first group is made up of other political leaders, particularly members of Congress, whom presidents cajole or press in attempts to either pass or kill specific pieces of legislation. The second group is the media and the general public, whom presidents seek support or positive portrayals from, not only to get re-elected but also to pressure Congress.

Books by Barber, Neustadt and Skowronek offer scholarship on the roles charisma and personality play in helping Presidents persuade other politicians, the media and the public. However, their approaches and conclusion vary, with Neustadt and Skowronek both voicing cautions that charisma and speaking ability may not be key elements to effective leadership. [24]

A similar conclusion is reached in a theoretical paper by Mouw and MacKuen, who find that presidents exert hardly any influence on congressional voting. They find political and ideological alliances – factors they refer to as “strategic configuration” – are more important than charismatic persuasion. [25]

According to a theoretical paper by Newman that draws on empirical data, how members of the public perceive the integrity of a President can affect how they evaluate his job performance and how able he, in turn, is able to persuade them. But performance in national and international issues is more important than a President’s character, Newman found. [26]

Discussion

The literature is lacking in analysis of the power and bully pulpit role of the U.S. Surgeon General, and how that’s changed, particularly in relation to other public health leaders inside and outside of government.

The literature is also limited in examining how those in positions like the Surgeon General – that is, someone who does not command the manpower or financial resources to force or implement a course of action – uses the bully pulpit to achieve goals through persuasion.

Part of the problem is the uniqueness of the Office of the Surgeon General. At one point in history, it was a powerful government position, with oversight over the FDA, CDC and other health agencies of the federal government. The office was stripped of those powers and duties, but somehow has maintained much of its traditional prestige – the Surgeon General continues to be known as “the nation’s top doctor.” [27]

Literature on the U.S. Presidency offers some insights into the practice of persuasion in certain instances in which the President does not have direct controlling power over a target, such as when the Administration is trying to influence members of Congress to pass or kill legislation.

But the power dynamic is vastly different. A President has bargaining power and can bestow rewards. For example, a popular President may promise to make campaign appearances with a member of Congress that might help that representative get re-elected. A Surgeon General does not have comparable influence over his or her targets.

In addition, the literature on both Presidents and other leaders is made up mostly of theoretical works that draw conclusions from facts or limited empirical studies. The empirical studies themselves often are polling data or limited surveys – helpful in the social sciences, but not exactly double-blinded, case-controlled research.

However, much of the research does seem to hold together – that is, it appears to have convergent validity, to use Trochim’s terminology. [28]

But the general literature, and polling data specific to the Surgeon General, suggests that when Surgeons General succeed in the bully pulpit, it is for other reasons. They are viewed by the public as better educated and more expert in the issues they speak about. That expertise is an asset that could and should be used, as is suggested by Cialdini's look at how public opinion is swayed by expert opinion that appears in mass media.

Lacking in the literature is a focused assessment of Surgeons General, their levels of influence, and what explains the influence they have. Because Surgeons General are physicians who inform the public about health issues, they don't fit the "guys like us" mold that is described as an asset in some political leaders.

More generally, some of the most important literature on how people without controlling power influence public opinion is decades old. Cialdini's paper noted much of the most detailed empirical work looking at influence on the public by non-politicians was done in the 1960s, and Parsons' paper comes from that same era. Much about society have changed since then, including the ways businesses do advertising and sales and the types of media the public turns to for information. It's not clear if some of the research is outdated. Perhaps, they remain timely, demonstrating "eternal truths" about what agent characteristics make them acceptable and influential to targets that still hold true today. Much of the work needs to be replicated to see if the conclusions still hold true.

Regarding the Surgeon General, some of the most valuable data that speaks to the question of influence and public opinion is an indirect indicator of credibility of the Surgeon General as a source of public health information that was provided in the 1991 survey discussed in Guttman's paper. But that survey is 15 years old, and was conducted not long after Dr. C. Everett Koop – generally considered the most charismatic and influential

Surgeon General in the last half century – left office. It’s quite possible that there has been a significant deterioration since then in what the public knows about the Surgeon General and how credible they see that official as a source of public health information. New polling needs to be done.

Although some literature discusses the importance of the media as a megaphone for those who would use a bully pulpit, more study should be done of the dynamics of that interaction. Some literature – only briefly discussed in this paper – examines “media priming,” in which the impact of issues and personalities covered by the media impacts political judgments made by the public. [29] The literature focuses on media priming related to issues, but not people. In other words, the literature is comparatively thin in assessing how the type and quantity of media appearances by specific officials influences public opinion, particularly those without controlling power. One of the few works that did, previously mentioned in this paper, was the expert’s opinion study noted by Cialdini. [30]

Despite these weaknesses, the literature informs potentially important new questions for exploration. The article by Cable and Judge, as well as the one by Garko, found that how leaders practice their powers of persuasion is influenced by what type of person they report to. This lesson may be applicable to the Surgeon General. Though they had many differences, Surgeon General Koop was in many ways cut from the same cloth as the President who appointed him, Ronald Reagan. Both were skilled, highly visible and forceful communicators who spoke with moral certainty. That too should be explored further.

In summary, the literature fails to adequately explore how leaders without power influence public opinion. Some of the research that best addresses the question is 40 years old, and new and more expanded work needs to be done. Generally speaking, there’s

insufficient empirical research on how leaders of any kind influence public opinion, and a clear scarcity of study focused on the influence of people without controlling power. But the literature does provide valuable examinations of important tangential questions that provided valuable fodder for my inquiry.

ENDNOTES

[1] U.S. Department of Health and Human Services Web site.

<http://www.hhs.gov/about/whatwedo.html/>

[2] U.S. Department of Health and Human Services Web site.

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[5] Yukl. Pg. 145.

[6] Pearce, Robert L. "The emerging office of the Surgeon General" *ADF Health* April 2002 Vol. 3: Pgs. 36-39.

[7] Parsons, Talcott, "On the Concept of Influence" *The Public Opinion Quarterly* 1963 27 (1): Pg. 49.

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[30] Cialdini article.

CHAPTER TWO

METHODS

STUDY DESIGN AND DATA SOURCES

This is a mixed methods study, involving a quantitative survey and qualitative work such as key informant interviews and historical research.

I considered various approaches to measure the influence of Surgeons General. One example: Surgeons General periodically issue reports on specific health topics, such as the 1964 report of smoking by Surgeon General Luther Terry, which is generally considered to be a turning point in reducing U.S. smoking rates. However, it must be noted that Surgeon General reports are products of committees of people at various federal agencies, they are promoted by an array of officials, and it is problematic to tease out the degree to which an individual Surgeon General is responsible for what the report says and for its impact on the general public. Indeed, a 1994 study suggested that the decline in smoking that could be directly attributed to the Surgeon General's report only lasted three months. [1]

Another possible approach involved surveying members of the public, or of reporters who cover health issues, to ask the degree to which they view different health officials as credible and/or influential. Such a survey was done in 1991. [2] Though I decided to include a survey component to my project, survey data are limited in helping me answer my research question, which is qualitative in nature.

What I ended up with was a project with three parts – that is, three types of data collected.

The first part was a quantitative survey of health journalists, who are considered “the megaphone” through which government health officials most often communicate with the general public.

I sought a representative sample, as it was beyond my time and economic resources to interview all the U.S. journalists who have covered federal health agencies and policy. I sought to gather results that are generalizable to the total population of U.S. journalists who cover public health and health policy. The problem is we don’t know the denominator – there is no good census of the total number of health journalists working in various media (including newspaper, magazines, wire services, Web sites, television and radio stations). A rough estimate, several years old, is 3,000. [3]

There are several professional organizations to which at least some of those journalists belong to, including the National Association of Science Writers and the American Medical Writers Association. But those organizations include only a small number of journalists who cover government health policy, at least partly because the NASW is heavily focused on science and not public health, and AMWA’s membership is largely public relations people.

So instead I focused on the Association of Health Care Journalists. AH CJ, with more than 1,000 members, is the nation’s largest organization of reporters and editors who cover public health and health policy. It is believed to have the largest number of journalists that cover the Surgeon General and other government officials who speak and act on matters of public health.

Using an online survey tool – SurveyMonkey – I asked journalists to share their opinions about the news value of appearances and reports put out by different government health

officials. In a manner of speaking, I was seeking to learn to what extent reporters care what the Surgeon General says.

I am an AHCJ member, and an elected member of the AHCJ Board of Directors. In the summer of 2007, I approached the organization's executive director and other members of the governing board about my hope to survey AHCJ members for this dissertation project. After receiving their consent, I posted an e-mail invitation to participate on Sept. 27. Follow-up e-mail requests were posted on Nov. 1 and Nov. 29.

The questions used in the survey are in **Appendix D**.

The responses were tabulated, and I used a scoring system to better analyze how the journalists viewed the newsworthiness and credibility of six different federal health officials – the director of the U.S. Centers for Disease Control and Prevention; director of the National Institutes of Health; director of the NIH's National Institute of Allergy and Infectious Diseases; U.S. Surgeon General; U.S. Secretary of Health and Human Services; and Assistant Secretary for Health at the U.S. Department of Health and Human Services.

The results and analysis are fully described in Chapter 4.

The second part of my project involved key informant interviews of 30 people who have held the office of Surgeon General, worked with people in that office, or who are considered knowledgeable in the Surgeon General's role in speaking to the public and trying to influence public opinion, health behaviors and policy.

My selection criteria: I sought to interview as many people as my time and resources allowed who had direct knowledge of the workings of the Office of the Surgeon General, or who were identified to me by insiders and experts as being knowledgeable about the Office. My list of interview subjects was limited by the resources of this project – I could only afford

to interview about 30, because of financial limitations that included transcription costs, travel limitations and the deadline for completing this dissertation. In addition, five potential interview subjects declined or did not respond to interview requests – current Acting Surgeon General Steve Galson, former Surgeon General Antonia Novello, former Acting Surgeon General Audrey Manley and former CDC Director William Foege. I also attempted to interview the current nominee for Surgeon General, James W. Holsinger Jr., just after a Senate confirmation hearing last July, but was told by HHS officials who intercepted me that Holsinger would not comment while the confirmation is pending. (It is still pending.)

In nearly every interview, the key informants were asked the same core set of questions, but additional questions were also posed based on the individual's experience and on responses to the core questions. Those questions are listed in **Appendix B**.

The complete list of questions was not asked in some interviews in which the time was limited or in which some of the questions did not apply – for example, an interview of U.S. Rep. Henry Waxman was limited to 20 minutes, and I did not ask him some of the questions specifically geared toward Surgeons General, such as; “How much direction did you receive from other HHS or Administration officials about what topics to address in the Surgeon General's bully pulpit capacity?”

I attempted to interview all of the seven Surgeons General since the office was reorganized since 1968, as well as other U.S. health officials. Six of them did interviews with me – Jesse Steinfeld, Julius Richmond, C. Everett Koop, Joycelyn Elders, David Satcher and Richard Carmona. Antonia Novello was the only one of the seven who declined an interview (she did not clearly state a reason).

The other key informants were: U.S. Rep. Henry Waxman; former HEW Secretary Joseph Califano; former HHS Secretary Louis Sullivan; former HEW Under Secretary Hale Champion; former ASH Phil Lee; former ASH James Mason; former CDC Director David Sencer; former CDC Director Jeff Koplan; former Acting Surgeon General Ken Moritsugu; HHS spokeswoman Rebecca Ayer; public health historian Fitzhugh Mullan; public health historian Howard Markel; American Public Health Association President Georges Benjamin; U.S. Senate staffer David Bowen; U.S. House staffer Art Kellermann; former HHS staffer Ken Thorpe; former HHS staffer Damon Thompson; former HHS staffer Karen Near; former HHS staffer Bill Pierce; Harmon Eyre, the former chief medical officer of the American Cancer Society; Jerry Farrell, executive director of the Commissioned Officers Association of the U.S. Public Health Service; and Jeff Levi, Kim Elliott and Sherry Kaiman, all with the public health advocacy organization Trust for America's Health.

I conducted all the interviews myself. The interviews were taped and transcribed in their entirety, with the key informant's knowledge and consent. Consent forms were offered to, and signed by, the key informants. They were informed that they could go on background or off the record, and that they had the right to withdraw from this project at any time.

No subjects were excluded because of age, gender, ethnicity, health status or other personal characteristics. No monetary inducement was provided, and no direct benefit to study participants was forecast. An improved understanding of the role of the Surgeon General in influencing public opinion on health issues may suggest measures for improving behavior- and policy-affecting communications. No risks to subjects are anticipated. There were no costs to subjects other than their time.

Interview subjects were allowed to designate the setting for interviews, meaning they may chose a location as private as they wished. When possible, the interviews were done in person – I did 23 in person and 7 on the telephone. Some of the in-person interviews were done in the Atlanta area, where I live, but others involved trips to Boston; Washington, D.C.; Hanover, N.H.; and Pomona, Calif.

Interview notes, tapes and other documents and materials related to the research were stored in a locked filing cabinet or in a password-protected computer.

The third part of my research involved reviewing books, public records and other documents that pertain to my research question. Among them: Transcripts of oral interviews done by the historian of the U.S. Public Health Service with former Surgeons General, biographies and historical texts, and public records from the U.S. Department of Health and Human Services that include such things as drafts of Surgeon General reports and the calendars/appointment books of Surgeons General.

My data were mostly qualitative – key informant interviews, containing observations and perspectives and historical facts, as well as historical documents.

The advantage of such data is they allowed a nuanced look at social, political and cultural factors that may be hard to quantify. “We aim to account for events rather than to simply document their sequence,” wrote the researchers Matthew Miles and A. Michael Huberman, in describing the merits of qualitative research. [4]

A potential challenge or limitation, however, is that methods of qualitative analysis often are not well formulated. “...The analyst faced with a bank of qualitative data has very few guidelines for protection against self-delusion, let alone the presentation of unreliable or invalid conclusions to scientific or policy making audiences,” Miles wrote. [5]

How did I guard against that? First, I used available tools to do a systematic analysis of qualitative data. Perhaps the most significant was ATLAS.ti, a software program that allowed me to code and congregate information from key informant interviews and other documents by theme and topic.

Also, as a check and balance, I discussed emerging themes and ideas with the experts I interviewed to hear their perspective on what does and does not make sense about different possible conclusions.

DATA MANAGEMENT AND ANALYSIS

As noted earlier, I used ATLAS.ti to code and analyze the key informant interview transcripts. Themes developed from that process were used to analyze public records and other documents.

Themes I used included “‘great man’ theory/personal characteristics,” referring to the traits of individual Surgeons General that might account for leadership success or failure; “politics/interactions,” referring to the individuals who had oversight of Surgeons General and to what degree they allowed Surgeons General the opportunities to lead; “issues/policy environment,” referring to public health issues that arose and needed addressing, irrespective of who was in office at the time; and “other conditions/public attitudes,” referring to other factors, including issues concerning the general public’s willingness to listen to – and be lead by – public health officials.

Materials grouped under those themes were broken down into more specific sub-categories.

IRB AND CONFIDENTIALITY ISSUES

In 2006, I was presented with two unusual opportunities.

I was going to be traveling through northern New England and learned that Dr. C. Everett Koop, the famous former Surgeon General, would be willing to let me interview him at his home in New Hampshire. Because Koop was 90 and having health problems, and because it's usually difficult for me to make such a trip, I saw it as my best (and perhaps only) chance to do this important key informant interview.

At about the same time, U.S. Surgeon General Richard Carmona was due to visit Atlanta, where I live and work, and indicated a willingness to talk to me. Normally such an interview would be difficult, given his busy schedule and the fact he was based in the Washington, D.C. area.

For those reasons, I approached the IRB and asked for an expedited review that would allow me to do the interviews. I was granted approval, but with the understanding that I would return to the IRB for further approvals. I have since been given clarification that interviews with current and former public officials do not require added approval, but other interviews will.

In my IRB application, and in my early key informant interviews, I used a consent form and fact sheet that I wrote with guidance from similar documents previously authored by Bryan Weiner. (Please see **Appendix A** and **Appendix C**). I also used a standard set of questions which were the basis for each interview, although each interview also involved follow-up questions – which varied from person to person – based upon their response. (The questions are seen in **Appendix B**.)

I went back to the IRB in the summer of 2007, after review and approval of my project from my dissertation committee. I was granted IRB approval and did a second, much larger set of key informant interviews, as well as the survey of journalists.

In my consent forms and in discussions with key informants before the interviews, I stated that the information gathered may also be used in a book or other work of journalism. If a key informant wished to say something off the record or not for attribution, they were told in advance that they had to tell (me) the interviewer his or her wishes and I had to agree.

ENDNOTES

[1] Franke article.

[2] Guttman et al.

[3] My notes from an October 2000 meeting of the Association of Health Care Journalists' Board of Directors, held in Minneapolis, MN. The estimates come from research done by the organization's founders.

[4] Miles, Matthew B. and Huberman, A.M., *Qualitative Data Analysis*, 2nd Ed., Sage Publications, 1994. Page 4.[1]

[5] Ibid, page 2.

CHAPTER THREE

HISTORY AND CASE STUDIES

HOW THE SURGEON GENERAL GAINED POWER AND A BULLY PULPIT

The U.S. Marine Hospital Service was falling apart.

Congress created the Service in 1798 to provide health care to sick and injured merchant seamen. But by 1869, only nine of the Service's 31 hospitals were functioning. One had burned down, one washed into a river, two were abandoned, two unfinished and most of the others had been sold off. "The marine hospital service of the country is upon the whole in an unsatisfactory condition," said Treasury Secretary George S. Boutwell, summarizing a staff report. [1]

Boutwell pushed for legislation, passed in 1870, that included a series of administrative changes for the Service. Among them was creation of a 'Supervising Surgeon' – a title that changed in 1873 to 'Supervising Surgeon General.' It was to be a civilian physician, Congress decided. [2]

However, the first to hold the job came with a military bent. Dr. John Woodworth, formerly of the Union Army, was appointed in 1871. Woodworth had played an important medical role in the Civil War – during General William T. Sherman's "March to the Sea," Woodworth was in charge of the ambulance train that brought the sick and wounded to Savannah. [3] Woodworth put the Service's doctors in uniforms, and centralized the personnel system so that doctors were no longer assigned to a specific hospital but to the general service. He also put in place examinations for applicants that replaced the former

practice of appointing doctors based on the recommendations of the local Collector of Customs. [4] Those exams – strengthened by Woodworth’s successor – far eclipsed the scattershot standards of U.S. medical schools at the time. [5]

Together, the changes created an elite group of mobile, career public health professionals known as the Commissioned Corps. They were a cadre of uniformed physicians that operated uniquely from the political patronage systems so common in post-Civil War America. [6] “To get into the Commissioned Corps, particularly in the early 20th Century, was an extremely competitive thing. You had to take a series of examinations, and you had some really good, smart people doing that,” said Howard Markel, a public health historian at the University of Michigan. [7]

Public health, by tradition and legal precedent, had long been the domain of state government. Woodworth worked to establish the Service as national leader on public health issues, and to assert its role in dealing with public health emergencies. The Service’s role expanded even more under his successor, Dr. John B. Hamilton, and under Dr. Walter Wyman, who was appointed when Hamilton resigned in 1891.

A series of federal laws in the early 1890s gave the Service the authority to establish national quarantines against epidemic cholera, smallpox, plague and yellow fever, and placed ultimate authority for quarantine enforcement with the Supervising Surgeon General instead of the states. [8]

In 1891, Congress also gave the Service responsibility for medical inspection of immigrants, including at the Ellis Island depot, which opened in 1892. “The officers of the Public Health Service, uniformed and disciplined as they were, constituted the immigrant’s

first contact with Americans in America,” wrote Fitzhugh Mullan, in his historical text *Plagues and Politics: The Story of the United States Public Health Service*. [9]

It was during Wyman’s twenty-year tenure that President William McKinley was assassinated and succeeded by a more dynamic and progressive politician, Teddy Roosevelt – to whom the phrase “bully pulpit” is credited.

Under a law signed by Roosevelt in 1902, the title Supervising Surgeon General was shortened to ‘Surgeon General,’ the name of the Service was lengthened to ‘the Public Health and Marine Hospital Service,’ to better encompass the growing number of roles the Service was playing, including quarantine activities and scientific research. [10]

It was also during this period that the Surgeon General gained more prominence in the press. Wyman was frequently mentioned in the New York newspapers when quarantine measures against a cholera epidemic were instituted there in 1892, and the Service played a leading role in imposing harsh quarantine restrictions targeted at Asians as part of an effort to control plague in San Francisco in 1900. Wyman also played a prominent role in the nation’s response to yellow fever epidemics.

The mass media at the time were essentially newspapers and magazines, so opportunities to communicate with the public much more limited than in later eras, and Wyman was more bureaucrat than public speaker. But he understood the public nature of his role and the need to communicate public health messages. [11] “He was definitely a Washington player,” and was often quoted in the press, Markel said. [12]

After Wyman died in 1911, Dr. Rupert Blue was appointed his replacement and over the next nine years helped grow the power and prestige of the Public Health Service (PHS) – as it was called from 1912 onward. In 1912 and 1913, the PHS gained the authority and funding

to initiate field research independent of state and county health departments, which lead to pamphlet-spreading public health education campaigns, such as one against trachoma in eastern Kentucky in 1913. [13]

Blue played an important role in the federal government's "Safety First" campaign of 1916, which sent a train of exhibit cars across the country. Using motion pictures, lantern slides, models and other means, the PHS car presented the dangers of careless garbage disposal and unsanitary toilets and explained how contagious diseases spread. More than 348,000 people visited PHS exhibits in the two months ended June 30 of that year. "The attendance exceeded all expectations," Blue reported at the time. [14]

In World War I, the role of the PHS continued to increase. The Service established venereal disease control programs, and produced vaccines against tetanus, typhoid and other illnesses. In 1919, it was tasked with providing health care for veterans, establishing a group of veterans hospitals that was later turned over to the Veterans' Bureau that Congress created in 1922. [15]

Blue resigned in 1920, and Dr. Hugh Smith Cumming was appointed, holding the job for the next 16 years. The new Surgeon General hosted a delegation of health officials from the League of Nations, showing off the PHS's Hygienic Laboratory in Washington, which had become a draw for international medical experts performing special studies. [16] In 1930, the lab was expanded and renamed the National Institute of Health.

Cumming was a quoted expert whose name was invoked in legislative debates. One example: In 1929, in a failed push by U.S. Sen. Reed Smoot for a law that would allow the U.S. Food and Drug Administration to regulate tobacco products, the Utah Republican cited

a statement Cumming had made that cigarettes caused nervousness, insomnia and other ill effects in young women. [17]

As the visibility and responsibilities of the Public Health Service grew, Surgeons General's insistence on some of the military-like details of Service life gradually faded. The Commissioned Corps had numbered about 100 at the turn of the century, a time when their martinet-like leader – Wyman – decided to minute detail the uniforms to be worn on hospital duty, at quarantine stations and on special occasions. [18] Indeed, photos of Wyman and Blue show doctors in full military regalia, sometimes even with swords. [19]

But as the Public Health Service grew, it added nurses, sanitary engineers and other staff. Most were civil service employees. By 1915, commissioned officers accounted for only 187 of the PHS's 2,131 staff. By 1925, there were about 250 regular service and reserve officers among 4,672 employees. [20] In the 1930s, commissioned officers routinely wore uniforms in hospitals and in quarantine areas, but the military dress was usually absent in field service and other assignments. "I got the uniform and kept it in a closet," said Dr. Warren Palmer Dearing, a PHS veteran, recalling his first years in the Corps in the mid-1930s. [21]

When Cumming retired in 1936, he was succeeded by Dr. Thomas Parran Jr., a Service veteran who became one of the most visible Surgeons General in the history of the federal government – though usually dressed in a suit.

Parran had gained national prominence in 1934, when he served as New York's state health commissioner while Franklin Delano Roosevelt was governor. He campaigned against venereal disease, and was asked to appear on a CBS radio program but was cut off the air when a station employee realized he was going to talk about syphilis – a topic many reporters and station manager felt was unsuitable for general audiences. [22]

“That was, you might say, a real taboo,” said Dr. Philip R. Lee, a public health scholar at the University of California-San Francisco. [23]

But Parran got around that. He called a friend in the press, Ernest Lindley, and CBS’s decision hit the newspapers. [24]

At his first press conference as Surgeon General in 1936, Parran again confronted censorship by the media. After he named syphilis and tuberculosis as two major preventable causes of death, an Associated Press reporter interrupted: “But Dr. Parran, the AP never uses the word ‘syphilis,’” the reporter said. “The Associated Press will use it from now on or it will probably have to omit all the pronouncements of the Surgeon General of the Public Health Service,” Parran replied. [25]

Parran appeared on the cover of TIME magazine in October 1936, and came to be known as “the No. 1 New Dealer in national health matters.” [26] In 1937, he published *Shadow on the Land*, a best-selling book about syphilis. In it, Parran argued syphilis must be dealt with frankly, and health officials had to not only treat the disease but identify contacts and work with law enforcement in addressing prostitution. [27] His influence with the public helped persuade Congress to pass the National Venereal Disease Control Act of 1938, which authorized \$15 million over three years – or roughly \$1.7 billion in today’s dollars – for the fight against sexually-transmitted diseases. [28]

In 1945, he addressed another taboo topic, labeling mental health as a top priority for health officials. “Mental illness is not a skeleton to be hidden in the family closet,” he declared. [29]

Some noteworthy changes in the administration of the Public Health Service followed. In 1939, the PHS moved from the Department of the Treasury – its traditional home – to the

newly created Federal Security Agency. In 1943 and 1944, new laws established a four-bureau structure for the Service that remained in place until 1967. They set forth that the Surgeon General was to be appointed by the President to a four-year term, selected from the Commissioned Corps, and his appointment was to be ratified by the U.S. Senate. [30]

After World War II, the International Health Conference in New York elected Parran its president, and he used that position to help engineer the creation of the World Health Organization in 1948. [31] Parran considered the diplomacy involved in that effort – and the resulting product – to be one of his greatest achievements, some say. [32]

Roosevelt, Parran's great political patron, died in 1945. Roosevelt's death proved to be one of several political developments that contributed to the ouster of the popular Surgeon General, public health veterans and scholars said.

Another was Parran's role in a debate over creating a system of national health insurance. Parran was a supporter of an effort to create a national health insurance system, such as was proposed in the Wagner-Murray-Dingell bill introduced in 1943. He supported the Hospital Survey and Construction Act of 1946, also known as the Hill-Burton Act, as an infrastructure-supporting measure that would precede federal funding for medical care. [33]

Understanding that national health insurance was bitterly opposed by the American Medical Association and other interest groups, Parran tempered his public advocacy of national health insurance. [34] But quietly, Parran wanted the PHS to play a principal role in the national system that would be created. [35]

Nevertheless, AMA editorialist Morris Fishbein attacked Parran for supporting Truman's call for national health insurance, and some believe Parran became a political victim of the backlash. [36]

Another problem for Parran was his contentious relationship with Oscar R. Ewing, who in 1947 succeeded Watson B. Miller as Federal Security Administrator. Ewing didn't brook opposition, but Parran – a long-time, well-known national public health leader – was not one to roll over. “Parran was speaking up,” Dearing recalled. [37] Among their disagreements was what role the federal government should take in supporting medical education, and on the timing of a National Health Assembly in May 1948 that was intended to propel a compulsory health insurance bill. [38]

In 1948, President Truman declined to renew Parran's term, and Dr. Leonard Scheele was appointed Parran's successor in April of that year.

Scheele benefited from growing support for biomedical research. The Service's NIH – it became the plural National Institutes of Health in 1948 – received the generous and forceful support of entities like the American Cancer Society and the influential philanthropists Albert and Mary Lasker, who became allies of Scheele's. [39]

In 1953, President Dwight D. Eisenhower elevated the Federal Security Agency to cabinet status. It was renamed the U.S. Department of Health Education and Welfare (HEW), with Oveta Culp Hobby named as Secretary. Hobby was the lone woman in Eisenhower's cabinet, and received significant attention from the press. [40] Also a new position, Special Assistant for Health and Medical Affairs, was established in the Secretary's office to handle high-level negotiations on politically sensitive matters. The position was meant to accommodate the AMA's desire to have a designated physician high in the ranks of the new department. [41] That position would later evolve to become the undoing of the Surgeon General's administrative powers, but in the 1950s the Special Assistant did not directly infringe on the Surgeon General's responsibilities. [42]

Indeed, no laws were rewritten in the creation of the HEW, and the Surgeon General retained all of his authorities. [43] HEW was basically “a holding company” in the 1950s. “The agencies (under it) were almost autonomous,” said John Kelso, a long time HEW administrator. [44]

Scheele proved much less active in the bully pulpit than Parran, but at certain times made important statements to the public. One, considered a success, occurred in 1951: He made a public and unqualified recommendation for the fluoridation of drinking water – a controversial innovation. [45]

Considered by many to be a failure, though, was his handling of what came to be known as ‘the Cutter incident.’

In the early 1950s, at the height of a national polio epidemic, Dr. Jonas Salk and other scientists developed vaccines against the disease – one of the great public health triumphs of the century. Salk developed a protocol for manufacturing a vaccine that was 55 pages long, but as production of polio vaccine was fast-tracked, U.S. officials shortened the protocol and did not require manufacturers to notify the government about batches of vaccine that failed safety tests. Hobby pressed for speedy approval from a licensing advisory committee, giving them only hours to decide. Late on the afternoon of April 12, 1955, Hobby held a press conference to announce the signing of licenses granting permission for five pharmaceutical companies to distribute polio vaccine. [46]

Only weeks into the vaccination campaign, however, reports of new cases of polio emerged in children who had been vaccinated and in those they had been in contact with. Cutter Laboratories, the first manufacturer to distribute vaccine, immediately came under scrutiny. On April 27, Scheele asked the company to voluntarily recall all of its vaccine.

Scheele issued a statement, saying that in the judgment of the Public Health Service, there was no cause for alarm. He also it was not clear there was a link between the vaccine and new cases of polio. But public alarm grew, as reports of children who were paralyzed or killed proliferated, reaching 30 by April 30. [47]

A government investigation indicated safety tests couldn't be trusted and the vaccine manufacturers were not consistently able to inactivate polio virus. On May 6, Scheele announced the postponement of polio vaccinations until further notice. Two days later he went on television to address the public:

“Because the Public Health Service believes that every single step in the interest of safety must be taken, we are undertaking, with the help of manufacturers, a reappraisal of all their tests and processes. This can be thought of, if you like, as a double-check...But we believe – and I am sure the American people join us in believing – that in dealing with the lives of our children, it is impossible to be too cautious.” [48]

A day later, Scheele again appeared before the press, emphasizing that Cutter was the only company to release a product linked to paralysis and death and those shots were off the market. [49] But in the weeks that followed, cases were also linked to a lot made by another manufacturer, Wyeth Laboratories.

HEW officials came under heavy criticism for their handling of the matter. “There is no excuse for starting and stopping, scaring everyone to death... It is one of the worst bungled programs I have ever seen,” said U.S. Sen. Estes Kefauver of Tennessee, in subsequent hearings. [50] Hobby received much of the criticism, and resigned in the summer of 1955.

[51]

Scheele regretted his decision to allow companies to withhold information on vaccine lots that had failed safety tests. [52] He “was spiritually a casualty” of the Cutter incident, Dearing said. [53]

Scheele resigned in 1956. Some say he was forced out when his term expired, although Dearing maintained that Scheele took a job in industry – with a pharmaceutical company, Warner-Lambert – only after learning he was appointed to his third four-year term. [54]

Eisenhower appointed Dr. Leroy Edgar Burney in August 1956. By all accounts he was a quiet administrator who generally stayed away from the bully pulpit and focused instead on his administrative duties with the Public Health Service. His interest was in keeping public health separate from medical care; his guiding credo was “don’t get identified with anything that organized medicine would really take out after you,” said Dr. William Stewart, a PHS physician who would later become Surgeon General. [55]

“He never created much of a stir about anything,” said Dr. David Sencer, who in 1965 became director of the PHS’s Communicable Disease Center in 1965. [56]

Well, almost never. In 1956, Burney had urged the American Cancer Society and others to form a study group on the impact of cigarette smoking on health. In July 1957, after receiving the group’s report, Burney issued a statement to newspapers saying excessive smoking was likely a cause of lung cancer – a statement the journalist and public health historian Richard Kluger described as “tepid.” [57]

Tepid as it was, it made Burney the first Surgeon General to publicly link smoking with lung cancer. In 1959, Burney made a similar statement, after another study group produced more information on such a link. The statement did not include a call to action or a push for new policy. However, it was attacked in a Journal of the American Medical Association

editorial that argued there were not enough facts to warrant a statement on causation. Burney was shocked by the response. [58] Burney had an article in the same issue, but it had no impact. [59]

It was during Burney's tenure that the Office of the HEW Secretary began to really assert itself. "I recall well the stories that whenever Congress – and I guess the White House, too – wanted to deal with matters of health, they dealt directly with the Surgeon General's office or with the components of the Public Health Service," said Dr. Charles Miller, who joined the PHS in the 1950s and later became a prominent HEW administrator. But that changed noticeably in the late 1950s, as the Secretary's office played a larger and larger role in determining program priorities and developing budgets, he said. [60]

Burney resigned when his term expired in 1961, allowing the new Kennedy Administration to pick its own man. PHS veterans note, however, that the changeover was unusual – Scheele, Parran and other Surgeons General were reappointed even when Democrats and Republicans switched places in the White House. "Burney was so poor and weak as the Surgeon General, he was the only Surgeon General in the whole history of the Surgeon General with a term appointment that was not reappointed," said Dearing, who unsuccessfully lobbied to become Burney's replacement. [61]

Kennedy instead chose Dr. Luther Terry, a cigarette-smoking heart specialist with a keen interest in research. Kluger described him as "a honey-voiced Alabaman who, as a youngster, had picked tobacco." [62] According to legend, politics played a major role in his selection – the influential U.S. Sen. Lister Hill called the White House and recommended Terry, who was Hill's personal physician. [63]

Although the AMA had proved unfriendly on the issue of tobacco and smoking, Terry quickly heard from another group pushing for action. Three months after Terry took office, Kennedy received a June 1 letter from the American Cancer Society, American Heart Association and other groups urging the government to establish a commission to study the effects of smoking on health. [64] Terry set up such a commission the next year, after an influential report from the Royal College of Physicians in Britain concluded smoking was a clear cause of lung cancer and bronchitis, and probably contributed to cardiovascular disease as well. [65]

Terry released his Advisory Committee's report on Jan. 11, 1964. Terry later described it as "probably having the greatest impact of any government report every issued." [66]

The report said smoking caused lung cancer and bronchitis, and added that there was evidence suggesting – but not proving – that it also caused emphysema, cardiovascular disease and some other types of cancer. Furthermore, the committee concluded that smoking was a hazard and the government should do something about it. [67]

Released on a Saturday, the report made newspaper front pages across the country on Sunday morning – the day of the week with highest newspaper circulation. It was treated as blockbuster news: The New York *Herald Tribune*'s headline said; "It's Official – Cigarette Smoking Can Kill You." *The New York Times* said the report effectively dismissed the arguments against the ill effects of smoking that had been made by the tobacco industry and others. [68]

U.S. cigarette consumption dropped by about 20 percent in the three months after the report was issued. It later crept back to near normal levels, but Terry's report served as an

important first salvo in a public health campaign that ultimately drove smoking rates down from about half of all adults in the 1960s to fewer than a quarter today [69]

It marked a turning point in government policy regarding tobacco. The next year, Congress passed the Cigarette Labeling and Advertising Act of 1965, which mandated health warnings be placed on cigarette packs. It also required that the Surgeon General report annually to Congress on cigarette advertising and the relationship of smoking to illness. It also created a National Clearinghouse on Smoking and Health, and sparked other measures to draw attention to, and discourage, cigarette smoking.

Much of Terry's term was consumed with testifying to Congress about smoking and working on the tobacco issue. That work made him a public health hero, said Dr. Harmon Eyre of the American Cancer Society's recently retired chief medical officer.

Of the Surgeon Generals up to that time and since, "he made the biggest impact on the health of this country," Eyre said. [70]

He was echoed by Dr. Philip Lee, who years later would become an important agent of change for the U.S. Public Health Service. "If you look at the long term, probably the Surgeon General who accomplished the most would be Luther Terry. Thirty million people quit smoking following this report," Lee said. [71]

Nevertheless, Terry did not endure in the office. A new HEW Secretary, John Gardner, came into office in August 1965 with a mission to shake things up. Terry, though only 54, retired from government service in October as his term ended. Apparently, President Lyndon Johnson wanted someone new, said Stewart, the man who would succeed Terry. [72]

The soft-voiced Stewart, who Burney had recruited to join his staff in 1957, was surprised when he was nominated to replace Terry. Only weeks earlier, Terry had appointed

Stewart as director of the National Heart Institute at the NIH, a post Stewart considered his career goal. [73] Dr. Jim Shannon, the widely respected head of NIH, was surprised as well – he felt Stewart was not the caliber of leader needed to run the Public Health Service, an opinion he also held of Terry and Burney. [74]

President Johnson called Stewart to the White House, and told him; “They tell me you can run the Public Health Service. I’m not sure of that, but they tell me you can. I’ll be watching you,” Stewart later recalled. [75]

It was a responsibility Stewart would not hold for long.

HOW THE SURGEON GENERAL LOST POWER, BUT NOT HIS PULPIT

In Stewart’s Senate confirmation hearing in September 1965, the first question came from Sen. Jacob K. Javits of New York.

“To what extent do you feel the Secretary of Health, Education and Welfare has authority over the Surgeon General?” Javits asked.

Stewart replied the Surgeon General had many authorities, although he noted HEW had been growing and some of the new activities had been placed under the jurisdiction of the HEW Secretary.

“Do you feel that you are a political or a professional official?” Javits asked next.

“I feel that I am a professional official,” Stewart responded.

A moment later, Javits continued; “Are you prepared, if the professional responsibility calls for it, to declare that your professional responsibility comes first if you differ with the Secretary of Health, Education and Welfare?”

“I think I would stand on my professional responsibilities.”

“Can you conceive,” Javits persisted, “of a situation where you felt so strongly about your professional responsibilities that you would be willing to resign rather than to carry out the orders of a Secretary under whom you serve?”

“I can conceive of it, but I hope it does not happen.”

“But can you conceive of it?”

“Yes.”

“Are you morally, in good conscience, prepared to assume that kind of responsibility?”

“Yes, I am,” Stewart replied. [76]

Javits’ questions would prove prophetic. How Surgeons General respond to the political pressures of government superiors would become a standard by which Stewart and others would be judged.

For Stewart in particular, Javits’ questions would cut to the core of an HEW reorganization effort over the following three years that would strip the Surgeon General of most of the powers the position had accumulated over more than 90 years. Stewart would lose his authorities precisely because he was professional, not political. And many of his peers would judge him harshly for his compliance with the most significant shake-up in the history of the office.

“It was really the politicization of the Public Health Service,” said Sencer, referring to the changes that occurred during Stewart’s term. [77]

HEW Secretary Gardner clearly had plans for changes in the Public Health Service. In announcing Stewart’s appointment, Gardner said of the PHS; “It stands at a critical point in its history. It will either take a leap forward, or it will become mired in its own internal conflicts and history will pass it by.” [78]

One of the primary challenges involved Medicare, the federal health insurance program for the elderly, which Congress created in 1965 and placed in the hands of HEW. The program was to take effect in 1966, but Gardner and some of his key administrators had been disturbed by the unwillingness of PHS staffers to play a role. “I heard people in those days in PHS say ‘We’re not in the check-writing business,’” recalled Kelso, the former HEW administrator. [79]

Some say PHS officials were reluctant to become involved in a program like Medicare because past battles with organized medicine over the issue had made many of them gun shy. The mighty Parran was the last Surgeon General to champion national health insurance, and some believed it had cost him his job. “The bitterness of this 30-year fight with the AMA made a lot of people just not want to tackle it,” said Dearing, who served in the PHS from 1934 until 1961. [80]

But in the eyes of Gardner and one of his top lieutenants, Wilbur Cohen, not tackling the issue was not an option. Cohen was “a liberal of the first order” and proponent of national health insurance. “And when he didn’t get an enthusiastic response, he wanted to fix things,” Kelso said. [81] But Cohen liked Stewart – they worked closely together in the early 1960s, when Cohen was HEW Assistant Secretary for Legislation and Stewart was a sort of in-house expert at PHS on issues related to health services delivery and third-party reimbursement. [82]

Initially, Stewart – a pipe smoker – was active in the bully pulpit, speaking out on the dangers of smoking on “The Today Show” and in other forums, sometimes in debates with officials from the tobacco industry. [83] Stewart said President Johnson was pleased with his job as, essentially, the government’s point man on tobacco issues. He recalled being at the

White House one time when Johnson pulled him aside and said; “Keep it up, but don’t let it get up here” to the White House. [84] Indeed, Lee argues that Stewart was as active on tobacco as Dr. C. Everett Koop, the outspoken Surgeon General of the Reagan years, but Koop received more credit because his anti-tobacco speeches were a stark departure from what others in the Reagan administration were saying, whereas Stewart’s served in an administration that was more supportive. [85]

But Gardner quickly gave Stewart other assignments. One had to do with Medicare: The government had said that for hospitals to be eligible for Medicare reimbursement, they had to be certified as in compliance with Title 6 of the Civil Rights Act of 1964. In other words, they had to be desegregated. And Stewart was put in charge of making that happen.

It was an extremely difficult task. Lee, a key Gardner aide at the time, recalled a visit to Atlanta’s Georgia Baptist Hospital at the time. “A cardiologist said ‘Dr. Lee, if I put a nigger in a room with one of my patients, it will kill the white patient.’ That’s the kind of attitude they had.” [86] Many field staff with the Public Health Service were not much help, saying things like; ‘Can’t you compromise this Title 6 stuff so that we can get patients into the hospital?’ recalled George Silver, another important administrator in HEW at the time. [87]

The PHS field staff were reflecting the resistance of the communities in which they were supposed to provide leadership, said Silver, who like Cohen and others, developed a low opinion of the Service. “It was sort of an anachronistic animal, anti-Semitic, anti-black, had to be dragged kicking and screaming into the 20th Century,” Silver said. [88]

Stewart, however, was a forceful agent of change in meetings with hospital leaders regarding desegregation of the facilities, Lee said. “It’s one thing for a Social Security person to say ‘You have to be desegregated or we’re not going to pay you.’ It’s another for a doctor

to say ‘You have to desegregate because it’s best for the patient.’ And so he had a very, very strong influence,” Lee said. [89] Those discussions weren’t covered much in the media, but had a huge impact on the nation, he added. [90]

At about the same time, Stewart was called on to oversee a reorganization of the Public Health Service intended to make it more responsive to the political agenda set by the Johnson Administration and the 89th Congress. On April 25, 1966, Gardner issued a directive transferring all the statutory authorities of the Surgeon General to the Secretary, giving Gardner the power to restructure the PHS. He put the Surgeon General in charge of five bureaus, and Stewart announced specifics of the reorganized PHS in October of that year. [91] The change conflicted with the federal Public Health Service Act of 1944, but Johnson in 1966 worked with Congress to empower the HEW Secretary to reorganize the Public Health Service without formal Congressional approval. [92]

It lasted 15 months. The commissioned officer physicians at the top of the PHS resisted the change, and Gardner quickly grew impatient and didn’t see the progress he was expecting. Stewart asked for patience, and on at least one occasion refused to dismiss a commissioned officer that Gardner wanted out. [93] “His style was to bring people in the Corps along, not just order them,” Silver said, recalling that Stewart like to say; ‘You don’t always pull a tree up by its roots to see whether it’s growing.’ [94]

But Gardner showed little inclination to wait for the PHS to come around. There had been a swing back in the 1966 election, with some liberals losing office, and Congress could no longer be counted on to approve the Johnson administration’s health proposals. [95]

What’s more, for years Gardner and his key lieutenants had watched the PHS pass up opportunities to lead the government’s efforts in health insurance, environmental regulation,

automobile safety, family planning and other initiatives important to advocates, Congress and the public. In some cases, the PHS was not only unwilling to respond; it was unable to, lacking leaders with expertise in some of the emerging areas of public health concern. [96]

In 1967, Gardner quietly decided he had to take responsibility for the Public Health Service away from Stewart. [97] He put it in the hands of Lee, who was serving in the Special Assistant for Health and Medical Affairs position created in 1953, which had been re-titled Assistant Secretary for Health and Scientific Affairs.

(Gardner wasn't there long enough to oversee the transition. He resigned in 1968, effective March 1. He wanted Johnson, pushing both his 'Great Society' agenda and fighting the Vietnam War, to go to Congress to raise taxes. But Johnson would not, and Gardner refused to make more cuts in the HEW budget.) [98]

Gardner's successor, Cohen, implemented Gardner's plan on March 13, ordering a reorganization that placed the PHS and FDA under the supervision of the Assistant Secretary for Health and Scientific Affairs. "For the first time in the history of the PHS, a non-career official had become the nation's top health officer," the public health historian Fitzhugh Mullan wrote. [99]

Lee was a physician, but technically the ASH position didn't have to be a doctor. [100]

The change meant a political appointee now had official oversight of about 45,000 HEW employees and programs budgeted at nearly \$3 billion. [101] The Surgeon General was made a deputy to Lee, his powers and administrative support scattered to Lee, Cohen and others in HEW.

It was understood at the time that the Surgeon General would still function as an important spokesman on health issues – a career professional free of politics. "They would

leave the Surgeon General free to make public pronouncements, whether they were politically popular or not,” Kelso said. [102]

But it was small consolation to Stewart, who earlier had tried to persuade Gardner against the reorganization. “I didn’t like the idea of having to have a spokesman who had no authority to do anything,” Stewart said. [103] Indeed, some key health officials within HEW had already lost respect for his position, including Jim Shannon, the powerful head of NIH. Shannon routinely skipped meetings Stewart called, even when they were held on the NIH campus, Ehrlich recalled. “He felt the NIH was an agency that was bigger and stronger and had more political clout than the Public Health Service did. In some respects, he may have been correct,” he added. [104]

Stewart grew frustrated and apathetic after the reorganization, some said. “After that, he never really put out,” Silver said. [105]

Richard Nixon was elected President in November 1968. Stewart submitted a letter to Nixon the following April. He said he wished to resign effective Aug. 1 so he could take a job at the LSU Medical Center in New Orleans. LSU officials wanted him to be in place before the start of the academic year, and his term was almost up anyway. [106]

At the time, and in the years that followed, Commissioned Corp members criticized Stewart for not trying harder to retain control of the Public Health Service. “He sort of let things roll over him and didn’t take any kind of strong leadership position. I’m sure he would not agree with that characterization, but at least that is what many people said,” said Dr. Paul Ehrlich, a Commissioned Corps officer who would become Acting Surgeon General in the 1970s. [107]

Critics also vilified Cohen, Lee and Silver as arrogant wiz kids who dismantled a time-honored organization because its leaders didn't comply with their politics. Coordination between public health agencies was never the same again, some say. And the administrative powers that had first enabled Surgeons General to speak with authority were torn away.

Dr. Donald Whiteside, a dentist who served for years in the Public Health Service, repeated a common perception of how leadership of the PHS had changed. "... that guy (the Surgeon General) was appointed, had a four-year appointment, and he did not have to kowtow to the administration. He could say, 'I don't care what the administration's policy is on any health issue. I'm going to tell you what is in the best interest of the American public, so far as a health issue is concerned. I don't care who likes it. I don't care who doesn't like it. I'm here for four years and you can't touch me.' And we had Surgeon Generals who did that, I mean who went up against the administration and said 'Kiss off.' Now what you have is a Public Health Service that is run by political appointees..." [108]

Other public health leaders offered less impassioned assessments, but agree the reorganization was lamentable.

"Phil's heart is in the right place, and I think Phil's a wonderful policy guy, but I think they were wrong in doing this. I really do," said Dr. Georges Benjamin, executive director of the American Public Health Association. [109]

It's unclear whether the reorganization would have achieved what Gardner, Cohen and Lee intended. Nixon's election meant the political appointees who had gained control of the PHS were suddenly on their way out. Cohen was replaced by a new HEW Secretary in January 1969 and Lee left the government a month later.

“Stewart left, Phil Lee left, and then it was ‘Okay, these changes have been made. Now how are they going to be implemented in 1969?’ I think that’s when things kind of went from bad to worse,” Ehrlich said. [110]

DR. JESSE STEINFELD, 1969-1973

Almost immediately, the Nixon Administration had a problem with the newly-created position of Assistant Secretary for Health and Scientific Affairs – setting off a chain of events that would usher in one of the most activist Surgeons General of the bully pulpit era, Dr. Jesse Steinfeld.

The problem with the ASH position, as it came to be called, was that new HEW Secretary Robert Finch was unable to fill it. He wanted to hire Dr. John H. Knowles, the general director of Boston’s Massachusetts General Hospital. Knowles was an admired and innovative administrator, but also a critic of the size of doctor’s fees, and an advocate for comprehensive health insurance for all Americans. The American Medical Association and conservative Republicans fought the idea. The battles dragged on for months.

“Nixon’s office finally told Finch; ‘Pick someone else, or we will,’” said Dr. Roger Egeberg. He was Finch’s next choice. [111]

Egeberg was dean of the University of Southern California’s medical school. He was seen as loyal to Nixon, and ‘the Knowles fiasco’ had dragged on too long, impacting Finch’s ability to run the department. True, Egeberg was a Democrat, but in this case Nixon’s people seemed OK about that. “I guess the assumption was it would be easier to get him confirmed” by a Senate that was still largely Democratic, Ehrlich said. [112]

Egeberg needed help, and leaned on Dr. Jesse Steinfeld, a cancer researcher who was just finishing up a stint as deputy director of the National Cancer Institute. For several years,

Steinfeld had been a medical professor at USC, where he had impressed Egeberg. “I’d been at meetings at USC, where he’d been teaching, and I had liked the way he looked for facts. And I liked the way he often went against the grain,” Egeberg recalled. [113]

Steinfeld and his family had been planning to return to California – indeed, his wife had already left Washington with the kids – but Steinfeld agreed to stay on for a few weeks. He was quickly involved in meetings with Finch and other top officials, and had an influential voice regarding fluoridation of water and other important topics. He liked it. “It was kind of exciting. I mean, I had never been at the center of things,” Steinfeld said. [114]

At about that time, HEW officials had a meeting at Camp David to discuss the structure of the department, and whether to do away with the reorganized Public Health Service and the defanged Surgeon General. After the meeting, Steinfeld recalled, “Bob Finch came to me and said; ‘Would you stay here if we appointed you Surgeon General and we kept the Public Health Service?’” [115]

Steinfeld agreed – a decision Egeberg and other Nixon Administration officials grew to regret.

Small in stature, smart in school

Jesse Leonard Steinfeld was born Jan. 6, 1927 in a town in western Pennsylvania, not far from Pittsburgh. He was a short kid, but academically gifted, skipping grades and finishing high school at age 16. He graduated the University of Pittsburgh two years later, and completed medical school at Cleveland’s Western Reserve University at age 22. [116]

He enlisted in the Public Health Service a short time later, when the Korean War started. He was always interested in research, and was soon assigned to a National Cancer Institute outpost in San Francisco, followed by NCI assignments in the Washington, D.C. area. He

found he was among a number of smart young doctors who had joined the PHS for the same reasons. “The major attraction was to avoid the Army, Korea, or being shot at. So we had our choice, generally – people who were very high in their class and interested in research,” he recalled. [117]

He left the government in 1959 to teach at USC where he came to know Egeberg. Steinfeld returned to the NCI in Washington in 1968, thinking he was getting in line to become the NCI’s Director – the man in the job, Dr. Ken Endicott, was expected to take over the NIH when Jim Shannon retired. But Endicott didn’t get the job, and Steinfeld had decided to return to the Los Angeles area to try and start a cancer hospital.

That’s when he was asked to stay on in Washington for a few weeks, and then to be Surgeon General. He was 42 at the time.

He stepped into a bit of a mess. Much of it had to do with Egeberg, who was new to government and had taken a position that was not well defined. Although the Assistant Secretary for Health and Scientific Affairs was the titular head of the Public Health Service, many of the administrative powers over the PHS were placed with other officials. Budget management, personnel management and other functions were instead placed under other HEW officials, and the leaders of PHS agencies like the FDA and NIH began going around Egeberg on a variety of matters. [118]

By the spring of 1970, press accounts described a department in disarray.

“Morale is sagging. A lack of leadership from Dr. Roger O. Egeberg, who has not yet mastered the complexities of his health empire, has caused more than one official of an operating program to throw up his hands in despair trying to get decisions out of the front

office,” wrote *Washington Sounds*, a newsletter of the National Association of Hearing and Speech Agencies, in its June 18, 1970 issue. [119]

The same week, *TIME* magazine ran an article entitled ‘Sickness at HEW,’ which described a department torn by struggles between the Nixon Administration’s desire for hard-line budget trimming and by progressive HEW staffers with more Democratic ideals. Finch was leaving, but some of the blame was laid at the feet of Egeberg, who had presided over a series of top-level firings at the FDA and other disruptive personnel changes, but was having trouble finding replacements that were politically acceptable to Nixon’s men, *TIME* reported. [120]

Egeberg’s relationship with Steinfeld was also deteriorating.

Steinfeld had wanted some line authority to go with the Surgeon General job, and so was also appointed Deputy Assistant Secretary. [121] It led to conflicts, as Egeberg began to believe that Steinfeld was keeping important information from him.

Said Egeberg; “He became imbued with the idea that I was the enemy of the Public Health Service, because I was in this new job which was really put over the Public Health Service. So he went, I think, beyond what any other person would have done in his efforts to discredit me and keep me in the dark about things. You know, I finally had to go to his secretaries and say; ‘I’m going to try to get you people transferred if you don’t give the mail that comes to me, to me!’” [122]

Egeberg gradually started holding meetings without Steinfeld. For his part, Steinfeld told associates he was surprised Egeberg was acting the way he did, Ehrlich recalled. [123] The root of the clashes has remained a subject of speculation. Some believe Steinfeld, not willing to accept what was largely a figurehead job, was behaving like he had more power than he

actually had. [124] Others felt Egeberg was the problem, and that perhaps he was made to mistrust Steinfeld by civil servants who convinced Egeberg the Surgeon General and his Commissioned Corps were problems that HEW had to get rid of. [125]

The relationship was further strained by Steinfeld's use of the Surgeon General's bully pulpit.

Steinfeld and the Bully Pulpit

Early in his tenure, Egeberg had proved himself to be a funny and effective public speaker, and clearly enjoyed it. Indeed, when he was first considered for the ASH position, Egeberg asked if he could also be Surgeon General. He was told that was not possible because of a requirement at the time that the Surgeon General had to be younger than 65, recalled Egeberg, who was just over that age limit at the time he was named the Assistant Secretary. [126]

Egeberg has said in interviews that he never intended to take over the traditional bully pulpit of the Surgeon General. "The Surgeon General was our representative all over the world, and he had gained a great deal of respect over the years. I certainly didn't think any administration should or could step in and destroy something that was as important and useful as that," he said, in a 1988 interview. [127]

Nevertheless, other HEW officials said it irked Egeberg that Steinfeld quickly proved aggressive about speaking to Congress and the public on a range of health topics, and that those audiences clearly preferred to hear from the Surgeon General.

"It was always a problem then and even continued later, because the public and the Congress recognized the name Surgeon General, or the title of the Surgeon General. Whenever there was some testimony that had to be given, the congressional committee

would always ask for the Surgeon General, not for the Assistant Secretary. That used to just rankle the Assistant Secretary and the people around him. They would frequently go back to the committee and say, ‘The Surgeon General is not the spokesman on this issue. The Assistant Secretary is. If you want somebody, the Assistant Secretary will come.’ And that used to antagonize some of the people in Congress, because they didn’t want some Assistant Secretary testifying; they wanted the Surgeon General. That just added fuel to the fire of the Assistant Secretary not being identified as the senior line officer, and the Surgeon General being his deputy,” Ehrlich said. [128]

Others who served in HEW around that time shared that assessment. Egeberg wanted to be the No. 1 health voice. But Steinfeld believed that was his role. “I think Roger was either threatened or resented it,” said Dr. Merlin DuVal, who was appointed to replace Egeberg in 1971. [129]

“By the time I got there, the two men were literally no longer speaking to each other,” DuVal said. [130]

Steinfeld became highly visible on a number of topics. He advocated mild sanctions, but not imprisonment, for marijuana users. [131] He was a leading voice in arguing against proposals to do away with the Commissioned Corps, which some argued was an unnecessary second personnel system within HEW. And he was the medical expert at HEW press conferences, fielding press questions on topics ranging from FDA warnings about oral contraceptives to the storage of poison gas. [132]

He also was a much-quoted government voice on cyclamate and saccharin, artificial sweeteners linked to cancer in animal experiments. Steinfeld was part of the October 1969 announcement that the FDA was banning the sale of cyclamate in the United States. [133]

Sencer, who was CDC Director at the time, described Steinfeld's role in the announcement as "courageous" and said it was "one of the first times the Public Health Service had taken a strong stand on an environmental issue or a toxic substance issue." [134]

But probably the two highest-profile topics Steinfeld spoke on were cigarette smoking and television violence.

Of course, speaking on smoking had essentially become part of the job description. Especially since the Terry report in 1964, Surgeons General were considered the government's spokesmen on the issue. That role was formalized in the Cigarette Labeling and Advertising Act of 1965, which required the Surgeon General to make an annual report on smoking and health to Congress.

But whereas Terry and Stewart – both smokers – were careful and even diplomatic in their presentations, Steinfeld was impassioned. He removed the ashtrays Stewart had left around, and worked to hit new dangers of smoking in the annual report to Congress. [135]

The 1971 report blamed maternal smoking for retarding fetal growth and discussed new studies that said carbon monoxide in smoke lead to heart disease. It also tacitly endorsed a study that found dogs that had been exposed to cigarette smoke for more than two years had higher rates of lung cancer. Steinfeld took that endorsement a step further in the 1972 report, in which he warned of the dangers of secondhand smoke to people. [136]

His statements stoked a nascent nonsmokers' rights movement in the country, and sparked discussions about banning cigarette smoke in public buildings and transportation. It was an alarming development to tobacco companies, who complained Steinfeld had far exceeded science in his statements and accused him of anti-smoking propaganda.

“The results of public misinformation are evident. Public transportation, for example (including the open-decked Staten Island Ferry), is beset with no smoking policies on the basis of the Surgeon General’s arbitrary campaign to ban all smoking,” wrote David S. Peoples, the president of R.J. Reynolds Industries Inc., in a letter to the HEW Secretary in 1972. [137]

Steinfeld’s status on the tobacco front was enhanced by a law passed by Congress in 1969 designed to update its 1965 cigarette labeling legislation. The new law mandating that beginning in 1971, the warning label in cigarettes was broadened to include the words ‘Surgeon General.’ Specifically, all packages began to announce: “Warning: The Surgeon General Has Determined That Cigarette Smoking Is Dangerous To Your Health.” [138]

“Even this the industry found oppressive; to concede that that their product ‘is dangerous’ was going a good deal further than to admit that it ‘may be hazardous,’ as the expiring law had worded it,” Kluger wrote, in his Pulitzer-winning history of tobacco-related health policy battles in America. [139]

Steinfeld became a regular presence in the newspapers and even television – in February 1972, he appeared on “The Mike Douglas Show” during a week it was co-hosted by John Lennon and Yoko Ono. John and Yoko even suspended their chain-smoking during his appearance. [140]

Still, Steinfeld is not remembered as a mesmerizing orator. “He was not a good speaker,” Sencer said. “He gave a good scientific paper, but he was not a stem winder.” [141]

It didn’t help that at times Steinfeld grew tired of stumping on the hazards of tobacco. “I must say that after giving the talk a couple of times I didn’t like to do it. I felt that my occupation had changed from physician to minister. Now maybe public health people give

the same talks over and over again, but I had been doing research and I wanted to talk about new things. And this really wasn't new. It was something that had been known for a long time. So I did give a number of talks but it always bothered me that wherever I went people just wanted to hear that talk," Steinfeld later recalled. [142]

He found a new topic in 1972, when he spoke out on television violence.

A commission reporting to Steinfeld prepared the report, which concluded that TV violence does incite a small percentage of children to behave aggressively and inappropriately. "Not necessarily in everyone, maybe only in a few individuals – but it doesn't take very many violent individuals to create havoc in a society," Steinfeld said years later, summarizing the findings. [143]

When the commission's findings came out, the White House ordered Steinfeld not to testify about it to Congress. Steinfeld was subpoenaed to appear. DuVal, who had taken over as ASH, also appeared, but he was quickly dismissed, his written testimony being entered into the record. Steinfeld, however, was given plenty of time at the microphone and gave testimony at the March 1972 hearing that hadn't been cleared by the White House. [144]

Steinfeld said there should be a period of broadcasting when violence should be subdued or stopped, he called for a "violence index" review and he made plans to prepare a government booklet for parents on how to watch TV with their kids. It was the first time a government health official had so publicly raised questions about the effect of the new medium on public health, and it alienated him to yet another powerful group of executives.

"This was a significant item that unfortunately did not endear me to the Administration... the networks contributed (to political candidates) and also influenced how people were perceived – politicians, that is," Steinfeld said. [145]

But at that point, he was already on the outs.

How Steinfeld lost his job

Steinfeld started out under Bob Finch and Roger Egeberg, and flourished in the bully pulpit as Finch and Egeberg stumbled in their jobs. But his work environment changed when Finch was replaced as HEW Secretary by Elliot Richardson in 1970, and Egeberg was replaced by Merlin DuVal in 1971.

DuVal recognized the weakness of the ASH in its ability to govern the Public Health Service. With the backing of Richardson, he set about a reorganization that put the ASH more directly in control of the FDA, NIH and other Public Health Service agencies. He accomplished it in 1972, along with a shortening of his title – “and scientific affairs” was dropped, leaving it as Assistant Secretary for Health.

DuVal also asserted his role as spokesman as important health controversies arose. One striking examples was his handling of the disclosure of the Tuskegee Syphilis Experiment, a Public Health Service experiment started in the 1930s in which researchers watched the progression of syphilis in black sharecroppers, but did not treat it.

When an Associated Press reporter broke the story in July 1972, it was DuVal who fielded questions from the press and appointed a commission designed to give the issue harsh scrutiny. “I wanted a panel that would be sympathetic to the public point of view rather than the scientific or factual point of view, so I loaded it with angry blacks,” he said in 1973. “I knew we were going to pay a penalty for Tuskegee, and I figured we should take the whole penalty – that way there would be no criticism.” [146]

But DuVal found that he was not allowed to voice his position on controversial topics he wanted to address. He believed firearm ammunition should be treated as a hazardous product,

and tried to get other HEW officials to have a public dialog on the idea of legalizing heroin, as England had done. “But it simply wouldn’t fly,” DuVal recalled. [147]

DuVal said he got along with Steinfeld, but made it clear to him that the new HEW regime intended to abolish the Surgeon General position. [148] The struggle became public in February 1972, when NBC Nightly News reported the Nixon Administration was trying to force Steinfeld to resign, and even drafted an announcement saying they would strip him of his authority if he would not step down. [149]

The campaign to dump Steinfeld had taken some petty forms, NBC reporter Ron Nessen said. For example, although Steinfeld had been instrumental in negotiating an agreement with the Soviet Union to increase cooperation in medical research, the Surgeon General was not invited to the ceremony where the agreement was announced. [150]

It has become an often-repeated legend among people in the Public Health Service that once Administration officials realized they couldn’t legally force Steinfeld to resign, they attempted even nastier measures. “Steinfeld, they took away his office, took his secretaries, they took away his parking. He wandered around with no place to sit except chairs in the hall,” said Dr. C. Everett Koop, who became Surgeon General about ten years later. [151]

But Steinfeld said much of that is false. “I didn’t lose any (privileges). I just was not consulted,” he said. [152]

While Steinfeld could not be fired without cause, the President could choose to not reappoint him to another 4-year term. When Nixon was re-elected by a landslide in November 1972, he asked for the resignation of top officials. Steinfeld – who still had a year to go in his term – believed his would not be accepted, because he needed only another year

or two until he qualified for retirement benefits. “Usually they were very nice to people who have another year or two to go to retirement,” Steinfeld said. [153]

Nixon accepted Steinfeld’s resignation, but Steinfeld was the only one who was surprised. “He was quite angry,” Ehrlich recalled. [154] His resignation was effective Jan. 30, 1973. [155]

Steinfeld’s term is an example of the Great Man Theory in action. He was a self-described zealot who aggressively used the bully pulpit, sometimes to the displeasure of officials about him in the bureaucratic hierarchy. The Long Leash Theory also has resonance in his case, in that his opportunities to be a leading federal voice on public health issues were gradually decreased and he was tricked into resigning early.

After his departure, HEW officials – tired of the headaches caused by the aggressive Steinfeld – had no intention of having a Senate-confirmed replacement. “The last thing we wanted was a Surgeon General to deal with; we had problems enough without having a Surgeon General,” said Dr. Charles Edwards, who became the Assistant Secretary for Health in 1973. [156]

Indeed, HEW pushed for legislation to abolish the position of Surgeon General, but U.S. Rep. Paul Rogers of Florida – who headed the committee overseeing Public Health Service programs, and was known at the time as “Mr. Health” – told them the Surgeon General is a very important position and such a bill would never make it to the floor. [157]

Ehrlich became Acting Surgeon General in 1973, a role he held until Jimmy Carter was elected President in 1976. It was under Carter that the Surgeon General job would be revived – but overshadowed by a limelight-loving HEW Secretary named Joseph Califano.

DR. JULIUS RICHMOND, 1977-1981

Victor Cohn was suspicious.

The medical reporter for *The Washington Post* was peppering federal health officials with questions about the simultaneous appointment of Dr. Julius Richmond to two positions – Surgeon General and Assistant Secretary for Health. The journalist was “thinking of all kinds of ulterior motives,” Richmond later recalled. [158]

Joseph Califano, the outspoken HEW Secretary who picked Richmond, told Cohn that putting one guy into two jobs was a money-saver for the government. Plus, it meant a little bit more salary to entice Richmond, a prominent child development expert who had started the government’s Head Start program, to join the new Carter Administration.

Califano told Richmond about his chat with the press, and Richmond winced. “I said, ‘No, Joe, that’s not quite the way it is,’” said Richmond, who had proposed the dual appointment. Richmond called Cohn. He explained there were other reasons, having to do with his wish to combine a position of historical prestige and visibility (the Surgeon General) with a less-recognized job with more administrative power (the Assistant Secretary for Health). [159]

On May 31, 1977, Cohn’s story about Richmond’s selection appeared in the *Post*, describing a choice that promised a powerful new presence in HEW. “He is a gentle, soft-spoken man with a velvet glove, his friends say. But inside the velvet glove is a steel hand,” Cohn wrote, of the 60-year-old Richmond. [160]

Richmond served four years in the position, and became one of the most powerful and accomplished Surgeons General of the bully pulpit era. He is credited with creating the so-called *Healthy People* report, which for the first time set national goals for health

improvement and helped shift public perceptions to a great acceptance of personal responsibility for illness prevention. He also became a globe-trotting diplomat, and was an important domestic spokesman on issues ranging from cigarette smoking to toxic shock syndrome.

But Richmond never relished public speaking, and was overshadowed by Califano, a crusading politician who personally took on the tobacco industry and was HEW's first speaker on a host of other health issues. "I was really the bully pulpit, in a sense," Califano recalled. [161]

Richmond did not disagree. "You can't tell a Secretary, you know, that he shouldn't appear here or there or anywhere," he said. [162]

'A well-developed social conscience'

Julius B. Richmond was born Sept. 26, 1916 in Chicago. He was raised in the Chicago area, traveling downstate to attend the University of Illinois at Urbana and then returning to Chicago for medical school, an 18-month rotating internship at Cook County Hospital, and two pediatric residencies.

Most of his education occurred during the Great Depression, and he developed an intense interest in the creation of new programs that addressed societal health problems. "I seemed to have a well-developed social conscience," Richmond recalled. [163]

During World War II, he was inducted into the Army Air Corps (subsequently called the U.S. Air Force). Richmond served from 1942 until 1946, as a flight surgeon with the Flying Training Command. His duties included examinations of Air Force cadets – a group he expected to be in better physical and mental condition than most other recruits, but who had a

surprising amount of psychological and social problems. From that experience, Richmond developed an interest in the development of young children, he said. [164]

“... If these young people represented the cream of the crop, then there were earlier experiences that should have – and perhaps could have – been better, and should have created an atmosphere of greater competence,” Richmond said. [165]

After World War II, Richmond finished his pediatric training and moved into a series of academic positions, first at the University of Illinois, then at the State University of New York at Syracuse College of Medicine, where he became dean in 1965. During that time he increasingly focused on how a child’s cognitive abilities developed, and how poverty threatened that development. His research came to the attention of Sergeant Shriver, who created the Peace Corps in the Kennedy Administration and became head of a new federal agency, the Office of Economic Opportunity, under President Johnson. Shriver wanted Richmond to head a new program to be called Head Start, which would provide comprehensive education, health, nutrition, and parent involvement services to low-income children and their families.

“So with the excitement of the era and all, I had, of course, to come face to face with the fact that we had only done our studies on a small scale; and here he was asking me to... implement something on a national scale. I remember it intrigued me considerably, but I sort of teased him with the notion that, well, if you wanted to do a large-scale program, why didn’t you get somebody who had been doing large-scale programs? Then typical of Shriver’s fashion, he said, ‘Well, if I’d wanted a bureaucrat, I would have looked for one,’” Richmond recalled. [166]

Richmond served as Head Start's director for about two years, in what was technically a part-time position for him – he was on leave from his job in Syracuse, an arrangement he brokered with Shriver. [167] While at Head Start, Richmond helped develop a grant program that provided grant funding to local institutions and embedded the program in communities.

He returned to Syracuse in 1967, after a bout with tuberculosis, and then moved to Boston in 1971, where he became chief of psychiatry at Boston Children's Hospital, a professor of child psychiatry and human development at Harvard, and director of the Judge Baker Guidance Center. Not long after he got there, a Harvard dean asked him if he would also chair the university's department of preventive and social medicine.

Richmond recalled the conversation; "... I said, 'But I came, really, to focus my attention on some issues in child development and child psychiatry.' And he smiled and said, 'Well, you've always held more than one job, so this will be sort of in character.'" [168]

'A very activist kind of Secretary'

After he was elected President in the fall of 1976, Jimmy Carter selected Joseph Califano to lead one of the federal government's largest and most important divisions, the Department of Health, Education and Welfare.

Califano was a political veteran who had served as President Johnson's senior domestic policy aide. He was no shrinking violet, and had demonstrated time and again he was willing to take on powerful entities, including the government itself. He also was receptive to the idea of working with the press: Indeed, as a Washington lawyer in the early 1970s, Califano represented *The Washington Post* when it faced possible threat of a legal injunction when it decided to publish portions of the Pentagon Papers, the leaked, top-secret federal report

documenting the government's internal planning and policy making regarding the Vietnam War.

“... I had a grudging respect for the power of the media. In the LBJ White House, I saw how the press drove so much of what we did,” Califano recalled. [169]

As he began to build his HEW staff, Califano looked for a dynamic physician with strong credentials to lead the department's Public Health Service Programs. Like Secretary Finch at the beginning of the Nixon Administration, he initially pursued the general director of Massachusetts General Hospital, who at the time was Dr. Charles Sanders. Sanders turned him down because the position didn't pay enough, said Hale Champion, who was Califano's undersecretary for health. [170]

“Money. Straight-out money” was the reason, Champion recalled. “As a matter of fact, he would have taken the job if somehow we could have found a way for him to get another \$50,000... He was willing to make a sacrifice, but not that big a sacrifice at that time” [171]

Califano turned to Dr. Chris Fordham of the University of North Carolina, who agreed to the ASH program and began working with Califano in Washington. But he left after only a few weeks – a decision that was widely seen as being prompted by Califano's penchant for meddling. “I think Califano, as he has a tendency to do, was just getting too much involved in what Fordham and others felt were the duties of the Assistant Secretary,” said Paul Ehrlich, the Acting Surgeon General from the Nixon and Ford years who remained with HEW in the early days of the Carter Administration. [172]

Califano asked Richmond in the spring of 1977, and Richmond – ‘Julie,’ to his friends – said he would take it if he could also be Surgeon General. Richmond believed that having

separate individuals in the two jobs would create operational problems, as well as confusion for outsiders who still perceived authority in the Office of the Surgeon General.

“The fact that there had only been an acting Surgeon General for that length of time indicated to me that the position really wasn’t serving all that important a function. And yet, I was also aware of the fact that the symbolic role of the Surgeon Generalship was really very important,” Richmond said. [173]

“I don’t even know if I hadn’t brought up the Surgeon Generalship, whether he would have thought about it as an issue, because nobody was stirring any pot about that,” Richmond continued. “I think that he saw it as an expediency. He said, ‘Well, if that’s what it takes to get you, why not?’” [174]

Whether combining the two jobs was originally Richmond’s idea is a subject of historical debate. It’s likely that Richmond was the first to mention the idea in the conversations between he and Califano, Champion said. But the idea of combining the jobs had been discussed regarding other ASH candidates, he added. [175] Charles Miller, who became a deputy to Richmond in 1978, has noted that different people have taken credit for the idea, including Peter Bell, one of Califano’s assistants. [176]

Whoever came up with the idea, it made Califano happy, Richmond said. “Califano said to me one day, ‘You know, that was a great idea.’ And I asked, ‘Why do you say that?’ And he said, ‘Well, everywhere I go, when I refer to you as Assistant Secretary, nobody knows quite what that means – they wonder if you take shorthand or something. But when I say the Surgeon General suggested this, that or the other thing, everybody thinks they know.’ So he felt that had sort of simplified his life,” Richmond recalled. [177]

But working for Califano was not easy. Administratively, Califano recruited a team of young people – called special assistants – who he placed throughout HEW and who reported to Califano, giving him intelligence on what was going on. He also tended to deal directly with the directors of the CDC, FDA and other public health agencies.

“The point needs to be made that the people who served Joe Califano as Assistant Secretary for Education, ... Assistant Secretary for Health or even the Commissioner of Social Security, were to some degree ineffectual, because the policy decisions were made in Joe’s office. If there were any major operating problems or decisions or crises, Califano or Champion or one of Califano’s special assistants would pick up the phone and deal directly with the people responsible,” Miller said. [178]

“Califano was clearly a very activist kind of secretary,” said Richmond, who said he could co-exist with Califano because their values and opinions were similar on nearly every health issue. [179]

“I thought that his management style was too activist; that he would often dip into dealing with people in the agencies without letting me know,” Richmond continued. “I could always confront him with it, and he’d always vow that he wouldn’t do it again. But I knew and he knew he would do it again. But it was never something of crisis proportions.” [180]

Richmond and the Bully Pulpit

Califano’s activism extended to speaking for HEW on matters of public health.

Many newspaper and wire service articles from the period followed a similar structure: The government speaks on an important health issue, such as a campaign to eliminate measles or an investigation into workplace illnesses associated with beryllium. The first, punchiest quote comes from Califano. Then Richmond is introduced – identified as the

official who will implement the program or oversee the task force – and is, or isn't, quoted in a section providing more scientific details about the situation. [181]

“He was ‘the science,’ if you will,” Califano said. [182] “While Julius, wasn’t out front, I think part of the bully pulpit is the guy that turns the electricity on so that you can speak into the microphone. And Julius Richmond certainly gave me plenty of electricity,” he added. [183]

No where was that relationship more evident than on the topic of smoking.

Califano had smoked four packs a day during his stressful years working for Johnson, but gave it up when his son, turning 11, said the birthday present he most desired was for his father to quit smoking. [184] Carter instructed Califano to mount a health promotion and disease-prevention program, and the HEW Secretary decided to focus on what Richmond and others told him was a major issue – cigarette smoking. Indeed, he designated it ‘Public Health Enemy No. 1.’ [185]

On Jan. 11, 1978, the 14th anniversary of the Terry report, Califano outlined the hardest-hitting anti-cigarette program ever proposed by a Cabinet-level official: He proposed banning smoking on all commercial airline flights; prohibiting smoking in federal buildings; and increasing the federal excise tax on cigarettes, which had been set at 8 cents a pack for 27 years. [186] It drew heavy political fire, particularly from politicians in North Carolina, Kentucky and other tobacco-producing states. President Carter’s father had died of lung cancer, but the White House was sensitive to political pressures and decided to distance themselves from Califano’s effort without disavowing it. [187]

Following the launch of his anti-smoking campaign, Califano asked Richmond to assemble a 15th anniversary report that would provide strong ammunition for his effort. He

later summarized his instructions this way: “OK, Julie, you get the science,” Califano said.

[188]

Richmond made a point of putting together a doorstep report that was 1,200 pages long. “It was with real intent that 15th anniversary report is not a short summary, but it physically is a very thick volume that’s very heavy to carry around. Because I wanted particularly the journalists to see what has developed” in terms of research demonstrating the harmful effects of tobacco, Richmond recalled. [189]

The report was political dynamite days before its scheduled Jan. 11, 1979 release. U.S. Sen. Jesse Helms – who had criticized Califano in 1978 for “demonstrating callous disregard for economic realities, particularly for the economy of North Carolina” – was clearly agitated about its potential impact on the public. [190] He asked for a copy in advance and complained to the press when Califano declined. “In short, by delaying any possibility of simultaneous challenge, Mr. Califano knows that the audience will be lost and that the first impression of his one-sided report will prevail in the minds of millions of Americans,” he said, in a prepared statement. [191] On Jan. 10, tobacco industry officials also attempted a pre-emptive strike, attacking the federal war on smoking as a “publicity stunt” staged by Califano, who they said displayed “all the zeal” of a “reformed sinner” who preferred “propaganda barrages” to responsible investigation. [192]

In fact, Richmond did rein in Califano on a few points. For example, Califano wanted the 1979 report to declare smoking addictive, but Richmond declined, saying at that point they lacked sufficient scientific data to make such an unequivocal declaration. [193]

The Surgeon General's report made front-page headlines, with Califano and Richmond sharing the billing – but Califano spinning the better quotes. It again illustrated the symbiotic relationship the two had developed.

Califano gained legitimacy on the issue, with Richmond's name on the report and with Richmond standing next to him at the press conference. "I couldn't have done any of this stuff without a Surgeon General. I'm not a doctor. I wasn't a health expert," Califano said.

[194]

Richmond, meanwhile, was able to focus on matters of science and face minimal political heat from an increasingly concerned White House and a shrill pack of tobacco industry officials and tobacco-state politicians. (Califano was forced to resign in 1979, and HEW was split into two agencies – the Department of Health and Human Services and the Department of Education. Califano and Champion said the dismissal was largely due to his activism on tobacco, and Carter's nervousness about losing tobacco states in the 1980 election.) [195]

Richmond also was OK with Califano doing most of the talking because, frankly, this Surgeon General wasn't particularly fond of speaking to the press or public.

"I didn't find it enjoyable," said Richmond, who said he did only a few press interviews each month and made public speeches only about once a week. He acknowledged the low activity level made him much less visible than later Surgeons General as C. Everett Koop, Joycelyn Elders and even the less-than-famous Richard Carmona. [196] "But again, if it fit with policy, I was glad to do it," he added. [197]

Besides, because he was also the ASH, he had greater administrative responsibilities than other Surgeons General of the bully pulpit era. And he was focused on accomplishing other things.

His proudest accomplishments

Richmond has been praised for a variety of accomplishments, many of which are little-known or little-remembered.

Califano said it was Richmond who came to him in 1979 and pointed out that for decades the Public Health Service had characterized homosexuality as “a mental disease or defect” under immigration law, and had denied gays or suspected gays from entering the United States. Richmond asked Califano to change that, though he warned there might be an explosive reaction. [198]

Aside from Richmond, no one else had raised it, meaning it was a controversy that could have lied dormant, Califano recalled. “This was no hot-button issue in those days... that kind of issue had never crossed my mind. And I said, ‘Absolutely, let’s do it.’ But if he hadn’t brought it to me, I never would have done it,” Califano said. [199]

The White House repeatedly expressed appreciation for Richmond’s medical diplomacy. The Surgeon General went to Cuba in 1977 as part of a ground-breaking exchange of medical personnel. [200] He went to the USSR in 1978 as part of an early step toward lifting a moratorium on visits by U.S. officials to the Soviet Union. [201] Also in 1978, Richmond met with Egyptian President Anwar Sadat to talk about food and nutrition concerns. [202] And then in 1979, Richmond and Rosalynn Carter traveled to Thailand with Rosalynn Carter to tour refugee camps filled by Cambodian refugees following Vietnam’s invasion of Cambodia.

“I am so grateful that you could break away on such short notice to accompany me to Thailand,” Rosalynn Carter wrote, in a November 1979 note to Richmond. “I am certain you feel as I do that this trip was one of the most significant experiences of our lives.” [203]

(Not everyone appreciated Richmond's travels. Champion wasn't crazy about Richmond as an administrator, and felt his trips were part of the problem. "Things would happen, and you'd look for Julius and he was in Budapest or some place," said Champion, who said he pushed for a deputy administrator for Richmond who would be a more constant presence.)

[204]

Richmond also received plaudits for mobilizing Commissioned Corps officers in responding to sea-born refugees from the Cuban and Vietnamese governments. He impressed Patricia Harris, who succeeded Califano in 1979, when he said he could – within five days – dispatch a sizable team of Commissioned Corps officers overseas to do medical screenings of Vietnamese refugees and ease domestic concerns that the refugees were bring diseases to the United States. "She just looked and said, 'I didn't think anybody could get over there before a month,'" Richmond recalled. [205]

The action served as a powerful counter-argument to the perennial call by the Office of Management and Budget for doing away with the Corps. "She became a very potent advocate for what our potentialities were," Richmond said. [206]

But Richmond is perhaps best remembered by Public Health Service veterans for his leadership in creating quantitative goals for improving the public health. In July 1979, he released *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. The report set objectives for reducing infant mortality and improving other health measures by 1990, and helped the public light a fire under federal, state and county health officials to make more progress.

"Once we got that out, the journalists began to get the message," Richmond said. In addition to an initial splash of coverage, reporters began to mine *Healthy People* for statistics

and feature story ideas and magazine pieces. “I think that’s a pretty good example of dissemination,” Richmond said. [207] It also reinvigorated voluntary health agencies, he added. [208]

But perhaps most importantly, Richmond and some others believe, the *Healthy People* report ultimately became a turning point in how Americans think about their health. Unsanitary conditions and terrible infections were no longer the largest threat – unhealthy behaviors were. The report called on Americans to cut their intake of alcohol, salt, sugar and saturated fats. Califano, who was on his way out at that point, said the report represented a medical consensus as important as Terry’s report on smoking and health. [209]

It became the first in a series of Healthy People reports – subsequent reports set revised goals for 2000 and for 2010 – and proved a lasting legacy that is often under-appreciated by the general public, some experts said.

“I think Julius was the under-rated Surgeon General,” said Dr. David Satcher, who became Surgeon General in the 1990s. “He is quieter, but when you look at what he did, the things he launched in this country, I think he was one of the most productive.” [210]

The *Healthy People* report illustrated Satcher’s words well, in both positive and negative terms. Important as it is considered in retrospect, it got very limited play in the press at the time. The Washington Post buried the story on page A28, and the reporter covering it – Cohn – noted that it suffered from a lack of advance publicity and a failure by health officials to push the media to carry the message. It was simply released, along with a written statement by Califano, “with no fanfare whatsoever, despite its ambitious goals,” Cohn observed. [211]

After the Reagan Administration took power in 1981, Richmond stepped down from his dual posts and returned to academia.

His term seems to illustrate the Long Leash Theory: He was consistently overshadowed by Califano, who in many ways took over Richmond's bully pulpit. Nevertheless, the two had a good working relationship and Richmond didn't seem to mind not being in the spotlight, which suggests that Richmond may not have had the ambition for frequent public speaking that were seen in some of the more charismatic and better remembered Surgeons General of the modern era.

After Richmond left office, the posts of Surgeon General and Assistant Secretary for Health were again separated. And he was replaced by a new Surgeon General – a Philadelphia surgeon who looked like a biblical prophet and proved to be the all-time master at using the bully pulpit.

DR. C. EVERETT KOOP, 1981-1989

The Reagan Revolution opened with a federal blitzkrieg on public health.

Within 48 hours of Ronald Reagan's election in November 1980, the conservative Heritage Foundation issued a blueprint for the Public Health Service, calling for the closing of federal hospitals and taking PHS programs that dealt with drug abuse, mental health and other issues and turning them into block grant programs. By January 21, all of the Carter political appointments in health had been removed at the U.S. Department of Health & Human Services, including Richmond. "They just disappeared," said Ed Martin, a PHS veteran who became an Assistant Surgeon General. [212]

The conservatives backing Reagan had strong opinions about who should take over key public health roles at HHS. For Surgeon General, they quickly settled on Dr. C. Everett Koop, a pediatric surgeon who built a brilliant career at Children's Hospital in Philadelphia. Koop – known as "Chick" to friends and colleagues – was credited with establishing the first

neonatal intensive care unit in the nation, and was awarded the French Legion of Honor for his work in surgical procedures on newborn infants. [213] His unquestioned medical credentials were an attraction to conservatives, but so was Koop's controversial outspokenness on the subject of abortion.

Koop had conducted a lecture tour in 1979, telling audiences in twenty cities that abortion was akin to euthanasia of the elderly and Nazi death camp morality. [214] Koop had also helped create a movie project called *Whatever Happened to the Human Race?* Koop appeared several times on film, including one infamous scene in which he stood on a tiny island in the Dead Sea surrounded by a thousand floating dolls, each representing the abortions a thousand unborn babies in the United States. [215] He also was on the governing boards of several anti-abortion groups, including National Right to Life. [216]

"... I was maybe the most outspoken physician against abortion in the country," Koop later recalled. [217]

In the summer of 1980, Koop was contemplating retirement from Children's Hospital – he was going to turn 65 the next year – when he received calls from three Reagan supporters to see if he'd be interested in joining the Reagan administration as Surgeon General. One of the calls was from the Heritage Foundation: "When they called me they said that I had turned up in their database as the kind of person they wanted," Koop recalled years later. [218] Koop was lukewarm to the proposal at the time, but after Reagan's election in November, he found the phone numbers, called them back, and gave them a more emphatic yes. [219]

The next month, he was in Washington meeting with Reagan's transition team. They said they were submitting his name to Richard Schweiker, Reagan's Secretary of Health and

Human Service. [220] Koop knew Schweiker, a former U.S. Senator from Pennsylvania, from ribbon-cutting ceremonies. [221]

The men were on friendly terms, but by several accounts Schweiker and many PHS veterans were leery of giving Koop any power at HHS. Many felt Koop knew next to nothing about public health, let alone the Public Health Service, and perceived Koop to be a religious zealot. Indeed, the American Public Health Association broke its tradition of being neutral about Surgeon General nominees to voice strong opposition to Koop's nomination. [222]

Schweiker had political and administrative concerns. He wanted his own man to serve as Assistant Secretary for Health, and envisioned that person as the main force over government public health. "Koop was not Schweiker's man," said Charles Miller, the former deputy to Richmond, who was Acting Assistant Secretary for Health for the first few months of the Reagan administration. [223]

There was another problem: Koop was about to turn 65, which would exceed the statutory age limit for members of the Public Health Service Commissioned Corps, of which the Surgeon General – by law – had to be a member. The law needed to be changed if Koop was to take office, meaning liberals who opposed Koop would have another lever, another set of hearings, in which to oppose him.

Schweiker selected Koop and agreed to push for the law change, under pressure from the White House. Knowing it might take time to amend the age ceiling and get Koop confirmed, he appointed Koop Deputy Assistant Secretary for Health for the interim. But it was merely a placeholder. Miller wrote the job description, but was told to change it to make clear that Koop would not assume any of the ASH's responsibilities if the ASH was absent. "The idea was to keep Koop out of the line" of authority, Miller said. [224]

Koop said he was only dimly aware of the organization chart machinations going on at the time. “The Surgeon General would drop down one echelon in the hierarchy and would now report to the assistant secretary,” Koop said, of how his position as Surgeon General would differ from Richmond’s. “All this mattered little to me at the time, and I understood it even less. I was simply relieved that I would, after all, become the Surgeon General.” [225]

But the arrangement put Koop in grueling limbo from March 1981, when he started as Deputy ASH, until January 1982, when he was sworn in as Surgeon General. He had left his surgical career and pro-life group board positions for a job with no power, no budget and no voice. Schweiker told Koop to keep his head down and his mouth shut during the confirmation process. [226] The Assistant Secretary for Health who was selected, Dr. Edward Brandt, quickly established himself as a tough administrator who was capable of talking to the press and public about public health matters.

Meanwhile, it seemed to Koop impossible to get a fair hearing in the press – *The New York Times* and other prominent newspapers editorialized about what a terrible choice he was for Surgeon General. Even the United Mine Workers opposed him. [227] And at HHS, he was isolated both by his own ignorance of how the department worked and by PHS veterans who deemed him unfit for such a historically important, science-based office.

“One day I decided to have lunch in the Humphrey Building cafeteria. As I walked into the dining room itself, I heard someone say, ‘Here he comes.’ By the time I reached my intended table at the far end of the room, the usual hum and clutter had subsided and a hush had fallen over the entire room. As I walked to my seat, I was absolutely astounded to see how many forks were poised in midair between plate and mouth as this unbelievable two-headed monster, the most unqualified Surgeon General appointee in history, prepared to eat

his lunch,” Koop recalled. “My sense of isolation grew even worse. It was really more like solitary confinement.” [228]

But as he sat in meetings with PHS officials, they found him personable and gradually felt sympathy. “Those of us who knew Dr. Koop during those days sort of marveled at the fact that he stayed here in town, because of the enormous attacks upon him,” Martin said. [229]

Koop said those days in limbo proved pivotal to his later success. He established rapport with key officials at the FDA, the CDC and elsewhere in the department. “... Out of those tough months I made a number of very important friends in HHS who believed in me, believed I was being given a raw deal, who did think I was credible, who did think I was able, who did think when I had an idea and the ability to do something with it, I would be successful,” Koop said. He would later call on those friends to lend him staff and funding for the Surgeon General workshops and reports that helped make him famous. [230]

‘Crabs in a barrel’

Charles Everett Koop was born in Brooklyn, New York on Oct. 14, 1916, an only child and a descendant of Dutch settlers. [231]

He developed an interest in medicine as a young boy, impressed by Dr. Justice Gage Wright, a commanding, neatly-pressed homeopathic physician who made house calls carrying a huge doctor’s bag filled with hundreds of corked glass vials. “When he entered the house my family spoke more softly, as though a normal sound would break the spell,” Koop wrote in his autobiography. [232]

Koop went to Dartmouth College, graduating with a bachelor’s in 1937, and then went to Cornell Medical School, which he graduated from in 1941. He interned at Philadelphia

Hospital for a year and then a University of Pennsylvania surgical professor – an intimidating bear of a man named Dr. I. S. Ravdin – invited him to do a five-year residency. [233] Ravdin helped get Koop declared as essential to Penn and thus excused him from military service in World War II. [234]

In 1946, at Ravdin’s urging, Koop became a specialist in pediatric surgery and was soon named surgeon-in-chief at Children’s Hospital. At the time, surgeons customarily operated only on adults, and it was extremely rare for surgeons to specialize in pediatric cases. Koop was, by his own count, just the sixth U.S. doctor to make that his focus. [235] Over the next three decades he built the surgical program at Children’s, and it had eight divisions of surgical specialties at the time he left the hospital. [236] He became known as one of the fathers of pediatric surgery, and was recognized around the world for his contributions.

His medical experiences left him somewhat unsuited for life inside a government bureaucracy. He had never really worked for anyone before, and he was, well, a surgeon.

“You know, I’ve never met a surgeon who didn’t have a strong ego,” said Brandt, who became Koop’s supervisor at HHS. “As a matter of fact, I think it is probably essential to going in the operating room and picking up a knife and start cutting on people. If you don’t believe you are right, it would be pretty hard to do that.” [237]

Surgical training is extremely competitive and helps form such personalities, said Dr. Georges Benjamin of the American Public Health Association. “Everyone who goes into surgical training doesn’t end up as a surgeon, and so it’s crabs in a barrel. And so that means he’s tough,” Benjamin said. [238]

Of course, the Reagan Administration and Congressional Republicans were powerful allies during the nomination process. In July 1981, a complex compromise had been reached

to remove the age limit of 64 on the Surgeon General and other members of the Public Health Service Commissioned Corps. [239] In November, the Senate confirmed Koop by a vote of 64 to 28, and Koop was sworn in as Surgeon General on Jan. 21, 1982.

A war on tobacco

Koop's first press conference was held a month later, to present the latest in the annual series of Surgeon General reports on smoking. Brandt, the ASH, was there also. But Koop stole the show.

Koop proved a commanding presence in his Commissioned Corps uniform and distinctive, mustache-less beard, which gave him a look that has been described by various wags as akin to an Amish farmer, a Dutch sea captain, an Old Testament prophet, and one of the founders of the Smith Brothers cough drop company.

But what most swayed to the press, Koop later said, were his clear and unsparing answers to reporters' questions about smoking dangers. The report broadened the list of cancers attributable to tobacco use and dismissed arguments by the Tobacco Institute that a scientific conclusion on causation could not yet be reached. "The evidence is strong and scientific and we stand by it," Koop said in the press conference, according to *The New York Times*' front-page account the next day. [240] Koop also called smoking "the most important public health issue of our time." [241]

Koop had prepared for that press conference, knowing that smoking had become the issue most closely linked with the Surgeon General. "I think I saw smoking as the most visible thing my predecessors had done, and if I wanted to have some kind of platform from whence to jump to other things, I better do that one well," he said. [242]

Koop quickly emerged as a striking contrast to other members of the Reagan Administration regarding the topic of smoking. Federal Trade Commission Chairman James C. Miller III told the press he didn't have time to read the results of a five-year FTC investigation into cigarette advertising abuses and had no interest in strengthening health warnings. "If people want to smoke, that's their business," Miller said. [243] Brandt, though pledging that expanded cigarette warnings had a high priority, was unable to accomplish change. [244]

Koop had no real authority to make such a change, either, but he quickly became known for his blunt talk about the need for it. "Over the ensuing seven years, Koop's would be the sole voice within the administration to speak out forcefully on the smoking peril," the journalist Richard Kluger wrote, in his Pulitzer-winning book *Ashes to Ashes*. [245]

Koop said the February 1982 press conference was the turning point in his relationship with the press. "... I never withheld any of the venom that I had for the cigarette companies, and still do. And the press attitude toward me changed overnight. Whereas I had been a pariah and nobody had a kind word to say, I began to be quoted as an authority. And the press from that time on were on my side until I left Washington," he said. [246]

Each year, Koop came out with a new report on the dangers of tobacco. He also gave speeches to medical associations, high schools and numerous other groups, hammering away at the same message. In May 1984, speaking at the annual meeting of the American Lung Association, Koop called for a smoke-free society by 2000. Edward Horrigan, chief at R.J. Reynolds, wrote Reagan two months later to complain about "the increasingly shrill preachments" of Koop, which he called "the most radical anti-tobacco posturing since the days of Joseph Califano." [247]

Shrill or not, he was widely considered to be effective. Current smoking rates dropped from 38 percent in 1981 to 27 percent in 1989, according to Gallup poll information. That was the largest drop seen since Gallup started regular polling on smoking rates in the early 1940s. [248]

Baby Doe, and other issues

Koop did indeed use tobacco as a springboard into other topics. He talked about the dangers of marijuana, and lectured on youth violence. By the fall, he was upsetting the video game industry by fingering them as unhealthy and a contributor to youth violence. Koop's words were "one of the most irresponsible and unthinking statements we have ever heard from an official of the federal government" and could "cast serious doubt on every action and statement emanating from the office of the Surgeon General," according to a statement released in November 1982 by the National Coin Machine Institute, which represented the cigarette machine and video game industries. [249]

But aside from smoking, Koop's biggest early media splash came from the controversial topic of Baby Doe, an infant born in Bloomington, Indiana in April 1982. The boy was blue and was diagnosed as having Down syndrome. The obstetrician who delivered the child said the baby would be severely retarded and would probably die of pneumonia in a few days, but other doctors said he should be referred to an Indianapolis hospital for surgery. The parents agreed with the obstetrician, and went along with medical orders to sedate the child. Others said the sedation and other steps ordered by the obstetrician endangered the baby's life, and a fierce battle broke out among the medical staff about the right course of action. The situation rapidly escalated, hitting the media and the courts, with other families trying to adopt the boy. The baby died six days after his birth. [250]

Reporters called Koop – the renowned pediatric surgeon and suddenly credible Surgeon General – for comment. He initially declined, but a combination of factors would cause him to be the government’s lead spokesman on the matter.

President Reagan was moved by the story of Baby Doe, and instructed HHS Secretary Schweiker to develop rules to prevent doctors from stepping back from infants born with birth defects, with the intent of allowing such children to die. But Schweiker left office by March 1983, when the rule was introduced. Brandt, the Assistant Secretary for Health who had opposed the rules as too harsh, was overruled and stood aside. [251]

The rules were promptly challenged in federal court by medical groups that included the American Academy of Pediatrics and the National Association of Children’s Hospitals and Related Institutions. [252] Margaret Heckler, Schweiker’s replacement, was unfamiliar with clinical issues and averse to controversy. [253] She let Koop do the talking.

In a hastily called press conference in March 1983, Koop defended the rule as necessary. [254] The regulations failed to pass, and Koop said this time he wanted more control. “After having taken all that flack, I went to Margaret Heckler and said, ‘If you think I should continue to take this flack, I think it is only fair that I write the next set of regulations, so that at least any flack I take is deserved,’” Koop recalled. [255] Koop wrote a new set of regulations, which also were struck down in court. But he also gathered the American Academy of Pediatrics and other groups together to forge a consensus document, which led Congress to expand the definition of child abuse to include the withholding of fluids and nutrition – a victory of sorts – which Reagan signed into law in October 1984.

Koop’s handling of Baby Doe and other issues won him respect inside and outside HHS, which gained even more visibility as power vacuums began to appear at the end of Reagan’s

first term. Brandt and others left HHS, creating “a period where we had ‘Actings’ everywhere,” Martin remembered. [256]

Among them was Dr. James Mason, the CDC Director, who agreed to also be the Acting Assistant Secretary for Health in 1984 – a role he would keep until 1986. Mason was very busy running the Public Health Service, and was happy to let the Surgeon General continue in the bully pulpit. “I don’t see my big ability as public speaking and it’s not something I particularly enjoy doing,” Mason said. “I could not have done what I was doing plus what he was doing, nor could he have administered the United States Public Health Services and its agencies and still been an effective spokesman.” [257]

Koop forged a similar relationship with Dr. Otis Bowen, appointed in 1985 to replace Margaret Heckler. Bowen, the former governor of Indiana, was an astute politician who recognized Koop had built tremendous credibility with the media. He was content to not only give Koop a long leash, but also to tap him as spokesman for Bowen on certain controversial health topics. “When we wanted to explore an idea or had something that we wanted to get a fair shake, Chick talked about it for us. Chick operated within the Public Health Service, but I gave him broad discretion on what he did,” Bowen later recalled in his autobiography. [258]

Koop was given a second term in office as Surgeon General. After that, Bowen and other administration officials decided to rely on Koop to speak about the public health scare of the decade – AIDS.

Koop and AIDS

In June 1981, while Koop was still in his confirmation limbo, the CDC published the first report of an immune system-destroying disease that was later called Acquired Immune Deficiency Syndrome.

AIDS was a natural topic for a Surgeon General to talk about, Koop said. “If ever there was a disease – an opportunity for a command performance, regarding the Surgeon General – AIDS is it! By Congressional mandate – by public health law – the one thing that is absolutely clear and indisputable is that the Surgeon General is to provide information to the public on how they can protect themselves against disease, and what they can do to promote good health,” he said. [259]

But Brandt told him he would not be assigned to cover AIDS. And when Koop was to appear before the media, HHS public affairs staff told reporters he would not be answering questions on AIDS. “The attitude of the people that handled public affairs for me – who dealt with my speaking engagements and so forth – was almost as though there was some tribal taboo on the very word AIDS passing through my lips,” Koop said. [260]

Koop said he initially didn’t consider himself muzzled on AIDS, but rather felt the disease had been made the responsibility of other health officials through a division of labor. Brandt in 1983 had created an Executive Task Force on AIDS, that included top-level staff from the Public Health Service. Koop found his exclusion awkward, but Brandt said it was simply an administrative decision. [261] Heckler and Brandt were the ones answering AIDS questions at news conferences, calling it the administration’s “number one health priority” but generally providing assurances about risks to the general public and fending off questions about why the government wasn’t spending more on AIDS research. [262]

Brandt was, at times, muzzled and restricted. One example: In May 1984, he had agreed to attend an annual awards dinner held by the Fund for Human Dignity, the fund-raising arm of the National Gay task Force. He was to present an award to a San Diego organization that had recruited hundreds of disease-free lesbians to give blood. Conservative groups heard about the appearance and flooded the White House with telegrams demanding Brandt be fired if he attended. Heckler was worried about the political fallout, and soon after an HHS spokesman announced Brandt was disappointed but he would not be going to the dinner because of another meeting. [263]

Brandt left HHS that year and Heckler grew embattled. Her claims that the administration was giving researchers what they needed were challenged by prominent researchers and by U.S. Rep. Henry Waxman, a California Democrat, and other members of Congress. [264] In late 1985, the CDC stopped spending money on AIDS education, buckling to pressure from White House conservatives who believed the government was essentially teaching gay men how to commit sodomy. [265]

President Reagan had been silent on the issue of AIDS, prompting growing criticism from the gay community and others. Finally, in February 1986, Reagan asked Koop to prepare a report on AIDS for the American people. The Surgeon General spent most of the rest of the year interviewing health officials, researchers, leaders of the gay community and others. His report, released in 1986, called for Americans to set aside their differences and work together to prevent the spread of the AIDS virus. Koop's report – described as “unusually frank” by reporters – also called for condom use and sex education which, he said in answer to a reporter's question, should start in the 3rd grade. He also opposed compulsory testing. [266]

Koop did almost all of the writing of the report himself. He did not submit it for White House clearance, and had tens of thousands of copies made. It was a media sensation, wrote the journalist Randy Shilts.

“This wasn’t some tedious call for a blue-ribbon commission or bureaucratic coordination; this was about rubbers and sex education,” Shilts wrote in *And The Band Played On*, his book about the AIDS epidemic. “Uncorrupted by the language of AIDSpeak, Koop was able to talk in a way that made sense; at last, there was a public health official who sounded like a public health official. Not only that, he was able to utter words like ‘gay’ without flinching... Koop quickly became so in demand for speeches that he was called a ‘scientific Bruce Springsteen.’” [267]

Some in the White House, however, were not pleased. Particularly unhappy was Gary Bauer, Reagan’s domestic policy advisor and a staunch defender of “family values,” public health officials recalled.

“You know, this same-gender attraction thing was such an enigma to the White House that, I hope I’m not misjudging, but it was almost as though it was a vindictiveness toward the gay man and they were hoping that this disease would take them all out,” Mason recalled. [268] He noted that some in the White House were in favor of mandatory testing and isolating the infected from the rest of society – something Koop had argued against.

Some Reagan staffers were extremely irritated about Koop’s frank talk about condoms. Two people from the White House visited Koop a few months later, asking that he drop the word ‘condom’ from the next edition of the report. Koop didn’t believe they had been sent by Reagan himself, but rather by others in the White House, and refused. [269]

Koop also wrote “Understanding AIDS,” a brochure sent to all 107 million households in the United States in 1988. It was the largest public health mailing ever done. [270]

Koop said Bauer made it difficult for him to call or meet with the President. But he believed Reagan was not against him. “Ronald Reagan had the attitude ‘I appoint people after I have consulted with whom I think are the most knowledgeable people, and I make the best choice I possibly can. And until my appointee proves to me he is not doing the job, I leave him alone. And I support him in every way I can.’ He never corrected me. He never called me up... His staff would call up my staff and say ‘My boss didn’t like what your boss said.’ We had a standard answer; ‘When your boss feels that way and talks to my boss, he’ll get some action.’ Period. He never called about anything like that,” Koop said. [271]

Pride in the uniform

While AIDS was becoming a speaking-circuit superstar, Koop was also working on an issue that was highly controversial within HHS – reinvigorating the Commissioned Corps of the Public Health Service.

Koop had never seen military service, yet he immediately adopted the Navy-modeled, vice-admiral uniform that went with his title. He perceived it would give him a greater aura of authority, but also saw it as important for assuming his role as the titular head of the Commissioned Corps. [272]

The uniform had fallen out of favor at PHS agencies like the NIH, FDA and CDC, which were full of researchers who lacked military inclination. The Vietnam War hadn’t helped, nor had the perception that some of those who had joined the Corps in the late 1960s and early 1970s were mainly trying to avoid service in the real military, giving birth to the derisive description of Corps members as ‘yellow berets.’

“The uniform became a symbol of derision. I mean, if I was to have worn my uniform in the ‘70s through the Humphrey Building or even the Parklawn Building, I think people would have thrown eggs at you,” said Paul Ehrlich, the former Acting Surgeon General, referring to two Washington, D.C.-area buildings where PHS administration was concentrated. [273]

The Corps was seen as a second personnel system that bestowed better benefits, and carried with it the chance that a member would be pulled out of his or her job in a time of emergency and sent to a disaster area or place of concern. For many, it was just a choice of benefit structures, with no greater meaning, Ehrlich said. [274]

But Koop took his role seriously, and believed the 5,500-person Corps – just a fraction of the people who worked at PHS agencies – had languished. Without action, he believed, the Office of Management and Budget would succeed in its long-standing attempts to do away with the Corps. [275]

Koop believed Corps members needed to start wearing their uniforms again to make them more visible and build a perception that they were a vital group of personnel. With Bowen’s support, Koop assumed formal command authority over the Corps’ officers in April 1987. He required people to wear the uniform more often, promoted recruitment to the Corps and revised mobilization guidelines. [276] As many predicted, it did not go over well with many PHS researchers and scientists.

“There were a couple of places where we had some very serious problems. The first place was among some of the officers in the Center for Disease Control,” recalled Martin, who was appointed Koop’s chief of staff for promoting revitalization. He described a meeting at the CDC with hundreds of officers upset about ‘What does mobility mean to me?’ and ‘What’s

this bullshit about wearing a uniform?’ and ‘Here I am, a lab scientist. What do you mean I’m going to be sent to the Indian Health Service?’

But CDC’s leadership stood behind Koop, and Koop was – as usual -- forthright and forceful. “He just said, ‘This is the way we’re going to do it, and we are not just another personnel system,’” Martin said. [277]

Opposition dissolved in six to twelve months within the PHS. It didn’t hurt that OMB officials in the late 1980s voiced support for the Corps – the first such statement from that office in four decades. [278]

Koop’s final days

Koop was on good terms with Vice President George Bush, who had sought Koop’s counsel on AIDS and other issues, sometimes over lunch. [279] When Bush was elected in 1988, Koop – at the height of his popularity in the waning years of the Reagan administration – believed he was a logical choice to become Bush’s Secretary of Health and Human Services. Koop spread word of his interest through Jim Baker, Bush’s designated Secretary of State. [280]

Bush, however, settled on Dr. Louis Sullivan from Atlanta, an old friend of Bush and his wife, Barbara. Koop quickly became disheartened. He made a call to Sullivan the day the announcement became official, offering congratulations and advice, but it wasn’t returned. His morale eroded when his friend and supportive boss, Otis Bowen, was told by a White House staffer to clean out his desk within three days. The Bush people were rude and Koop concluded he was not wanted. He submitted a letter of resignation to Bush in February 1989, saying he would serve several more months but would finish by the time his term expired that November. [281]

Koop's final months were, in some ways, embittering. Sullivan's staff took away Koop's personal assistant, leaving him with two secretaries. [282] They also took away his executive dining room privileges. [283]

But he enjoyed a victory lap of sorts with the media and public, as examples of his willingness to speak truth to power accumulated.

In January 1989, he disclosed to the press that his office had studied the health impacts of abortion on women at the request of President Reagan, but determined there was not conclusive evidence of harmful physical and emotional consequences. Koop remained opposed to abortion, but "we could not prepare a report that could withstand scientific and statistical scrutiny," Koop told a House subcommittee two months later. [284]

"On the abortion issue, Koop made it clear he was the nation's doctor, not the nation's chaplain," the syndicated columnists Jack Anderson and Dale Van Atta wrote two months later. [285]

In the late spring, Koop took on alcohol, recommending new taxes on beer, restrictions on alcoholic beverage advertising and reduction of the permissible blood-alcohol level for drivers. Even conservative columnist George Will – who found the proposal for raising taxes debatable – praised Koop for his "constructive irritability" and his "splendid legacy." [286]

Koop's term officially ended Oct. 1, 1989. But nearly two decades later, he is considered the best-recognized Surgeon General.

"We all remember Dr. Koop as the Surgeon General," said Dr. Kenneth Moritsugu, who served as Acting Surgeon General from 2006 to 2007. "Even today, when we talk about the Surgeon General, people always come back at me and say, 'Oh, you mean Dr. Koop! What ever happened to Dr. Koop?'" [287]

Koop can be viewed as an illustration of several theories. Many see him as emblematic of the Great Man Theory, viewing him as charismatic, full of integrity and a persuasive speaker. Several key informants – including Koop – say the Long Leash Theory also was applicable, in that Reagan, Bowen and other key leaders did not try to restrict his use of the bully pulpit. The Great Issue Theory applied to his case as well, in that the AIDS crisis erupted on his watch.

DR. ANTONIA NOVELLO, 1990-1993

When asked recently why he settled on Dr. Antonia Novello as a candidate for Surgeon General, Louis Sullivan said it was because she was a Hispanic woman.

Sullivan, who became the first black Secretary of Health and Human Services under President George Bush, was keenly interested in addressing the health needs of blacks, Hispanics and other minority populations. Sullivan had met Novello when he was president of Atlanta's Morehouse School of Medicine and she was at the National Institutes of Health.

“Several things about her stood out. First of all, she was female and I was interested in having females in my administration. And secondly, she was Hispanic, and I was interested in promoting minorities in significant positions in my administration,” Sullivan said. [288]

Novello declined to be interviewed for this project, and so what she accomplished during her three years as Surgeon General is left to the interpretation of others.

Some are not kind.

“She was pretty much a zero,” said Dr. David Sencer, who was director of the CDC in the 1960s and 1970s. [289]

“She never focused on stuff with any kind of depth on the subject matter and, to me, she lacked substance in what she did,” said Dr. Jeff Koplan who ran the CDC in the late 1990s and early 2000s. [290]

Others gave a more positive assessment, calling Novello a capable Surgeon General and good speaker. Her main failing, they say, was that she wasn’t C. Everett Koop.

“Koop was a very hard act to follow,” said Jeff Levi, executive director of the Trust for America’s Health, a Washington, D.C.-based public health advocacy organization. [291]

‘A pushy mother’

Antonia Novello was born Antonia Coello on Aug. 23, 1944. She was born in Fajardo, Puerto Rico and grew up in a modest concrete house in the center of town. [292] Her father died when she was 8, and her mother was the guiding force in her life.

“I was one of those middle-class kids who had a pushy mother,” Novello said, in a 1994 interview for the Academy of Achievement, a non-profit organization that exposes students to political leaders and accomplished professionals. [293]

Her mother was Ana Delia Flores, principal of the town’s junior high school, and later, of the high school. Her mother would sometimes be the substitute teacher for Novello’s classes, and would pre-select the teachers in charge of Antonia’s education. “She would say, ‘Education is the reason by which we exist, and I will make sure that the best teaches you, because public school is a good system.’ She made sure of that. All my life I almost felt that my grades were not mine, that my grades were a product of my mother making sure that I was educated by the best,” Novell said. [294]

She described herself as a cut-up and actress in school. She was the lead soprano in the high school chorus and did her best to make others laugh. [295] But at times, some students

questioned her academic achievements, suggesting her mother not only placed her with the best teachers, but also negotiated top grades for her daughter. “It only motivated me to be better,” she recalled. [296]

Novello’s interest in becoming a doctor came from her experience as a patient. She was born with congenital megacolon, which left her unable to move her intestines. She spent two weeks in the hospital every summer as a child. “I always felt I was going to be a doctor. I didn’t know when, but I knew that was the only thing that I really had role models on a constant basis,” she said. [297]

She was told she needed surgery at 8, but by her account got lost in the health system, despite the presence of her strong-willed mother. Novello didn’t receive corrective surgery for the condition until age 18. She suffered complications from the surgery until age 20.

[298]

Novello received her bachelor’s degree from the University of Puerto Rico at Rio Piedras in 1965, and her medical degree from the University of Puerto Rico School of Medicine at San Juan in 1970. She met a Navy flight surgeon, Joe Novello, and married him in 1970, the day after her medical school graduation. [299]

Joe and Antonia Novello moved to Michigan in 1970, where she did her internship and residency in pediatrics at the University of Michigan. When she finished, she opened her own pediatrics office, but closed it in 1978 to take a job with the National Institutes of Health.

[300]

She held a series of jobs at NIH, rising to Deputy Director of the National Institute of Child Health and Human Development. She also served as the coordinator for AIDS research at NICHD, starting in 1987 – a responsibility that gave her visibility as a specialist in

pediatric AIDS. She was the U.S. delegate to an International Ethics Committee on AIDS in Paris, and during a legislative fellowship worked for U.S. Sen. Orrin Hatch, who later became her main Senate backer during the Surgeon General confirmation process. [301]

She also gained some visibility through her husband, who had become a child psychiatrist who frequently made television and radio appearances in Washington to speak on health topics. In addition, her marriage made her the sister-in-law to Don Novello, a comedian who had gained fame as playing a hip Catholic priest, Father Guido Sarducci, on the TV show *Saturday Night Live*. [302]

Still, her nomination for Surgeon General was a complete surprise, she later recalled. “I almost died of shock because life has made us believe that you must be a politician to succeed in government life. Life has made you believe that you have to have connections, that you must be at the right place at the right time and have the right friends. None of those things happened to me,” she said. [303]

Novello said she asked Sullivan why he picked her, and wondered out loud if it was to fill some kind of minority hiring quota. “And he said, ‘I have read your curriculum and I can see that you can do it. I don’t need quotas, because I myself am a minority.’ That’s when I said, ‘Okay, let’s keep going on the interview,’” she said. [304]

Asked what made her stand out as a candidate, Novello said she felt she was “a package deal” – a woman, a doctor with AIDS credentials, a minority who embodied the American Dream, and “someone who was kind of conservative, but with common sense.” [305]

Novello’s selection was not a quick one. Koop had nearly a year left on his second term when Bush was elected, and speculation raged for several months about who would be named the replacement. Among the names circulated were Dr. Robert Redfield, a noted

researcher at Walter Reed Army Institute of Research; and Dr. James H. “Red” Duke, a charismatic Texas trauma surgeon who hosted the PBS television show *Bodywatch*. But anonymous White House sources at the time said they wanted to lower the Surgeon General’s profile, and some believed it should be awarded to James Mason, the former CDC Director, who had become the Assistant Secretary for Health and could have held the Surgeon General position in a Richmond-like arrangement. [306]

In November 1989, a month after the official end of Koop’s term, the White House announced the selection of Novello. Her NIH colleagues told the media she was a skilled administrator with a non-confrontational style. The White House said she was chosen after Bush was satisfied she could support his opposition to abortion except to protect a woman’s life or in the event of rape or incest. [307]

“We don’t hire people that don’t support our policies. That is a hard and fast rule,” said White House spokesman Marlon Fitzwater. [308]

Novello’s confirmation went smoothly, and she officially began her term in March 1990, at the age of 45. When she was sworn in, she told Bush ‘Mr. President, thank you very much for bringing West Side Story to the West Wing,’ she later recalled. [309]

One of Novello’s first official acts was to return to Fajardo, her hometown, where 4,000 people filled the seats of a baseball stadium to cheer her as she walked down a makeshift runway, carrying a bouquet of flowers. “I’ve been in the White House and in the senate of Puerto Rico, but there is no feeling like this one,” Novello, in tears, told the crowd. “I am the Surgeon General of the United States, but in this town I’m still Miss Flores’ little girl.” [310]

Attacking Joe Camel

Novello came into office more than a year after Sullivan and Mason were in place. Sullivan, also a physician, had seized the pulpit on the tissue of tobacco – a topic that had, except perhaps for the Richmond-Califano years, been largely as the province of Surgeons General.

In his first year in office, Sullivan pushed R.J. Reynolds to cancel “Uptown,” a new cigarette brand aimed at blacks. He also proposed a smoking ban in all federal buildings, and said he expected recipients of federal health grants to restrict smoking in their offices. His activity prompted an approving William Raspberry column in The Washington Post that carried the headline “Sullivan Comes Out Smokin. ” [311]

“Certainly, smoking was one of my areas of great interest so I was quite prominent in using the bully pulpit to try and discourage smoking, but she was not excluded from that,” Sullivan later recounted. “She also would speak about smoking at times, but it was understood between us that this was really a major interest of mine.” [312]

It was understood by HHS public affairs staff as well. Her appearances before the media were cleared through Sullivan’s office. “... It was very tightly controlled in the speaking area, and Lou Sullivan got the pick of talks and Toni got what was left over,” Mason said. [313]

In addition to Sullivan’s desire for the pulpit on smoking, politics was also an obstacle. In early 1990, Mason delivered a forceful keynote address at a World Conference on Tobacco and Health meeting in Australia, saying U.S. tobacco companies had been “playing our free-trade laws and export policies like a Stradivarius violin.” He also said it was “unconscionable” for those firms “to be peddling their poison abroad.” But when U.S. Rep.

Waxman called on Mason to repeat his statements at a Congressional hearing in May, Mason's appearance was canceled with an HHS letter that said it was deemed inappropriate for a health official to discuss trade matters. [314] Waxman said it was an example of the Bush administration muzzling an anti-tobacco voice. [315]

The incident appeared to have made an impression on the new Surgeon General. In September 1990, Novello was asked at a press conference why she hadn't opposed U.S. Trade Representative Clayton Yeutter's efforts to start selling U.S. cigarettes in Thailand and other Asian countries. (Koop had been a strong critic, saying; "There is a higher good than the greed market.") [316]

But Novello said she had no comment about that. "For me to talk about it would be almost disrespectful of my (political) party," she said. [317]

At the beginning of her term, some tobacco industry officials did not consider Novello to be a threat, according to internal documents from the Washington office of Philip Morris Cos. Inc. that were printed years later in *The Washington Post*. [318]

In an Oct. 18, 1989 memo, Philip Morris lobbyist Jim Dwyer said he had learned that Novello was being considered for Surgeon General and had searched for any speeches, statements or papers she had made on tobacco and found nothing. "She seems to be a candidate least likely to interfere with our activities and we may well want to discuss possible ways to express support for her appointment," Dwyer wrote. [319]

In a March 8, 1990 memo, penned a day before Novello officially started her job, Dwyer wrote that he had discussed Novello with the White House. "We intervened with the White House, OMB and HHS to urge that Dr. Novello take no position on any pending anti-tobacco legislation. We stressed to her handlers and to interested parties that we were interested in

making sure she focused on non-tobacco health problems. We were successful in that both our objectives were met,” Dwyer wrote, without fuller explanation. [320]

Much of Novello’s time in office was spent on other issues, but she did speak out on certain tobacco topics. Indeed, perhaps her most noted use of the bully pulpit was her attack on Joe Camel, a cartoon character that R.J. Reynolds started using in the late 1980s to market cigarettes.

In March 1992, Novello and the American Medical Association asked the tobacco company to withdraw its cartoon campaign because they said it was an effort to encourage under-age smoking. It was said to be the first time a Surgeon General had called for a halt to a continuing ad campaign for an existing cigarette brand, and received a flurry of national media coverage. Novello later that year acknowledged – and voiced surprise – that her fight against Joe Camel had caused her highest visibility while in office. [321]

It was, however, ultimately ineffectual. R.J. Reynolds flatly refused, issuing a statement that said; “No linkage has been made between advertising and the consumption of cigarette products.” [322] The company kept with the campaign, and its market share in the 24-and-under crowd rose from 4.4 percent to 7.9 percent. [323]

Almost from the beginning, some public health advocates and others labeled the Joe Camel campaign a weak effort that skirted more substantive issues like increased taxes on cigarettes, tougher trade restrictions or even an outright ban on smokes. “Of all the half-hearted measures to come along lately, this joint government/AMA proposal to ban Old Joe Camel ranks up there with metal bars on park benches and cab drivers wearing jackets and ties,” wrote the novelist Emily Prager, in a March 1992 newspaper editorial. [324]

Novello and the Bully Pulpit

Despite his strong anti-tobacco statements at the Australian conference on smoking, Assistant Secretary for Health Jim Mason made no concerted effort to compete with Novello for the bully pulpit, observers said. “Jim Mason... was not a charismatic person, had no interest in having a public profile, and was very happy with Toni Novello being the Surgeon General and was very supportive of her,” Sullivan recalled. [325]

The bigger problem was Sullivan, who was much more interested in public speaking than the HHS Secretaries that Koop had worked for. “Koop had the whole field to himself because Bowen wanted none of that,” Sullivan observed. [326]

Sullivan wasn’t active only on tobacco. He made key appearances on AIDS. He led the charge for better food labeling. He was spokesman for racial disparity issues that had a strong African-American angle. And he took credit for a revision of Richmond’s Healthy People report – this time setting goals for 2000. [327]

Novello’s designated topics included promoting vaccinations, childhood nutrition and initiatives aimed specifically at the Hispanic community, Sullivan and others said. Among her initiatives was a series of regional workshops in Chicago, New York, Miami, Los Angeles and San Antonio to get a sense of Hispanic health issues on the local level in preparation of a national report. [328] She endorsed medical screening for signs of domestic violence. [329] And she spoke out against drunken driving and underage drinking, including a speech to members of Mothers Against Drunk Driving – “a group that didn’t need much convincing,” one reporter observed. [330]

When she was confrontational, her targets were very specific and her attacks were done in partnership with other groups. One example occurred in April 1992, when she joined the

Oglala Sioux campaign against the makers of Crazy Horse malt liquor, charging the name was insensitive and ignored the high rate of alcohol-related problems among Native Americans. The manufacturer, Heileman Brewing Co., ignored the call for a name change. [331]

Novello discussed her views of negotiating the job of Surgeon General years later, in a dissertation she wrote in pursuit of a doctorate in public health at Johns Hopkins University. In her dissertation, entitled “The Modern Era Surgeon General: A Retrospective Review,” Novello evaluated seven of the eight Surgeons General who served from 1961 to 2000. (She did not evaluate herself, saying she wouldn’t be able to muster the required degree of intellectual detachment for that task.)

In her evaluations, she repeatedly focused on the doctors’ ability to work within the political framework around them. She praised Luther Terry for his public relations savvy and his ability to adapt to political realities. [332] She complimented William Stewart as a realist who never let what he wanted cloud his judgment as to what was feasible within HEW. [333] And she lauded Koop – not, as many others did, for his outspoken independence – but rather for being a crafty politician. “As he became more secure in his position, he thought carefully about the players and their power, and then mapped the political terrain. He built linkages with other stakeholders. He recognized the value of personal contact and face-to-face conversations. Above all, he understood and masterfully used moral persuasion to achieve goals. At the end of his tenure he was as much a politician as medical expert. [334]

Her harshest assessments were for Jesse Steinfeld and Joycelyn Elders, two of the Surgeons General most aggressive in using the bully pulpit.

She said that while Steinfeld showed courage in taking on controversial topics, but he was unnecessarily confrontational and didn't know his place, failing "to understand the boundaries of his job and that of the three ASHs under whom he served," she wrote. [335] And Elders may have been brave, outspoken and scientifically sound, but she was "politically naïve" and failed to think about repercussions of her statements, Novello wrote. [336]

How Novello lost her job

Bill Clinton was elected in November 1992. In the few months before he took office, his transition team lead the kind of house-cleaning frenzy not seen at the beginning of the Reagan administration.

On Tuesday morning, Dec. 15, 1992, Novello was getting ready for work when she heard on the radio that the President-elect was going to make someone else the Surgeon General. Novello had 15 months left on her term, and had said a few weeks earlier that she planned to stay in office until then. [337]

But Clinton wanted Dr. Joycelyn Elders, who had run the Arkansas Health Department while he was the state's governor. Phil Lee, who had agreed to come back to government service as Clinton's Assistant Secretary for Health, would negotiate Novello's departure.

"So it was my job as the Assistant Secretary to give Toni a job but also to convince her to leave gracefully and not raise a stink," Lee recalled, adding "they wanted to give her (Novello) a job in a hurry." [338] Lee talked to the head of UNICEF and secured Novello as a job as special assistant to the director. Novello was interested in international health and agreed. "She was very decent about it," Lee said. [339]

Novello left office in June 1993. When asked by a reporter if she had any advice for her successor, she replied; “Have your facts ready and be realistic.” [340]

Novello is seen by some as being an illustration of the Long Leash Theory, with her agreeably standing aside as Sullivan was the government’s lead voice on many public health issues. She was on a relatively short leash and didn’t seem to mind it; many of her comments indicate an over-riding sensitivity to political considerations.

DR. JOYCELYN ELDERS, 1993-1994

The selection of Dr. Jocelyn Elders as Surgeon General hit conservatives like a stomach punch.

Elders, the outspoken, liberal director of the Arkansas Health Department, had already made national waves. She had endorsed providing condoms in schools, and during a January 1992 appearance at a Pro Choice rally, she said abortion opponents needed to “get over their love affair with the fetus.” [341]

She was, by nearly all accounts, a polarizing figure. People either prized her for saying what no other health official would about teen sex, abortion and other controversial issues... or they detested her for the same reason.

“It’s ominous to see her in a position of so much authority,” said Wanda Franz, president of the National Right to Life Committee, in an interview with *The Washington Post* the day after Elders’ name surfaced as Novello’s proposed replacement. [342]

After a stormy confirmation process, Elders would end up serving less than 15 months. Hers was the shortest term of any Surgeon General. But in that limited time, she became one of the most famous.

A review of newspaper clippings and broadcast transcripts showed that for more than a year and half, there was something about Elders in the media nearly every single day – a news item about a national controversy she had stirred; an article about one of her many speeches and appearances; or, most often, a letter to the editor or other opinion piece. Conservative radio host Rush Limbaugh ridiculed her on a weekly basis.

Today, she remains one of the best remembered Surgeons General. Indeed, she ranks second only to Koop in name recognition, according to the estimations of many public health service veterans and advocates.

“She was quite a pistol,” said Dr. Georges Benjamin, executive director of the American Public Health Association. [343]

Babies from watermelon seeds

Elders was born Minnie Lee Jones on Aug. 13, 1933. Her birth and childhood were in the tiny town of Schaal, Arkansas, in a rural area west of Little Rock. She grew up poor in a sharecropper family, in a house where the only reading material was a copy of the Bible and a weekly farming newspaper her father got, *Grit*. [344]

As a child, she had little exposure to doctors, who were considered too expensive and far away. The first time she could remember anyone going to a doctor was when she was 9. Her brother Bernard’s stomach swelled and he wouldn’t break a fever. Her father placed Bernard on a mule and took him to see a doctor, who treated him for a burst appendix and then sent him right home, as there were no hospitals nearby taking black children. [345]

Health information was scarce. The family used coal oil as an antiseptic. No one used – or had ever heard of – aspirin. Her first menstrual period was a terrifying experience; she recalled practically hyperventilating in school, shocked that she was bleeding and trying to

cover her lap so no one noticed. When she did learn about menstruation, it was from a home economics teacher who handed out Kotex package inserts. [346]

“Sex was a secretive thing, not to be mentioned. Children were told that babies were brought by storks, or that they came from swallowing watermelon seeds. As youngsters we spent a lot of time trying not to swallow a watermelon seed,” Elders later wrote in her autobiography, *Joycelyn Elders, M.D.* [347]

She was a good student and was valedictorian of her high school class, an achievement that opened two doors: First, she gave the valedictory speech at the diploma ceremony – a nervous address about doing your best that was her first big brush with public speaking. Second, as valedictorian she was awarded a full-tuition scholarship to Philander Smith College, a well-regarded Methodist institution in Little Rock. [348]

In college, she changed her name to Minnie Lee to Minnie Joycelyn, then just Joycelyn. The name came from a peppermint candy she liked, and was part of her attempt to distinguish herself from the other Minnie Joneses in her family. [349]

She earned her bachelor’s degree in 1952 and married a Philander Smith student named Cornelius Reynolds. She followed him to Milwaukee, where he got a job with the IRS and she took a job as a nurse’s aid in a Veteran’s Administration hospital. The couple quickly realized the marriage was a mistake, Elders said. She enlisted in the Army in 1953, enticed by the promise of GI Bill tuition benefits, and left Milwaukee. [350]

During her three years in the Army, she trained as a physical therapist. She was assigned to a military hospital in Denver, where she treated President Dwight D. Eisenhower after his heart attack. [351] She also took several classes, including one on public speaking taught by a Catholic priest at a Denver Jesuit school. [352]

The priest taught her how to speak with rhythm, and to never read from paper while giving a speech. His lessons were later accentuated with advice from her brother Chester Jones, who has become a Methodist minister. But her undisputed skill for rousing a room was born in that Denver class, she said. “Probably the most valuable course I’ve ever taken,” Elders said. [353]

After the Army, Elders got a medical degree from the University of Arkansas Medical School, graduating in 1960. The same year, she married a Little Rock basketball coach, Oliver Elders. [354]

Then, she interned at the University of Minnesota Hospital before returning to Little Rock for a pediatrics residency and to earn a master’s in biochemistry. In 1967, she became an assistant professor of pediatrics at the University of Arkansas Medical Center, then moved up the academic ranks there to become a full professor in 1976.

Her research focused on pediatric endocrinology and she became an expert on childhood sexual development. She met Bill Clinton, a young political star, at a political function when he was the state’s attorney general.

In 1987, when Clinton was governor, he appointed Elders as director of the Arkansas Department of Health. She leaned on Tom Butler, the deputy director, and the two formed a good working partnership that resulted in improved immunization rates and childhood health screenings. Elders proved to be an effective and empathetic speaker as she visited schools and health facilities around the state. Butler complimented her once, noting that he was initially concerned she would be an aloof academic type. ‘Dr. Elders, at least we don’t have to teach you how to be poor,’ she recalled him saying. [355]

Her passion for addressing the teenage pregnancy problem lead to an incident that was repeatedly raised later: In 1991, after the Arkansas Health Department learned that condoms being distributed in the state's public health clinics had an unusually high rate of breaking – 50 per 1,000 condoms, which was much more than the FDA's safety-standard maximum of 4 per 1,000. Elders quietly ordered the recall of undistributed condoms, but declined to disclose the problem to the public, fearing it would scare people away from using condoms. “We made a decision for the greater public good,” she later said, in a Senate hearing. [356]

Generally, she got good marks from other public health professionals, and was elected president of the Association of State and Territorial Health Officers in 1992. She was “knowledgeable, smart, understood public health issues,” said Dr. Jeffrey Koplan, who was CDC Director from 1998 to 2002.

“It's a logical stepping stone to be a state health department director and then to move to a national level in a parallel role,” he said. [357]

‘Like low-grade hamburger

When Clinton was elected President in November 1992 and contacted the 59-year-old Elders about the job as U.S. Surgeon General, she initially wasn't interested. “I felt the job I has as Director of Health for the State of Arkansas was, frankly, a better job. I was... responsible in a direct way for more people,” she said. [358]

But Clinton convinced her that she could do something about teenage pregnancy on a national level. Elders' elderly mother was also persuasive: “She told me she saw the President on TV today and he just looked pitiful, and she said, ‘You need to go on up there and help him,’” Elders recalled. [359]

Elders was embroiled in controversy almost immediately. Her race – she stood to be the first African-American to hold the Office of Surgeon General – received little public comment. But critics were vocal about her abortion rights statements and endorsement of frank sex education for kids.

She said condoms needed to be advertised on television. She backed the medicinal use of marijuana. She supported giving the contraceptive implant Norplant to drug-addicted prostitutes, gratis. And in comments cited by conservatives as blasphemy against Catholics, she said; “Look who’s fighting the Pro-Choice movement – a celibate, male-dominated church.” [360]

She was a lightning rod for controversy, but was not the only one Clinton was dealing with. The nomination of Lani Guinier for civil rights chief at the Department of Justice exploded in June 1993 when Republicans and some Democrats assailed her academic writings as evidence of radical views on minority rights. Clinton dropped Guinier – a move that was sharply protested by the NAACP and other groups. [361] Conservatives pressured Clinton received to drop Elders too, but abandoning another black nominee would have cost him dearly in the African-American community, some political observers noted. [362]

Some Republicans put up a stiff fight, using parliamentary tricks, delays and allegations of financial impropriety to try to derail her nomination. When she was finally confirmed by the Senate in September, by a vote of 65 to 34, she told the President; “I came to Washington as prime steak, and after being there a little while I feel like low-grade hamburger.” [363]

Not cowed at all by the political battles she had just weathered, Elders immediately took to the road, giving speeches and press interviews at a pace unmatched by any of her predecessors.

Elders and the Bully Pulpit

From the very beginning of her term, Elders was in high demand as a speaker. She traveled across the country, speaking at colleges, medical conferences, schools, churches and many other forums – sometimes giving three speeches in a day.

It wasn't a matter of Elders pushing her message on different groups, said Phil Lee, who was Assistant Secretary for Health and Elders' boss. "It was more a pull. People wanted her to speak because they knew she would speak out on issues that were controversial," Lee said.

[364]

She was not only controversial, but also a powerful orator capable of stirring an audience's emotions. "Listen to her, and you'd be sitting on the edge of your chair, practically. She was that good," Lee said. [365]

Her speaking skills were admired even by those who thought she too often allowed opinion to supersede science in her talks. "When she talked about the poor and disenfranchised... she wasn't talking theoretically. She was coming from the gut, and she was passionate about it, and I give her credit for that," said Damon Thompson, an HHS public affairs officer from 1996 to 2002 who served under Elders' lower-key successor, Dr. David Satcher. [366]

Her bosses were accommodating. Lee, as the Assistant Secretary for Health, handled most administrative matters pertaining to the traditional Public Health Service agencies. And Donna Shalala, the Secretary of Health and Human Services, was a firm believer in delegating authority, according to Lee and others who worked for her. [367]

Indeed, at times, the administration promoted her visibility. Along with Koop, Elders was used to stump for the need for national health reform. The night Clinton unveiled his health

plan to Congress in September 1993, Elders was seated next to Hillary Rodham Clinton in the House gallery – guaranteeing the Surgeon General would be repeatedly on television when the cameras panned to the First Lady.

Most of the time, Elders was on the road at speaking engagements, or talking to groups that met in Washington. “I always spoke to anybody I wanted to... Nobody told me what I was going to say, either,” Elders said. [368]

That was true of her dealings with the press as well, she said. HHS press secretaries did little in the way of funneling calls away from her, and she enjoyed talking to reporters, she said.

She was sometimes surprised, however, when her comments blew up into controversy.

One such instance occurred in early December 1993, when – in response to a question at a National Press Club luncheon – she said legalizing drugs could reduce crime and the idea deserved further study.

She was not the first health official to voice the idea: In one example from the Nixon administration (which I previously mentioned), Assistant Secretary for Health Merlin Duval had suggested to HEW officials that they hold a public dialog on the legalization of heroin. [369] But Elders aired her thoughts in public, at a time when battles between the Clinton administration and Republican lawmakers were escalating. The reaction was dramatic.

Clinton’s press officers immediately distanced the President from Elders’ remark, saying he was firmly against legalizing drugs and had no desire to study the issue. Nevertheless, Republican Governor Pete Wilson of California called on Clinton to fire Elders. Mischaracterizing her comment as an outright call for the legalization of drugs, Wilson

characterized her words an insult to the narcotics officers who bravely fought drug trafficking. [370]

Senate Majority Leader Bob Dole was more temperate, but knew political ammunition when he saw it. “Americans must be wondering if the Surgeon General is hazardous to our health,” Dole said to *The New York Times*. “I am relieved that the President has disassociated himself from Dr. Elders’ remarks but remain concerned with this Administration’s commitment to fighting drugs.” [371]

The fallout grew much worse less than two weeks later, when an arrest warrant was issued for Elders 28-year-old son, Kevin. He surrendered a few days later to face a charge that he sold cocaine to undercover agents. Elders said she supported her son. Shalala told the press she supported Elders, but privately she expressed her displeasure, and Elders learned that Shalala had made a point of telling others that Elders had never been her personal choice for Surgeon General. [372]

How Elders lost her job

The arrest hung over the Elders family the rest of the year, but she was undaunted in her public speaking.

In January, she said she remained convinced the legalization of drugs merited further study. [373] In February, she said the Medicaid program must have been developed “by a white male slave owner” because “it fails to provide services to poor women to prevent unwanted pregnancies, and this failure contributes to poverty, ignorance and enslavement.” [374] In March, *The Advocate* magazine published an interview with Elders in which she said an irrational fear of sexuality was behind conservatives’ anti-gay behavior. [375]

She called for the government regulation of tobacco products. She thanked abortion providers for helping women. She told Congress that sitting in a smoke-free section does not adequately protect nonsmokers' health.

In June, 87 Republican House members called for Elders to resign, and former Secretary of Housing and Urban Development Jack Kemp – who was considering a run for President in the 1996 election – said he felt Elders “should have been bounced or fired for her views, original views far, far, far to the left on social policy of the American people.” [376]

Elders thought she always had Clinton's support. He had stood by her when she first got the health director job in Arkansas, on that day they met with reporters and she surprised the Governor by saying she would hand out condoms at school-based clinics. Clinton, his face turning scarlet, said finally; “I support Dr. Elders.” [377]

He had stood by her through all her controversial statements since. Indeed, he picked her for Surgeon General in spite of them. But his breaking point came in December, after an off-hand comment Elders made about masturbation.

On Dec. 1, Elders had given a speech at the United Nations for World AIDS Day. During a panel discussion after her speech, a mental health physician – he has been described as a psychiatrist or a psychologist in various accounts – asked her a question. He wanted to know if she thought the campaign against AIDS should include discussion and promotion of masturbation. Elders said she advocated comprehensive health education starting at an early age, and that masturbation is a part of human sexuality and perhaps should be taught. [378]

For several days, her comments went unmentioned in the press. But a reporter for *U.S. News & World Report* decided to include them in a story in the magazine's Dec. 12 issue.

White House Chief of Staff Leon Panetta, who had warned Elders about her off-the-cuff remarks, told Clinton about it. [379]

“There have been a number of statements where the President has indicated he disagreed with her views, and this is just one too many,” Panetta said at a Dec. 9 news conference announcing her departure. [380]

Initially, Panetta called her for her resignation, but Elders said no, she had to hear it from the President. Clinton called her and, in a brief conversation, told her he wanted her to resign immediately. [381]

“At any other time, we probably could have faced the heat,” Clinton later wrote, in his autobiography *My Life*.

“But I had already loaded the Democrats down with my controversial budget, NAFTA, the failed health-care effort, and the Brady bill and assault weapons ban, which the National Rifle Association had used to beat about a dozen of our house members” in the November 1994 election. “I decided I had to ask for her resignation. I hated to, because she was honest, able and brave, but we had already shown enough political tone-deafness to last through several presidential terms,” Clinton wrote. [382]

Elders said she briefly weighed staying in office anyway, but only briefly. While she had a four-year term and could not technically be terminated by the President, she determined that she could not stump without a travel budget or other support. [383]

In his autobiography, Clinton said that he hopes one day Elders will forgive him. [384] In a recent interview, Elders said an apology wasn’t necessary. “I don’t think Bill Clinton, in any way, felt that I did anything wrong. I think it was just the political pressures,” she said. [385]

Asked about her accomplishments during those 15 months, Elders acknowledged that her push to get school-based clinics in all underserved schools ultimately failed, as did health care reform and some of the other calls to action she lead or was involved in. “I think my proudest accomplishment is that I really increased the awareness of the American people about the sexual health of our people, the problem of teenage pregnancy” and other issues, she said. [386]

Elders returned to her old job at the University of Arkansas, and there was one final flurry of letters to the editor and opinion pieces commenting on her departure.

Among the bitter was a letter to the editor of *The Seattle Times* by a reader named Alison Slow Loris, which said in part; “Over and over she has spoken out for common sense and honesty and the value of knowledge. It’s not surprising that the Republican commitment to upholding ignorance, and Clinton’s commitment to apparently nothing at all, have succeeded in driving her out of office.”

Loris continued; “I suppose we can count on the next Surgeon General being afraid to speak up about anything at all; since public speaking is virtually the only power or duty attached to the office, the post might as well be abolished. It would save some money.” [387]

Loris was not the only one to voice such thoughts. Elders departure was followed by years of nasty political fighting over who should replace her, and whether the Surgeon General should simply be abolished. It was not until 1998 that a distinguished physician named David Satcher would, after repeated entreaties, agree to take the job.

Elders’ short-lived but very prominent turn in the bully pulpit seems to support the Great Man and Long Leash theories. She was a strong personality and dynamic speaker who courted controversy and those characteristics brought her tremendous public attention. She

was able to travel and use the pulpit because of non-interference from Shalala and Lee – until the Clinton administration decided Elders was too great a political liability and she was forced out of the job.

DR. DAVID SATCHER, 1998-2002

Less than three weeks after Dr. David Satcher was sworn in as the 16th Surgeon General, a Senate bill was introduced designed to shutter his office.

It was nothing personal, said Sen. Conrad Burns, the Montana Republican who introduced the bill – “The Office of the Surgeon General Sunset Act” – on March 6, 1998.

[388]

Burns and other Republicans had been trying for years to abolish the position. They viewed Joycelyn Elders’ short-lived term in office as a debacle. And they were outraged when President Clinton nominated as her replacement Dr. Henry Foster, a distinguished former medical school dean who, it turns out, had performed abortions.

President Clinton had withdrawn the Foster nomination to end a firestorm of controversy in early 1995. Burns had introduced a bill not long afterward to prevent another Clinton nominee from ever holding that job again. The bill failed, time passed, and here – in February 1998 – David Satcher had taken office.

Satcher was a proponent of needle-exchange programs, an opponent of a ban on late-term abortions and a champion of public health research highlighting the dangers of hand guns. But all of that was beside the point, Burns said.

“This legislation is not about Dr. David Satcher, or about any previous Surgeon General,” Burns remarked, when he introduced the bill. “Dr. Satcher will continue to be Surgeon General and the office would sunset immediately after he vacates it. This legislation will

sunset an office that has become a political football and has long since outlived its usefulness.” [389]

Indeed, Burns argued, the office had been vacant for more than three years “and there was no shortage of voices on major health issues.” The Clintons had been talking about health reform, the Food and Drug Administration Commissioner David Kessler had been railing against tobacco, and so on. “The Surgeon General and his staff of six serve no compelling purpose,” Burns said. [390]

Apparently, others disagreed. “Oh gosh, when he came in there had been a reservoir of demand,” said Damon Thompson, the HHS press officer assigned to Satcher. “People were just relieved to start talking to the Surgeon General again, and the phone started ringing off the hook – even before he got sworn in.” [391]

Many were optimistic that Satcher, 56, would restore power and dignity to the Surgeon General’s bully pulpit.

“Beyond being eminently qualified, he is also an inspiring individual – an African American raised in poverty on an Alabama farm who rose to the highest ranks of his profession,” wrote *The Pittsburgh Post-Gazette*, in a February 1998 editorial celebrating Satcher’s confirmation. “If the post of Surgeon General is no more than what a person can make of it, then the Senate has confirmed someone who has the standing and experience to do the job proud.” [392]

Studying in jail

David Satcher was born in Aniston, Alabama on March 2, 1941, one of eight children who grew up on a 40-acre family farm. He nearly died of whooping cough at age 2, and in

the years after his mother would speak gratefully about the black physician that saved him. By the time he was 8, Satcher knew he wanted to be a doctor. [393]

Satcher attended the only black high school in the county, and was so adept at mastering math formulas and other material that teachers would ask him to teach class when they were ill. But he did most of his studying on the bus, because after school and on weekends he worked in the foundry where his father, Wilmer, was employed. [394]

In 1959, Satcher got a full scholarship to Atlanta's Morehouse College. He joined Julian Bond and other Morehouse students in civil rights protests. But he carried books with him, so when he was arrested – and he was, several times – he could study in his cell. [395]

Satcher graduated Morehouse in 1963 with honors, and then attended Case Western Reserve University in Cleveland, graduating with an M.D. and Ph.D. in genetics in 1970. He had married a woman he met while attending Morehouse, and after Cleveland the couple moved to Los Angeles where he took a position at Martin Luther Jr. King Medical Center in Watts. He later became director of the hospital's sickle cell disease center and was interim director of the King-affiliated Charles R. Drew Postgraduate Medical School. [396]

His wife, Callie, died of breast cancer in 1978 after giving birth to their fourth child. He remarried a California mother of five, who became mother to his children, and the family moved to Atlanta where he became head of community and family medicine at the Morehouse School of Medicine. [397] From 1982 to 1993, he served as president of Meharry Medical College in Nashville, the nation's largest historically black, private institution dedicated to educating scientists, physicians and health-care professionals.

By the time Clinton was elected, Satcher was considered a national expert on the medically underserved. In 1993 – while Elders was Surgeon General – Clinton appointed

Satcher the director of the Centers for Disease Control and Prevention in Atlanta. Satcher had no background in public health, but quickly gained a reputation as a data-driven administrator and a steady, forceful voice on controversial topics. [398]

He pushed for progress combating teen-age smoking and in improving immunization rates. He helped persuade Clinton to issue an apology to the survivors on the Tuskegee experiment. And he championed CDC-funded research into the role firearms play in violent injuries and death – a cause that put him in the cross-hairs of gun advocates and forced him to contend with budget-restricting maneuvers by Congressional conservatives.

Phil Lee, serving as Assistant Secretary for Health under Clinton, cited Satcher's work on firearms violence as particularly courageous. He praised Satcher for "his willingness to take that on, his willingness to deal with people on the Hill who were confronting him about that, his willingness to work very hard to prevent the kind of clobbering of the program that would have occurred had he not been there." [399]

The White House saw Satcher as a potential Surgeon General early on, and HHS Secretary Donna Shalala approached him about the job after Elder's resignation. He turned her down for two reasons: First, he was still new at the CDC and wanted to accomplish some things before moving on. Second, although he understood the rationale for Elder's forced resignation, he was uneasy with the politically-charged environment surrounding the office at that point in time. "I didn't want to walk into that situation as I saw it in 1994," Satcher said. [400]

Combining roles

Meanwhile, the structure at HHS had been changing. Lee, who had helped create the Assistant Secretary for Health position as an administrative replacement for the Surgeon

General, was again the ASH and again believed there was a need for change. But this time the ASH position was seen as more of a problem than a solution.

“They got caught up in reinventing government – Al Gore’s thing of ‘let’s simplify government, take out the middleman, streamline,’” Thompson, the public affairs officer, recalled. In a re-organization, the directors of the CDC, NIH and other public health agencies started reporting directly to Shalala. Lee became chief advisor to the Shalala on health matters and took on a weaker, coordinating role with the public health agencies. [401]

When Shalala approached Satcher about the job of Surgeon General again in 1997, Lee was getting ready to retire. Lee advised Satcher to also ask for the ASH position. “He was saying ‘I believe one person can serve both roles,’” Satcher recalled. [402]

As a practical matter, there was a lot of upside to following Lee’s advice: It would guarantee that Satcher would be the top public health advisor to the Secretary, and though the ASH was in a weakened state, the position still commanded a larger budget and staff than what was available to the Surgeon General. Those resources would come in handy in issuing Surgeon’s General reports, which cost on the order of \$1 million each to produce. [403]

The down-side of the arrangement was that on some issues, a data-driven Surgeon General might be compelled to take one position and a politically-appointed ASH might be pushed to another.

Such a situation occurred only two months after Satcher became Surgeon General. While he was CDC director, the agency studied needle-exchange programs, an HIV-prevention strategy in which drug users can bring in used syringe needles and get clean ones. The research concluded needle-exchange cut the spread of HIV and did not contribute to increased addiction, and Satcher planned a press conference in April to tout the results.

“I remember the day we were getting ready to release it and shortly before noon – with reporters on the way – they got word from the White House that the President was going to oppose federal funding for needle exchanges,” Thompson said. [404]

The White House had decided that providing needles to drug addicts would send the wrong message. “Well, suddenly you’re in a touchy area there. You’ve got science that says this thing works. And you’ve got your President saying he’s not going to support funding for it.” [405]

With 15 minutes to decide, Satcher chose to go on with the press conference. He carefully and evenly explained the scientific conclusions and the President’s position. On this issue, he said, he disagreed with the President and with a House vote banning federal money from being spent on needle exchange programs. “They should find the funds,” Satcher told reporters. [406]

“It was really a proud moment for him. I knew we were going to be all right when he got through that day because it was really one of his first challenges and he just really laid it out there,” Thompson said. [407]

Satcher and the Bully Pulpit

In an interview last fall in Atlanta, Satcher suggested the needle-exchange decision wasn’t particularly difficult.

“I was a student here at the Morehouse College during the civil rights movement. I went to jail for what I believed. I did things in medical school that could have gotten me put out of medical school, like walking out on a rotation because I didn’t like the way the patients were being treated. I think my commitment throughout my life has been that if you believe that

something is right, you are supposed to do it, and you're not necessarily so much worried about what's going to happen to you," Satcher said. [408]

Nothing happened to Satcher for taking his stand on needle-exchange. Indeed, the Clinton Administration relied on him to lead a racial and ethnic health disparities initiative, which included a report on tobacco use among minorities that was issued just days after the needle exchange press conference.

In May, Satcher backed warning labels for cigars. In June, he called for televised condom commercials. In the months and years following, he addressed parents' concerns about mercury in vaccines, chided the public about habits that lead to obesity, urged state and local governments to hike cigarette taxes, and spoke about the impact of the media and gun accessibility on youth violence after the 1999 shootings at Colorado's Columbine High School.

Often, he found himself in disagreement with powerful politicians, business executives, religious leaders or others, but the controversy rarely seemed as heated as during the Elders era. Health officials who know the two said Elders is a dynamic, emotion-rousing speaker who was sometimes too quick with an opinion. Satcher was a bit more measured, a bit less inflammatory.

His academic and CDC credentials gave him gravitas, but his speaking style was also an asset, said Dr. Jeffery Koplan, who succeeded Satcher as CDC Director and heard him speak many times.

"I like David Satcher's style," Koplan said. "I enjoy his rhythm and cadence and low-key manner. I think it's low-key without being uninteresting, and low-key without being soporific." [409]

Satcher was a veteran Sunday school teacher accustomed to speaking in church, Thompson noted. “He’s not a thunderous fire-and-brimstone type of speaker. But he spoke with a calm authority, and he spoke seriously, and he was good at it,” Thompson said. [410]

Satcher’s speaking talents were put to frequent use. He put out seven Surgeon General reports – more than anyone since Koop. And he chose never-covered-before topics that prompted flurries of breaking news stories, second-day features and (mostly) laudatory editorials and letters to the editor.

One of his biggest splashes came in late 1999, when he issued the first Surgeon General’s report on mental health. The report was a careful review of earlier research, and concluded that 22 percent of the U.S. population had a diagnosable mental disorder. It also attacked the stigmatization of mental illness, and was hailed by advocates as a turning point in the government’s position on psychological conditions.

“This is a historic day,” said Michael Faenza, president of the National Mental Health Association, in an interview with *The New York Times*. “It’s wonderful that we have a Surgeon General talking about mental health and mental illness, in a voice that has not been used in Washington before.” [411]

A first-ever report on oral health was released the following May, noting that most Americans could expect to keep their teeth for life (thanks mainly to fluoride in drinking water) but disturbing disparities existed in the dental health of minorities and the poor. It too was hailed for putting a government imprimatur on efforts to combat a health issue many felt had been under-recognized. “We’re the stepchild of health care in the United States... We think this report will help change that,” said Robert Klaus, president of Oral Health America, said in an interview with *The New York Times*. [412]

A new administration

Satcher was in good standing with Vice President Al Gore, whose wife was an advocate on mental health issues – an interest stemming from depression she suffered following the death of their son from a car accident. In the midst of Gore’s campaign for the presidency, Washington insiders speculated that Satcher was a favorite to replace Shalala as Secretary of Health and Human Services under the new administration. [413]

However, George W. Bush emerged the victor and Tommy Thompson, the Wisconsin governor, was chosen as the new HHS Secretary.

There was no call for Satcher to resign his post as Surgeon General – he was, after all, a term appointment. But Satcher lost his political appointment as Assistant Secretary for Health, and the position was given to Eve Slater, an executive for Merck Research Laboratories.

Life in the Bush administration started fairly well for Satcher. When Thompson met HHS staff in January 2001, he was generous in his praise for Satcher. [414] And Slater was an intelligent but quiet person who did not fight Satcher for the spotlight. [415]

The relationship grew tenser in June, when Satcher decided to release a report on sexual health. It had actually been completed when Clinton was still in office. But Satcher was hampered from releasing it by leaders in the Clinton administration who were contending with the fallout from Clinton’s affair with a White House intern, Monica Lewinsky. [416]

The Clinton administration was not going to sign off on it, and neither were the Bush people. “It took me a while to figure out how to get it out,” said Satcher. [417] He settled on designating it a ‘Call to Action’ – a new, shorter kind of document that Satcher had started to issue when an official ‘Surgeon’s General report’ was deemed problematic.

Satcher briefed Thompson on it. Thompson did not endorse it, but he did not forbid it, either.

“I handed him this report and said ‘Tommy, I just want you to read this. I just want you to read it and tell me what you think.’ And he came back to me later and said ‘David, the American people need to read this report’ And then he said ‘But you know Washington better than I do, and you know that politically we’re going to have trouble with this report,’” Satcher said. [418]

“Now, I’m selective in my hearing sometimes so basically what I heard was ‘the American people need to read this report.’ So I started making plans to get it out. So I called him one day and told him that I had scheduled a press conference to release the report. I think he almost fainted on the other end of the line. But when he recovered he asked me if I would wait and I said, ‘Tommy you know, we’ve already paid the money for the hotel and everything to release this report so we’ve got a lot of people coming and so we’d rather not wait.’ He said ‘I’ll get back to you.’ So I guess he called the White House and then he said ‘David, go ahead but you’re on your own. I’m not going to be able to protect you in this one, you’re on your own,’” Satcher recalled. [419]

“We released the report about 10 days later. He didn’t sign off on it, he didn’t participate in the press conference, but he didn’t stop it, and I appreciate that,” Satcher said. [420]

In the report, Satcher said encouraging youth to abstain from sex was important, but schools and communities should also teach about birth control and support clinics that provide contraception. And though it said there’s wisdom in abstaining from sex outside of committed and monogamous relationships, it didn’t say that relationship had to be a

marriage. One more thing – the report said sexual orientation is established early in life and there’s no good evidence it can change.

Conservatives were outraged, and Bush quickly distanced himself from the Clinton appointee. “The President understands the report was issued by a Surgeon General that he did not appoint, a Surgeon General who was appointed by the previous administration,” Bush spokesman Ari Fleischer told the Associated Press. “The President continues to believe that abstinence and abstinence education is the most effective way to prevent AIDS, to prevent unwanted pregnancy.” [421]

Many political observers said any hope Satcher had of being re-appointed by Bush ended with that report. But nevertheless, the Bush administration found it had a critical need for Satcher’s gravitas a few months later, following the anthrax attacks of the fall of 2001 and a communication bungling by Secretary Tommy Thompson.

The Anthrax Attacks

Satcher was in Boston on Thursday, Oct. 4, to speak at a recognition ceremony held by World of Children, a non-profit organization focused on raising awareness of issues that affect children. [422]

In so many words, HHS officials called and explained that Bob Stevens – a Florida-based photo editor for a tabloid newspaper called The Sun – has been confirmed to have the inhaled form of anthrax. Inhalation was extremely rare. It was the first U.S. case reported in 25 years.

“No one told him to shut up about this. They just said, ‘You’re in Boston, here’s what you need to know, and the Secretary is going to be making a statement,’” said Damon Thompson, the press officer assigned to Satcher, who was with the Surgeon General on the trip. [423]

HHS Secretary Tommy Thompson did make a statement, that morning, at a White House briefing. Thompson was accompanied by Dr. Scott Lillibridge, Thompson's special advisor on bioterrorism, who had been the CDC's director on bioterrorism preparedness. [424] Lillibridge was not identified to the reporters as a bioterrorism expert, however, but only as another official from HHS. [425]

Thompson did nearly all the talking. He said the CDC had just confirmed the diagnosis of anthrax in a 63-year-old man in a Florida hospital, and it appeared to be an isolated case.

The press conference was being held less than a month after Sept. 11 terrorist attacks, and the first question from reporters was whether the man's illness was the result of terrorism. Thompson said there was no evidence of terrorism. [426]

He went on to say that the patient had traveled to North Carolina. A reporter asked about possible sources of anthrax infection. "That's why the doctor is here," Thompson replied, turning the microphone over briefly to Lillibridge, who said contact with wool and animal hides were possibilities. [427]

Then Thompson took back control of the microphone, and made a series of statements that would be cited for years afterward as a historic blunder in crisis communication.

Thompson volunteered that investigators know the man was an outdoorsman who, during his trip to North Carolina the previous week, drank water from a stream. Thompson said the case was still under investigation, and drinking water from a stream was only one possible explanation for the man's illness. But Thompson was very reassuring, his words more certain as the press conference went on that there was no need for others to worry. "This is an isolated case and it's not contagious," Thompson said. [428]

But it turned out not to be an isolated case, and Stevens' illness had nothing to do with drinking water from a stream. The next week, officials announced that an assistant to NBC News anchor Tom Brokaw had developed skin anthrax after opening a letter. Two days later, Senate Majority Leader Tom Daschle's office was quarantined after a letter containing anthrax was opened there. More reports streamed in about anthrax letters received at ABC News, *The New York Post* and other media companies. And on Oct. 17, 31 Congressional staffers tested positive for anthrax, the House of Representatives was shut down for testing. Panic had set in, as well as pointed criticism of the reassurances Thompson had offered earlier that month.

"Shooting from the hip with a definite answer is not a clever way to go... It's more credible to say, 'We can't yet make predictions about this or statements about that,'" said Dr. Sheila Jasanoff of Harvard University, in an Oct. 23 article in *The New York Times* that would be one of the first of many articles analyzing the government's handling of the anthrax crisis. [429]

Thompson was faulted for not only what he said, but also for being the one behind the microphone answering the questions. A politician with no formal training in medicine or public health, the HHS Secretary was an adherent of the Bush administration's 'One Voice' philosophy, which dictated that the administration speak with – and in many cases, through – one voice on health matters or other topics, said Damon Thompson, the Satcher press officer. [430] For about two weeks after the press conference, HHS public affairs staff funneled questions about anthrax to the Secretary's office. [431]

However, as the anthrax situation spiraled, HHS staff started using Satcher, CDC Director Jeff Koplan, NIH scientist Dr. Anthony Fauci and others to answer questions, with

several of them sometimes appearing together. “An explosion of spokespersons,” said Dr. Georges Benjamin, executive director of the American Public Health Association. [432]

That, too, was problematic, Benjamin said. “The national public health voice had gotten confused,” he said, adding that the situation was preferable in the late 1980s when Koop was the government’s recognized health authority. [433]

Dr. Mohammad Akhter, who was the APHA’s executive director at the time, said Satcher should have been running the daily briefings. “Our people (public health workers around the country) consider him our leader,” Akhter told one reporter in November 2001. [434]

How Satcher lost his job

Columnists and other observers later said Satcher was a natural point person for the administration on anthrax, given his CDC credentials and performance on other controversial topics, but that he was sidelined by the Bush administration because of its lingering distaste over the June sexual health report. [435]

Bill Pierce, who was HHS Deputy Assistant Secretary for Public Affairs under Sec. Thompson, offered a different explanation. He said Thompson was accustomed to speaking for whatever organization he was heading up and the department did the best it could to deal with a complicated and spiraling public health emergency that was also tied to a criminal investigation. [436]

In early November, Satcher told reporters that he would not seek re-appointment when his term expired in February 2002. He remained active in the bully pulpit, addressing health disparities, obesity and a range of other topics in his final months.

His last week in office, he met with reporters and voiced concern about what would happen to the Office of the Surgeon General after his departure. He noted the office's \$1

million budget did not cover the cost of even one surgeon general's report, and the lack of a "meaningful budget" would damage the office. It was essential, he said, to have a doctor who is "independent enough to report directly to the American people on the basis of public health and science." [437]

Satcher is proof positive of the Great Man Theory, using his government experience, speaking skills and personal integrity to pursue first-of-their kind reports and statements on issues ranging from mental health to sexual health to needle-exchange programs.

The Long Leash Theory also applied: He thrived in office in the first part of his term because he was given a fair amount of freedom by the Clinton administration. Under the more restrictive Bush administration, he was somewhat less visible – especially during the anthrax crisis.

His successor encountered similar difficulties. Satcher was replaced by a doctor known as a hard-charging Green Beret who, nevertheless, would virtually disappear into the government bureaucracy.

DR. RICHARD CARMONA, 2002-2006

If ever a candidate seemed destined to be a bold new voice in the Office of the Surgeon General, it was Dr. Richard H. Carmona.

Carmona grew up in Harlem, was a Green Beret in Vietnam, and gained national attention in 1992 when he rappelled from a helicopter to rescue a person stranded on a cliff – inspiring a made-for-TV movie. [438] He was a trauma surgeon, a SWAT team member and a professor at the University of Arizona.

Some colleagues in Arizona called him confrontational and out-spoken, an assessment he agreed with. Republicans liked him because he was a law-and-order type committed to

working on bioterrorism and emergency preparedness (and, by the way, was neutral on the issue of gun control). [439] And Democrats thought he seemed enough of a maverick to be a strong and independent voice within the Bush administration.

“We need a strong and independent Surgeon General who will put public health first, and leave politics and ideology well behind,” said U.S. Sen. Edward M. Kennedy of Massachusetts, in a July 2002 statement welcoming the 52-year-old doctor to the job. [440]

For his part, Carmona was giddy as a child about the opportunity. “It is as if the fairy godmother reached out and touched me and cast me in the best Disney movie ever made,” Carmona said at the time of his confirmation hearing. [441]

But Carmona’s four-year term would prove to be more like a horror film that nobody went to see, according to many public health veterans.

When it was over, Carmona and a few others would detail how he was tightly muzzled by the Bush administration after his first year in office, with speaking engagements canceled, reports suppressed and his bully pulpit virtually cordoned off.

Many in the general public, meanwhile, would react to news reports of Carmona’s post-term disclosures with a collective; “Who?”

Carmona was a “do-nothing Surgeon General. He faded into the woodwork for whatever reason,” said Kim Elliott, deputy director of Trust for America’s Health, a Washington, D.C. based public health research organization. “He was M.I.A.” [442]

A street fighter

Richard Henry Carmona was born in Harlem on Nov. 22, 1949. A self-described street kid from a poor Puerto Rican family, he dropped out of high school. But after talking to an

Army Special Forces officer who was passing through the neighborhood, he decided to talk to an Army recruiter and, at age 17, enlisted. [443]

“In retrospect, it was the best thing I ever did,” Carmona would say years later in speeches, as he recounted his life story. “It gave me a platform to be successful the rest of my life.” [444]

He was sent to Vietnam, where he was a medic and became a member of Army Special Forces. He lost three good friends in combat, and earned two Purple Hearts, a Bronze Star and other service awards and decorations. When he got out of the Army, he married his childhood sweetheart and decided to go to college and become a doctor.

He attended the University of California-San Francisco, and struggled at times. “I had average intelligence, but I had a great deal of tenacity... It’s something Special Forces instills in you,” Carmona said. [445]

Carmona graduated with a bachelor’s degree in biology and chemistry in 1976, and a medical degree from the same university in 1979. After completing residency and fellowship in San Francisco, he moved to Tucson, Arizona in 1985, recruited by Tucson Medical Center to lead the region’s first trauma care program. In 1986, he became a doctor for the Pima County Sheriff’s Department and a leader of its SWAT team. [446]

He became something of an action hero in the 1990s because of two incidents. In 1992, he was part of a helicopter rescue team that responded when another helicopter crashed on a mountainside. Carmona was lowered down and carried a survivor to safety.

Then, in 1999, while driving to work, Carmona stopped at the scene of a traffic accident, where a man driving a pick-up truck had hit another vehicle and was threatening the other driver with a gun. Carmona ordered the man repeatedly to put down the gun. The man – Jean

Pierre Lafitte – fired at Carmona, grazing his scalp. Carmona fired back seven times. Three shots hit Lafitte, who died. A few hours later, Lafitte’s father was found stabbed to death, and investigators concluded Lafitte had killed him earlier that day. [447]

Carmona also was a veteran of management conflict. He was fired from Tucson Medical Center in 1993, and he filed a wrongful termination lawsuit. In court documents, TMC officials said Carmona had alienated doctors and administrators with his “street-fighter” attitude. Carmona said he was fired for protesting illegal and unethical practices at the hospital, including what he claimed was substandard care by another doctor and unnecessary consultations by other physicians. [448]

The suit was settled two years later, with Carmona receiving \$3.9 million and a full-page newspaper advertisement in which the hospital apologized and praised his skills. [449]

Despite the legal turmoil, he was hired in 1994 to run the financially-troubled Kino Community Hospital. Carmona eliminated the hospital’s operating deficit in two years, but financial reports later showed that a mounting balance of uncollectible accounts made Kino seem like it had more money than it actually did. His forced resignation in 1999 prompted him to say; “I’ve exposed problems, and now I’m being held responsible for those problems.” [450]

Carmona was teaching surgery, public health, and family and community medicine at the University of Arizona when Bush selected him in 2002.

Proponents, thinking of the recent terrorist attacks, focused on his law enforcement experience as an asset. “That background is particularly valuable at this time,” said Sen. Jeff Sessions, an Alabama Republican, at the time of Carmona’s confirmation hearing. [451] His

management conflicts were raised at his confirmation hearing, but the Senators quickly moved on, and Carmona was approved without opposition or debate. [452]

Carmona and the Bully Pulpit

Carmona's term began with an emphasis on preventing disease, correcting racial health disparities and preparing the nation for crises. His first full month on the job – September 2002 – included meetings at the White House and Pentagon, an event at the National Press Club, speaking engagements in California, Arizona and Illinois.

Eve Slater, the Assistant Secretary for Health who supervised Carmona, was by many accounts a reasonable but quiet administrator who was content to let Satcher use his bully pulpit and did not try to restrict Carmona, either.

And Carmona proved to be a very good speaker. He had a standard talk in which he narrated his life story with humor, humility and passion, and then finished with a short discussion of health disparities or some other health topic. "He had a very good, effective story to tell and he used that effectively in getting across messages," said Bill Pierce, who served as Deputy Assistant Secretary for Public Affairs from 2001 to 2005. [453]

A problem, critics later said, was that the script never changed much. "I think Carmona gave the same speech every time," said Dr. Jeffrey Koplan, who was CDC Director from October 1998 to February 2002. "It's a nice story – up from a tough neighborhood, poor background, rose through this and did all these things and now look where he is... But after a few times, you got it, and you gotta move on to something else." [454]

Another problem was that his health topics – important issues like health disparities and health literacy – were not appetizing to the press, observed Dr. Georges Benjamin, executive director of the American Public Health Association.

The topic of health disparities was a particularly hard sell. It was old news in that it had been addressed before, extensively, by Satcher. It was complicated, too: “It’s not a 30-second sound bite,” Benjamin said. “They (the media) just simply didn’t cover it,” he said. [455]

So for various reasons, Carmona started out as somewhat quieter Surgeon General than his recent predecessors. But two things would happen in June 2003 that many say would mark a turning point in Carmona’s ability to use the bully pulpit.

The first occurred in early June, during a Congressional hearing on smokeless tobacco and ‘reduced risk’ tobacco products. Carmona made strong statements about the dangers of tobacco. U.S. Rep. Ed Whitfield, a Republican from the tobacco-growing state of Kentucky, at one point asked Carmona if he would support the abolition of all tobacco products. “I would at this point, yes,” the Surgeon General replied. [456]

There was little reaction from the legislators after he said it, but Whitfield later said he was disappointed and shocked at Carmona’s sweeping condemnation. “I’ve never heard anything like that from any public official” or even from anti-tobacco advocates, Whitfield said. [457]

The White House quickly distanced itself from Carmona’s comments. “That is not the policy of the administration,” White House spokesman Scott McClellan told reporters later that day. “The President supports efforts to crack down on youth smoking, and we can do more as a society to keep tobacco away from kids. That’s our focus.” [458]

It quickly became conventional wisdom in Washington that Carmona, who had not been a particularly high-profile Surgeon General to begin with, was put on a much tighter leash following the hearing. “He went off his script and he really took on the industry... I think he was muzzled after that,” said Kim Elliott of Trust for America’s Health. [459]

It proved to be an unfortunate event that was as much Whitfield's fault as Carmona's, Benjamin said. "Why would you, a legislator (from a tobacco state), ask the Surgeon General of the United States that question? That's a silly... don't get me started," he said. [460]

A second turning point was a change in management within HHS. Slater had left the Assistant Secretary for Health job in February, and was replaced in July by Dr. Cristina Beato. By all accounts, Carmona and Beato did not get along.

Critics of Beato say she had a very Republican ideology that clashed repeatedly with Carmona. She pushed him to give more credit to the White House in his speeches, and began to exercise a level of bureaucratic control that Carmona hadn't experienced before, according to Pierce and other sources. [461]

"He and Cristina Beato could not get along if they were the last two people on the face of the earth. They would kill each other rather than cooperate. It was as ugly as anything I've ever seen," said one person who worked with both and recalled incidents in which they screamed at each other. On one occasion at an event in Philadelphia they were nose-to-nose and, it seemed, nearly at blows, the official said. (The source shared recollections about some of the more confrontations between Carmona and Beato on the condition that the information not be attributed.)

Carmona was not Beato's only problem. In the summer of 2004, press reports detailed a series of questions about her resume. Discrepancies in her credentials included her uncorroborated claims that she had a master's degree in public health from the University of Wisconsin, that she had published a scientific paper on inert gases, and that she had been a medical attaché to the U.S. Embassy in Turkey. [462]

Her Senate confirmation was delayed while Senators sought answers to what increasingly appeared to be a series of fabrications. In 2005, she left the post and was replaced by Dr. John Agwunobi, a public health official from Florida.

By that time, when Carmona appeared in the national media, it was usually as part of a group of federal health officials appearing together at a press conference – and his comments did not challenge the party line.

One example: In June 2005, he appeared with CDC and NIH officials and Lynn Swann of the President’s Council on Physical Fitness and Sports at a press event to discuss obesity and the environment. It was billed as a Surgeon General’s press conference but NIH official David Schwartz acted as the emcee, and Schwartz and the others did most of the talking. One exception came when a question was addressed specifically to Carmona concerning the government’s continuing focus on individuals and their personal responsibility for fitness. The question: Besides haranguing people to eat right and exercise, wasn’t there something more the government could do to attack the problem, perhaps through regulation? “As far as regulatory issues, yes, sir, that is above my pay grade,” Carmona replied. [463]

The pattern held true in the days after Hurricane Katrina hit the Gulf Coast, an occasion in which Carmona’s oversight of the Commissioned Corps might have been on full display.

Carmona and the Commissioned Corps

The military had turned Carmona’s life around when he was a young man, and he quickly took to the position’s military vestments.

The Commissioned Corps was a historic sub-component of the Public Health Service that had been re-invigorated under C. Everett Koop. Koop wore the Navy-model uniform accorded to the Surgeon General, which by virtue of title was a three-star admiral in the

Commissioned Corps. Koop required others to wear the uniform more often, too, and promoted recruitment to the Corps and revised mobilization guidelines.

Carmona had similar goals. He wore the uniform, worked to instill pride in the Corps and was a happy participant in the many ceremonies and traditions that went with being a Corps member. He also spoke frequently with officials in the Department of Defense to improve relations between the Commissioned Corps and other uniformed services, said Jerry Farrell, executive director of the Commissioned Officers Association of the U.S. Public Health Service. [464]

Carmona “emphasized the uniform service identity very heavily, and struggled mightily to do as much as he could to recentralize his authority over the Commissioned Corps,” Farrell said. [465]

However, under Beato’s authority, the responsibilities for Commissioned Corps compensation and other personnel issues were split up and distributed to different HHS officials. “Nobody was quite sure any more who was in charge,” Farrell said. [466]

When Hurricane Katrina hit the Gulf Coast, it was necessary to mobilize Commissioned Corps members who were working at the CDC, the Indian Health Service and other federal public health agencies. Though Carmona was the titular head of the Corps, he did not simply call up people and send them out. The HHS Assistant Secretary for Public Health Emergency Preparedness coordinated the personnel response to the disaster, telling Carmona how many people were needed in what location for what purpose, and he put together which individuals made the trip. [467]

About 2,000 officers – or roughly a third of the Commissioned Corps – were deployed for Katrina. [468] Carmona went to the Gulf, too, as part of a touring group of Bush

administration officials that included Mike Leavitt, a former Utah governor who had replaced Tommy Thompson as HHS Secretary in 2005.

Carmona appeared at press conferences, but usually as one of several officials standing on stage. Someone else would do most of the talking – as Department of Homeland Security Secretary Michael Chertoff did at a Sept. 3 press conference on hurricane relief, or Leavitt and CDC Director Julie Gerberding did at a Sept. 6 press conference on the public health response. [469]

When he was one on one with a reporter, he frequently would get asked why he didn't stand out more, as Koop and Elders had. When the question came in a November 2005 interview with The Houston Chronicle, he answered this way; "I'm the 17th Surgeon General of the United States and, of those (other Surgeons General), only a couple had to step up and take a very forcible, visible, vocal position. I think you choose those moments wisely because you don't want to expend your political capital if you can move the agenda another way." [470]

How Carmona lost his job

Carmona put out three reports during his term. Two were released in 2004 – the first was a report on smoking and health that concluded that smoking causes illness in nearly every organ of the body; the second gave statistics and predictions about the prevalence of osteoporosis.

Though praised by some health advocates, Carmona's reports did not get the kind of media attention that accompanied the higher-profile reports of Satcher, Elders, Koop, Richmond and Steinfeld. As his first term drew to a close, he worked hard to get at least one more major document out.

He succeeded. In late June, Carmona released his final report, which addressed the health hazards of secondhand smoke. The report looked back on two decades of studies and concluded that even trace amounts of cigarette smoke is dangerous to non-smokers.

“The debate is over as far as I’m concerned,” Carmona told the media. “Based on the science, I wouldn’t allow anyone in my family to stand in a room with someone smoking.”

[471]

Carmona got what would be his biggest media splash since his ‘ban all tobacco products’ comment in 2003. Anchorman Charles Gibson lead the *ABC World News Tonight* broadcast that evening with news of Carmona’s report, emphasizing the finding that even a brief exposure to smoke could cause harmful cellular changes, and noting the report likely would be important ammunition for advocates across the country pushing for local smoking bans.

[472] Carmona was on CBS’s *The Early Show* the next morning, advising co-host Hannah Storm not to go into any room where someone was smoking. [473]

“I think that Carmona saw this report as the crowning achievement of his time as Surgeon General,” said Dr. Arthur Kellermann, an Atlanta-based emergency medicine specialist who recently finished a fellowship as a health policy staff member for U.S. Rep. Henry Waxman.

[474]

That report was a major accomplishment, said Dr. Harmon Eyre, former medical director of the American Cancer Society. “It will change the landscape of the debate,” Eyre said, in a 2007 interview. [475]

Others were less impressed. Many newspapers played the story inside, noting that Surgeons General had been warning of the dangers of second-hand smoke since the 1970s. Some public health experts said a national push for local smoking ordinances was already

well underway, and reacted to the report with a shrug. They noted it did not lead to Congressional briefings, as was customary in the wake of past Surgeon General reports. And it did not help along any federal tobacco-control legislation, said Sherry Kaiman, who at the time was a staffer for U.S. Sen. Christopher Dodd of Connecticut.

“There was nothing” in terms of the report’s impact on Capitol Hill, said Kaiman, who is now director of policy development at Trust for America’s Health. [476]

It apparently also had little immediate impact on the general public. A Gallup poll conducted in early July, less than two weeks after the release of Carmona’s report, found attitudes were basically unchanged on the subject, with about 56 percent considering secondhand smoke to be very harmful, about what a similar poll had shown the previous summer. [477]

About six weeks later, Carmona’s term expired. HHS officials who knew him said they believe he had hoped to be reappointed to a second term, but as the date approached, he heard nothing from the Bush administration. “They were moving boxes out of his office and he still hadn’t been told officially from the President that he was not to be renewed,” said Dr. Karen Near, who served as Carmona’s senior science advisor. [478]

Finally, Carmona announced he was resigning, though he offered no specifics of what he would do next. HHS officials made no announcement about it, and referred questions to the White House, which declined to comment. [479] Asked about it in an interview three months later, Carmona said he had no idea why the administration declined to renew him. [480]

Near and other colleagues said Carmona had carried out his job with honor, and lamented that no proper appreciation ceremony marked his departure from office.

Others said the relative silence over his departure was apropos of his entire term.

“It’s hard to remember another Surgeon General who was so largely invisible as he has been, and that’s a tragedy,” said Dr. Sidney Wolfe, of Public Citizen’s Health Research Group, in an interview with *The Arizona Daily Star*. [481]

Carmona Speaks Out

Carmona did not quietly fade away after leaving Washington, however. In January 2007, while speaking at the annual dinner of the Public Health Service Commissioned Officers Foundation, he made pointed comments about the Bush administration. “I increasingly witnessed a government that was more and more using theology and ideology to drive its policies and its people: stem cells, abortion, Plan B, the war and many more,” he said. [482]

Kellermann was there, and relayed the comments to Waxman’s office. In July 2007, Waxman convened a hearing on the office of the Surgeon General in which Carmona, Koop and Satcher appeared together. Each talked about moments when the presidential administrations they served under hindered their attempts to use the bully pulpit. But Carmona gave examples never discussed publicly before, and was clearly the star of the show.

He said his speeches were vetted and censored by HHS officials, and he was prohibited from talking about the ‘Plan B’ emergency contraception drug, stem cell research and other topics. “In fact, I had two speechwriters that ultimately quit because they were so intimidated and browbeaten by appointed officials who would vet my stuff and rewrite it,” Carmona said. [483]

He said he was not allowed to speak freely with reporters. He said he was pushed to speak at events benefiting Republicans, but wasn’t allowed to make a speech at the Special Olympics because of the program’s long-standing association with the Kennedy family. And

he said he was prohibited from pursuing his wish to issue reports on emergency preparedness and mental health. Reports on prison health and global health were also suppressed. [484]

The global health report was particularly galling to Carmona and some of his colleagues. Some perceived the villain to be William Steiger, a 30-something political appointee who headed the HHS Office of Global Health. He had once worked for Thompson, and his family had ties both to President Bush and to Vice President Cheney. Carmona didn't name Steiger, but his testimony suggested that Steiger was the official who prohibited Carmona from mentioning global warming and pushed the Surgeon General to spend more of the report talking about how the United States had helped people in Iraq and Afghanistan and other countries. [485]

An HHS spokesman told reporters that Carmona's report was never published because the science was poor. [486] Pierce, the former press officer, said he believed it was Steiger's staff who really did the rewrite and that Steiger is a "good and capable guy." [487]

"My advice to Carmona was 'Screw Steiger. Publish it. Who's going to stop you?'" said Farrell, the head of Commissioned Officers Association.

"You know, he was more cautious than that, probably because he has aspirations for something beyond Surgeon General," added Farrell, who noted Carmona's name had been floated as a candidate for political office in Arizona. [488]

Koop, the former Surgeon General, said Carmona used to call him for advice. Koop said he gradually formed the opinion that Carmona did not want to take a step that might cost him his job. "Carmona – he plays by the rules, and he's afraid to get fired," Koop said, in a July 2006 interview, near the end of Carmona's term. [489]

Some applauded Carmona for finally coming forward, and said they could understand an impulse to stay in office and accomplish at least some things rather than simply walk away in disgust.

Fitzhugh Mullan, the public health historian, gave good marks to Carmona for his efforts to revitalize the Commissioned Corps and said it is no small matter that he opened up at the Waxman hearing. “The fact that he came forward and described the ways that his issues were handled, I think, is important. I think it brought public attention to this area of political management,” Mullan said. Indeed, Carmona may be remembered for having done his most important work as Surgeon General after he left office, Mullan said. [490]

Others said it was too little, too late. Carmona could have quietly told members of Congress while it was going on, or made a more public stand, said Jeff Levi of Trust for America’s Health.

Surgeons General have multiple options for voicing their concerns while still in office, he argued. “When these things are happening to you, at a certain point you give voice to that,” Levi added. “He’s wanting us to see him as a hero in retrospect.” [491]

Carmona was a textbook example of the dark side of the Long Leash Theory, with tight restrictions from the Bush administration effectively keeping him muzzled. Some say the Chorus Theory may also have been in play during his term, with Gerberding being seen as a more useful and trustworthy communicator by HHS leaders and as credible by the public.

ENDNOTES

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[18] Furman, pg. 199.

[19] Pictures of Wyman can be found in Furman on pgs. 200 and 259. Picture of Blue can be found on pg. 53 of Mullan.

[20] Mullan, pg. 80.

[21] Dearing, W.P., *Oral history: Interview of Dr. Warren Palmer Dearing by Fitzhugh Mullan*. Interview conducted on Oct. 21, 1988. This is one of dozens of oral histories with former federal public health officials that are on file the Office of the Public Health Service Historian, U.S. Department of Health and Human Services. Pg. 19 of the transcript.

[22] Furman, pg. 399.

[23] Lee, P., *Key informant interview, Philip Lee interviewed by Mike Stobbe, Saturday, Oct. 27, 2007*. Telephone interview. Pg. 2 of the transcript.

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[34] Ibid.

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[36] HHS Parran biography Web site.

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[38] The examples come from the Dearing oral history, pg. 19, and Furman, pg. 459.

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[43] Mullan, pg. 131.

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[45] Ibid.

[46] Offit, Paul A., *The Cutter Incident*. 2005, New Haven, Conn.: Yale University Press. Pgs. 60-63.

[47] Ibid, pg. 79.

[48] Ibid, pg. 98. Note: I relied on Offit, although historical accounts vary. For example, Mullan said six companies were licensed, not five, and he that Scheele’s statement was made on May 7, not 6. I sided with Offit because his research focused on the Cutter incident and appears more comprehensive.

[49] Ibid, pg. 100.

[50] Ibid, pg. 118.

[51] Miles, R.E., pg. 33.

[52] Offit, pg. 113.

[53] Dearing oral history, pg. 26.

[54] Ibid. But note here's another topic on which accounts differ. Offit, pg. 118, said he was fired.

[55] Stewart, W., *Oral history: Interview of Dr. William Stewart by Fitzhugh Mullan*. Interview conducted on Sept. 28, 1988. This is one of dozens of oral histories with former federal public health officials that are on file the Office of the Public Health Service Historian, U.S. Department of Health and Human Services. Pg. 30 of the transcript.

[56] Sencer, D., *Key informant interview, David Sencer interviewed by Mike Stobbe, Tuesday, Sept. 25, 2007*. In-person interview, Decatur, Ga. Pg. 2 of the transcript.

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[60] Miller, C., *Oral history: Interview of Charles Miller by Fitzhugh Mullan*. Interview conducted on Aug. 24, 1988. This is one of dozens of oral histories with former federal public health officials that are on file the Office of the Public Health Service Historian, U.S. Department of Health and Human Services. Pg. 3 of the transcript.

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[64] Parascandola speech, pg. 7.

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[71] Lee key informant interview, pg. 14 of the transcript.

[72] Stewart oral history, pg. 42.

[73] Ibid, pg. 37.

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[79] Hatch/Kelso oral history, pg. 63.

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- [89] Lee key informant interview, pg. 3 of the transcript.
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- [91] Mullan, pg. 158.
- [92] U.S. Department of Health and Human Services' *Historical Profile of the Leadership of the Public Health Service*. Pg. 7.
- [93] Hatch/Kelso oral history, pgs. 57-58.
- [94] Silver oral history, pg. 18.
- [95] Lee oral history, pgs. 30-31.
- [96] An assessment voiced by Silver in the Silver oral history, pgs. 25-26, but also in R.E. Miles' book, pg.193.
- [97] From Silver oral history, pgs. 25-26, and Lee oral history, pg. 42.
- [98] Silver oral history, pg. 43.
- [99] Mullan, pg. 158.
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- [101] U.S. Department of Health, Education and Welfare, *U.S. Department of Health, Education and Welfare 1968 Annual Report*. 1968. Washington, D.C.: U.S. Government Printing Office. Pg. 73.
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[123] Ehrlich oral history, pg. 20.

[124] Miller oral history, pg. 20-21.

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[176] Miller oral history, pg. 34.

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CHAPTER 4

ANALYSIS AND DISCUSSION

In this chapter, I will first present the results of a survey of health journalists regarding the credibility and newsworthiness of the Surgeon General as contrasted with other federal health officials who communicate health messages to the public. The survey will begin with an abstract of the findings, and then a full description.

Then I will present a discussion of themes I saw develop from key informant interviews, archived documents, the survey and other sources.

PART A: SURVEY OF HEALTH JOURNALISTS

Context: Anecdotally, some observers say the U.S. Surgeon General has lost visibility and status in recent years as a primary federal communicator of public health messages.

Journalists are seen as a primary conduit – a megaphone, of sorts – of government health messages.

Objective: To survey journalists with the most experience reporting on government public health and health policy, and ask their opinions about the credibility and newsworthiness of different federal health officials.

Design, Setting and Participants: The Association of Health Care Journalists, with 1,023 U.S. members, is the largest journalists-only group of media professionals covering medical issues, health care, public health and health policy. Through e-mail messages posted on the Association's listserv in fall 2007, AH CJ members were invited to take an anonymous Web-based survey.

Results: The Director of the Centers for Disease Control and Prevention was seen as the most newsworthy and most credible of six prominent U.S. health officials, according to the journalists surveyed. In comments, many journalists said the way they ranked health officials depended at least in part on whether they believed the health official would provide accurate and complete information even in situations where doing so would run counter to political considerations. The Surgeon General was most often ranked near the bottom in both credibility and newsworthiness.

Conclusion: In the survey, the Surgeon General was often perceived as being among a group of HHS officials who are influenced by politics and so are considered as sources with relatively low credibility.

The influence of the media in U.S. society is widely recognized. “The mass media’s ability to set the public agenda and amplify and lend legitimacy to the voices and views of our nation’s political debates render them essential participants in social change of any kind,” as Lawrence Wallack and his co-authors stated in their text *Media Advocacy and Public Health*. [1]

Journalists play many roles – such as dispassionate informer, conscientious watchdog, cheeky entertainer and incendiary editorialist. But in their coverage of government, they also serve as megaphones for authority. That role is the focus of this chapter.

Reporters are not stenographers. Journalists evaluate what government sources tell them, choosing the most useful or important information to their readers, listeners and viewers, and dropping the rest. Although journalists may be directed to certain spokespersons by government agencies, the reporting process involves making decisions about which sources to approach and how prominently to quote them in the story.

There is little in the peer-reviewed literature about how journalists view different federal health officials in terms of their value as a source of information. This survey study attempts to fill that gap, with the additional motive of learning journalists' views of the U.S. Surgeon General (the subject of this dissertation).

Methods

Participants

In the United States, there are thought to be approximately 116,000 professional journalists working for mainstream news media in 2002, according to a survey study by Weaver et al. [2] The study estimated that about 1,700 covered "health and family" issues, although no more specific breakdown was made. [3]

The exact number covering health issues, including medical science, health care business, public health and government health policy, has not been studied. But rough estimates by professional associations put the number at about 3,000. [4] Given that Weaver's work did not incorporate freelancers or other health reporters not in mainstream media, the 3,000 estimate sounds plausible.

Many professional health journalists belong to one or several professional associations, some of which – like the American Medical Writers Association and the National Association of Science Writers – also include people who work in media relations and public affairs.

In 1998, a group of reporters founded the Association of Health Care Journalists in an attempt to create a new, journalists-only professional group. AHCJ has grown steadily, and now has a membership of more than 1,000 members. It is the largest health-journalists-only association in the United States.

I am an AHCJ member, and an elected member of the AHCJ Board of Directors. In the summer of 2007, I approached the organization's executive director and other members of the governing board about my hope to survey AHCJ members for this dissertation project. After receiving their consent, I posted an e-mail invitation to participate on Sept. 27. Follow-up e-mail requests were posted on Nov. 1 and Nov. 29.

The survey was reviewed and approved by the UNC IRB, as was the wording of the first solicitation e-mail posting and of the follow-up solicitation postings.

Survey Content

I asked 12 questions in a survey designed to take only five to ten minutes. The first six were demographic in nature, asking the respondent to give his or her gender and age. They also were asked whether they were a full-time employee of a media organization (many AHCJ members are freelancers); what type of media company is their primary employer; what type of health issues do they focus on (medical science and research, health care business, public health and health policy, or a mix); and how long they've been doing health journalism.

The next two questions were designed to check how often respondents interacted with the health officials they are being asked about. The intent was to see if there's a difference in the perceptions of those who regularly interview federal health officials as compared to the views of health journalists who don't often deal with the government.

The next two questions asked journalists to rank six prominent federal health officials in terms of their newsworthiness, and then in terms of their perceived credibility. The six – director of the U.S. Centers for Disease Control and Prevention; director of the National Institutes of Health; director of the NIH's National Institute of Allergy and Infectious

Diseases; U.S. Surgeon General; U.S. Secretary of Health and Human Services; and Assistant Secretary for Health at the U.S. Department of Health and Human Services.

The final two questions were open-ended, asking respondents to look at the two officials they deemed most credible and explain why, and to do the same for the two officials they deemed least credible.

Admittedly, “newsworthiness” and “credibility” are two imprecise measures. Newsworthy is generally defined simply as timely and important or interesting, and opinions about what is newsworthy are formed by a journalist’s own experiences and interests as well as their view of the judgments of editors and of the journalists’ audience. Credibility is commonly defined as believability, or the quality of being a trustworthy source of accurate information.

Newsworthiness and credibility are not synonymous – for example, White House reporters may dutifully cover a President because of his importance/newsworthiness, even if they question the accuracy of his statements. But they may also seek out other sources they see as credible, even if that source is lower and in the government hierarchy.

Statistical Analysis

A simple analysis was done using tools available on Microsoft Access and Excel.

Results

I used SurveyMonkey, a popular Web-based survey service.

The survey netted 103 responses, a small result representing about a 10 percent response rate for the 1,023-member Association. That is low, but considered to be in the customary response rate range for mailed questionnaires. [5]

SurveyMonkey records the Internet Protocol address of each person taking the survey to guard against an individual taking the survey multiple times. An IP address is a unique address that certain electronic devices use to identify and communicate with each other. It's commonly thought of as a unique identifier for each computer, but servers, printers, some telephones and other machines can have IP addresses.

There were duplicate IP addresses among the responses. Four responses came from one IP address, three from two others, and two from three others.

I was unable to track the responses back any further – SurveyMonkey did not provide e-mail addresses, names or additional identifying information for each respondent to this anonymous survey.

I carefully compared each response from these IP addresses. I considered the possibility that perhaps some respondents timed out or aborted an initial attempt to take the survey, but came back to complete it, listing answers that were consistent with the earlier attempt. I also looked for signs of different complete responses, including age, sex and other identifying information: It's possible two different people used the same machine, perhaps a husband and wife pair of journalists who use the same home computer, or two people at the same workplace.

I e-mailed a detailed report on the different responses to Ned Brooks, my dissertation committee chair, and gathered his advice on which it made sense to include and which to exclude.

Based on that consultation, I prepared an analysis that excludes seven responses.

Analysis – 96 responses

This is how the 103 responses were whittled down to 96: In instances where multiple responses came from the same IP address, responses were kept that identified as different individuals in terms of age, sex, place of employment and/or other characteristics. In a case in which the same person appeared to be trying to answer multiple times, all the responses were dropped from the analysis.

Each survey participant did not answer every question. Most answered demographic questions, but fewer answered the later questions about how often they interview health officials, and fewer still ranking health officials in terms of newsworthiness and credibility. Of the 96 responses, 95 (99 percent) answered all of the demographic questions; 73 (76 percent) answered all the questions about how often the interview health officials; 72 (75 percent) answered the rank-the-officials questions in accordance with directions.

Responding journalists were predominantly women (58 of the 94 who answered the question about gender, or 62 percent). That's consistent with AH CJ membership's demographics – 61 percent of the Association members are female, according to an AH CJ census that includes gender information on about 75 percent of the membership. [6]

Most were employed by newspapers (34 percent) or were freelancers/self-employed (26 percent). That is similar to AH CJ's overall membership – about 40 percent of the Association's members have identified themselves as newspaper journalists, and 24 percent as freelancers/self employed.

In terms of age, the largest group (34 percent) was in their 50s. The next largest groups were people in their 40s (26 percent), those in their 30s (17 percent), and those under 30 (13

percent). There is no AH CJ breakdown of the membership by age, or by what type of health coverage they specialize in.

Of particular interest was the breakdown of how often people interview federal officials. Those who interview federal officials a few times a month or more are the most likely to cover the kinds of issues and announcements for which the Surgeon General or other health officials would act as spokesperson.

Of those 73 that answered the question about how often they interview federal health officials, 23 _ or 31.5 percent _ said they interviewed federal health officials a few times a month or more. That suggests that many of the responses on the newsworthiness and credibility of different federal health officials were from journalists who based their opinions less on recent, direct observations than on past experiences or on perceptions formed in other ways.

In total, 73 of the respondents answered the questions asking them to rank different health officials by newsworthiness and credibility. However, respondents were supposed to give a No. 1 vote to only one of the officials, a No. 2 vote to only one, etc. One respondent gave No. 1 rankings to several officials in each question, so her response was not counted. That left 72 – including all of the 23 who said they interview health officials a few times a month or more.

For the overall group, the CDC Director (currently Dr. Julie Gerberding) was ranked No. 1 in terms of newsworthiness in 42 responses. That means 42 of the 72 responses (or 58 percent) that did do rankings put CDC Director at the top.

The results were similar in rankings in terms of credibility: CDC Director was ranked No. 1 in 41 (or 57 percent) of the responses that answered this question.

In the newsworthiness rankings, no other position came close. The next highest was the Secretary of the U.S. Department of Health and Human Services, who was ranked No. 1 in 10 of the responses. The rest – the NIH Director got six first-place votes for most newsworthy, the NIAID Director got six, the Surgeon General six, and the HHS Assistant Secretary for Health got one.

In the credibility rankings, the CDC Director again was ahead by a large margin. The NIAID Director (currently Dr. Tony Fauci) was next, with 19 of the responses listing him No. 1. The NIH Director was listed as most credible in six of the responses; the Surgeon General in three; the HHS Secretary got two and the HHS Assistant Secretary for Health in one.

It's worth noting that the Surgeon General was ranked least credible in 13 of the 73 responses that did rankings, or 18 percent. The Assistant Secretary for Health was ranked least credible in 28 of the responses, and the U.S. Secretary of Health and Human Services was ranked the least credible the most often, in 27 responses.

I created a scoring system: Looking at the Surgeon General in terms of newsworthiness, the scoring was 1 (for ranking) x 6 (for the number of journalists ranking Surgeon General a No. 1 in newsworthiness), then that was added to 2 (ranking) x 18 (number of journalists giving the Surgeon General a No. 2 in newsworthiness) and so on. The final sum was divided by the number of journalists who ranked the Surgeon General in terms of newsworthiness.

I made similar calculations for each of the six federal health officials in terms of both newsworthiness and credibility. The lower the score, the more newsworthy or credible the respondents considered each official to be. Here are the results, in table form.

First, newsworthiness (Table 1):

Table 1 - Newsworthiness

CDC Director	1.78
NIH Director	3.22
Surgeon General	3.34
NIAID Director	3.63
HHS Secretary	3.83
Assistant Secretary for Health	5.00

Now, credibility (Table 2):

Table 2 - Credibility

CDC Director	1.82
NIAID Director	2.31
NIH Director	2.85
Surgeon General	3.74
HHS Secretary	4.82
Assistant Secretary for Health	5.00

Another analysis focused on the responses of those who interview federal health officials a few times a month or more (what I will call “the megaphone group,” because it is these journalists who are most likely to write or broadcast what federal health officials say).

In this 23-person megaphone group, no one ranked the Surgeon General at No. 1 in terms of newsworthiness. Five ranked the position at No. 2, four at No. 3, six at No. 4, four at No. 5 and four at No. 6.

One person in the megaphone group ranked the Surgeon General tops for credibility. Five ranked the position at No. 2, one ranked it at No. 3, ten ranked it at No. 4, three ranked it at No. 5 and three ranked it at No. 6.

In looking at other federal offices, 13 ranked CDC Director as most newsworthy (or 56 percent), and 12 ranked that position as most credible (52 percent). The HHS Secretary got the next largest number of votes for newsworthiness, with five votes, but was somewhat

lower in the rankings in terms of credibility. The NIAID Director, Dr. Tony Fauci, got eight votes for most credible, placing him second to the CDC Director in that assessment.

I created a scoring system specific to the megaphone group, too. As was the case with the larger group, the lower the score, the more newsworthy or credible the respondents considered each official to be.

First, the newsworthiness results:

Table 3 - Newsworthiness

CDC Director	1.78
NIAID Director	2.96
HHS Secretary	3.04
NIH Director	3.26
Surgeon General	3.91
Assistant Secretary for Health	4.83

Next, credibility:

Table 4 - Credibility

CDC Director	2.04
NIAID Director	2.26
NIH Director	2.52
Surgeon General	3.78
HHS Secretary	4.91
Assistant Secretary for Health	4.96

(Note in the credibility results, the standings were the same in both the overall and megaphone groups. But in newsworthiness, there was a difference. In the overall group, the NIH Director and Surgeon General were second and third most newsworthy. But in the megaphone group, the NIAID Director leaped to second place.)

In the last questions, survey participants were asked specifically about the credibility rankings and why they rated certain positions at the top and at the bottom.

Far and away, the leading reason given as to why a certain official did or did not have credibility had to do with politics. Those journalists felt that officials with strong political motivations or influences were less likely to provide frank, complete and accurate science-based information.

The words “politics,” “political,” “politician(s),” or “politicization” were used in 30 of the 66 responses that wrote comments about why certain officials were ranked most credible. That’s about 45 percent of those responses. The same words appeared in 46 (or 70 percent) of the responses of who ranked least credible. Similar points were made in other responses, though using different words.

Some examples, that spoke specifically about the Surgeon General:

“Political hacks,” wrote a female freelancer in her 60s, of the Surgeon General and HHS Secretary, who she ranked as the two least credible.

“The Surgeon General’s office has proven in the past year to be politically run, and HHS has long been political as well,” wrote a female freelancer in her 40s.

“U.S. Surgeon General has become a political position. Carmona did not have public health expertise, and even when he tried to put out evidence-based reports, he was squelched by political operatives,” wrote a male freelancer in his 50s who ranked Surgeon General as least credible.

“Appear to most influenced (sic) by political/lobbyist pressures,” wrote a male freelancer in his 50s, who ranked the Surgeon General as least credible.

“The credibility of the Surgeon General’s Office has been destroyed by the Bush administration. Ditto the assistant secretary slots,” wrote a magazine writer in her 50s who put the Surgeon General at fifth in credibility, above only the Assistant Secretary for Health.

“Particularly U.S. Surgeon General, the role is a talking head in regards to policy matters and usually mirrors whatever administration’s policies are during their time in office,” wrote a journalist in her 30s who ranked the Surgeon General dead last.

Some were more kind:

“Good speakers,” wrote a male wire service reporter in his 40s (not me), who ranked the Surgeon General as most credible and CDC Director as second-most credible.

“The CDC Director and Surgeon General are usually more scientific and less political,” wrote a male magazine writer in his 50s.

“The CDC seems to be the closest to the science and the least politically influenced. The Surgeon General also is (supposed to be) immune from political influence, and generally his/her statements are backed by sound data,” wrote a female magazine writer in her 30s.

“They have, in my experience, been shown to stick to the science, leaving politics out of the question,” wrote a male journalist in his 40s who works at a trade publication, who ranked the NIH Director and the Surgeon General as the most credible officials.

“Surgeon General has always had somewhat of an air of independence from the Administration. Same is true for the Director of NIH,” wrote a male newspaper reporter in his 60s, who ranked the Surgeon General as the most credible.

“I’d actually rank them equally, so for both, they have the medical background to speak with some authority and knowledge...,” wrote a female newspaper reporter in her 50s, who put the CDC Director and Surgeon General at the top of her list.

Discussion

There have been few survey studies looking at perceptions about the credibility of the credibility of the Surgeon General and other federal health officials. The best known was a

1991 national telephone survey, published in Public Health Reports, in which 1,622 Americans were asked to assess the reliability of the Surgeon General, the CDC and state health departments on the subject of HIV and AIDS. More people had heard of the Surgeon General than of the other entities, although the CDC was ranked higher in terms of reliability. [7]

This survey attempted, with limited resources, to address a gap in the literature in terms of surveyed perceptions of federal health officials' credibility.

Limitations of the survey include its small sample size. Only about 9 percent of the AH CJ's membership submitted responses, and only 6.5 percent submitted complete responses that included ranking the six named U.S. health officials in terms of their newsworthiness and credibility.

Although the demographics of the response sample seem similar to that of AH CJ as a whole, the size of the sample makes it difficult to generalize the findings to that of the whole Association, let alone to the larger pool of all U.S. health journalists. Likewise, it is not possible to generalize these findings to the audiences of the participating journalists.

However, this survey is believed to be the one of the first of its kind – no similar surveys were found in a literature search. Therefore, it offers some new insights into how journalists who cover public health and medicine view the credibility of certain key federal health officials who often are primary sources of public health information.

Because this dissertation is focused on the Surgeon General, it was noteworthy that more journalists deemed the Surgeon General among the least credible of federal health officials than considered the Surgeon General among the most credible.

In reviews of journalists who most often covered federal health officials, the gap was equally as stark – just one of the journalists in that group deemed the Surgeon General as most credible, and none saw the position as most newsworthy. In contrast, three ranked Surgeon General as least credible and four as least newsworthy.

My scoring system also showed that the megaphone group, who do the most coverage of these federal health officials, hold the Surgeon General in somewhat lower esteem than do the respondent group of journalists as a whole, particularly in terms of newsworthiness.

Again, these numbers are small, but the findings suggest that at least some of the so-called megaphone journalists are not placing much priority on covering announcements from the Surgeon General, or in seeking out the Surgeon General for comment on important issues.

Judging from the written comments of those survey respondents who explained their reasons for ranking the Surgeon General's credibility as high or low, a primary consideration in journalists' minds was whether the Surgeon General is likely or unlikely to make statements that are not influenced by political considerations. Although some respondents noted the Surgeon General has had a history of being considered an independent voice, a larger number indicated they believe the office now is likely to stick to political scripts, even at the expense of complete and frank science-based information.

Only two officials consistently scored less credible with the journalists. One was the Assistant Secretary for Health – the position created in the 1960s to supervise the Surgeon General and assume many of his past administrative duties. The other was the HHS Secretary.

These findings suggest a credibility problem with the Surgeon General and his/her supervisors, and indicate that the CDC Director and the NIAID Director currently are seen as most credible to journalists.

CASE STUDY THEMES

In this section, I will first discuss the challenges of assessing the bully pulpit performances of different Surgeons General. Then I'll discuss themes and possible explanations for why some were perceived as being more skillful in the bully pulpit than others.

Challenges

It is difficult to measure how well any Surgeon General uses the Bully Pulpit. Ideally, a good Surgeon General communicates information and advice to the public in so effective a manner that it leads to both changes in personal behavior and in public policy, with an ultimate effect of improving the public's health. But even the textbook examples of successful Surgeons General's communications are open to interpretation.

For example, Dr. Luther Terry's landmark 1964 report on Smoking and Health is widely cited as the most influential report ever issued by Surgeon General, and many contend it was a crucial first salvo in the nation's public health campaign against tobacco. But a look at smoking rates during Terry's term in office show that U.S. cigarette consumption dropped by about 20 percent in the three months after the report was issued, but later crept back to near normal levels. The most substantial declines did not occur until the 1980s. That's not to say experts are not correct about the importance of Terry's report, but showing a cause-effect impact of the report on smoking rates is no simple matter.

Conversely, the last two Surgeons General – Dr. David Satcher and Dr. Richard Carmona – spoke frequently about the negative health effects of obesity, and strongly urged people to exercise

and eat better. But U.S. obesity rates continued to escalate during Satcher's term, then began to level off under Carmona. [8] How do we interpret that? Was the leveling off due to Carmona? Was it a delayed pay-off from the work of Satcher? Or was it triggered by factors completely unrelated to these two men? We can't say for sure.

In her 2000 dissertation, former Surgeon General Dr. Antonia Novello used research compiled for her by the Office of the Public Health Service Historian. Novello chose as measures of success the number of times each Surgeon General gave speeches, appeared at Congressional hearings, issued reports, was named in articles in *The New York Times*, and authored articles in two journals (*Public Health Report* and the *Journal of the American Medical Association*). [9]

That approach, too, is imperfect.

In terms of counting speeches, Dr. Julius Richmond wasn't particularly fond of public speaking, and Dr. Jesse Steinfeld loathed giving the same speech over and over and also passed on speaking opportunities. Yet Richmond is seen by some as being a paradigm-shifting Surgeon General who, through his *Healthy People* report, helped the media and the public view health as a matter of personal responsibility. And Steinfeld, in his day, was considered an influential and more visible presence than some of his successors who were more active public speakers.

Also problematic is the measure of Congressional hearing appearances. Dr. Joycelyn Elders spoke at five hearings during her short term in office, and Dr. C. Everett Koop spoke at 30 during his eight years in office. That suggests both were less visible than Richmond and Steinfeld, who both appeared at 36. [10] But it's difficult to determine if they had more influence on legislators than Elders or Koop. And we must grapple with the common observation that Elders and Koop are by far the two best remembered Surgeons General, no matter the tally of trips to Capitol Hill.

Counting citations of a Surgeon General's name in the media is not easily accomplished in a meaningful way. Nexis is the best and largest current data base of newspaper articles, broadcast media reports, press conference transcripts and press release archives, but the growth of its data base has been gradual, and the contributions of many media outlets didn't start appearing in the data base until the 1990s or later. (I know this from experience: I was working as the health writer at *The Florida Times-Union* in Jacksonville in the mid-1990s. That paper joined the Nexis data base in early 1996. I can use Nexis to look up my Times-Union articles published on or after Jan. 21, 1996, but Nexis does not contain any of the hundreds of pieces I wrote for the paper before that date. So it might appear from the Nexis data base that I had – until early 1996 – deemed the Surgeon General unworthy of coverage, when that wasn't the case at all.)

That limitation of Nexis makes it impossible to comprehensively compare the media interest in a Surgeon General who served, say, in the early 1970s to a Surgeon General who served a few years ago. Novello attempted to get around that problem by focusing only on citations in *The New York Times*, a presumably complete data base from decade to decade. The *Times* is perhaps the nation's most important and influential newspaper. Nevertheless, one publications' decision to cover or not cover an activity by the Surgeon General may not be consistent with what the majority of other news outlets did that day, and cannot be considered representative.

(As a point of information, I'll mention that Novello's review – which looked at Terry, Stewart, Steinfeld, Richmond, Koop, Elder and the beginning of Satcher's term – reported 1,108 *New York Times* citations for Koop, 109 for Terry, 82 for Stewart, 63 for Steinfeld, 41 for Elders, 26 for Richmond, and 10 for Satcher as of the time of her writing.) [11]

Novello's measurement of how many articles Surgeons General authored in *Public Health Reports* in *JAMA* is not instructive. Doctors are indeed part of a Surgeon General's audience, but

these are only two publications and are not necessarily the most prestigious or influential journals that reach U.S. physicians. What those numbers tell us is not clear. Elders wrote three articles for *JAMA* while Richmond wrote only one. Does that indicate Elders had more important messages to communicate with doctors, or that Richmond was too busy with his ASH responsibilities to write for that particular journal? Koop had 13 articles in *Public Health Reports* while Steinfeld, Richmond and Elders didn't have any. Does that mean Koop was a better writer, or saw more importance in having something published in that particular journal, or none of the above? [12]

Judging a count of Surgeon General reports is challenging as well. The reports, as we know them today, first appeared during the term of Luther Terry. (That document, it should be noted, was not a report *by* the Surgeon General, but rather the report of an advisory committee to the Surgeon General.) Terry is credited with only one report, though it is considered the most influential report ever issued by a Surgeon General, indicating that volume may not be as important as content or timing. Elders issued only two, but again was a highly visible Surgeon General and a prolific communicator.

There's more to consider on that topic: Generally, the reports are not authored by Surgeons General or their staffs, but rather by a collection of people from the CDC, other agencies or outside experts. Generating a single report costs an estimated \$1 million, and the Office of the Surgeon General has consistently had an annual budget too small to foot such a bill, so production of the reports has often relied heavily on the ability of a Surgeon General to beg or borrow resources to put them out. C. Everett Koop – by all accounts an outlier – issued 22 reports during his eight years in office, far and away surpassing the production of the other Surgeons General. But next on the list were Julius Richmond and David Satcher, who both issued seven but who both also served as Assistant Secretary for Health and therefore had more administrative power and budgetary resources

available for generation of the reports. [13] “I took advantage of the resources and the authority of the ASH” to bolster Surgeon General activities, Satcher said. [14]

Also worth noting is that there have been changes through the years in how Surgeons General report summarizations of science to the general public. Satcher began the practice of issuing shorter documents called ‘Calls to Action,’ which generally are thinner and less thoroughly vetted documents than the more traditional ‘reports.’ Topics were handled with ‘Calls to Action’ for various reasons, including concerns that political or resource-procurement obstacles would make growing them into full reports too difficult, according to former Surgeon General staff member Dr. Karen Near and others. [15] The Office of the Surgeon General also holds ‘workshop’ meetings on different health topics, and proceedings from those meetings have been released as a source of information to the public, though with less trumpeting than a report or ‘Call to Action.’ [16]

Satcher said he never meant for his ‘Calls to Action’ – which included controversial documents on sexual health and suicide – to be considered less weighty than conventional report. “A ‘Call to Action,’ from my perspective, was meant to be a report, but we were using that terminology to draw attention to something that we considered to be almost an emergency” action that could prompt swift reaction from the public, Satcher said. [17] But he acknowledged historians and medical librarians have often grouped those documents in a separate category from reports. [18]

A measurement not discussed by Novello is polls and surveys of public and media perceptions of the credibility and importance of Surgeon General messaging. That too, alas, is problematic because few such polls seem to have been done.

A literature search found only a few examples. Among them:

(1) A 1973 survey done for Philip Morris Inc. found that only about 3 percent of smokers were aware of the Surgeon General’s health warnings of about the dangers of smoking. [19]

(2) A 1991 national telephone survey, published in Public Health Reports, in which 1,622 Americans were asked to assess the reliability of the Surgeon General, the CDC and state health departments on the subject of HIV and AIDS. More people had heard of the Surgeon General, although the CDC was ranked higher in terms of reliability. [20]

(3) A 1999 survey by Perea and Slater looked at responses by 73 Mexican American and Anglo American young adults to televised drinking-and-driving warnings, and found that Latinos rated ads featuring the Surgeon General as the source of information as more believable than ads without the Surgeon General. They found that for Anglo Americans, the opposite was true. [21]

Like most surveys, these were snapshots of opinions of a limited group of people at a certain point in time and focused on a specific set of questions. Because the surveys were not repeated in years prior to or afterward, the results can't be used to determine whether public perceptions of the Surgeon General changed over time.

As discussed in the previous chapter, I did a survey of journalists that attempted to assess how the Surgeon General was perceived in relation to five other top federal health officials. That survey was limited by a low participation rate and cannot be considered clear evidence of how well a Surgeon General is heeded.

In my 30 key informant interviews, sources offered various ideas as to why some Surgeons General were considered better in the bully pulpit than others. Those ideas boil down to four theories – 'the Great Man Theory,' 'the Long Leash Theory,' 'the Chorus Theory' and 'the Great Issue Theory.'

The Great Man Theory

The theory suggests we can explain history by focusing on the genius, charisma or other outstanding personal attributes – or lack thereof – of key people in history. The nineteenth-century

Scottish historian Thomas Carlyle is considered the historical proponent of this thinking. Carlyle once declared; “The history of the world is but the biography of great men.”

The theory has become passé in academic circles. “Most historians... hate ‘the Great Man theory’ of history” said Howard Markel, a public historian at the University of Michigan. Nevertheless, the theory is probably at least part of the explanation for why some people did better in the Surgeon General job than others, he said. [22]

Key informants offered a list of personal attributes that are important for success in the bully pulpit.

Richmond said it’s important for a Surgeon General to have a plan, and not just be reactive. “I don’t mean this immodestly, but you had to have some vision about policy and looking down the road at institutionalizing health goals for the nation,” he said. [23]

Steinfeld said passion for doing the right thing is another requisite. “I’ve always been a zealot,” he said. [24]

Personal characteristics seem to have been important in the success of Koop, an outsider to Washington who arrived in Washington facing a very difficult situation. His new colleagues at HHS feared he was a religious extremist and many steered clear of him. The American Public Health Association and some Democratic lawmakers strenuously opposed his nomination. Newspaper editorial writers predicted he would be a disaster. And he was placed under a strong Assistant Secretary for Health who was part of a group that made sure he had no substantial administrative powers.

But he won people over. Colleagues grew to respect and sympathize with Koop as they watched him report to work every day through the difficult confirmation process, and he made friends who would later help him as he put together reports and stepped up into the bully pulpit. Reporters, too,

were impressed by his communication skills and authoritative, unblinking responses to tough questions. Indeed, some of the people who were his biggest detractors at the beginning of his first term became some of his biggest fans by the end of his second term, including U.S. Rep. Henry Waxman.

“He had something that was very, very important, and that was an enormous amount of integrity. He was willing to take on the tobacco industry. He was willing to take on the AIDS epidemic, even though he came from a social conservative point of view... He saw his job as representing public health, and he wasn’t going to be turned away from doing what he thought was the right thing to do,” Waxman said. [25]

Koop agrees that his personal traits were part of the reason he is considered one of the greatest bully pulpit practitioners – especially when it came to dealing with the media.

“In a sense, the Surgeon General has the ability to build his own credibility. And the better he builds it, the more powerful he becomes. I have to be immodest and say that it needs a little bit of charisma to do it. If you’re pretty dull on your feet and don’t respond quickly to questions and you don’t respond accurately to questions, the press pays very little attention to you,” he said. [26]

Relations with the media is, by all accounts, a key part of how successful a Surgeon General is in the bully pulpit. Reporters can become megaphones for the health messages of Surgeons General. “I made the snowballs and they threw ‘em,” Koop said, of his relationship with reporters. [27]

But reporters are not stenographers, and holding a press conference doesn’t mean anyone will cover it. It’s important to recognize that reporters are attracted to controversy and to officials who seem willing to speak truth to power, said several key informants, including Elders.

“I never really had any problems with the press. The press got to where they felt they could ask me anything they wanted to and Number One, I would answer them, and Number Two, I would give them a very straightforward answer,” Elders said. [28]

It is perhaps no accident that among the Surgeons General with the lowest visibility while in office was Carmona, who demonstrated little willingness to speak out on controversial issues or to contradict his political bosses on issues he felt strongly about. (The same has been said about Novello, who also had a relatively low profile.) But many who know Carmona praise him as a man of great personal integrity, and his colorful life story indicates that courage is not one of his deficits. His example offers a segue into an alternate theory.

The Long Leash Theory

The Long Leash Theory, as I call it, suggests that each Surgeon General’s success in the bully pulpit was influenced by the political and administrative environment in which he or she worked. An important facet of that involves each Surgeon General’s relationship with his or her political superiors – including the Assistant Secretary for Health, the Secretary of HHS/HEW, and key officials in the White House.

Under this theory, Koop was successful because after his initial year or two in office, he worked for ASHes and HHS Secretaries who were willing or even eager to let him speak for the department on difficult and controversial topics. Margaret Heckler, who became HHS Secretary in 1983, was described as unfamiliar with clinical issues and averse to controversy. She was willing to let Koop do the talking on the Baby Doe issue. James Mason, who became the Acting ASH in 1984, was busy with two administrative jobs and was happy to let Koop speak to the public about tobacco and other issues. Otis Bowen, appointed HHS Secretary in 1985, likewise was a non-meddling administrator who gave Koop a very long leash.

Like a talented and eager young football player, Koop had the personal characteristics to succeed on the field but needed there to be an opening for him in the game, and for his coaches to put him in, or so the theory goes. Koop agrees with that.

“The reason I got into AIDS is that in a double-term presidency, an awful lot of the people that the president kept with him in the first term started going home. They started going home about Election Day so by the time the new term has arrived, it’s just as empty in the White House as it was before he came. And I filled a lot of vacuums. People were asking questions, nobody was giving answers and... they were answers that I could give succinctly,” Koop said. [29]

Gary Bauer and some others in the White House were unhappy with the freedom and stardom that Koop was enjoying, but those critics were not in a position to give Koop the hook, and he knew that, he said.

The Long Leash Theory resonates in the story of every other recent Surgeon General as well. Steinfeld, though courageous in his use of the pulpit, faced an increasingly unfriendly Nixon administration which progressively separated him from important public health issues and engineered his early resignation from office.

Richmond, despite holding the ASH job and having a larger budget and staff than other Surgeons General, was never the government’s lead spokesman on smoking and some other key health issues because he worked for the limelight-loving Joe Califano. Ditto Novello, who had to contend with HHS Secretary Louis Sullivan and his desire to be the main spokesman on smoking and even racial health disparities.

Elders and Satcher, both counted among the best in the bully pulpit, both also served under President Clinton and HHS Secretary Shalala. The majority of the time, Shalala was a hands-off administrator who allowed Surgeons General and other health officials great leeway in how they did

their job. But both ran into trouble when Clinton faced political turmoil. Clinton called for Elders' resignation in 1994, when he decided she had become too much of a political liability. And Satcher was discouraged from issuing a sexual health report late in Clinton's second term, when the Monica Lewinsky scandal was in the newspapers.

And then of course there's Carmona, the poster boy for the Long Leash Theory. He was on an extremely short leash, especially after his 2003 statement agreeing with a ban on all tobacco products. Initially, Carmona worked under HHS Secretary Tommy Thompson, who often acted as the main voice for the department. He also served under ASH Cristina Beato, who was described as a political ideologue who restricted his access to the press and made sure he didn't deviate from the administration's script.

"I was blocked at every turn," Carmona said in his appearance last summer before Waxman's House Committee on Oversight and Government Reform. "I was told the decision had already been made. 'Stand Down. Don't talk about it,' he said, referring to how issues like stem cell research would be addressed by the government. [30]

Koop was sympathetic.

"... You're expecting a Surgeon General who is wearing a muzzle and wrapped in a straightjacket to take care of the health of this country, and he can't do it," Koop said, in a 2006 interview shortly before Carmona left office.

"I never had to fight any of that," he continued. [31]

However, he added that he would not have handled the situation the same way Carmona did. "I'm a little different kind of character than Carmona. Carmona, he plays by the rules and he's afraid to get fired," Koop said. [32]

The Chorus Theory

The Chorus Theory holds that how well a Surgeon General stood out was influenced by how many other government health officials were speaking to the public at the time and whether what they were saying was similar or different from what the Surgeon General was stumping on.

Under this theory, Koop succeeded in the bully pulpit because he was perceived as the only Reagan administration official who was tough on tobacco, who would answer questions on Baby Doe, and who would speak frankly about AIDS.

“Uncorrupted by AIDSpeak, Koop was able to talk in a way that made sense; at last, there was a public health official who sounded like a public health official,” wrote Randy Shilts in *And The Band Played On*, as he described how Koop’s report to the nation on AIDS was a watershed moment in how the government talked to the public about the disease. [33]

In the 1990s, the Clinton administration would create the position of National AIDS Policy Coordinator – the so-called ‘AIDS Czar.’ Clinton chose Kristine Gebbie, a state health official from Washington who had been an outspoken opponent of the Reagan administration on the issue of AIDS testing. She was a political appointment and her job was supposed to be largely administrative, but “what I ended up doing was being extremely responsive to this incredible flood of speaking invitations from around the country,” Gebbie said, in an interview with Office of the Public Health Service Historian in 1999. [34]

“I spent between a third and a half of my time on the road,” speaking, she added. [35]

Gebbie spoke frankly about the need for needle exchange programs and better sex education, and the existence of an AIDS Czar theoretically lessened the need for Elders, the Surgeon General at the time, to speak on AIDS as often as Koop had. But Gebbie’s role did little to diminish Elders’ visibility. I did a Nexis search for both Gebbie and Elders for the period Aug. 1, 1993, to Aug 1,

1994, when both were in office. The search resulted in 422 articles, transcripts and other media material that mentioned Gebbie, and 3,312 that involved Elders.

Gebbie's tough talk served her no better, in terms of job longevity, than Elders' did. Gebbie resigned under fire in the summer of 1994, after less than a year in the job, issuing a statement that the administration hadn't supplied her with the resources she needed to gain the trust of the AIDS community. She was embattled during almost her entire term, with outsiders criticizing her as ineffectual and some White House officials complaining she was not doing enough to publicize the administration's accomplishments, such as increased funding for research or faster federal approval of some AIDS drugs. [36]

In an interview, Elders acknowledged there were other federal voices on AIDS and other health topics during her time in office. But her voice rose above the other because her selection of topics included not only AIDS but also controversial subjects like sex, teenage pregnancy and other sexually-transmitted diseases. "The media loves controversy. If it's not controversial, it gets a day or two of play and it's gone," she said. [37]

Elders' comments suggest that the voice of a Surgeon General – a term appointment who (technically) cannot be fired without cause – is able to rise above those of serves-at-the-pleasure-of-the-President political appointments. The Surgeon General has more freedom to discuss controversial subjects than those other officials, and the Surgeon General's office has more historical credibility with the media and the general public than many other federal health positions, key informants said.

But other voices do sometimes take center stage, especially if the head of the federal health department wants to be primary spokesman. Califano was much more visible than Richmond. A Nexis search shows that Sullivan was mentioned in the media more often than Novello in every year

of their shared time in office except for 1992, when her fight against the Joe Camel ads was in full swing.

In Carmona's term, it appears, something a bit more complicated occurred. Carmona served under two HHS Secretaries, the vocal Tommy Thompson and the not-as-prominent Mike Leavitt. Judging from Carmona's testimony, his primary challenge was not a stage-hungry HHS Secretary but rather muzzling by political appointees in the department. However, another factor was at play as well – a talented communicator at the CDC, Dr. Julie Gerberding.

I searched Nexis for the period Aug. 1, 2002 to Aug. 1, 2006 for three federal health officials who all came into office in 2002 – Carmona, the Surgeon General; Gerberding, the CDC Director, and Dr. Elias Zerhouni, head of the National Institutes of Health. (I also searched Dr. Anthony Fauci, an NIH infectious disease expert who was in office previous to 2002 but is commonly mentioned as a respected, Surgeon General-like straight-talker with a high media profile.)

The results:

Julie Gerberding -- 4,043 hits
Richard Carmona -- 2,218 hits
Tony Fauci -- 2,190 hits
Elias Zerhouni -- 1,542 hits

Wondering if the public has come to think of the position of CDC Director as a more valued source than the Surgeon General on public health matters, I also searched David Satcher and Jeffrey Koplan for the 1998-to-2002 period they were Surgeon General and CDC Director, respectively.

The results of that search:

David Satcher -- 5,568
Jeffrey Koplan -- 1,588

Here's what I think is going on, based on key informant interviews and other information: The CDC Director is the head of the government's public health agency, and holds administrative

responsibilities that once fell under the Surgeon General. The CDC Director has a bully pulpit, and is an obvious choice to serve as spokesperson for the government in times of public health emergencies. But, as with the Surgeon General, personal characteristics are in play in this equation.

Koplan was in some respects a Richmond-like figure, sound and quietly influential in his science, but not as eager as others to step before the media. During the anthrax attacks in fall 2001, he declined to go on *60 Minutes* after Bush officials urged him to. [38] It was during that time that Gerberding, a lower-tier official, emerged as an eloquent and effective communicator who was willing to carry the agency's message to the media.

When Koplan left office, Gerberding was tapped to replace him. And though her administration has been plagued by internal dissent and morale problems, she has consistently received high marks for her communication skills.

"Jeff Koplan is not a good television personality," said Dr. David Sencer, who was CDC Director in the 1960s and 1970s. "On the other hand, Julie Gerberding came along and she was beautiful on television and articulate, so Tommy Thompson just turned to her and did Jeff in." [39]

Members of the media have been impressed by her too, according to responses in my survey of U.S. Health journalists. In the survey, respondents ranked Gerberding as far and away the most newsworthy and credible among a list of six top federal health officials that included the Surgeon General and the HHS Secretary.

"The CDC is the agency most involved with disease and Julie Gerberding seems to be an honest source," wrote a reporter in her 60s, as part of her survey response. "Honestly I think they're all mouthpieces who are constrained in what they can say. But Julie Gerberding is generally straightforward and accurate," wrote another, 40-something journalist.

Carmona was muzzled, but his visibility in the chorus of federal officials was also hurt by Gerberding's respected voice.

A chorus of voices is a challenge to the Surgeon General's bully pulpit, and can be a problem for the media and general public. In the case of the 2001 anthrax attacks, government's handling of health communications went from one extreme to the other, with Tommy Thompson's flawed performance as the government's one voice giving way to committees of officials that each talked about sub-components of the situation.

"An explosion of spokespersons" that was too problematic, said Dr. Georges Benjamin, executive director of the American Public Health Association. [40]

"The national public health voice had gotten confused," he said, adding that the situation was preferable in the late 1980s when Koop was the government's recognized health authority. [41]

The Great Issue Theory

One other idea discussed in key informant interviews was 'the Great Issue Theory,' in which some Surgeons General (like Koop) benefited from unusual circumstances that occurred on their watch.

The theory's premise borrows from the idea that Abraham Lincoln, considered one of the United States' greatest presidents, was both cursed and blessed by being in office at the time of an unusual set of issues and challenges. His wisdom and leadership might not have been as dramatically demonstrated had he lived and held office at another time in U.S. history.

In that vein, Koop may also have been in the right place at the right time. The nation's AIDS crisis erupted during his watch and, after other federal health officials failed to provide effective public leadership, Koop assumed that role.

In interviews, Koop has agreed that the AIDS crisis was an unusual situation that largely defined his term in office. “If ever there was a disease – an opportunity for a command performance, in reference to the Surgeon General, AIDS is it!” [42]

Richmond endorsed this theory as well.

“So when people ask, ‘How come I hear so much about Dr. Koop and I didn’t hear so much about you?’ I say ‘Well, that’s good because we didn’t have a crisis,’” Richmond said. [43]

“There were some (crises) that we might have had,” he continued. He referred to Three Mile Island accident in 1979, in which radioactive gases were released from a Pennsylvania nuclear power plant. It might have been a calamity requiring a massive federal public health response that would have deeply involved, who was both Surgeon General and the Assistant Secretary for Health. But no immediate deaths or injuries resulted.

“I have often said a book ought to be written about crises avoided. But you don’t ever get public credit for that, and some of them you avoid you can’t very well talk about, because the story would be told a different way as to who really had the credit for it,” Richmond said. [44]

Howard Markel, the public health historian, said the Great Issue Theory was a factor in Koop’s success. “HIV/AIDS – that was a real watershed moment in how we talked about human sexuality,” he said. [45]

Of course, events like the AIDS crisis don’t erupt every decade, so while it may have helped distinguish Koop, we must look to other theories to judge the merits of say, Satcher as compared to Carmona, or Elders as contrasted with Novello.

Markel said there are other aspects of timing to consider. Yes, being in office at the time of a major public health crisis can impact a Surgeon General’s bully pulpit importance. But another factor is whether a Surgeon General hits the right topic at the appropriate moment in history.

“The time has to be right where people are receptive to hearing about it. Twenty years ago, obesity was not as huge a problem, but it was a problem. I don’t think people were ready to hear that” then, he said. [46]

Plus, Koop was probably not the right person to deliver that message. “You could conceive of a situation where someone is saying ‘Don’t get fat’ or ‘Don’t eat too much,’ and they might be heavy themselves. Koop, for example, wasn’t exactly thin. That may not have been the best cause for him,” Markel said. [47]

Markel’s thoughts make sense. Timing is important. As a journalist who makes daily decisions about what is and is not “news” appropriate for the national wire, I weigh what officials say, checking whether it’s significantly different from prior statements and previously released information. I also consider reader interest, as demonstrated through how earlier stories on a topic played in the media.

The American Public Health Association’s Georges Benjamin said part of Carmona’s problem was he focused on issues that fell on reporters’ deaf ears. He has a point. Racial health disparities, though an important topic that deserves continuing coverage, is not as ground-breaking an issue as when Novello, Elders and Satcher discussed it. Reporters have been hearing about it for more than a decade, and we now have fairly extensive research documenting how the problem plays out. The problem has been reported, repeatedly. It’s old news.

Carmon’s emphasis on documenting family health histories is also important, but it’s a story easily told once. Issues that have an enduring presence in the media are those that have many facets, or that change significantly as new information or research emerges or – yes, Elders is right – are controversial. Stem cell research was a natural topic for someone in Carmona’s position to take on, to offer authoritative guidance to a public policy discussion confused by evolving science and strong

and opposing points of view from other prominent voices. Had Carmona spoken to the media on that topic, it's likely he would have been extremely visible.

The Bush administration last year nominated Dr. James W. Holsinger Jr. to serve as the next Surgeon General. A confirmation hearing was held last July, but the nomination has been on hold since then. Senate officials asked for more information from Holsinger before moving forward. The Bush administration, so far, has not provided it, said David Bowen, a key aide to Sen. Edward Kennedy. [48]

While considering Holsinger and other candidates, Bush administration officials had already set an agenda for the next Surgeon General. "When President Bush nominated Dr. Holsinger for the position of Surgeon General, he specifically charged him with working on the childhood obesity issue," HHS spokeswoman Rebecca Ayer told me. [49]

Ayer said that topic was selected because of its impact on the nation's health and because it would continue public health efforts that were already underway. When I asked other key informants why they thought the topic was selected, some said other reasons might explain it.

"You want the cynical answer?" said Jerry Farrell, of the Commissioned Officers Association. "The cynical answer is because that's one way of channeling him to make sure he doesn't talk about anything that might make the Administration uncomfortable." [50]

Conclusions

Nearly every key informant I asked said a combination of factors explains why some Surgeons General thrive in the bully pulpit while others do not.

Everyone, Koop included, said a long leash is a necessity. Although a Surgeon General is appointed for a four-year term and theoretically cannot be removed from office for saying something the White House or HHS Secretary doesn't like, the fact is politicians and their appointees can

isolate a Surgeon General from the media, interfere with his or her ability to respond to speaking invitations and silence a Surgeon General or cause him or her to leave office in frustration.

The Great Man Theory is also applicable. Koop was praised from all quarters for having a variety of attributes that served him well. Many lauded not only his charisma and gravitas but also his integrity. Novello saw in him an admirable skill in navigating tricky political waters. Sencer, conversely, thought Koop was special because of his ‘Damn the torpedoes’ attitude which enabled him to carve out a role for the Surgeon General that hadn’t really been seen before.

“The bully pulpit didn’t really come about until Koop,” Sencer said. [51]

Setting Koop’s remarkable example aside, one can still argue that personal attributes helped distinguish one Surgeon General from another. Steinfeld and Carmona both served under Republican presidential administrations that were notoriously guarded in their dealings with the media. Steinfeld, a self-described zealot who refused to accept a second-banana role in his department, became a high-profile Surgeon General who ignited important national discussions about the influence of television on children and the dangers of secondhand tobacco smoke. Carmona, who was accustomed to military chain of command and was happy just to be there, accepted the restrictions placed upon him by political appointees and was – many say – a non-presence.

In fairness, comparisons are difficult. In Steinfeld’s case, the role of Assistant Secretary for Health was very much in its infancy then. Arguably, he had more latitude to carve out a role in an unsettled terrain like that than did Carmona, who came on board well into Bush’s first term. The individuals were different as well, and perhaps Carmona, transported through time, might have been bolder in the Nixon administration than he was under Bush. It’s impossible to know.

The Chorus Theory, though worthy of consideration, can be thought of as a variation on the Great Man and Long Leash theories. Alternative voices succeed or fail for the same reasons Surgeons General do.

Julie Gerberding had a more visible bully pulpit than Carmona did. Her skills as a speaker are uncontested, but Carmona is a good speaker, too. Her success came from not only her personal attributes but also from the Bush administration's willingness to let her take center stage on a wide variety of health topics.

Tony Fauci has been an important national voice on AIDS and infectious diseases since the 1980s, and has been a leading voice on many other issues as well. He was one of the first officials brought up to the dais during the anthrax letters crisis after HHS Secretary Tommy Thompson stumbled. "What he (Fauci) does is takes a complex issue and he speaks about it in English that the average finds accessible. And he answers tough questions and is willing to say 'We don't know all of that right now,'" said Kim Elliott, of Trust for America's Health. "He would be the perfect Surgeon General." [52]

The Great Issue Theory helped Koop, but doesn't explain the high profiles of Surgeons General like Satcher, who made news with important reports on subjects like mental health, or Elders, who generated headlines simply by saying what no one else would.

In summary, I believe the Great Man and Long Leash theories best explain the respective bully pulpit performance of the nation's last seven Surgeons General. Any proposal to strengthen the Office of the Surgeon General must bear those theories in mind.

ENDNOTES

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[25] Waxman, H., *Key informant interview, Henry Waxman interviewed by Mike Stobbe, Wednesday, Aug. 30, 2006*. Telephone interview. Pgs. 1 of the transcript.

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[38] Koplan key informant interview, pg. 14.

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CHAPTER 5

PROPOSAL

DISCUSSION

My research concluded that the ability of Surgeons General to use the bully pulpit has been affected by political meddling, resource constraints and – some would argue – the selection of sub-optimal people for the job.

If the Office of the Surgeon General is to be maintained, and if policy makers decide the Surgeon General's bully pulpit should be enhanced, then those three issues must be addressed.

My proposal targets those concerns.

Why We Need A Surgeon General

Before I discuss my proposal, I'll note that there are a variety of opinions on whether the Surgeon General still has a place in U.S. society.

Conservative pundits have referred to the position as 'the nation's nanny' – an unnecessary scold who gets paid by the government to tell people what to eat and tsk-tsk them about smoking and drinking. And periodically there have been legislative and executive attempts to sunset the office and do away with the Commissioned Corps that falls under it.

Even some former health officials who admired past Surgeons General say that shuttering the office may not be such a bad idea.

"I sort of suspect the Surgeon General thing has had its time," said Hale Champion, the former HEW undersecretary for health during the Carter Administration. [1]

He said the mystique of the office has faded in recent years. More and more people understand that the Surgeon General is a paper tiger with no real power, he added. And it's become clear that some of the people who would be best in the job don't want it because of concerns about political meddling or because they would have to give up too much power and income in their current jobs to take a Surgeon General position that pays about \$148,000 a year in base salary. [2]

Champion and former CDC Director David Sencer said they feel that officials at the CDC should perhaps take complete control of the federal bully pulpit on matters of public health. "There are some very able people at the CDC," Champion said. [3]

Most of the key informants I interviewed, however, said it is a crucial position with the power to drive national conversations about health policy and educate the public about dangerous threats.

What's more, most said, is that changes are need not only to preserve the office but to make sure Surgeons General are unfettered in their ability to address important health issues and bring accurate and uncensored information to the public's attention.

"I think it's an imperative public health issue that we corral this problem and fix it as soon as possible," said the University of Michigan's Howard Markel. "I think we have to come up with safeguards that are as ironclad as possible... because our health depends on it." [4]

Under the best of circumstances, the Surgeon General is a one-of-a-kind position in U.S. public health, an ombudsman-like figure that can help the public cut through the growing mass of medical studies, government announcements and other information. It is a trusted

authority who can offer guidance not only on life-enhancing personal behavior but also on evidence-based public policy.

The Surgeon General should not be the spokesperson for the U.S. Department of Health and Human Services on all public health matters. The Department already has officials who can act as spokespersons on specific health topics, and it is inevitable – and, at times, logical – that the department will use people other than the Surgeon General to inform the public on certain topics. The CDC Director or one of her investigators may have the most complete and up-to-date information on a disease outbreak as it first unravels. An NIH official may be best suited to explain the intricacies of a brand-new scientific discovery. The HHS Secretary has the right to present a policy initiative that he or the President designed.

These people handle the breaking news, that's fine. But the Surgeon General must be able to come in after – sometimes *right* after – and review what the other officials said, interpret the information and turn it into guidance for the public. If a CDC study is poorly done, the Surgeon General must be free to question it. If a President adopts a health policy that contradicts scientific consensus, the Surgeon General must be allowed to say the President is wrong. The Surgeon General is not – or, rather should not be – subject to the political controls faced by the CDC Director or other officials.

What Can Be Done

But how can we make sure that each Surgeon General is protected enough so that they can be unrestricted and uncensored enough to do such work? Even Koop and Satcher – the most accomplished in the bully pulpit since Thomas Parran – had to struggle to get reports out, with Koop circumventing White House review to get his AIDS report out, and Satcher having to delay his sexual health report until Clinton left the White House.

Former HEW Secretary Joseph Califano said there is nothing that can be done. He dismissed recent House and Senate bills designed to offer such protections as a waste of time. “I don’t think laws like that do a lot of good in the real world. You’ve got to get the right President and you’ve got to get the right Surgeon General. There are all kinds of things in the federal government that are ‘insulated.’ It doesn’t work,” he said. [5]

It’s instructive to look at some instances where Congress designed certain other ombudsman-like federal positions and tried to insulate and protect them from political meddling and censorship.

I’ll explore two examples – the head of the Government Accountability Office, and the Inspectors General of various federal agencies.

The GAO, as it is called for short, is an independent, nonpartisan agency that works for Congress and is charged with investigating how the federal government spends taxpayer dollars. The head of the GAO – the Comptroller General – is appointed to a 15-year term by the President from a slate of candidates proposed by Congress. The lengthy term is designed to give the office a level of independence that is rare within the government, and he or she can only be removed for reasons of malfeasance or misfeasance through a joint-resolution of Congress. The GAO’s annual budget, currently about \$490 million, is appropriated by Congress and cannot be restricted by the Executive Branch.

The Inspectors General are positions established within federal agencies to investigate fraud and abuse. The Inspector General Act of 1978 gave IGs direct access to records and information, and authorized them to conduct whatever investigations they deems appropriate and to hire and control their own staff and contract resources. The President nominates IGs at Cabinet-level departments. Only a President can remove an IG, and both Houses of Congress

must be notified if that occurs. Although the IG is under the general supervision of the Secretary over his or her Department, the IG has an independent relationship with Congress.

Aspects of the Inspector General Act were echoed last year in two bills that were introduced regarding the Surgeon General.

The bills came on the heels of the July testimony by former Surgeon General Richard Carmona, who testified he was muzzled during his entire four-year term in office. He said he was walled off from media interviews, that his speeches were scripted and several of his reports suppressed.

On August 3, U.S. Rep. Henry Waxman introduced H.R. 3447 – called ‘the Surgeon General Independence Act.’

The bill would keep the Surgeon General's term in office at four years, appointed by the president from a list of six nominees presented by the HHS Secretary. (Currently, the Secretary can nominate any physician.)

Under Waxman’s bill, the Secretary’s list of six nominees would have to include at least three names compiled by a committee of Commissioned Corps officers that makes recommendations for promotions to senior rank. (In the bill, that entity is referred to as the ‘Regular Corp,’ the Corps’ official name.) In other words, at least three nominees would have to be members of the Commissioned Corps.

The bill would have the Surgeon General submit a budget proposal directly to the President for review and submission to Congress. He or she would have permission to hire and fire a staff of his choosing.

The Surgeon General would issue an annual report to Congress on the state of the nation's health, the bill also says. He shall choose the topics of the reports, calls to action and other

communications he issues based on his professional judgment. Only the HHS Secretary could disapprove issuance of a Surgeon General's report, call to action or other communication. But to disapprove such a communication would entail the Secretary providing a full explanation to Congress about the reasons why.

That bill, with 13 cosponsors, is currently sitting in the House Energy and Commerce Committee.

Waxman was not the first out of the gate, however. On July 12, only two days after Carmona's testimony, Sen. Edward Kennedy introduced S. 1777 – the 'Surgeon General Integrity Restoration Act.'

The bill would keep the Surgeon General's term in office at four years, appointed by the President from a list of ten names provided by the Institute of Medicine. There are no requirements that any of them be members of the Commissioned Corps.

The matter of the budget for the Office of the Surgeon General was handled in a similar manner as Waxman's bill. The Secretary is afforded an opportunity to comment, but not change, the budget proposal. It also says that the budget proposal must be made available not only to members of Congress but also to the general public.

It says the Surgeon General may submit the draft of any report or speech to the Secretary or other members of HHS for comment, but the Surgeon General can release the report or deliver the speech regardless of any objection that is raised.

It also says the Surgeon General can hire his own staff or consultants without obtaining Department clearance. And it prohibits any modification or censorship of a Surgeon General's work product for political reasons.

There is much to admire in the proposals, but I would make some changes.

First, I believe the term of office should be lengthened.

The Comptroller General is appointed to a 15-year term because it gives the office a level of independence and continuity of leadership that can stand apart from the political scaffolding erected by any specific President. I am not suggesting 15 years for a Surgeon General – there is a potential downside in having an individual in office that long, should he or she prove to be a milquetoast, an incompetent or worse. But four years is not long enough, judging from the experience of many Surgeons General in the last 40 years.

For various reasons, Koop didn't really hit his stride in the office until his second term. Carmona wasn't able to set out his reports on global health and other key issues in four years. And Steinfeld, despite his ambitions for the office, was thwarted in part by a term that ended too soon.

“Jesse wasn't there long enough to have much impact,” said former U.S. health official Dr. Charles C. Edwards, in a 1988 interview with the Office of the Public Health Service Historian. [6]

I propose a Senate-like term of six years. It's only a little longer than the current term, but guarantees a Surgeon General will outlive a one-term President and his or her political cronies, should they become an obstacle in the Surgeon General's performance as ombudsman.

I would also borrow language from the Inspector General legislation to make sure the Surgeon General is guaranteed complete access to scientific research and expert personnel at HHS agencies.

I would specify that the Surgeon General may not hold another appointment while in office.

Both Richmond and Satcher held the position of Assistant Secretary for Health as well as Surgeon General, a situation that afforded them more funding, staffing and administrative power than they would have had serving solely as Surgeon General. Satcher felt the arrangement made sense for him at that point in history, given the politics of the time and the need to re-establish the visibility and productivity of the Office of the Surgeon General after the office had been vacant of a permanent appointment for four years. But even he and others noted an ASH is pulled by political considerations and a good Surgeon General by other motivations. Asked in an interview if a Surgeon General today should also serve as ASH, Satcher replied; “That’s not my preference.” [7]

If a Surgeon General is granted an adequate budget and an independent staff, as is provided for in the Waxman and Kennedy bills, then there’s no need for a Surgeon General to hold a political appointment.

My last change would have to do with how candidates are selected in the nomination process.

Choosing the right individual for the job is absolutely crucial. In this age, a Surgeon General must be an authoritative and talented communicator who is comfortable with the press and who will give a frank and accurate assessment of science and health issues, no matter the circumstances.

I found it interesting that several key informants – including Koop, Elders and Sencer – shared the opinion that a Surgeon General has to be accomplished enough and determined enough to be willing to walk away from the job if his or her ability to speak truth to power is compromised. “You’ve got to have a person who is willing to make decisions and be willing to lose a job if it is necessary to make a right decision,” Sencer said. [8]

Koop and Elders, the best remembered Surgeons General of the last 40 years, both said they had the mindset that building and maintaining credibility with the public was paramount.

“... The first week I was in Washington, in an interview with the press, I said ‘If I am ever asked to say something that I do not believe, I will go home. And if ever I am asked not to say something that I do believe, I will go home,’” Koop said. [9]

“I think it’s an important attitude to have... I felt I was the people’s Surgeon General and I was there to serve and work in their best interest. I was not the President’s Surgeon General or the Congress’s Surgeon General,” Elders said. [10]

What is the best way to find such a person?

The Senate bill would place selection of the list of nominees in the hands of the Institute of Medicine, a nonprofit organization chartered in 1970 to serve as a national source for unbiased, science-based advice on matters of biomedical science, medicine and health. Its membership includes a lengthy and esteemed list of researchers and policy experts, most of them from universities.

The House bill leaves it to the Secretary to come up with as many as three nominees on his own, and at least three nominees from the ranks of the Commissioned Corps. It’s a proposal that honors the tradition behind the Office of the Surgeon General, recalling an era when Surgeons General always worked their way up through the Corps’ ranks. It also recognizes that the Surgeon General is the official head of the Corps, and a Corps member would better understand that aspect of the job.

I would suggest another option.

My idea is borrowed from Jeff Koplan, the former CDC Director, in a key informant interview. Koplan was explaining why he thought Elders was very qualified for the job when she came in. She “had previously been the state health director in Arkansas, and to me that’s worth a lot... it’s a logical stepping stone to be a state health department director and move to a national level in a parallel role,” he said. [11]

I don’t believe that former state health directors automatically make the best Surgeons General. But the pulpit power of Elders and the accomplishments of Satcher suggest to me that experience as the head of state or federal public health agencies – and all the dealings with the media that are attendant – is as or more important than being respected by the Institute of Medicine or the Commissioned Corps.

I therefore would argue that the list of nominees should be drawn up by the nation’s leading public health organizations. A list of six nominees should be presented to the president. Two would come from the American Public Health Association. Two would come from the Association of State and Territorial Health Officials. And one would come from the National Association of County & City Health Officials.

These organizations would not be required, or even encouraged, to draw nominees from their own memberships. But they would be expected to forward names of people who had stood in a public health bully pulpit before and performed admirably.

Regarding Kennedy’s idea of relying on the Institute of Medicine, I would speculate that such a body is more likely to recommend a Richmond-like personality than a Koop or Satcher. Richmond had many attributes, but if we’re looking for someone to move the masses, we need someone who will not only put together important reports but also will sell them (so to speak).

Regarding Waxman's use of the Commissioned Corps, I have questions about the Corps provides a broad enough talent pool for such an important position and whether the culture of the Corps is one that nurtures a spirit of speaking truth to power.

In recent months, Jerry Farrell – the executive director of the Commissioned Officers Association – has complained in the organization's monthly newsletter about Corps members who had communicated directly with Congress about their unhappiness with recent uniform and grooming rules. "Approaching Congress about personal preference issues for uniforms and grooming standards is not only silly, it may violate regulations that prohibit federal employees from lobbying the legislative branch," Farrell wrote, in the November 2007 issue of the Association's *COA Frontline* newsletter. [12]

His comments were not well received by some federal health officials, who said they saw a troubling philosophical underpinning to Farrell's words. "Although we may agree with Jerry Farrell... regarding both the content and manner these opinions have been expressed, we must also dissociate ourselves with the view that dissent can only be directed through the chain of command. The position that CC Officers give up their freedom of expression when joining the Corps is seriously wrong," according to an unsigned, March 3, 2008 posting on a blog for CDC employees. [13]

Here then (on the next page) is my bill. I used as a basis the Waxman proposal, which is more detailed than Kennedy's bill. Much of the wording is borrowed verbatim from the current Waxman legislation. My additions and changes are in bold type and underlined.

A BILL

To amend the Public Health Service Act to ensure the independence of the Surgeon General from political interference.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as '**the Surgeon General's Bully Pulpit Act**'.

SECTION 2. INDEPENDENCE OF THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

(a) In General – Section 204 of the Public Health Service Act 942 US.C. 205) is amended to read as follows:

SURGEON GENERAL

Sec. 204. (a) Appointment:

(1) IN GENERAL – **The Surgeon General shall be appointed for a 6-year term** by the President, by and with the advice and consent of the Senate.

(2) REQUIREMENTS FOR APPOINTMENT – The Surgeon General shall be appointed from individuals who –

(A) are licensed physicians with specialized training and significant experience in public health.

(B) are, or agree upon appointment to become, members of the Regulars Corps; and

(C) are nominated by the Secretary **of Health and Human Services** pursuant to paragraph (3).

(3) NOMINATIONS – The Secretary shall submit to the President a list of **five nominees**, who meet the requirements of paragraph (2) **Two of those names must be recommended by the American Public Health Association; two must be recommended by the Association of State and Territorial Health Officials; and one must be the recommendation of the National Association of County & City Health Officials**. The Secretary shall forward such list to the President, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, labor and Pensions of the Senate.

(4) TERM LIMIT – An individual shall serve no more than three full terms as Surgeon General.

(5) GRADE AND NUMBER – Upon expiration of an individual's service as the Surgeon General, the individual, unless reappointed, shall revert to the

grade and number in the Regular Corps or Reserve Corps which the individual would have occupied if not for such service.

(6) CONCOMITANT SERVICE – The Surgeon General will not be permitted to hold any other administrative position or office within HHS or any other federal agency or department during his/her term(s).

(b) Removal – The President may only remove the Surgeon General during a term for cause. If a Surgeon General is removed, the Secretary shall provide to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor and Pensions of the Senate a written explanation as to the cause for the removal.

(c) Line of Authority – Notwithstanding section 201, the Surgeon General, under the supervision and direction of the Secretary, shall administer the Office of the Surgeon General, the Regular Corps and the Reserve Corps.

(d) Budget Authority – Notwithstanding any other provision of law, for each fiscal year, the Surgeon General shall prepare and submit, directly to the President for review and transmittal to the Congress, an annual budget estimate (including the number and type of personnel needs for the Surgeon General) for the Office of the Surgeon General, after reasonable opportunity for comment (but without change) by the Secretary. **That proposal shall also be made available to the general public.**

(e) Staff – Subject to the availability of appropriations, the provisions of this title, and applicable federal civil service laws, the Surgeon General shall have the authority to hire and terminate employees of and consultants to the Office of the Surgeon General without obtaining approval by, or clearance from, any employee or consultant to the Department of Health and Human Services.

(f) Reports, Calls to Action, and Other Communications –

(1) IN GENERAL – The Surgeon General shall from time to time issue reports, calls to action and other communications on matters of importance to the health of the American people.

(2) ANNUAL REPORT – In carrying out paragraph (1), the Surgeon General shall submit to the Congress and make publicly available an annual report on the state of the nation's health. Each such report shall include an analysis of the potential impact of global health trends on the nation's health.

(3) PUBLIC HEALTH SCIENCE – The reports, calls to action, and other communications issued under paragraphs (1) and (2) shall be based on the Surgeon General's professional judgment regarding the best available public health science.

(4) **ACCESS TO SCIENCE – To ensure access to the best available public health science, the Surgeon General is authorized to have access to all records, reports, audits, reviews, documents, papers, recommendations or other material available on whichever matters of medicine or public health he/she deems necessary to carry out his/her duties.**

(5) **ROLE OF THE SECRETARY** – The Secretary shall have exclusive authority to disapprove the issuance of a report, call to action or other communication proposed by the Surgeon General. If the Secretary disapproves the issuance of a report, call to action or other communication proposed by the Surgeon General, the Secretary shall, within **five** days of disapproval, submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor and Pensions of the Senate a full explanation of the reasons for such disapproval.

ENDNOTES

[1] Champion key informant interview, pg. 10.

[2] Koentop, J. "Surgeon General Salary; Estimate of Potential Earnings." Faxed document from U.S. Department of Health and Human Services in response to my question. Received March 5, 2008. Note: This estimate is for someone who would be a newcomer to the Commissioned Corps, as Koop was. The government has a scale that adjusts the pay and benefits according to years of service.

[3] Champion key informant interview, pg. 11.

[4] Markel key informant interview, pg. 5.

[5] Califano key informant interview, pg. 5.

[6] Edwards oral history, pg. 22.

[7] Satcher key informant interview, pg. 4.

[8] Sencer key informant interview, pg. 12.

[9] Koop key informant interview, pg. 3.

[10] Elders key informant interview, pgs. 12-13.

[11] Koplan key informant interview, pg. 5.

[12] Farrell, J. "Misguided Missiles," column in *COA Frontline*, November 2007. Landover, Md. Pg. 23.

[13] Anonymous, posting on *CDC Chatter*, a blog for employees of the U.S. Centers for Disease Control and Prevention. March 3, 2008 posting. Available at <http://www.cdcchatter.net>

APPENDICES

Appendix A: IRB Consent Form

University of North Carolina-Chapel Hill
Consent to Participate in a Research Study
Adult Participants
Consent Form

IRB Study #

Consent Form Version Date: 08-20-07

Title of Study: The Surgeon General and the Bully Pulpit

Principal Investigator: Mike Stobbe, MPH, MSJ.

UNC-Chapel Hill Department: Health Policy and Administration

Email Address: MikeStobbe@gmail.com

Faculty Advisor: Ned Brooks

Funding Source: None

Study Contact telephone number: 404.377.9180

Study Contact email: MikeStobbe@aol.com

What are some general things you should know about research studies?

You are being asked to take part in a research study. To join the study is voluntary. You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study.

You will be given a copy of this consent form. You should ask the researchers named above any questions you have about this study at any time.

What is the purpose of this study?

We want to how the Surgeon General and other health officials influence public attitudes toward health risks and behaviors through speeches and other communications with the public. We are doing this study as part of a dissertation project.

How many people will take part in this study?

If you decide to be in this study, you will be one of dozens of key informants interviewed as part of this research study.

How long will your part in this study last?

The interview will take about one hour. You can choose to stop the interview at any time.

What will happen if you take part in the study?

We will ask you to discuss your experiences, observations and knowledge concerning the office of the Surgeon General, the Surgeon General's role in the U.S. government public health efforts, and the Surgeon General's efforts to communicate with the media and the public. You may also be asked about the role of other public health officials relating to the Surgeon General's communication efforts.

What are the possible benefits from being in this study?

Research is designed to benefit society by gaining new knowledge. Your participation is important to help us understand how public health can be influenced through communications from public health officials, but you may not benefit personally from being in this research study.

What are the possible risks or discomforts involved from being in this study?

We do not think you will experience any risks or discomforts during the interview or afterward. You may stop the interview at any time, and may request that certain information be treated as "on background" information that will not be attributed to you in any way.

How will your privacy be protected?

In addition to being used for the dissertation, information from the interview might also be used for a future book or piece of journalism on the subject by Mike Stobbe. It is assumed that information that you provide is eligible for inclusion in both works.

We would like to tape record the interview so that we can more completely and more accurately capture your comments. However, you will not be taped without your prior knowledge and consent. A transcript of the audiotape will be provided to you as part of an accuracy check.

During the interview, you may ask to speak "on background" if you wish to provide information that you do not wish attributed to you. If such an occasion arises, please stop the interview and discuss with Stobbe your wishes to say something "on background." If you and Stobbe both agree, the information will not be attributed to you, and Stobbe will not divulge your role as source of that information to anyone. However, he will take notes in order to remember the information.

We will not make copies of our written notes, which will be kept in a locked filing cabinet in Stobbe's home. We will secure any electronic files by password protecting them on our computers. Handwritten notes and other documents will be kept in a locked filing cabinet in

Stobbe's home. If you wish to review a transcript of the interview, Stobbe will work with you to make sure it is delivered in a secure fashion.

Will you receive anything for being in this study?

You will not receive anything for taking part in this study.

Will it cost you anything to be in this study?

There will be no costs for being in the study

What if you have questions about this study?

You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact the researchers listed on the first page of this form.

What if you have questions about your rights as a research participant?

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Public Health Institutional Review Board at 919-966-9347 or by email to IRB_subjects@unc.edu.

Participant's Agreement:

I have read the information provided above. I have asked all the questions I have at this time. I voluntarily agree to participate in this research study.

Signature of Research Participant

Date

Printed Name of Research Participant

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

Appendix B: IRB / Guiding Questions For Key Informants

University of North Carolina-Chapel Hill Questions for Key Informants

IRB Study # Consent Form Version Date: 08-20-07

Title of Study: The Surgeon General and the Bully Pulpit

Principal Investigator: Mike Stobbe, MPH, MSJ.

UNC-Chapel Hill Department: Health Policy and Administration

Faculty Advisor: Ned Brooks

Study Contact telephone number: 404.377.9180

Study Contact email: MikeStobbe@aol.com

Please state your name, current city of residence and current title or occupation.

Please briefly describe any past jobs or positions that would have given you knowledge about the Office of the U.S. Surgeon General. Please describe when you held that position or those positions.

Please share any observations about how the Surgeon General of that time viewed his or her “bully pulpit” role.

Please share observations about people, policies or other factors that may have motivated the Surgeon General to seek to speak to the media or public gatherings in an effort to influence public opinion or behaviors.

Please share observations about people, policies or other factors that may have served as obstacle or deterrents to the Surgeon General in his or her efforts to speak to the media or public gatherings in an effort to influence public opinion or behaviors.

Please share observations about any coordination or competition between the Surgeon General and other government public health officials in delivering public health messages to the public.

Please assess the effectiveness of the current Surgeon General in communicating with, and persuading, the public. Contrast that with the effectiveness of past Surgeons General, and say why you think the current office holder is more or less effective (including personal characteristics, organizational and environmental restrictions or assets, etc.).

Are there any organizational or environmental factors that suggest future Surgeons General will become more or less effective in their “bully pulpit” role? Please explain.

Can a Surgeon General be influential without being highly visible? Please explain.

Were you aware of polling results or other information at the time you (or the Surgeon General in question) were in office that spoke to how you/they were perceived by the public?

Were you (or the Surgeon General in question) advised or warned not to discuss certain topics? Were your (or his/her) attempts to generate a Surgeon's General report on a certain topic blocked? Please tell what happened.

How much direction did you (or he/she) receive from other HHS or Administration officials about what topics to address in the Surgeon General's bully pulpit capacity? Did you (he/she) need clearance before doing public speaking or doing press interviews? If yes, please elaborate.

Tell me a story of when you believe you had the greatest influence, and how you exercised that influence.

Tell me of your most concerted effort to influence policy or opinion that did NOT succeed, and discuss why you think it didn't?

What was the most controversial moment in your (his/her) tenure?

Appendix C: IRB / Fact Sheet For Key Informants

University of North Carolina-Chapel Hill Information about a Research Study

IRB Study # **Consent Form Version Date: 08-20-07**

Title of Study: The Surgeon General and the Bully Pulpit

Principal Investigator: Mike Stobbe, MPH, MSJ.

UNC-Chapel Hill Department: Health Policy and Administration

Faculty Advisor: Ned Brooks

Study Contact telephone number: 404.377.9180

Study Contact email: MikeStobbe@aol.com

What are some general things you should know about research studies?

You are being asked to take part in a research study. To join the study is voluntary. You may refuse to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. You may not receive any direct benefit from being in the research study. There also may be risks to being in research studies.

Details about this study are discussed below. It is important that you understand this information so that you can make an informed choice about being in this research study. You will be given a copy of this consent form. You should ask the researchers named above any questions you have about this study at any time.

What is the purpose of this study?

We want to know how the Surgeon General and other health officials influence public attitudes toward health risks and behaviors through speeches and other communications with the public. We are doing this study as part of a dissertation project.

How many people will take part in this study?

If you decide to be in this study, you will be one of dozens of key informants interviewed as part of this research study.

How long will your part in this study last?

The interview will take about one hour. You can choose to stop the interview at any time.

What will happen if you take part in the study

We will ask you to discuss your experiences, observations and knowledge concerning the

office of the Surgeon General, the Surgeon General's role in the U.S. government public health efforts, and the Surgeon General's efforts to communicate with the media and the public. You may also be asked about the role of other public health officials relating to the Surgeon General's communication efforts.

After the interview but before the project is completed, the investigator will send you a transcript of your interview. You will be asked to read it as part of a check for accuracy.

What are the possible benefits from being in this study?

Research is designed to benefit society by gaining new knowledge. Your participation is important to help us understand how public health can be influenced through communications from public health officials, but you may not benefit personally from being in this research study.

What are the possible risks or discomforts involved from being in this study?

We do not think you will experience any risks or discomforts during the interview or afterward. You may stop the interview at any time, and may request that certain information be treated as "on background" information that will not be attributed to you in any way.

How will your privacy be protected?

In writing up our notes, we will record your gender and some other personally identifying information. In addition to being used for the dissertation, information from the interview might also be used for a future book or piece of journalism on the subject by Mike Stobbe. It is assumed that information that you provide is eligible for inclusion in both works. However, you may ask to speak "on background" if you wish to provide information that you do not wish attributed to you. If you and Stobbe both agree, the information will not be attributed to you, and Stobbe will not divulge your role as source of that information to anyone. All notes will be locked in a filing cabinet or kept on Stobbe's password-secured computer.

As a research subject, however, you always have the right to withdraw your participation in the study.

Will you receive anything for being in this study?

We are not going to pay you for your information, but your information is very important to us.

Will it cost you anything to be in this study?

There are no costs for being in the study.

What if you have questions about this study?

You have the right to ask, and have answered, any questions you may have about this research. If you have questions, or concerns, you should contact the Principal Investigator at 404.558.1084 during regular business hours. You can also contact him at the email address listed above.

What if you have questions about your rights as a research participant?

All research on human volunteers is reviewed by a committee that works to protect your rights and welfare. If you have questions or concerns about your rights as a research subject you may contact, anonymously if you wish, the Public Health Institutional Review Board at 919-966-9347 or by email to IRB_subjects@unc.edu.

Thank you for helping us with this study.

APPENDIX D: SALUTATION, QUESTIONS FOR JOURNALISTS' SURVEY

Dear Health Journalist,

Hi, this is from Mike Stobbe, the Associated Press reporter who covers the CDC. I'm also membership co-chair with the Association of Health Care Journalists. I'm pursuing a doctoral degree right now, and was hoping you could help me on this project by completing this brief survey.

The question I'd trying to address: Which government health officials have the most credibility and speak with the most authority, and how did that come to be? I'm exploring this question through interviews and looking at historical documents, but believe a **confidential** and **anonymous** survey of health journalists would also help me.

Please take a few minutes to do this. As you know from covering health and medicine, the larger the sample size, the stronger the data, so every response is important. The responses will be anonymous. Participating in the survey should take between five and ten minutes. The overall results will be used in a study to be submitted for presentation and publication.

Taking the

If you have any questions about the project, please contact me at 404.558.1084 or at mikestobbe@gmail.com.

Thanks in advance for your help.

Mike Stobbe

Doctoral candidate, the University of North Carolina School of Public Health

INTRODUCTION

This confidential survey is part of a doctoral dissertation research project. A general theme of the project is how the federal government communicates important public health messages to the public, including communications with and through the media. It is hoped the research will provide the public with insight into how the government makes decisions about how to carry out such communications.

The survey should take no more than 10 minutes to complete. The risk of completing it is no greater than what is involved in other every day activities. The cost to participating is only the time spent answering the questions. There is no reimbursement or payment for your participation.

The survey is being done by Mike Stobbe, an Associated Press medical writer, who is also a doctoral student at the University of North Carolina School of Public Health. Mike is a member of the Association of Health Care Journalists and has received permission from the organization's executive director to post this survey.

The survey results will be submitted to UNC faculty as part of Mike's dissertation submission. It may also be mentioned in a future article or book, and Mike will share the results with AH CJ staff for a possible article in a future AH CJ newsletter.

No one who participates in the survey will be identified. Your confidentiality will be maintained in that no participant's name will appear in the study or any journalistic products that come out of it. The data will be reported only in aggregate form.

By clicking the NEXT button and filling out the survey, you are voluntarily agreeing to participate in the research.

Thank you for your assistance. If you have any questions regarding the study, please contact Mike Stobbe at (404) 558-1084 or at mikestobbe@aol.com. If you have any questions regarding your rights as a participant in research, you may also contact the University of North Carolina Institutional Review Board at (919) 966-9347.

1. How long have you been doing medical, health and/or health care journalism? (check one)
 - ☐ Less than one year
 - ☐ 1-4 years
 - ☐ 5-9 years
 - ☐ 10-14 years
 - ☐ 15-19 years
 - ☐ 20-24 years
 - ☐ 25 years or more
2. Do you: (check one)
 - ☐ Write mainly about medical science and research
 - ☐ Write mainly about health care and medical business
 - ☐ Write mainly about public health and/or health policy
 - ☐ Mixed
3. Are you a full-time employee of a media organization? (check one)
 - ☐ Yes
 - ☐ No
4. What is your primary employer? (check one)
 - ☐ Newspaper
 - ☐ Magazine
 - ☐ Trade publication
 - ☐ Wire service or syndicate
 - ☐ Television network or station
 - ☐ Radio network or station
 - ☐ Newsletter
 - ☐ Web/online news site
 - ☐ Freelance or self-employed
5. Are you... (check one)
 - ☐ Male.
 - ☐ Female.
6. How old are you? (check one)
 - ☐ 30 years old or younger.
 - ☐ 31-39.
 - ☐ 40-49
 - ☐ 50-59
 - ☐ 60-69
 - ☐ 70-79
 - ☐ 80 or older.
7. How many times a month do you interview local or state health officials, including spokespersons or leaders employed by state or local health departments, state departments of

medical licensure and professional regulation, state or local Medicaid officials, state or local insurance regulators? (check one)

- ☐ Never
- ☐ Once a month, if that
- ☐ A few times a month
- ☐ At least once a week
- ☐ Every day, or nearly every day

8. How many times a month do you interview federal health officials, including spokespersons or leaders employed by the NIH, CDC, CMS, FDA or other agencies or units of the U.S. Department of Health and Human Services? (check one)

- ☐ Never.
- ☐ Once a month, if that.
- ☐ A few times a month.
- ☐ At least once a week.
- ☐ Every day, or nearly every day.

9. Please rank these officials in terms of their newsworthiness on matters that affect the health of the general public – including a outbreak of a new disease or an act of bioterrorism. (That is, whose press conference would be most likely to attend.) Place a “1” next to the source you see as most newsworthy, and number them in descending order.

- ☐ Director of the Centers for Disease Control and Prevention.
- ☐ Director of the National Institutes of Health.
- ☐ Director of the NIH’s National Institute of Allergy and Infectious Diseases.
- ☐ U.S. Secretary of Health and Human Services.
- ☐ Assistant Secretary for Health, U.S. Department of Health and Human Services.
- ☐ U.S. Surgeon General.

10. Please rank these officials in terms of their credibility on matters that affect the health of the general public – including outbreak of a new disease or an act of bioterrorism. (That is, who would you trust to give frank and accurate information.) Place a “1” next to the source you see as most credible, and number them in descending order.

- ☐ Director of the Centers for Disease control and Prevention.
- ☐ Director of the National Institutes of Health.
- ☐ Director of the NIH’s National Institute of Allergy and Infectious Diseases,
- ☐ U.S. Secretary of Health and Human Services.
- ☐ Assistant Secretary for Health, U.S. Department of Health and Human Services.
- ☐ U.S. Surgeon General.

11. For the two officials that you deemed most credible, please say why (for each).

12. For the two officials you deemed least credible, please say why (for each).

Appendix E: H.R. 3447

110th CONGRESS
1st Session
H. R. 3447

To amend the Public Health Service Act to ensure the independence of the Surgeon General from political interference.

IN THE HOUSE OF REPRESENTATIVES

August 3, 2007

Mr. WAXMAN (for himself, Mrs. CAPPS, Ms. SCHAKOWSKY, Ms. LEE, Ms. SLAUGHTER, Ms. SOLIS, Mr. TOWNS, Ms. BALDWIN, Ms. DEGETTE, Mrs. CHRISTENSEN, Mr. COHEN, Ms. HOOLEY, Mr. COOPER, and Mr. LEWIS of Georgia) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to ensure the independence of the Surgeon General from political interference.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Surgeon General Independence Act'.

SEC. 2. INDEPENDENCE OF THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE.

(a) In General- Section 204 of the Public Health Service Act (42 U.S.C. 205) is amended to read as follows:

`SURGEON GENERAL

`Sec. 204. (a) Appointment-

`(1) IN GENERAL- The Surgeon General shall be appointed for a 4-year term by the President, in accordance with paragraph (2), by and with the advice and consent of the Senate.

`(2) REQUIREMENTS FOR APPOINTMENT- The Surgeon General shall be appointed from individuals who--

`(A) are licensed physicians with specialized training and significant experience in public health;

`(B) are, or agree upon appointment to become, members of the Regular Corps; and

`(C) are nominated by the Secretary pursuant to paragraph (3).

`(3) NOMINATIONS- The Regular Corps shall submit to the Secretary and the President a list of 6 nominees, who meet the requirements of paragraph (2), and of whom not fewer than 3 shall be Regular Corps officers of flag rank, to fill any existing or pending vacancy in the position of Surgeon General. The Secretary shall forward such list to the President, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Health, Education, Labor, and Pensions of the Senate.

`(4) TERM LIMIT- An individual shall not serve more than 3 full terms as Surgeon General.

`(5) GRADE AND NUMBER- Upon expiration of an individual's service as the Surgeon General, the individual, unless reappointed, shall revert to the grade and number in the Regular Corps or Reserve Corps which the individual would have occupied if not for such service.

`(b) Removal- The President may only remove the Surgeon General during a term for cause. If a Surgeon General is removed, the Secretary shall provide to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a written explanation as to the cause for the removal.

`(c) Line of Authority- Notwithstanding section 201, the Surgeon General, under the supervision and direction of the Secretary, shall administer the Office of the Surgeon General, the Regular Corps, and the Reserve Corps.

`(d) Budget Authority- Notwithstanding any other provision of law, for each fiscal year, the Surgeon General shall prepare and submit, directly to the President for review and transmittal to the Congress, an annual budget estimate (including the number and type of personnel needs for the Surgeon General) for the Office of the Surgeon General, after reasonable opportunity for comment (but without change) by the Secretary.

`(e) Staff- Subject to the availability of appropriations, the provisions of this title, and applicable Federal civil service laws, the Surgeon General shall have the authority to hire and terminate employees of and consultants to the Office of the Surgeon General without obtaining approval by, or clearance from, any employee of or consultant to the Department of Health and Human Services.

`(f) Reports, Calls to Action, and Other Communications-

`(1) IN GENERAL- The Surgeon General shall from time to time issue reports, calls to action, and other communications on matters of importance to the health of the American people.

`(2) ANNUAL REPORT- In carrying out paragraph (1), the Surgeon General shall submit to the Congress and make publicly available an annual report on the state of the Nation's health. Each such report shall include an analysis of the potential impact of global health trends on the Nation's health.

`(3) PUBLIC HEALTH SCIENCE- The reports, calls to action, and other communications issued under paragraphs (1) and (2) shall be based on the Surgeon General's professional judgment regarding the best available public health science.

`(4) ROLE OF THE SECRETARY- The Secretary shall have exclusive authority to disapprove the issuance of a report, call to action, or other communication proposed by the Surgeon General. If the Secretary disapproves the issuance of a report, call to action, or other communication proposed by the Surgeon General, the Secretary shall, within 10 days of disapproval, submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a full explanation of the reasons for such disapproval.'.

(b) Conforming Amendment- Section 201 of the Public Health Service Act (42 U.S.C. 202) is amended by striking 'The Public Health Service' and inserting 'Subject to section 204(c), the Public Health Service'.

Appendix F: S. 1777

110th CONGRESS
1st Session
S. 1777

To amend title II of the Public Health Service Act to restore the integrity to the office of the Surgeon General.

IN THE SENATE OF THE UNITED STATES

July 12, 2007

Mr. KENNEDY introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend title II of the Public Health Service Act to restore the integrity to the office of the Surgeon General.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the 'Surgeon General Integrity Restoration Act'.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Section 204 of the Public Health Service Act (42 U.S.C. 205) is amended to read as follows:

`SEC. 204. SURGEON GENERAL.

`(a) Appointment-

`(1) IN GENERAL- The Surgeon General shall be appointed for a four-year term by the President by and with the advice and consent of the Senate as provided for in paragraph (2).

`(2) REQUIREMENTS FOR APPOINTMENT- The Surgeon General shall be appointed from individuals who--

`(A) are, or who agree to become, members of the Regular Corps;

`(B) have specialized training or significant experience in public health programs; and

`(C) who are nominated by the Institute of Medicine under paragraph (3).

`(3) NOMINATIONS- Upon a vacancy in the position of Surgeon General, the Institute of Medicine shall submit to the Secretary and the President a list of 10 nominees, that meet the requirements of paragraph (2), to fill such vacancy. The Secretary shall recommend to the President a nominee from such list unless the Secretary has rejected all such nominees. If the Secretary rejects all such nominees, the Secretary shall provide a written explanation as to why each such nominee was unsatisfactory.

`(4) EXPIRATION OF TERM- Upon the expiration of the term of service, the Surgeon General, unless reappointed under this subsection, shall revert to the grade and number in the Regular or Reserve Corps that he or she would have occupied had he not served as Surgeon General.

`(b) Budget Authority- Notwithstanding any other provision of law, for each fiscal year, the Surgeon General shall prepare and submit, directly to the President for review and transmittal to Congress, an annual budget estimate (including the number and type of personnel needs for the Surgeon General) for the Office of the Surgeon General, after reasonable opportunity for comment (but without change) by the Secretary. Such estimate shall also be submitted to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives and made available to the general public.

`(c) Release of Reports- The Surgeon General may submit any draft of a speech or report prepared by the Surgeon General to the Secretary or any employee of the Department of Health and Human Services for comment. The Surgeon General may issue, deliver, or release such speech or report notwithstanding any comment or objection of the Secretary or any such employee.

`(d) Staff- Notwithstanding any other provision of law, the Surgeon General shall have the authority, subject to Federal civil service laws, to directly hire staff without otherwise obtaining clearance or undergoing review as generally required within the Department of Health and Human Services.

`(e) Prohibition of Censorship- With respect to any work product of the Surgeon General, such work product may not be censored in any manner (except to comply with Federal national security or privacy laws) by any Federal entity or official for political reasons. The Surgeon General shall identify and separately label any proposed modifications to such a work product that the Surgeon General does not consent to accept.'.

Appendix G: SURGEON GENERAL ‘SUNSET’ PROPOSAL OF 1998

105th CONGRESS
2d Session
S. 1725

To terminate the Office of the Surgeon General of the Public Health Service.

IN THE SENATE OF THE UNITED STATES

March 6, 1998

Mr. BURNS (for himself, Mr. HELMS, Mr. THOMAS, and Mr. KYL) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

A BILL

To terminate the Office of the Surgeon General of the Public Health Service.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ‘Office of Surgeon General Sunset Act’.

SEC. 2. DEFINITIONS.

For purposes of this Act:

- (1) ASSISTANT SECRETARY- The term ‘Assistant Secretary’ means the Assistant Secretary for Health of the Department of Health and Human Services.
- (2) FEDERAL AGENCY- The term ‘Federal agency’ has the meaning given to the term ‘agency’ by section 551(1) of title 5, United States Code.
- (3) FUNCTION- The term ‘function’ means any duty, obligation, power, authority, responsibility, right, privilege, activity, or program.
- (4) OFFICE- The term ‘office’ includes any office, administration, agency, institute, unit, organizational entity, or component thereof.
- (5) OFFICE OF THE ASSISTANT SECRETARY- The term ‘Office of the Assistant Secretary’ means the Office of the Assistant Secretary for Health of the Department of Health and Human Services.

SEC. 3. TERMINATION AND TRANSFER OF FUNCTIONS.

(a) TERMINATION- The Office of the Surgeon General of the Public Health Service and the position of such Surgeon General are terminated.

(b) TRANSFER OF FUNCTIONS- There are transferred to Office of the Assistance Secretary for Health all functions which the Surgeon General exercised before the date of the enactment of this Act (including all related functions of any officer or employee of the Office of the Surgeon General).

SEC. 4. DETERMINATIONS OF CERTAIN FUNCTIONS BY THE OFFICE OF MANAGEMENT AND BUDGET.

If necessary, the Office of Management and Budget shall make any determination of the functions that are transferred under section 3.

SEC. 5. DELEGATION AND ASSIGNMENT.

Except where otherwise expressly prohibited by law or otherwise provided by this Act, the Assistant Secretary may delegate any of the functions transferred to the Assistant Secretary by this Act and any function transferred or granted to such Assistant Secretary after the effective date of this Act to such officers and employees of the Office of the Assistant Secretary as the Assistant Secretary may designate, and may authorize successive redelegations of such functions as may be necessary or appropriate. No delegation of functions by the Assistant Secretary under this section or under any other provision of this Act shall relieve such Assistant Secretary of responsibility for the administration of such functions.

SEC. 6. REORGANIZATION.

The Assistant Secretary is authorized to allocate or reallocate any function transferred under section 3 among the officers of the Office of the Assistant Secretary, and to establish, consolidate, alter, or discontinue such organizational entities in the Office of the Assistant Secretary as may be necessary or appropriate.

SEC. 7. RULES.

The Assistant Secretary is authorized to prescribe, in accordance with the provisions of chapters 5 and 6 of title 5, United States Code, such rules and regulations as the Assistant Secretary determines necessary or appropriate to administer and manage the functions of the Office of the Assistant Secretary.

SEC. 8. TRANSFER AND ALLOCATIONS OF APPROPRIATIONS AND PERSONNEL.

Except as otherwise provided in this Act, the personnel employed in connection with, and the assets, liabilities, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds employed, used, held, arising from, available to, or to be made available in connection with the functions transferred by this Act, subject to section 1531 of title 31, United States Code, shall be transferred to Office of the Assistant Secretary. Unexpended funds transferred pursuant to this section shall be used only for the purposes for which the funds were originally authorized and appropriated.

SEC. 9. INCIDENTAL TRANSFERS.

(a) IN GENERAL- The Director of the Office of Management and Budget, at such time or times as the Director shall provide, is authorized to make such determinations as may be necessary with regard to the functions transferred by this Act, and to make such additional incidental dispositions of personnel, assets, liabilities, grants, contracts, property, records, and unexpended balances of appropriations, authorizations, allocations, and other funds held, used, arising from, available to, or to be made available in connection with such functions, as may be necessary to carry out the provisions of this Act.

(b) TERMINATION OF AFFAIRS- The Director of the Office of Management and Budget shall provide for the termination of the affairs of all entities terminated by this Act and for such further measures and dispositions as may be necessary to effectuate the purposes of this Act.

SEC. 10. EFFECT ON PERSONNEL.

(a) IN GENERAL- Except as otherwise provided by this Act, the transfer pursuant to this Act of full-time personnel (except special Government employees) and part-time personnel holding permanent positions shall not cause any such employee to be separated or reduced in grade or compensation for one year after the date of transfer of such employee under this Act.

(b) EXECUTIVE SCHEDULE POSITIONS- Except as otherwise provided in this Act, any person who, on the day preceding the effective date of this Act, held a position compensated in accordance with the Executive Schedule prescribed in chapter 53 of title 5, United States Code,

and who, without a break in service, is appointed in the Office of the Assistant Secretary to a position having duties comparable to the duties performed immediately preceding such appointment shall continue to be compensated in such new position at not less than the rate provided for such previous position, for the duration of the service of such person in such new position.

(c) **TERMINATION OF CERTAIN POSITIONS-** Positions whose incumbents are appointed by the President, by and with the advice and consent of the Senate, the functions of which are transferred by this Act, shall terminate on the effective date of this Act.

SEC. 11. SAVINGS PROVISIONS.

(a) **CONTINUING EFFECT OF LEGAL DOCUMENTS-** All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions--

(1) which have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions which are transferred under this Act, and

(2) which are in effect at the time this Act takes effect, or were final before the effective date of this Act and are to become effective on or after the effective date of this Act,

shall continue in effect according to their terms until modified, terminated, superseded, set aside, or revoked in accordance with law by the President, the Assistant Secretary or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) **PROCEEDINGS NOT AFFECTED-** The provisions of this Act shall not affect any proceedings, including notices of proposed rulemaking, or any application for any license, permit, certificate, or financial assistance pending before the Office of the Surgeon General at the time this Act takes effect, with respect to functions transferred by this Act but such proceedings and applications shall be continued. Orders shall be issued in such proceedings, appeals shall be taken therefrom, and payments shall be made pursuant to such orders, as if this Act had not been enacted, and orders issued in any such proceedings shall continue in effect until modified, terminated, superseded, or revoked by a duly authorized official, by a court of competent jurisdiction, or by operation of law. Nothing in this subsection shall be deemed to prohibit the discontinuance or modification of any such proceeding under the same terms and conditions and to the same extent that such proceeding could have been discontinued or modified if this Act had not been enacted.

(c) **SUITS NOT AFFECTED-** The provisions of this Act shall not affect suits commenced before the effective date of this Act, and in all such suits, proceedings shall be had, appeals taken, and judgments rendered in the same manner and with the same effect as if this Act had not been enacted.

(d) **NONABATEMENT OF ACTIONS-** No suit, action, or other proceeding commenced by or against the Office of the Surgeon General, or by or against any individual in the official capacity of such individual as an officer of the Office of the Surgeon General, shall abate by reason of the enactment of this Act.

(e) **ADMINISTRATIVE ACTIONS RELATING TO PROMULGATION OF REGULATIONS-** Any administrative action relating to the preparation or promulgation of a regulation by the Office of the Surgeon General relating to a

function transferred under this Act may be continued by the Office of the Assistant Secretary with the same effect as if this Act had not been enacted.

SEC. 12. SEPARABILITY.

If a provision of this Act or its application to any person or circumstance is held invalid, neither the remainder of this Act nor the application of the provision to other persons or circumstances shall be affected.

SEC. 13. TRANSITION.

The Assistant Secretary is authorized to utilize--

- (1) the services of such officers, employees, and other personnel of the Office of the Surgeon General with respect to functions transferred to the Office of the Assistant Secretary by this Act; and
- (2) funds appropriated to such functions for such period of time as may reasonably be needed to facilitate the orderly implementation of this Act.

SEC. 14. REFERENCES.

Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to--

- (1) the Surgeon General with regard to functions transferred under section 3, shall be deemed to refer to the Assistant Secretary for Health of the Department of Health and Human Services; and
- (2) the Office of the Surgeon General with regard to functions transferred under section 3, shall be deemed to refer to the Office of the Assistant Secretary for Health of the Department of Health and Human Services.

SEC. 15. SAVINGS.

Any amounts appropriated for the Office of the Surgeon General for fiscal year 1998 and remaining available on the date of enactment of this Act shall be transferred to the Secretary of Health and Human Services and utilized to carry out child immunization programs.

SEC. 16. ADDITIONAL CONFORMING AMENDMENTS.

(a) RECOMMENDED LEGISLATION- After consultation with the appropriate committees of the Congress and the Director of the Office of Management and Budget, the Assistant Secretary shall prepare and submit to the Congress a legislative proposal in the form of an implementing bill containing technical and conforming amendments to reflect the changes made by this Act.

(b) SUBMISSION TO THE CONGRESS- Not later than 6 months after the effective date of this Act, the Assistant Secretary shall submit the implementing bill referred to under subsection (a).

(c) REPEALS- Sections 204 and 205 of the Public Health Service Act (42 U.S.C. 205 and 206) are repealed.

(d) ADDITIONAL CONFORMING AMENDMENTS-

(1) Section 202 of the Public Health Service Act (42 U.S.C. 203) is amended--

(A) by striking paragraph (1); and

(B) by redesignating paragraphs (2), (3), and (4) as paragraphs (1), (2), and (3), respectively.

(2) Section 206(a) of the Public Health Service Act (42 U.S.C. 207(a)) is amended--

(A) in the first sentence by striking 'The Surgeon General' and all that follows through 'the Chief Medical Officer' and inserting 'The Chief Medical Officer'; and

(B) by striking the second sentence.

SEC. 17. EFFECTIVE DATE.

This Act shall become effective on the date on which the individual who is serving as the Surgeon General on the date of enactment of this Act resigns or is terminated or the date on which the term of service of such individual as Surgeon General expires, whichever occurs first.

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