

HOSPITAL  
ADMINISTRATION  
ORAL HISTORY  
COLLECTION

---

Lewis E. Weeks Series

John A. D. Cooper

JOHN A.D. COOPER

In First Person: An Oral History

Lewis E. Weeks  
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION  
Lewis E. Weeks Series

Produced in cooperation with  
American Hospital Association Resource Center  
Library of the American Hospital Association  
Asa S. Bacon Memorial

Sponsored by  
American Hospital Association  
and  
Hospital Research and Educational Trust  
Chicago, Illinois

Copyright (c) 1986 by Lewis E. Weeks. All rights reserved.  
Manufactured in the United States of America.

Lewis E. Weeks  
2601 Hawthorn Road  
Ann Arbor, Michigan 48104  
(313) 662-4298



John A.D. Cooper, M.D.

## CHRONOLOGY

- 1918 Born El Paso, Texas, December 22
- 1939 University of New Mexico State, B.S. in Chemistry
- 1943 Northwestern University, Ph.D. in Biochemistry
- 1943-1947 Northwestern University, Instructor in Biochemistry
- 1945-1947 U.S. Army, Sanitary Corps
- 1947-1951 Northwestern University, Assistant Professor in Biochemistry
- 1950 Northwestern University, M.B.
- 1951 Northwestern University, M.D.
- 1950-1951 Passavant Memorial Hospital, Chicago, Internship
- 1951-1957 Northwestern University, Associate Professor of Biochemistry
- 1954-1965 Veterans Administration Research Hospital, Chicago,  
Radioisotope Service, Director
- 1954-1969 Veterans Administration Research Hospital, Chicago, Consultant
- 1955-1969 Northwestern University, Graduate School Faculty
- 1956 University of Brazil, Visiting Professor of Biophysics
- 1956-1959 U.S. Atomic Energy Commission, Advisory Committee on Education  
and Training, Division of Biology and Medicine, Member
- 1957-1963 Argonne National Laboratory, Policy Advisory Board, Member
- 1957-1963 U.S. Atomic Energy Commission, Advisory Committee on Education  
and Training, Division of Biology and Medicine, Member
- 1957-1969 Northwestern University, Professor of Biochemistry
- 1958 University of Buenos Aires, Visiting Professor of Biophysics
- 1958-1959 Second World Conference on Medical Education, Committee on  
Scientific Exhibits, Chairman

CHRONOLOGY (Continued)

- 1958-1963 Argonne National Laboratory, Review Committee for Division of  
Biological and Medical Research and Radiological Physics,  
Chairman
- 1959-1963 Northwestern University, Associate Dean of the medical school
- 1960-1968 Northwestern University, Integrated Program in  
Medical Education, Director
- 1961 Association of American Medical Colleges, Committee on  
International Relations in Medical Education, Member
- 1962-1966 American Cancer Society, Advisory Committee on Personnel for  
Research, Member
- 1962-1969 Association of American Medical Colleges, Journal of Medical  
Education, Editorial Board, Member
- 1962-1969 Illinois Board of Public Health Advisors, Member
- 1962-1969 Illinois Legislative Commission on Atomic Energy, Member
- 1963-1965 U.S. Food and Drug Administration, Advisory Committee on  
Investigational Drugs, Member
- 1963-1968 Associated Midwestern Universities, Council Member
- 1963-1968 W.K. Kellogg Foundation, Medical Advisory Committee, Member
- 1963-1969 Northwestern University, Associate Dean of Faculties
- 1963-1969 Northwestern University, Dean of Sciences
- 1963-1969 Northwestern University, President's Administrative Council,  
Member
- 1963-1971 Association of American Medical Colleges, Journal of Medical  
Education, Editor
- 1963-1976 Pan-American Federation of Associations of Medical Schools,  
Treasurer; Administrative Committee, Member

CHRONOLOGY (Continued)

- 1964 National Institutes of Health, Advisory Committee on Health Sciences, Engineering and Biotechnology, Member
- 1964-1966 Associated Midwestern Universities, Vice President, 1964-1965; President, 1965-1966
- 1964-1966 Hospital Research & Education Trust, Advisory Committee, Member
- 1964-1968 W.K. Kellogg Foundation, Latin American Advisory Committee, Member
- 1964-1969 Illinois Board of Higher Education, Member
- 1964-1969 Northwestern University, Research Committee, Chairman
- 1965 U.S. Department of State, U.S. Specialist to Brazil
- 1965-1966 Mayo Foundation, Extramural Education Survey Committee, Chairman
- 1965-1969 Argonne Universities Association, Vice President, 1965-1968; Board of Trustees, Member, 1965-1969
- 1965-1969 National Institutes of Health, Advisory Council on Health Research Facilities
- 1965-1969 Northwestern University, Patents and Inventions Committee, Member
- 1965-1970 U.S. Food and Drug Administration, Consultant to the Administrator
- 1965-1970 Health Services Research, Editorial Board, Member
- 1965-1970 National Academy of Sciences, National Research Council Office of Scientific Personnel, Advisory Committee, Member
- 1966-1969 Illinois Governor's Science Advisory Council, Member; and Chairman (1967-1969)

CHRONOLOGY (Continued)

- 1966-1969 Northwestern University, International Programs Committee,  
Chairman
- 1966-1971 Agency for International Development, Advisor to Administrator,  
International health Manpower
- 1966-1971 National Academy of Sciences, National Research Council,  
Advisory Committee on a Study of a Training Program in  
General Medical Sciences, Chairman
- 1968-1969 Evanston Hospital, Board of Directors, Member
- 1968-1970 National Institutes of Health, Special Consultant to the  
Director
- 1969 Shedd Aquarium Society, Board of Trustees, Member
- 1969- Association of American Medical Colleges, President
- 1969-1970 Puerto Rico Nuclear Center, Medical Advisory Committee, Member
- 1969- National Resident Matching Program, Vice President (1969-1974),  
President (1974- )
- 1970 Georgetown University, Professorial Lecturer in Community  
Medicine and International Health
- 1970 U.S. Health Planning Delegation to the USSR, Member
- 1970-1971 Study of Accreditation of Selected Health Educational Programs  
Programs, Board of Advisors, Member
- 1970-1972 Gorgas Memorial Institute, Scientific Advisory Board, Member
- 1970-1973 National Academy of Sciences, National Research Council,  
Advisory Committee on the Study of Postdoctoral Fellowship  
Programs in the Biomedical Sciences, Member
- 1970-1973 National Institutes of Health, Consultant to the Division of  
Physicians and Health Manpower Education



CHRONOLOGY (Continued)

1970-1979 National Fund for Medical Education, Board of Directors, Member  
1972-1973 Federation of Associations of Schools of the Health  
Professions, Vice Chairman of the Council 1972,  
Chairman 1973  
1972-1974 Center for Family Planning Program Development, National  
Advisory Council, Member  
1972-1974 U.S. Department of the Navy, Consultant to the Surgeon General  
of the Navy for Education and Training  
1972-1975 Duke University, Board of Visitors, Member  
1972-1975 The Nutrition Foundation, Board of Trustees, Member  
1972-1978 National Academy of Sciences, Institute of Medicine, Membership  
Committee (1972-1975), AID Health Strategy Study Steering  
Committee 1978  
1973-1978 Duke University, Institute of Policy Sciences and Public  
Affairs, Professor of the Practice of Health Policy  
1973-1983 National Medical Fellowships, Inc., Board of Directors, Member  
1974- National Institutes of Health Council  
1974 National Institutes of Health, International Fellowship Review  
Panel, Member  
1974-1977 Georgetown University, Advisory Board on the Health Care Policy  
Center, Member  
1974-1982 World Federation of Medical Education, Treasurer  
1975- Northwestern University, Alumni Board of Councillors, Member  
1976 DHEW-sponsored Symposium in Warsaw, Poland, Member  
1976-1981 Advisory Committee for Institutional Relations, Member

CHRONOLOGY (Continued)

- 1977-1979 Coordinating Council on Medical Education, Vice Chairman  
(1977-1978), Chairman (1978-1979)
- 1977-1980 World Health Organization, Research Strengthening Group for  
Special Programs for Research and Training in Tropical  
Diseases, Member
- 1977-1982 Veterans Administration, VA Administrative Scholars Program,  
Department of Medicine and Surgery, Board of Governance,  
Member
- 1978 Pan-American Federation of Associations of Medical Schools,  
Honorary Consultant
- 1978- Pan-American Health Organization, Scientific Advisory  
Committee on the Regional Library of Medicine, Sao Paulo
- 1979 Disabled American Veterans Committee on Health Services  
Research, Member
- 1980- University of California, LA, School of Medicine, Board of  
Visitors, Charter Member
- 1980- National Board of Medical Examiners, Member
- 1981- Veterans Administration, Special Advisory Committee, Member
- 1981 Veterans Administration, Task Force on Affiliations, Member
- 1982-1984 Pan-American Federation of Associations of Medical Schools,  
Treasurer; Administration Committee, Member
- 1983- Educational Commission for Foreign Medical Graduates, Board  
of Directors, Member
- 1985 Harvard College, Visiting Committee, Member

## MEMBERSHIPS

American Association for the Advancement of Science

American Medical Association

American Society of Biological Chemists

Biomedical Engineering Society

Central Society for Clinical Research

Fairfax County (Virginia) Medical Society

Fairfax County (Virginia) Hospital Association

Medical Society of Virginia

National Academy of Science, Institute of Medicine

Society of Medical Administrators

## HONORS

Academy of Medicine of the Institute of Chile

Honorary Member, 1978

Alpha Omega Alpha 1950

American College of Hospital Administrators

Honorary Fellowship, 1982

American Hospital Association

Honorary Member, 1969

American Association for the Advancement of Science

Fellow, 1982

La Asociacion Venezolana Para el Advance del la Ciencia

Honorary Member, 1956

University of Brazil

Doutor Honoris Casa, 1958

Charleston (W.Va.) Area Medical Center

Health Services Award, 1973

Duke University

Doctor of Science (honorary)

George Washington University, School of Medicine and Health Sciences

Doctor of Public Service (honorary), 1983

Jefferson Medical College of Thomas Jefferson University

Doctor of Humane Letters (honorary), 1984

John and Mary Markle Award

Scholar in Academic Medicine, 1951-1956

Medical College of Ohio in Toledo

Doctor of Science (honorary), 1974

HONORS (Continued)

Medical College of Pennsylvania

Doctor of Science (honorary), 1973

Medical College of Wisconsin

Doctor of Science (honorary), 1978

National Medical Association

Scroll of Merit, 1978

New Mexico State University

Doctor of Laws (honorary), 1971

New Mexico State University

Outstanding Alumni Award, 1960

New York Medical College

Doctor of Science (honorary), 1981

Northwestern University

Alumni Medal, 1976

Northwestern University

Doctor of Science (honorary), 1972

Omricon Kappa Epsilon Dental

Honorary, 1969

State University of New York at Buffalo

Grady Reddick Memorial Lecture, 1971

Syracuse Medical Alumni Association

Herman G. Weiskotten Annual Memorial Lecture, 1973

U.S. News and World Report

One of the Five most Influential Leaders in the Field of Health, 1977-1981

Wake Forest University

Doctor of Science (honorary), 1985

WEEKS:

One of the things I noticed among the remarkable things about your career, was that you spent about thirty years at Northwestern. I was wondering how a Texas boy happened to go to Northwestern. That's a long way from home.

COOPER:

Actually, I am not really a Texas boy. I was born in El Paso, Texas, but that was only because there was no hospital in Las Cruces, New Mexico. So at about eight weeks of age I went to Las Cruces where my mother lived and really grew up in Las Cruces, New Mexico which was a small town of about 8,000 people. It was really a very wonderful environment to grow up in.

The family was not very well off and my father, who was the son of the Chief Justice of the Supreme Court in Mississippi, I didn't know very well. He traveled for a Goodyear company and, I never knew the details but there must have been a little problem between my mother and my father. So I was essentially raised by my mother. She worked very hard during her life. I started working part time at a very early age to help with the family finances.

I drove a bread truck in the summers. I worked for a mortician. I delivered papers -- I had a very long paper route that I did every afternoon after school and rarely got home before seven or eight o'clock at night. So it was a tough but a very pleasant childhood. Because of the financial situation, I attended what was at that time the New Mexico College of Agriculture and the Arts which was two miles from Las Cruces.

Fortunately, I had a very good academic record in high school, I was first in my class. I got some assistance at the college in the form of

scholarships. But in addition to that, most of the time I was in college I also worked for the state chemist. The chairman of the department of chemistry was also the state chemist and did most of the work on the things that state chemists do.

I graduated there in four years, again at the top of my class. I started out in engineering but switched for a very unusual reason. I saw that a new course was being offered in the College of Arts and Sciences on the history of the Far East. I knew very little about the Far East and I decided I wanted to take that course. I went to the dean of the School of Engineering and asked if I could have time to take this course. He said, "Well, engineering is a very structured curriculum and it really isn't possible. You may have an hour or two of elective time in your junior or senior year but it is not possible for you to take the course."

So I said, "Well, if you will just give me my folder, I will move to the College of Arts and Sciences."

Fortunately, I ranked number one in the engineering class in my freshman year and he was very upset when I made the decision, but it was a firm one. So I finished my degree in chemistry. There were a number of professors at New Mexico A&M -- now New Mexico State University -- who had gotten their Ph.D.s at Northwestern. It was an unusual school in that it still had a lot of people on the faculty who had been very distinguished people at other colleges who came to New Mexico because they had tuberculosis, went there for the cure and stayed after they got a taste of the area.

When I finished I was interested in taking graduate work in chemistry, particularly in the area of biochemistry. In part because of the financial situation, I didn't feel that I could go to medical school. It's quite a

different situation today where the students have access to financial support, mostly to loans, but in those days it was not really the usual thing for a student who could not afford medical school to go. And I applied for fellowships and did get a number of fellowship offers. Because of the influence of the professors who were alumni, I decided to attend Northwestern. I was offered a fellowship at the University of Wisconsin, in biochemistry, at that time, probably the outstanding department in the world in biochemistry. But I chose Northwestern and have never regretted my decision.

Northwestern gave me the magnificent sum of \$25 a month as the fellowship. This was in 1939. I had to do outside work while I was there to keep body and soul together. I was the night watchman at a girls' residence on the near north side of Chicago. I did some other things. I taught biochemistry at the School of Podiatry in Chicago which was really started by the Scholls who were interested in expanding podiatry in the country.

Most of my graduate school coursework was taken in the Department of Chemistry on the Evanston campus of Northwestern. My research work I did at the medical school and my fellowship was there. I worked with a Dr. Henry Bull, a very good preceptor. I finished my Ph.D. in 1943. Built one of the first liquid electrophoresis apparatuses in the Chicago area by hand. There were no NIH grants in those days. I designed the system on the basis of a description published by Arne Tisehus from Sweden who designed the system. I actually did a lot of the work myself on building the apparatus but had some departmental money available to purchase lenses and other components that were required.

My work at that time was largely on the structure of proteins. When I got my degree in 1943, the war -- World War II -- was in progress. I had been



deferred as a student. When I finished, the dean of the medical school, Dr. J. Roscoe Miller, who really became a sort of foster professional father to me, called me in and asked what I wanted to do. I said, "Well, I would like to continue doing research and teaching in the medical school."

He said, "You had better get the union card -- the M.D. degree."

I said, "Rocky, I really can't afford to go to medical school."

He said, "Oh, that will be no problem. I will appoint you an assistant professor of biochemistry and you can take as many of the medical school courses as is possible within the limits of some teaching responsibilities in the department."

So I started out in medical school and got married in 1944 to Jane Stratton, who was a microbiologist working in the department who produced penicillin. She grew the mold and extracted and prepared penicillin. The laboratory was supported by a wealthy man whose wife had subacute bacterial endocarditis for which civilians could not get penicillin. It was all reserved, of course, for the armed forces.

We got married in 1944 and I started the medical school coursework. During the end of 1944 and the beginning of 1945 the Battle of the Bulge was going on and they were sweeping up all the people they could into the army because of their concern about the German initiatives in that area. The draft board told me that they could no longer continue to defer me even though I was a registered student in medical school.

At that time, I knew Dr. John B. Youmans who was Dean of the Medical School at Vanderbilt. A very remarkable man who was at the time a colonel in the army working out of the Surgeon General's office who was in charge of the nutrition studies of the army. He had a program going in Germany doing

nutrition surveys of the German population to give the War Department information to counter the claims of some of the senators, who were sort of pro-German, that we were starving the German population at the end of the war and were as bad as the Nazis. Before Dr. Youmans could get me assigned to the nutrition study, I was assigned to Wakeman General Hospital to work with a Dr. John Bellows whom I had worked with at Northwestern on some research projects involving the eye while I was a graduate student there. He and I established a laboratory to try to develop a method to remove copper from the eye. It's a very serious problem. If a shell casing is ruptured during firing copper can get into the eye and it cannot be removed by a magnet since it's not magnetic. There's really no way to get it out of the eye. It's a very toxic material. It will not only destroy the eye but also requires that the eye be removed very quickly because it produces a sympathetic ophthalmia which would destroy the other eye as well.

I worked a year on the problem, unsuccessfully. We never got the copper out of the eye. As a matter of fact, I have followed the literature since and no way has yet been found to do it.

The laboratory was closed down by the Army and I was assigned to Wakeman General Hospital, which is in West Virginia, as a laboratory officer. While I was there, I received orders to go overseas to join the nutrition study group that was operating in Germany under Johnny B. Youmans. I went to Germany in 1946 and was assigned to Bavaria and lived for a very interesting year in Munich. With three other individuals -- two physicians and a nutritionist -- I did studies of the nutrition of the German population in Bavaria.

The U.S. army military governor of Bavaria, ordered the Minister President of Bavaria to develop a team with the same makeup as ours. We

taught them the techniques we used. The way we worked was to go to the town that we were going to survey and set up the survey and then travel around the area while they were gathering the data. So we saw a great deal of Bavaria.

During that period I had some very interesting experiences. I met a physician who was a urologist, from Hopkins, who was head of the public health office of the military government of Hungary. He got orders for me to go into Hungary and I spent about a month or so in Hungary during the period when there was a tripartite commission of the British and Americans and the Russians who were in control of the country.

The nutrition surveys were stopped in 1946 and I was assigned to Darmstadt, Germany, as a laboratory officer. Through the efforts of Dean Miller to get me back to Chicago, I was ordered home and discharged in 1947 and rejoined the faculty at Northwestern.

I continued my medical education experience in a very unusual way. I did not follow the regular curriculum. I took some senior courses in the second year and some second year courses in the senior year but I did complete the work for the M.D. degree in 1951.

During the period I was in medical school, I had a very large grant from the Atomic Energy Commission through the Office of Naval Research, and set up a radioisotope laboratory at Northwestern.

WEEKS:

That was rather new then, wasn't it?

COOPER:

Very new. I had the great advantage because my degree -- my Ph.D. -- was in physical biochemistry and I was very well acquainted with radioisotopes and their measurement which had been used in other areas of chemistry. So I was a

natural to combine some medical experience with this knowledge of radioisotopes.

It was such an early program, by the way, that the Atomic Energy Commission didn't even have a mechanism to provide grants outside of their own laboratories. They gave the money to the Office of Naval Research which actually gave me the contract. During that period of time I was pretty busy. I was participating in the teaching of biochemistry, I was running this research project, and I was going to medical school. All at the same time.

I graduated in 1951, as I said, and took an internship at Passavant Hospital which is right across the street from Northwestern. My grant was continuing during that period. At the end of 1952, I decided I would not continue house officer training and that my major interests were not in the practice of medicine but in research. At that time, I was doing my research mostly in the area of the use of radioisotopes in medicine. I did practice medicine on a limited basis and was responsible for the treatment of patients in the medical center with radioisotopes for carcinoma of the thyroid, hyperthyroidism and used radiogold and other compounds for the treatment of carcinoma of the lung. I also developed some new radioactive colloids to treat carcinoma of the prostate gland.

So I worked in research and in patient care during that period. The research really evolved around the use of radioisotope, radiocarbon and radiotritium in the study of metabolism in the human which was much simpler to do in those days than it is today because the restrictions on the use of radioisotopes in humans were not as great as they are in current time. Although, when I look back, the amounts of radiocarbon, radiotritium I used were well within the limits that finally were decided to be the upper levels

that one could use. So I did some interesting work in that area during those years.

WEEKS:

I have a note here about Argonne National Laboratory in Puerto Rico. Did it come about this time or was it later?

COOPER:

Well, what happened was that I became the Northwestern University representative on the policy advisory board to the Argonne National Laboratory. Before that I had been a member of the U.S. Atomic Energy Commission's committee on licensure; the committee licensed individuals to use radioisotopes in humans. I was on that committee from 1956 to 1959. I was also a member of the committee on education and training of the division of biology and medicine of the Atomic Energy Commission from 1957 to 1963. So I was deeply involved with the radioisotope movement in the country.

At the Argonne National Laboratories, as I say, I was appointed to be the university representative to the policy advisory board of the Argonne National Laboratory. Argonne was one of the original atomic energy laboratories where Fermi and others developed the first nuclear reactor. The laboratory had done much work in the area of the biology of radiation which was of importance in World War II. After the end of the war the availability of that laboratory to the midwestern universities had also expanded. Each one of the midwestern universities from Michigan, Minnesota, down to Illinois and so on really had members appointed to the policy advisory board whose purpose was to help faculty members from these institutions gain access to some of the specialized facilities at Argonne. I served on that from 1957 to 1963 and as chairman of its review committee for the Argonne division of biological and medical

research and radiological physics from 1958 to 1963. In 1963, I was elected as a member of the council of the Associated Midwestern Universities (AMU), an organization established by the midwestern universities replacing the policy advisory board as the organization to deal with the University of Chicago on the usage of that laboratory by others. The University of Chicago found it very difficult really to give up any of their authority and use of the laboratory to others because they had been the original contractors and considered it their facility. I became vice president of the board of directors in 1964 and president in 1965, and participated very actively in the negotiations with Chicago about use of the laboratory by midwestern universities faculties and led to, and I was a participant in, the development of, the Argonne Universities Association (AAU) which was the successor to the Associated Midwestern Universities. It was a more formal organization and became a contractor to the Atomic Energy Commission. There was a tripartite contract then for Argonne with the Atomic Energy Commission, the University of Chicago, and the Argonne Universities Association as contractors.

I was a member of the board of trustees of the organization from 1965 until 1969 and was vice president from 1965 until 1968. I was also responsible again for the monitoring of the activities of the division of biological and medical research and radiological physics.

About that time I was also involved in a great number of activities relating to the State of Illinois. Governor Otto Kerner appointed me to several state bodies during his term of office. I became a member of the board of higher education, a very pioneering approach by a state to the allocation of resources among the state educational institutions. It was a very interesting experience. The board had really overarching responsibilities

for all of the state systems from the University of Illinois to the community colleges. During that period of time we supported the development of a very extensive community college network through the state of Illinois.

I was also appointed by Governor Kerner to be a member of the board of public health advisors from 1962 to 1969. It was the outside group advising the Department of Public Health of the State of Illinois. About the same time, I was also a member of the Illinois Legislative Commission on Atomic Energy responsible for control over the use of radioisotopes within the state.

In 1966 I was appointed as a member of the Governor's Science Advisory Council which is a statutory council in Illinois. When Fred Sites, who was a faculty member of the University of Illinois, left Illinois to go to Washington as the president of the National Academy of Sciences (NAS), I was appointed chairman of that council.

That was an interesting experience because in looking at the needs of Illinois in science, I decided that it badly needed help from its great universities to improve the environment for developmental industry. We had been upstaged by Route 126 in the Boston area -- and by the beginnings of activities in high tech industry on the west coast -- Silicon Valley and the rest.

I decided that instead of continuing the traditional interests of the science advisory council, I would try and devote its energies to seeing how we could improve the development of high technology industry in Illinois, which at that time was a major manufacturer of television sets, machine tools, and other production industry, but had little, or no, developmental industry, industry of the future.

Actually, I appointed as a member of that board the president of the

Continental Illinois Bank, who wondered why he should be a member of the Governor's Science Advisory Council since he knew nothing about science. I told Tilden Cummings, "Because you're the enemy. The financial groups in Illinois have not provided risk capital for people to develop new kinds of industry."

Actually the meetings of the council were held in the board room of the Continental Illinois Bank. The Governor had eleven appointments. The wonderful thing about Governor Kerner was that he didn't believe that politics belonged in education and science. He said, "I have eleven positions, you appoint them. You don't need to get my permission to appoint the people."

So I appointed some very good people. Quite a different board. There were also statutory members from the legislature who also served on the board. I continued as chairman until I moved to Washington.

I engaged in some other things during that period.

In growing up in New Mexico, I learned to speak in Spanish. I had a nanna, a woman who cared for me while my mother worked, who was Spanish. Isabel Lopez was my second mother. She spoke to me only in Spanish and my mother, who went to New Mexico as a pioneer woman when it was still a territory, had never learned Spanish. So my mother could not talk to her own child until I was three years old.

Since I spoke Spanish and understood Latins, I became involved in Latin American activities. About 1958, Ward Darley, who at that time was executive director of the Association of American Medical Colleges, had attended a meeting in Mexico City and there was some talk there about the need for a Pan American organization of medical schools. He arranged for a grant from the Rockefeller Foundation and we invited the deans of all the Latin American



medical schools to the annual meeting of the Association in Miami that year. A large number of deans accepted the invitation. He really gave me the responsibility for developing the meeting and for developing the discussions on what kind of organization might be formed.

It was decided at that meeting that it would be very useful to have a federation type of organization whose members would be national associations of medical schools in the hemisphere, such as the Association of American Medical Colleges. Unfortunately, there were very few national associations in Latin America, largely because most of the schools were government schools and there really had never been any feeling of the need for such an organization. But when we talked about it at the meeting, it became obvious that having an organization of the deans in each country would give them more clout in dealing with the ministries of health or education in budgetary matters, development, and so on.

So, it was tentatively decided that we should make plans for such a federation. The following year another grant was obtained from Rockefeller and we had the meeting of the Association in Toronto, Canada. At that time, Hernon Alessandri, who was the brother of the president of Chile, and a very distinguished internist, chaired the meeting and was very effective in getting agreement among those present that a federation should be formed.

I was given the task of trying to legitimize such a federation with some of the other Latin American organizations related to medicine and medical education. I went to Montevideo in Uruguay and attended a meeting of the Association of Latin American Faculties. Uruguay at that time was fairly far to the left. The students were in great power. Many of the delegates to this meeting had leftist tendencies. I was not on the official agenda but I did,

through friends of mine in Latin America, arrange to get put on the agenda and did have the idea of a federation put to a vote. It was passed successfully with a lot of help of my Latin American friends who lobbied the membership of the organization.

The students who thought that this was Yankee imperialism hung me and burned me in effigy and invited me to my own hanging and burning. I told them that I was a very sensitive kind of guy and I really didn't think I could watch myself being subjected to that kind of torture.

From then on we developed the federation. We had the first meeting in Vina del Mar and I was elected treasurer of the organization, a position that I held until 1976. That was fourteen years in the office.

The federation established headquarters in Rio de Janeiro. We got funding from some of the American foundations to support the basic cost of the federation and its development and we began to carry out projects in Latin America. Meetings are held every two years of the membership and each time I was re-elected, although the original bylaws which I helped write limited officers to two terms. To my surprise, at the meeting later in Panama, without my knowledge, the membership voted to amend the bylaws so that only the treasurer could repeat his term for life, which was, I thought, a great accolade for the only Yankee officer.

Later we moved the federation's headquarters from Rio to Bogota, Colombia and then from Bogota, Colombia to Caracas, Venezuela. I was involved in the choosing of the executive director in each of those places.

The federation prospered, particularly during the period when it was headquartered in Bogota and the executive director was Jose Felix Patino, a very distinguished surgeon who had been trained at Yale, minister of health,

and also president of the National University of Colombia.

In 1976 I decided that others ought to have an opportunity to participate and so I said that I would not stand for re-election. They did ask that I rejoin the administrative committee of the federation, which is really the board of trustees, in 1982. I served another two year term.

WEEKS:

What were the goals of this organization?

COOPER:

The goals were to improve the quality of medical education in the hemisphere. It's an interesting organization in that it's the first western hemisphere organization that Canada joined. Canada had been oriented mostly towards the Commonwealth. And with a little arm-twisting among friends in Canada we finally got them to recognize that they were members of the western hemisphere and they joined and have been very active members. Most of the medical schools in the countries of Latin America during the period after the formation of the federation did establish national associations, organized in a similar way to the AAMC. They vary in strength. Some of them, the Colombian and the Venezuelan associations, are very strong and the Brazilian association has a good staff and carries out some very important activities in their countries to improve the quality of their education. Other countries had smaller organizations, part time employees, and were not as effective. But they still did contribute in their own countries to improving their quality of medical education in their countries.

WEEKS:

How many medical schools are there in South America?

COOPER:

I can't tell you the count.

WEEKS:

Do most countries have medical schools?

COOPER:

Oh, yes. All of the countries have medical schools. Many of them have more than one.

WEEKS:

During this time, or before this time, didn't you serve as a visiting professor in Brazil and Argentina?

COOPER:

Yes, because in my relationships with friends in Latin America it became obvious that they needed some help in introducing radioisotopes into research and into diagnosis and treatment. Through the invitation of Dr. Carlos Chagas of Brazil, who was head of an institute of biophysics at the University of Brazil in Rio, I was given a grant from the State Department to go to Brazil and offer a course in 1956.

We had children that were four and six years of age and I was going to be down there for about three months so my wife Jane went with me and we took the children -- against the advice of all of her friends who said it's not a good place to take children. We had a wonderful time in Rio and I did give a course. That course, much of it in Spanish which Portuguese can understand, was attended by faculty members from most of the large countries of Latin America. It was not just a Brazilian course. As a matter of fact, I had participants in the course from Portugal. I'm very proud that most of the pioneers in the use of radioisotopes in medicine in Latin America were alumni

of that course and I have kept up with them over the years. Two years later I gave a second course as a visiting professor at the University of Buenos Aires with a similar broad spectrum of representation from institutions in Latin America.

During the period from 1966 to 1971, because of my interests in international medicine and medical education, I was appointed a member of the advisory committee to the administrator of the Agency for International Development in the area of international health manpower. We advised the administrator on the ways in which that program could be more effective in improving health manpower in these developing countries.

One of the interesting things about being on the committee was the opportunity to become a friend of Margaret Mead who was also a member. That was really an experience because she was a very remarkable woman. We had the same ideas and worked very closely together in developing the programs for international health manpower through this committee.

WEEKS:

I remember seeing her on television when she was alive.

COOPER:

She was a remarkable woman, remarkable woman.

WEEKS:

I made a little note of your progress as a teacher at Northwestern and the fact that by 1957 to 1969 when you left -- during that period you were a full professor and must have felt quite settled in.

COOPER:

Yes. I was very comfortable at Northwestern. I had many...all of the opportunities I could possibly ask for. I was Associate Dean of the Medical

School at that period and did a lot of the work for the Dean in the area of academic medicine. I was also chairman of the admissions committee and I was on a great number of committees of the medical school.

WEEKS:

One I wondered about. I saw mention of the fact that you were director of an integrated program in medical education at Northwestern.

COOPER:

Yes. Through my role as director of admissions to the medical school, I saw an opportunity to develop a new approach to medical education which would integrate the college years of medical education with the medical school years. I was particularly interested in developing a program for very bright students. Because, at that time, the curricula and the courses in high school had been greatly strengthened. Many of the bright students in major high schools were really taking courses which were the equivalent of college level courses.

So I worked with Dean Moody Prior, who was Dean of the Graduate School and a former head of the Department of English, to flesh out this idea. We did get the approval of the faculty of the College of Arts and Sciences and of the medical school and the university administration to institute this program. I was able to get grants from the Commonwealth Fund, which ultimately totaled about a million and a half dollars, as the seed money for the development of this new honors program in medical education or, as it sometimes is called, the integrated program in medical education.

In the beginning the program accepted only twenty-five students. We had specially designed courses in the sciences for the two years of the college phase of the program. It was a six year program for the M.D. degree. Very

high level, not chemistry or physics or biology related only to medicine. These scientific disciplines were developed for the very bright students in the program. Half of their time was spent in the science -- they took two science courses a quarter -- the other half was completely elective.

It's amazing that I also got, with the help of Moody Prior, the agreement of the faculty of the College of Arts and Sciences to waive all prerequisites for the honor students, for it went against all of the traditions of faculty prerequisites. All that the student had to do was to talk with the professor and come to a mutual agreement that the student was able to take a course, in spite of the fact that he or she may not have had any of the usual requirements to register for the course.

I'm reminded of one student who had had about eight years of French by the time she got to college. She had gone to New Trier High School north of Chicago, in Winnetka. She signed up for French as one of her non-science courses and was put in third year French. She took one quarter of that third year French and decided that she had had enough French and she wanted to study Russian. But there was no first quarter Russian course offered in the second quarter. So I said, "It's no problem. Just go talk to the Russian professor."

She did. He told her there was no first quarter Russian course given in the quarter.

She said, "Well, I have Christmas vacation and I will prepare myself for the second quarter." So he agreed. By the end of the year she was first in the class and she got a scholarship to go to Moscow for six weeks during the summer.

The whole basis for the conceptualization of the honors course was that

one should not design an educational program merely on the basis of years, that different students have different abilities and develop at different rates, and that one should have flexible programs to permit students to gain their education in the way most suited to their own abilities. I think it's proved true. The course still is in operation and it has been expanded. It has changed a little bit in its concepts but has been very successful. Studies have shown that the students who graduate from medical school in this program cannot be distinguished from those who have had a more traditional educational program.

It was one of the first in the country. Boston University started one in the same year but it was really not quite the same, and it had a different conceptual basis. I got the best faculty members on the Evanston campus to teach. Physics was taught by a colleague of Enrico Fermi's. The reason I could get them interested is, through a large Commonwealth Fund grant, I had money to release them of all other teaching responsibilities for a year so they could develop a unique course, and they were given great freedom on how that course was to be designed.

For example, in physics, the professor said, "I don't know what medical students need to know in physics. What do you think they need to know?"

I said, "I haven't the foggiest notion."

He said, "You must know somewhat."

I said, "No. What they really need to have is a very rigorous course in physics and one which gives them an understanding of the approaches, the concepts, and the way that physicists think, and an exciting course."

He finally agreed and asked, "Supposing I use the whole second quarter of the physics course to discuss symmetry."



Symmetry is a very theoretical branch of physics -- matter, anti-matter, the black holes, protons, anti-protons and so on.

I responded, "Fantastic."

It's very interesting. He came to me at the end of the second quarter and complained "John, I am very disturbed."

I asked, "What about?"

He said, "I know that I'm not teaching things that they need to know in medical school."

I asked, "What do you think they are missing?"

He said, "Well, I don't cover anything, for example, surface tension."

I suggested, "Well, why don't you just have them write papers in areas that you don't cover?" And he agreed.

He called me up during the middle of the third quarter and said he'd like me to come to his office. He showed me a stack of papers the students had written. He bragged "I want to tell you something. Ninety percent of those papers could serve as the introduction to a master's degree thesis in physics. The background and the knowledge are there." So he was satisfied.

By the way, the physics course included not only physics but mathematics as well. Most of these students had already had calculus. It became a course in differential equation physics. It was not a survey course of physics. In the areas it covered, it went into great depth, it was a very rigorous course.

The same was true in chemistry. It was a one year course which covered inorganic chemistry and organic chemistry taught by a faculty member I brought in. He soon became a member of the National Academy of Sciences. That's the quality of the faculty that participated. In organic chemistry many of the biological, not medical, biological examples were used rather than the

industrial examples that are used in most organic chemistry courses.

The students also took a course in physical chemistry, a calculus-based physical chemistry course. It was not a special course because it was so well taught by a member of the chemistry faculty that it fulfilled all the criteria we had for such a course in the program.

The biology course was a one year course taken in the second year with prerequisites as physics and chemistry. Most biology courses are first year courses with no prerequisites. They are largely descriptive courses with little of the exciting molecular and cellular biology. This was a course three quarters in length and covered the modern biology of the time. As a matter of fact, the example of how well that worked, is that it caused the biology department to change their own major course basing it on prerequisites of physics and chemistry. As a biology major, you could not take a biology course until the second year. It changed their whole approach which I thought was a bonus of the special program because if you had tried to convince the faculty of that department to change their major, they would never have done it. But with the example the honors course provided, they did.

Why do I think it was a successful venture?

It was a very successful course. The students were not required to limit their college experience to two years; their place in medical school was held open for them. They could continue in college and get a bachelor's degree and some of them did. One individual finished a major in English during the period. Another student took eight years from entrance to college to the M.D. degree and got a Ph.D. in biochemistry. At his graduation, he received his first two college degrees, an M.D., and a Ph.D. -- he had no bachelor's degree.

It was really refreshing because you see how excited these students were, how challenged they were. They were not in a locked-step kind of curriculum and it really stimulated them to become real scholars rather than pre-med students trying to gain the grades necessary to enter medical school because their admission was guaranteed if they did adequate work. Nobody told them what grades they had to get, just adequate grades. We had very few who didn't do well. I picked the first two classes myself and I'm very proud. They have become sort of my alumni and I see them from time to time. Many of them are out at the National Institutes of Health doing research. Others are on medical school faculties and the rest have successful medical practices.

WEEKS:

It must give you a lot of satisfaction.

COOPER:

Yes. That was a great experience.

In 1963, I had, of course, become very deeply involved with the Evanston campus of Northwestern because of my involvement with the honors course in medical education. Rocky Miller, who had been my medical school dean and was now president of the university, asked me to come up and join the central administration of the University. He didn't want any vice presidents. So, I had a strange title of Dean of Sciences. Now what were my responsibilities? I'd say I had no position description when I went to Evanston. I was to work in the general area of science and this course. But I made my own job. I developed my own position description as I went along. I ultimately assumed responsibility on a staff level, in the central administration, for the engineering school, the physical sciences, the biological sciences, mathematics, and the dental and the medical schools. In addition I had

responsibility for, not operating but staff responsibility, for the Northwestern University Press and for the development of a centralized computing center. I really had a broad involvement in the University.

I also set up an office of research coordination to improve the outside funding of research at Northwestern. We had a good faculty but they had not competed, in my view, adequately in obtaining federal, foundation and other funds. So I established an office, got some staff into it, and, in three years, we tripled the amount of outside funding for research in the university. That office is still operating. The individual who holds that office is now vice president for research, but he does not have the same responsibilities in the educational area that I did.

I stayed there until 1969 and was a member of President Miller's cabinet. There were about eight of us who met once a week to talk about university affairs. One of the things in which I was deeply involved was the efforts to increase the number of minority students in the university. We set up programs which reached into the high schools and were successful in getting the high schools to direct to us students who they felt had great potential but who may not have had the same grades and scores on tests as other minority students who were gobbled up by Harvard, Yale and the other schools. This was a very exciting program. It was a period of student unrest, particularly in the blacks, and we had a sit-in in one of our administration buildings. I was deeply involved with the negotiations. It was settled amicably and the students, I think, felt they got what they needed. We felt that we did not in any way compromise the university in that settlement.

So there were a lot of interesting things at the university. I learned how different university faculties are from those in medical school.

WEEKS:

Gary Filerman told me that he approached you when you were at Northwestern to approve a plan -- it must have been for the Pan American Federation of Associations of Medical Colleges. They were going to meet somewhere in Latin America and he wanted to have the Latin American programs in hospital administration to have a joint meeting or at least to meet at the same time and the same place. And I think he had to get your approval in order to get a grant from Kellogg to pay the expenses of the American members. At that time he remarked that when he began looking about to find out who would approve it and he found out there was a man right in the Chicago area that would do it. So he came to see you.

COOPER:

Well, I don't remember the specific incident but I do remember that there was a joint meeting at the time and I can't remember which one of the meetings it was at. But Gary did talk to me about the matter and we did arrange that the hospital administrators could meet jointly and that way establish a better relationship between the deans of the medical schools of Latin America and those who were participating in the management of the teaching hospitals.

WEEKS:

He also mentioned -- just as an aside here -- he mentioned that the W. K. Kellogg Foundation director for Latin America was a man by the name of Ned Fahs. I have never met him. I have met some of the recent directors of Latin America. Didn't he come to this job through some State Department connection?

COOPER:

I really don't remember Ned Fahs' background.

I had an interesting experience with the Kellogg Foundation from 1963 to

1968 as a member of their medical advisory committee. I worked with Emory Morris, the first president, whom I greatly respected. He was a remarkable man who really was responsible for making the Kellogg Foundation what it was.

I had another interesting relationship with the Kellogg Foundation. About 1964, the Rockefeller Foundation pulled out of their medical fellowship, medical programs in Latin America. They consolidated their activities by giving grants to a few universities, one to Cali, Colombia, the University of Cali, and one to Bahia in Brazil. Before the change in their program, they had provided fellowships for training of academic physicians for Latin America, given a lot of grants for research and so on. The Kellogg Foundation was concerned about the loss of their partner in these programs and appointed a small committee to review the new situation. It was called the Latin American Advisory Committee and met for about four years.

The charge to the committee was to examine the situation and to advise the Foundation on whether they should modify their programs relating to Latin America. We met, did a fair amount of traveling in Latin America to review their programs and came up with the recommendation that they not change their approach which had been very successful.

One of the amazing things about the Kellogg Foundation's program in Latin America was that in the early days it was headed by an individual, Ben Horning, who was a very remarkable man. He selected the Kellogg Fellows for training in this country and had an uncanny ability to identify young people with promise. I think much of the success of the program at that time was really due to his abilities. He was revered in Latin America. Every country asked him to retire to their country when he retired and offered everything from land to a house for him to live in. In his diplomatic way he promised

each one of them that he would live in their country but he ended up retiring in San Diego.

I am deeply concerned about recent changes in the Kellogg Foundation programs. One of the ways that this country can best assist other countries is in the education and training of specialists. We are not good in community medicine. We are not good in the education and training of health promoters. We are not really good in the education and training of the kind of primary care physicians that are appropriate for Latin America. The Kellogg Fellows that came here were educated and trained in the specialties and subspecialties.

While this committee was doing its work, I asked that the present position of all the Kellogg Fellows be identified from Foundation records. It's amazing. They were presidents of countries. They were ministers of health. They were rectors of universities. If they weren't in a governmental position, they were taking care of presidents, ministers of health and others. It is one of the most effective ways that we have for developing good relations with other countries. Unfortunately, none of those opportunities are now available to us. The Kellogg Fellows are now old and are not being replaced. The Kellogg Foundation has directed their whole activity towards family medicine, health promotion and community medicine. I recognize there's a need for this kind of help.

As a matter of fact, the AAMC had a general Kellogg Foundation grant to work in Latin America. After I became president of the Association, we developed a training program for health promoters in Guatemala because the national medical school refused to recognize the need for these people in the outlying rural areas of Colombia. Johnny Long, who was on the faculty of

Duke, headed the program in Guatemala for us. He became enamored with Guatemala and we had a very successful program. Doing something in developing countries with some managerial and organizational expertise from here is appropriate. But it is inappropriate to bring people into this country for this kind of education and training.

I'm very disturbed that no foundation today is interested in providing fellowships for medical specialty training here. I have been to the State Department over the past five years trying to get them to restore programs in effect at the time, during the 1950s through the 1960s, the predecessors of AID to support this kind of training. But they also are disinterested in specialty training of physicians.

WEEKS:

Do you think that the fact that Bob Sparks is now president of the foundation and a physician and a former dean of a medical college -- would he have an interest?

COOPER:

I think the whole orientation in the Foundation is quite different.

WEEKS:

I was going to make a remark too. One, I was going to ask you about what you did on the medical advisory committee at Kellogg. And I was also going to remark that your being on this advisory committee for Latin America -- I don't know of anyone else who has been on two principal advisory committees for Kellogg. Maybe you have set a record of some kind.

COOPER:

I don't know about that.



WEEKS:

The reason I'm asking about the advisory committee for medicine for Kellogg is that I have talked to persons about the advisory committee for hospitals. I was wondering whether your committee operated any differently from that?

COOPER:

How did they say they operated?

WEEKS:

They just discussed ideas.

COOPER:

That's right.

WEEKS:

And then went away.

COOPER:

Yes.

WEEKS:

And then Kellogg did what they...

COOPER:

Right.

WEEKS:

Is this the approach?

COOPER:

Yes. Emory Morris was a very strong man.

WEEKS:

Yes, I know he was.

COOPER:

And that's good because he was bright and he had a great feel for programs. I don't disagree with that approach. As a matter of fact, I think the responsibility for the Kellogg Foundation or any foundation rests with the staff under the general policy direction of the board or advisory committee. But you cannot run a foundation by committees or advisory boards. So we did exactly the same thing.

New areas in which Emory was interested in would be presented and discussed. We could bring in new ideas about where we thought the foundation could go -- and I must say, our advice was taken very seriously, but we did not operate the programs. And I think that's absolutely appropriate, absolutely appropriate.

WEEKS:

Hoping that you have a strong man on top.

COOPER:

That's right. A strong man who can listen but makes the decisions with the approval of the board of trustees. They advise the staff and the staff uses them to help oversee in a general way in the operation of the programs and developing new programs or stopping old programs. The trustees are ultimately responsible, not for operating the programs, but for general direction.

WEEKS:

I think that Dr. Morris had a stronger position than any of his successors have had because he was a personal friend of W. K.

COOPER:

He was his dentist.

WEEKS:

Yes. He was a dentist in Battle Creek.

COOPER:

He was W.K.'s dentist.

WEEKS:

Oh, he was W.K.'s dentist?

COOPER:

Yes.

WEEKS:

I knew he was a dentist and I knew they were close, but I...

COOPER:

He was his dentist.

WEEKS:

He was actually his dentist too?

COOPER:

I must say W.K. Kellogg was a very bright man to have chosen Emory Morris to start his foundation.

WEEKS:

I think he was a good judge of character. He was a difficult man to work with, I understand, but...

COOPER:

But Emory was a remarkable man. He's one of the greats in the foundation. Besides Alan Gregg of Rockefeller, I think Emory Morris was one of the greatest of any foundation president that I have known.

WEEKS:

I attended his funeral, as a matter of fact.

COOPER:

Let's go back to my relation to the Association.

I first got involved with the Association when I became Director of Admissions at Northwestern Medical School as a member of the group on student affairs of the Association made up of individuals from medical schools who were involved with admissions and student finance and so on. I got to know Ward Darley very well.

In 1963, he asked me to be editor of the Journal of Medical Education, which was a part-time job while I was at Northwestern. I was editor until 1971.

The Association was founded in 1876 by a group of deans in Philadelphia. Dr. Biddle, who at that time was Dean of the Jefferson Medical College, issued a call for a meeting of medical school deans which led to the development of the Association. Samuel Gross, a great surgeon at Jefferson, was the second president.

The group of deans who responded were very concerned about the quality of medical education in this country. Most of the schools then in operation were proprietary schools, established by three or four physicians who rented some space in a building and provided lectures for which they sold tickets. The general preparation for medicine called for a student to apprentice himself to a physician and read on medicine from his books, to go with the physician while he treated his patients, compound the drugs, and ride with the physician on house calls. When proprietary medical schools started, the student then often attended a four month course of lectures by the faculty of the medical school.

There were very few medical schools related to universities. Penn was

the first to start one. There had been immigration of very few physicians from England because they didn't feel that really the colonies were the place to advance their medical careers. I have a different view about the proprietary schools than I used to have. There were few university-related medical schools -- and really some of them were only very loosely related to the university. They were really proprietary schools themselves because the university provided no funds and the professors sold tickets for income as they had been in proprietary schools. The only difference was that they had this tenuous relationship to the university.

But let us take a country that was growing in population, moving westward, with sparsely settled country at the time, particularly in the west, who needed physicians. These were not being provided by the university-related schools. Very few students were going to England or to the continent to study medicine. We had to have physicians and so proprietary schools served an important purpose. Although the physicians may not have been educated and trained in the traditions of the continent, they were better than nothing. So I have modified my feelings about them.

But, it's obvious that the country was now developing. The industrial revolution had come, educational levels were being raised in the country, universities were becoming more widespread and stronger and the time had come to transform American medicine to improve its quality. The AMA had been started earlier in the nineteenth century with the express purpose of improving the quality of medical education. That was its founding purpose, but it had been unsuccessful.

These deans, then, decided they had to do something. So at the meeting in Philadelphia they established the Association, and set high standards for

membership. The standards were so high that for a couple of years no meetings were held because the "members" would not come to the meetings. They recognized that they were not fulfilling the requirements for membership.

There was a very remarkable man that associated early with this organization, Fred Zappfe. Fred was the secretary. He actually made site visits. He gathered information from the schools about their programs, about their finances and so on to see if they met the criteria of membership. Then he visited the school to make certain that what they said was correct. So the AAMC really started the first accreditation program for any education in the United States.

WEEKS:

What were some of the criteria? For instance, in reading Flexner, we learn at that time that not many schools required a baccalaureate.

COOPER:

Right. They still didn't require a baccalaureate at the beginning. The criteria changed after Flexner and beyond. They did require that you graduated from high school and that a graded curriculum be established, which, by the way, was first established at Northwestern. Northwestern University Medical School was established by a dissident group from Rush Medical School who recognized that just having a series of four months of lectures which you took twice was not very appropriate for education. In the graded curriculum courses followed in a logical manner from basic sciences to clinical medicine.

One of the requirements was that the name of the recipient had to be printed on the diploma given him because some people were getting diplomas and selling them.

But the Association really began a change. At the beginnings where there

was question of the schools whether they could really fulfill the requirements of the Association membership and compete for students -- because there were a lot of schools that would let you in with little preparation the deans finally decided that they had to get some quality into medical education. And it went very well from then on.

In 1907 the American Medical Association suddenly discovered the AAMC and appointed its Council on Medical Education and Teaching Hospitals, and they began to have more effect. But the way had been led by the AAMC. Then Flexner -- I'm writing a history, by the way, of the Association. It never has been done. But you always hear that the American Medical Association got Flexner to do it. This is not true.

When Frank Pritchard became the president of the Carnegie Foundation for the Advancement of Teaching, he became interested in a study of professional education that he felt was bad. As a matter of fact, he first approached the divinity schools and they said, no, our directions come from higher up, we don't need any reform. He then went to the law schools. They said, we have a perfect system. We have the case method system and it's perfect and we don't need any assistance. Then he went to medicine. Actually, he talked to both the AMA and the Association. As a matter of fact, Fred Zappfe, secretary of the AAMC, accompanied Abraham Flexner on his visits to the medical schools.

WEEKS:

Is that right?

COOPER:

Yes.

WEEKS:

I've heard another story too, that the AMA had collected some information

about schools but they didn't feel that they should have a study bearing their name. That it might be misinterpreted. And that a man named Dr. Colwell did assist Flexner in some way.

COOPER:

He made the trips in the same way that Fred Zappfe made the trips with Flexner. In Flexner's book, he acknowledges the contributions of both the AMA and AAMC.

WEEKS:

This is it. I've read about Flexner, of course, in various places. But Campion, the new AMA book, doesn't seem to give the AAMC any credit. I didn't know what your role was at that time.

COOPER:

It was as important as the AMA's.

WEEKS:

One point I wanted to ask you. Among the criteria, was there anything about clinical experience?

COOPER:

Yes. There was a requirement for clinical experience as well as better basic science education.

WEEKS:

The reason I asked that was that I interviewed a man by the name of Bloese who had been a secretary and confidant of John Harvey Kellogg. We were talking about Kellogg's educational background. He went to the University of Michigan and took some of these lectures, as you say, and left in disgust because he didn't feel that he knew enough. He didn't know anything about a patient. At that time, Bellevue Hospital and Medical School in New York had a



short course in medicine, but with clinical experience where he could lay hands on the patient. Previous to that he had gone to one of these water-cure colleges. Maybe it was good they didn't believe in strong medicine where some of the doctors did.

COOPER:

Fortunately.

Then, the AAMC did some very interesting things during the 1920s and 1930s. It was one of the major movers to form the National Board of Medical Examiners. Willard Rappleye, who was a very remarkable man and who had a great influence on American medicine during the 1920s, '30s and '40s. We had a commission on medical education that started in 1925 and reported in 1932, which really examined medical education and made many of the same recommendations about changes in the system that our recent committee on the general professional education of physicians did. As a matter of fact, we could have just changed the dates and a few names and republished.

WEEKS:

This is not the Millis?

COOPER:

No.

WEEKS:

Millis was before that, wasn't he?

COOPER:

No, no. Not before 1932.

WEEKS:

Oh, you were talking 1932. Millis was in the 1960s, wasn't he? Just before you came here.

COOPER:

Right. But we had preceded Millis with the Coggeshall report, which was the big report on medical education.

The Association also did a very extensive study on graduate medical education and residency training. Although Willard Rappleye was the staff director of the first study, he was the chairman of the committee on the second study. A very remarkable man.

All during this period AAMC conferences were being held on medical education and related matters. In 1942, we joined with the AMA in forming the Liaison Committee on Medical Education which is the official accrediting body. We had both been visiting medical schools and decided to get together. It's been a very effective organization.

WEEKS:

Basically, you two organizations have the largest number of appointees to this committee.

COOPER:

We have all the appointees.

WEEKS:

Isn't there somebody from Canada too?

COOPER:

Oh, yes.

WEEKS:

That's a courtesy sort of thing?

COOPER:

Yes. Because we also accredit Canadian schools, with the help of the Canadian association of medical schools. But until they came on we appointed

all of the members and the staffing alternates between the two organizations. We take it one year and the AMA takes it the next and so on. It's been a great joint enterprise.

In World War II, two things happened to change the nature of the Association; at that time it was really a deans' club. We had small annual meetings, of several hundred people only, mostly deans and some of their staffs. They did consider major issues of the time but it was really a sort of relaxed organization, except for the accreditation which was one of its major activities. We also developed the MCAT examination in the 1930s, the standardized medical college admission test which is now taken by all the applicants.

The increase in biomedical research during World War II brought some changes in medical schools. The government also intruded very extensively into medical education during the war. The curriculum had to be shortened. The armed forces wanted to appoint many of the students to the medical school. Finally an agreement was reached about how the classes were to be selected. At the same time, the medical schools took on a great burden of research through the Office of Scientific Research and Development, mostly on the medical and biological sciences related to the wartime problems.

The federal government funds, were supporting the biomedical research that was being done. Then after World War II, the wartime funding provided by the Office of Scientific Research and Development for basic research was continued through the expansion of the National Institutes of Health, a small agency at the time, and the National Science Foundation.

So it was obvious that the Association, in order to represent the medical schools more effectively in this interrelationship with the federal government

had to strengthen itself. In the middle 1950s, Ward Darley was brought on as executive director. Ward had been dean of the medical school of the University of Colorado and then president of the university. He got some foundation support and started the expansion of the AAMC. The Association began to become a more effective voice for medical education and medical schools.

The headquarters was in Evanston. In 1963, it was decided that a committee should be appointed to study the future of the Association and its relationship to the nation's health and to biomedical research and education. Well, Lowell Coggeshall who was then Dean of the University of Chicago College of Medicine and who had been president of the Association, chaired the committee. That committee came out with a landmark report. We've reprinted it twice. It was called the Coggeshall report, "Advancing the Nation's Health Through Medical Education."

The report did look extensively at the medical requirements of the country. And in addition, how the medical schools fit into meeting those requirements. So it was not related only to the AAMC. It really was a report that looked at medicine more generally. But it did recommend some changes in the organization and governance of the Association. One recommendation was that it become the umbrella organization for all health professional education, everyone, nurses, pharmacists and so on. I guess the committee had forgotten to talk to the dentists and the pharmacists and the nurses. They were really not interested in the recommended role for the AAMC.

However, as a result of the recommendation, we did form the Federation of Associations of Schools of the Health Professions which was really a substitute for this Association taking over a broader responsibility. A former

president of the Association was elected a lifetime president of that organization.

WEEKS:

Is this more or less for exchange of information?

COOPER:

Yes, and there were some problems with its role. I'll talk about those later.

It also recommended that the governance structure be expanded to incorporate the representation from the faculties and from the teaching hospitals. The teaching hospitals had been meeting informally as a section, with the Association, during the late 1950s and 1960s. The faculty really had had no official organization relating to the Association.

It also recommended that a full-time chief executive officer be hired and that the Association move to Washington. I was asked to be the first full time president in 1969. So it was my responsibility to move the Association to Washington, to incorporate into the governing structure the faculties and the teaching hospital directors. My friends told me I was a fool to consider this position. They argued that deans, faculties and hospital administrators are natural enemies and you couldn't have an organization in which they all participated in the governance. It would be bedlam.

Well, I didn't really feel that that was the case. I felt it was a very opportune time to bring these three groups into more cooperation because of the problems and issues facing them. I was fifty years of age. I had a very secure and fine position at Northwestern. But I decided that I wanted to do something else with my life. So I resigned. Rocky Miller asked me if I wanted to take a leave of absence. I said, "No, I don't want a leave of

absence, I want to resign."

So I started part time in February of 1968, moved to Washington and took over the full time job in August of 1969. Fortunately, before I came, the question was how should the faculty be incorporated into the Association? Should there be a faculty representative from each medical school? Or was there a better way? Fortunately, an AAMC committee had made the decision. It had recommended and the executive council had accepted the recommendation that faculty be represented by discipline, not by institution.

So the Council of Academic Societies was formed which is made up of representatives of other organizations, everything from the Association of Anatomy chairman to the American College of Physicians. This was, I think, very wise. Because the Association should not be the place where local problems are worked out at a national level. If you have faculty from an institution, and the dean from an institution, and the hospital administrator, that might end up being the major orientation of the Association. I think it was very fortunate that the faculty was by discipline, not by institution.

The Council of Teaching Hospitals was formed. It really was made up of what was the section that had been meeting informally with the Association and already had offices at the Association.

Each one of the councils, the Council of Deans, the Council of Academic Societies and the Council of Teaching Hospitals, had representation on the executive council, which is really the board of trustees of the Association. The deans have the majority of the representation, which is agreed to by the other councils, since the medical school is basic to medical education. The chief elected officer of the Association is now called the Chairman and each one of the councils has a chairman. And each one of the councils has an

administrative board. They meet quarterly and consider policies and programs.

I think the basis of whatever successes I have had was my high regard and involvement with all three councils. I was a member of the faculty, I was an associate dean and in the dean's office, I was on the board of Evanston Hospital. So, I really had an interest and knowledge about all of the areas. Also, I think each one of the councils believes that I'm their man, which is true.

I arranged for a great change in the way the Association operated. The Association used to have, like most of the other organizations had always had, very long, thick agendas for meetings and many standing committees. I talked with the executive council and we got rid of most of the standing committees of this Association. As a matter of fact, there are really no really standing committees, except for an audit committee, that's appointed each year. There are some others that are stand-by committees that meet only on call. The officers agreed with me that we would work with ad hoc committees, commissions, and task forces. Identify a problem, charge a committee or task force, and when its report was submitted it was thanked and discharged. This really streamlined the operation.

It's very difficult to sit and think all the time of what are you going to do at the next meeting of the standing committee on such-and-such. There may be nothing to talk about but you have to have the committee meeting. And secondly, the committee always believes that it has to be consulted in anything to do with their area. That just paralyzes an organization. In these times, you have to be able to move very rapidly. Things are not slow. The pace has increased tremendously and you cannot operate in that form.

The second thing that we did, we changed the meeting -- the agendas. Our

agendas are very small. I had been on the board of a large Chicago corporation and learned about how business runs their meetings and what their agendas look like. I was very impressed with what the chairman of the board of that company said one time. He said, "If you can't put your proposal on two sides of a piece of paper, it means you don't understand what you want and we will not consider it."

It reminds me of Descartes who said, "I apologize for writing you a long letter, I didn't have time to write you a short one."

The agendas were greatly compressed and the staff always makes a recommendation which can be accepted or changed. As a result, I think we move through meetings rapidly, and effectively. Everybody has a chance to talk, but it's a much more fruitful affair.

When I took this position, I told the executive council that I would take it if I was the chief executive officer. I was not to be the chief operating officer. Before this, the Association had really been run by the executive council. You know, they would come in a few times a year for a couple of days. You simply cannot operate an association or a company on that basis. I said we will develop policies, broad policies, with the executive council. But, I must have freedom of action within those policies. And they agreed. I said, "If you don't like what I do, fire me, but don't run my business." And they again agreed. And I think it's worked out very well for both of us.

We have a mechanism on decision-making. We try and develop broad policies on issues. If something comes up where we don't have a policy, and it's between meetings of the executive council and a decision has to be made, then we have a meeting of the executive committee of the executive council usually by conference call, I serve on both the executive council and the



executive committee. The executive committee is made up of the chairman of the Association, the chairman-elect of the Association, the president, and the chairman of each of the three councils. If things move so fast we can't get a phone meeting, then the chairman and the chairman-elect and I discuss it. If we can't even get those together, the chairman and I or the chairman-elect and I decide it. If I can't get either one of those in time, I decide. There have been no serious problems with the system.

WEEKS:

You certainly offer a lot of alternatives up to the point where you make a decision by yourself. So you certainly couldn't be accused of...

COOPER:

But I sign a lot of letters here to the administration, to the Congress, and they are not reviewed by anybody. But they're within the policies that we've established.

The other thing that I insisted upon was each committee always have a representative at each of the councils.

By the way, I forgot to say, that in 1972 an organization of student representatives (OSR) was added to the governance of the Association. That student is selected by the medical school.

WEEKS:

Do they have a vote?

COOPER:

Oh, yes. They are on the executive council, two members on the executive council. I'll talk about the assembly in a minute.

As I said, a representative of each council is appointed to every task force. It may be a task force on Medicare reimbursement to hospitals, but you

have to have a dean and faculty member on it. If it's on biomedical research, there has to be somebody from the Council on Teaching Hospitals on it. If it's on some medical school administration matter, it has a faculty member and, where appropriate, students. This approach has helped to bring cohesion in the constituency.

The other thing I think has brought cohesion is an agreement with the executive council that the staff was the staff of the Association. It was not the staff assigned to a council or task force.

Because this organization is called the Association of American Medical Colleges, some problems are created for the teaching hospitals. It doesn't for the faculty. I think we should have changed the name to the Association of American Medical Centers. But, we didn't. But a rose by any other name smells as sweet. We are usually referred to by our acronym "AAMC" which helps with the teaching hospital problems.

We have an executive staff organization because I have tried to make our work a joint affair for all for us. We meet weekly, problems are discussed, and tasks are assigned depending on the basis of who has time and effort available. I had another great opportunity when I took over. Almost none of the staff of the Evanston office moved to Washington so I could recruit my own team.

WEEKS:

Is that right? Well, I can understand.

COOPER:

So I had the opportunity to reappoint almost the entire staff. All of these together really helped develop cohesion of the separate parts of the constituency and the staff.

The other thing that I accomplished was to convince the executive council about was the chairman of this organization should not always be a dean.

WEEKS:

Is this a yearly election?

COOPER:

Yearly election. You are elected chairman-elect. The next year you are chairman and then you are past-chairman.

It was agreed. There is an informal alternation of the chairman, not in the bylaws, as follows: dean - CAS - dean - COTH - dean - CAS - and so on. That makes a dean either chairman or chairman-elect. But it also puts one of the other constituents into the position. There was no problem with the others in recognizing that the deans are a very important part of the organization. Russ Nelson, M.D., very distinguished person, from Hopkins, was the first AAMC chairman from COTH.

Then the next problem was to make certain that there was a feeling that the chairman didn't have to be an M.D. to have a full participation in this organization. So Charles Womer was elected the chairman of the Association from COTH. He was the nonphysician director of Yale-New Haven Hospital. We had a great deal of difficulty convincing him that he should accept the nomination because he just didn't feel that a non-M.D. could do it. But he did a very great job, and now there are really no classes of the membership.

WEEKS:

I was thinking when you were talking about the AAMC being the Association of American Medical Colleges but you could have changed the C to Center, that there is a problem that always seems to exist in a university medical center between the medical school and the hospital. I was wondering how you bring

this together in your organization. Do you find ways of smoothing out the differences?

COOPER:

I think, as I said earlier, we have insisted that members of each one of the councils participate in policy development in all areas of the academic medical center's activities. I think that has made each one of the councils feel that they have an input into all policy and programs. It's very interesting. We try and avoid having multiple members on any task force from one institution. It's amazing that people can be statesmen when they are not in confrontation or discussions with their colleagues in that same institution.

I think the Association has come together. The most suspicious group was the Council of Teaching Hospital membership and I've had statement after statement from them that although they had questions in the beginning, they are now very comfortable in this organization.

So I think the warnings of my friends were wrong. It was done.

Now I must tell you though, that with the change in environment, there are more centrifugal forces trying to pull the academic medical center apart and the Association apart with it. It is going to take increased effort to make certain that we keep together, not only in the Association but in the institutions. Because many of the traditional goals and objectives of the university are being threatened by the environment, and there is more friction developing between its parts.

For example, today almost half of the general operating budget of a medical college, on the average, comes from the income earned by the practice of the full-time clinical faculty. That has increased tremendously since

1965. That tends to change the medical school from a true part of a university into a different kind of organization. In addition, the faculty are developing their own enterprises, companies, relating to their research work -- genetic engineering and all of that that's pulling the departments apart. So, I see that in the future we're going to have a much tougher time keeping different groups in the academic medical center pulling together and keeping it, more importantly, a part of a university. Because many of the things are happening in medical schools much more rapidly and much more extensively than they are happening in the university. I hope that we can avoid going back to a more trade school proprietary kind of institution like we had in the 1900s.

WEEKS:

I was just going to remark that several times in the last couple or three years I have heard persons express opinions in which they say that university hospitals should become separate from the university and from the medical school. They should be separate corporation. Would that be good or bad, do you think?

COOPER:

I think it depends upon the institution. We have a lot of institutions that have separated their hospitals. It is certainly true that the hospital has to pay more attention to the non-medical school environment if it is to remain fiscally viable. I mean, it is in a much more competitive situation than it has been in the past and it's going to make it much more difficult for it to operate in a different way than a hospital that is not related, not a teaching hospital. It's a real problem. The financing of medical education, the research support, all of those have not kept up with the fiscal

requirements of the institutions. It is going to be an even more real serious problem in the future. I don't think medical schools will close because communities believe that the medical school does have an effect upon the quality of care in its area, not only in the town but in the surrounding area.

There have been attempts recently, because of the beliefs of many that we're producing too many physicians, to close some medical schools. Ohio tried it. But the townspeople in those areas where medical schools were located objected vigorously. Not so much because of the loss of places for medical students, but because of the total contributions of the academic medical center that is really the keystone of the American medical care system. Also, the center provides substantial employment in the area. That's another matter which is of great concern to communities. Medicine is a large industry. It's very difficult to understand why policy-makers and even business men believe that we should expand other business, but that medical care should not expand. Part of that is because, unfortunately, forty percent of the payment for that care comes from local, state, federal government and about an equal percentage from businesses. They are concerned about costs and are leading the effort to contain medical care costs.

Business coalitions are trying to change the nature of medical care by increasing competition that will create problems for our academic medical centers. They are more expensive because they give higher quality care and train the next generation of physicians. The latter contribute only a small part of higher costs. Academic medical centers deliver a different kind of care, complex tertiary care to patients that are generally sicker and require more intensive care and more utilization of resources.

I notice that a business executive bragged that his company had reduced

the cost of their medical insurance by increasing the co-insurance and deductibles on health insurance and placing limitations on the physicians employees could use. He took the money saved there and put it into other benefits for the workers. What better benefits could his employees have than good medical care they could afford?

WEEKS:

One aspect of this situation that I have noticed -- it may be peculiar to Michigan -- but, let me say that twenty-five or thirty years ago, outside of Henry Ford Hospital and maybe Harper-Grace in Detroit, there was no medical center comparable to the University of Michigan. In fact, the University of Michigan Hospital didn't draw its patients so much from Detroit as it did from out-state. In recent years, with the spread of specialism -- specialists are available now, they have settled in Grand Rapids and Flint, Petoskey, Traverse City, Kalamazoo -- so that you can get fairly complete care in any one of those medical centers and they are really competing with the University of Michigan Hospital for those out-state patients. What effect is those going to have do you think?

COOPER:

I think there is no question that the medical centers have educated and trained specialists and sub-specialists which have really become their competition. There is a great movement today to reduce the education and training of specialists and subspecialists. Not of primary care specialists. It is claimed and we believe that we probably have prepared too many subspecialists and that there should be more focus on primary care specialties. As a matter of fact, the legislation now in the Congress that has been endorsed by the Association would limit the years of payment under

Medicare for residency stipends and benefits to primary board specialty or five years, whichever is least. And this will remove a lot of support for fellowship training for sub-specialties.

But the academic medical centers still differ from the community hospital that may have a lot of subspecialists on their staffs because "cutting-edge" medicine is still provided almost entirely in our academic medical centers.

WEEKS:

I don't remember if you attended the meeting of the medical schools since 1960. Dr. Hunt of East Lansing conducted it. Kellogg was behind this and I had to edit the papers.

COOPER:

Community-based medical schools.

WEEKS:

Community-based medical schools and the fact that they were getting their clinical experience from community hospitals with no connection with the school, no financial connection. What is that doing to medicine?

COOPER:

Well, really, all medical schools are community based. They all provide care. Not only tertiary, highly complex care but primary care as well. The difference at Michigan State and Southern Illinois University and others is that there is no single major teaching hospital, but there is always a movement towards the middle ground. More of the old-established schools are using more community hospitals for clinical education and training. The community-based medical schools are asking for the construction of a university hospital.



WEEKS:

Do you think that there will be a merger of some of the schools? There are what, a hundred or so now?

COOPER:

A hundred twenty-seven.

WEEKS:

That has nearly doubled in the last twenty-five or thirty years.

COOPER:

We had eighty-six in 1960. About fifty percent. I don't think there will be any closings for the reasons I talked about earlier. I don't think we are going to see any new schools started. I think the class size will be decreased. We have decreased class size, now, about 300 since 1982. I think the decrease will continue. The number of applicants to medical schools is falling. Medicine is not looked upon by many of the young people as exciting and rewarding a profession as it used to be, largely because of so much imposition by the federal government and other changes in medicine. It is no longer considered to be the same scholarly profession it used to be. Unfortunately for medicine and for the health of the American people, medicine is moving away from a scholarly profession caring for patients into a business marketing products to consumers. HMOs, PPOs, and the other forms of organized medicine have resulted in a different kind of medical care.

WEEKS:

The store front clinics and this kind of thing.

COOPER:

Ambulatory surgery and so on. It's too bad that economics has become the guiding principle to medicine rather than quality and availability of care.

The number of poor that are able to get care is being reduced through restriction in funding. In the new competitive environment academic medical centers, that have always been the place of last refuge for someone who can't get care elsewhere, find it difficult to provide charity care because they are no longer able to charge those who can pay enough to help cover the cost of those who can't. There are going to be great problems in the future on the care of the poor. The percentage of poor in our population is increasing, particularly in the elderly because of reductions being made in Medicare payments. The elderly are being required to pay a larger and larger fraction of their medical care costs. As a matter of fact, today, they are paying a bigger percentage of their health care costs than they did in 1964, before Medicare.

All of that is going to create a very serious problem for maintaining the health of the Americans and for providing opportunity for them to receive the modern medical care which does make a difference in the quality of life, in the prevention of premature death and premature disability. I'm very concerned about that.

WEEKS:

Some of the HMOs now, I have noticed, are appealing to senior citizens to enlist with them for \$15 or \$20 a month to pay all benefits beyond Medicare.

COOPER:

Medicare will pay ninety-five percent of the usual and customary costs for Medicare recipients to an HMO. That relieves them of paying co-insurance.

Let's get back and talk a little bit about the Association.

For me it has been a fantastic sixteen years. The Association has grown from some sixty employees to one hundred and eighty-five. We have developed a

centralized application service. We have completely revised the MCAT test to make it more appropriate for evaluating students, by the admissions committees. We have also carried out a number of very important studies. We have made our presence in Washington recognized. I was chosen for five successive years by the U.S. News and World Report poll as one of the five outstanding, most influential persons, in public policy.

The other thing that I think is important, during this period of time we have established much stronger relationships with other private sector organizations, both in the research fields, because there are many organizations that are interested in biomedical research. We have formal and informal, close relationships with them.

But I think most important, we have a very strong relationship with the AMA and with the American Hospital Association. As a matter of fact, two weeks ago I was given a special recognition by the board of trustees of the AMA. And next week I will get a special recognition from the American Hospital Association.

As I told Jim Sammons and Alex McMahon, I am very proud and honored that it's given in my name, but I think the most important thing that the awards testify that these three organizations now work very closely together for the benefit of all of us. We exchange information very frequently. We talk to each other. We work together and I think it has been for the benefit of the American people, for medical schools, for practicing physicians, and for all hospitals. The teaching hospitals do look to us rather than the AHA because they have different problems than the six thousand community hospitals, but that in no way means that we are in competition with the AHA. The AHA really, I believe, considers us as the teaching hospital part of their activities. And

that kind of cooperation did not exist before and I'm very proud of the kind of relationship that has been forged, which is critical.

WEEKS:

When you are here in Washington talking to the legislators, how do you consider yourself? As representing the colleges? Or do you represent physicians in addition to the colleges?

COOPER:

This is an organization whose policies are developed by all the constituents of the academic medical centers, the deans, the faculty and the teaching hospitals. The Association tries to speak for academic medical centers and all their parts.

We also work with the Congress differently than most organizations. We do not pad around on the Hill. We have a group that keeps up to date and talks with the staff and so on up there, but in most of our interaction with the Hill, we use our constituency. It is my theory that a congressman is much more interested in what's happening in their state or their district than they are in what some national association talks to them about. So we have developed a very effective network of congressional contacts through our institutions. They are very effective in helping their Congressmen and Senators develop their views on legislation.

WEEKS:

So you use people from the organizations to help you represent.

COOPER:

The people in the constituency work with the Congress a lot. We establish a policy on which they agree upon and then they sell the policy. We do not have a PAC. We do not make contributions. But we're still looked

upon, I believe, as a white-hatted professional group. We are called by the Hill as much as we call on them. We have an extensive data base here which they find useful.

WEEKS:

You make yourself available for information.

COOPER:

We provide them with the raw information they ask for.

I'm not saying that we don't try to influence legislation. As a professional organization we use professionals rather than traditional lobbyists to work with the Congress and its staff.

WEEKS:

We were talking about medical schools and their connections a moment ago. One thing I was wondering about, your opinion on the increase in female students in medical colleges. Is this going to change the medical care picture?

COOPER:

I think it's very good for medicine. We have worked very hard over the past fifteen years to increase the representation of women and minorities. We had one of the first studies done, in 1972, on under-represented minorities in medicine and came out with a plan on how we could increase it. We did increase it substantially over a period of time. It has sort of plateaued now for a variety of reasons. One is that the blacks and the Chicanos have more opportunities now in other professions. It's a long, costly educational program and there is inadequate financial support for them. Generally, minorities come from low-income families. So they are very... I predicted ten years ago that about a third of the applicants and of those attending medical

school would be women. It's about thirty-four percent now. I think it's going to level off.

Actually, we hit the peak number of applicants in 1974, about 42,000. The number of applicants has been decreasing since then. The number of women applicants has been increasing. It is their increase that prevented a faster fall in the number of applicants.

I think they are going to be a good thing for medicine. I think they bring a different perspective and I don't think they are as entrepreneurial as men. I think they may be more professional in the old sense than men.

WEEKS:

They look at the sociological side of medicine more.

COOPER:

They are not as entrepreneurial.

We now have ten women that are full professors of surgery. We have one woman that is chairman of the department of urology in a medical school. There is a change. So, women have broadened out from the past traditional specialties of the women, pediatrics or obstetrics and gynecology, into every one of the specialties and subspecialties. I think it's been good.

WEEKS:

Just one thought crosses my mind here in hearing you talk about all the things you are doing. What do you do for finances?

COOPER:

Because the institution's membership recognizes that the Association has become more effective than it was in the past, they support us generously. But only twenty-five percent of the annual budget, which is now about \$11,000,000 a year, comes from dues. The rest we get from a variety of

places; from the centralized application service, from MCAT, from government grants and foundations, and the services. So seventy-five percent of the budget comes from other than the membership.

WEEKS:

Your accrediting groups, the liaison committees for medical education -- there's one for graduate medical education, isn't there? And one for continuing?

COOPER:

Yes.

WEEKS:

Are those partly financed from outside sources?

COOPER:

Some. The liaison committee on medical education that accredits medical education, we and the AMA finance completely. The others are financed in part through fees for accreditation. But we also contribute, as do the other organizations that are members of the accrediting bodies. We decided long ago that it's our responsibility to cover the costs of medical school accreditation and neither the AMA nor AAMC has ever considered charging the medical schools.

WEEKS:

Now, when you were talking of research -- is it your group that's doing longitudinal studies?

COOPER:

We've had longitudinal studies with our enormous data base. For example, we have data on every full-time faculty member in the United States. We have a lot of information about faculty: where he was trained, his movements through

medical faculties, his promotions. We know the salaries. We have a great deal of information about institutions, their financing, their space, buildings, etc., etc. All on-line. We have every applicant to medical school back to about 1940 but it isn't all on-line. We have a student data base in which we can follow students from application to acceptance then through medical school. Did they progress normally? Did they drop out for research? Did they have to repeat a year? We have all of that kind of information. Now, we are now following them through their residency programs.

We do studies on students, on faculty, on manpower requirements, the movement of faculty, and so on.

WEEKS:

Do you make information available to collateral groups?

COOPER:

Yes. We make charges for the costs of the process.

WEEKS:

I have a few items here. Did you want to say more about the Association?

COOPER:

Yes. One of the other things I do want to say...I have been honored by the institutions that have representatives on AAMC. I am very humble about the fact that I have been honored by so many of the institutions by honorary degrees and both of my alma maters have given me outstanding alumni awards. Those things really make one feel that maybe he has made some contribution.

WEEKS:

That Markle Award was quite an honor too. What was it, five years you had that?



COOPER:

That is one of the greatest programs that any foundation has ever had. It, unfortunately, no longer exists. It supported young faculty, not with a lot of money, but with recognition to keep them in academic medicine. The funds provided could be used with great flexibility. It was very important in shaping my career, very important. It also was important in shaping the careers of a lot of the leaders of American medicine today. It used to be a list of faculty where you could identify those with promise, as you were looking for faculty. Unfortunately, when John Russell retired as president, the new president abolished the program. I doubt if you even know what the Markel Foundation does today.

WEEKS:

No. I am not familiar with it.

COOPER:

No. But you know what it did before. It has sort of lapsed into the unknown.

WEEKS:

The government hasn't been very kind about foundations. I can understand their general approval. But isn't it necessary for each foundation to spend a little more than it earns each year?

COOPER:

Well, it has to spend five percent of its corpus return. I was deeply involved, when that legislation was going through, with the foundations in representation to the Congress. We used to have meetings in the AAMC, actually.

WEEKS:

Is that right?

COOPER:

Yes. And I testified on several occasions with Father Hesburgh from Notre Dame and some of the presidents of the universities and deans of medical schools. I am becoming concerned about foundations. I don't think they really serve as unique a purpose as they used to. When Emory Morris was head and Allan Gregg, foundations developed ideas but they also accepted ideas from outside. They were open to all suggestions and gave support to those that they decided were worthy, innovative, and exciting. Now most foundations have defined their portfolio very narrowly. Actually, in some cases, it's easier to get money from the federal government today than it is from a foundation. The government has broader interests than foundations.

I think that foundations have lost many of the original unique roles they played. They are much more directive and autocratic. I gave one foundation president -- I found the book on Allan Gregg, on the difficulty of giving money. He was one of the greatest foundation leaders of all times. He responded to a broad spectrum of proposals when he was at the Rockefeller Foundation. He played a seminal role in developing psychiatry in the medical schools in this country and in Canada. Because of his important contributions, the AAMC established the Allan Gregg lectures at its annual meetings.

WEEKS:

There should be a very imaginative person at the head of the dispensation of money. I know Andy Pattullo very well. I often think, there's a man who came in at the very beginning of hospital administration. He was in one of

the first classes of Chicago. He knows everybody and everything. He's been there while it's developed. Now, Bob DeVries who is his successor is a younger man who doesn't have the advantage of that. I'm sure he's a very capable person, but he doesn't have that background of experience of being in on the beginning and seeing the basic problems. This would seem to me to be one of their weaknesses today.

COOPER:

I agree. I did a lot of research before I became involved in administration. Almost half of my bibliography, which is now about 300 publications, is in science and that's one of the reasons that I get along well with the faculties. Because I have the tickets, the research tickets. I think that has been very important. I'm accepted by them as one of them, a faculty member. It was the same situation with Andy Pattullo. He was a very capable foundation executive and my good friend.

WEEKS:

Talking about research and bibliography, your own bibliography and others which I suppose you will consult during the writing of your history, brings up the name of Paul Sanazaro. He left the AAMC shortly before you came in, didn't he?

COOPER:

Yes.

WEEKS:

At the press, this press I was telling you about at the University of Michigan, we published a book by Paul and Evelyn Flook, of the Public Health Service, on research. It was a health services research book. That took a great deal of work. I think much of the scut work was done by Miss Flook.

She is a remarkable lady. Retired now and sort of one of the old guard of the Public Health Service.

One thing you didn't talk about was your work with the Food and Drug Administration on investigational new drugs (IND).

COOPER:

That was an exciting thing. I was on the first advisory committee to the administrator when the new drug applications were introduced as a result of Senator Kefauver's legislation. It was a period when there was great opposition in some quarters to the new FDA requirement. I also think there was suspicion by the FDA administrator that we would act against the best interest of the public by trying to weaken that program.

It was an interesting group of people and we worked effectively together. Actually, in some cases we suggested strengthening requirements for INDs. When we saw some of the things going on in drug development, we often requested stricter regulations.

I think it was an interesting period in the FDA. The administrator at that time was not very knowledgeable about drugs. He had come out of the food part of the Food and Drug Administration. I don't think he understood or considered the committee's advice very useful to him.

But I haven't really worked with the FDA since then in any formal way.

WEEKS:

Talking about drugs, you were mentioning the University of Wisconsin and their biochemistry department. You mentioned something about their research. Did that happen to be -- I can remember back in the 1940s when viosterol was discovered by somebody at Wisconsin and the royalties from that went back into the university and it was quite a...

COOPER:

I don't know whether Conrad Elvejehm did it or not. It's very interesting. His department, biochemistry, is in the School of Agriculture. But it did much of the important early work on identifying metabolic pathways, the enzymes, intermediates and so on. It was really the greatest biochemistry department in the world in the 1940s. From Wisconsin came the patents on producing vitamin D in milk by ultraviolet radiation and dicoumarin, an anticoagulant and rat poison.

WEEKS:

Is that a land grant college?

COOPER:

Yes.

WEEKS:

I didn't realize. Like our Michigan State.

I was going to ask you about your connection with HRET. I notice that you were on the advisory board. You came in after they were established, a few years. I know the cause, but not the particulars, of why HRET was formed. It was formed so that it could accept research money from outside sources.

COOPER:

Yes, particularly from foundations because they couldn't count the use of their income if it was not given to a 501-(C)(3) organization. AMA has a similar foundation. We are a 501-(C)(3) organization. Most trade associations with a 501-(C)(6) classification have set up foundations.

WEEKS:

Was Colin Churchill at HRET then?

COOPER:

Yes.

WEEKS:

What were they thinking about in those days? I'm interested because I was just looking at their report the other day and they seem to be doing many things that I didn't realize that they were doing.

COOPER:

You know, I really can't remember specifically. A lot of it had to do with training and health service research. But there were a wide variety of things it was doing.

WEEKS:

You were on their journal, on the editorial board.

COOPER:

Yes. I was on the advisory committee.

WEEKS:

Yes, I know you were on the advisory committee also.

COOPER:

One of the other things I did which I didn't remark upon. Robert Marston became the director of the National Institutes of Health, he was a Markle Scholar and we had known each other. He called me up and asked me if I would come and be his deputy at the National Institutes of Health. This was in about 1968. I said no, I did not want to join the government. I told him I would be happy to help him in anyway that I could but I did not want to take a full time position with the government. He called Rocky Miller who was then president of Northwestern and told him that he had talked to me about a position and I was not interested but he wanted me to be a special advisor to

the director and to come to Bethesda three days a week.

Rocky called me in and said, "I got this call from Bob Marston, he wants you to come to the National Institute and be a special advisor three days a week, and I think you ought to do it."

I said, "I have a big job here."

He said, "Well, I'll give you some extra help if you need it, but I think you ought to take it."

So I took an airplane every Sunday night into Washington and got an airplane every Wednesday night and went back to Chicago. And I did my other work, with some help, during the rest of the week. It was a great opportunity because it gave me an insight into the National Institutes of Health from the inside, which you don't get in any other way. I really felt that I was a member of the NIH staff. It was very instructive, very interesting, and has given me a different kind of relationship with the NIH than most people have.

I recruited John Sherman who was deputy director of NIH for many years as my vice president at AAMC.

WEEKS:

You were an advisor to AID also, weren't you?

COOPER:

I was. That was the one when I told you about when Margaret Mead and I were together.

WEEKS:

Is there any connection between the American Council of Education and the...

COOPER:

Council on Education?

WEEKS:

Yes.

COOPER:

We are members of that. They are the owners of this National Center for Higher Education. They are an umbrella organization for all the higher education.

WEEKS:

That's what I thought.

Is the liaison committee for graduate medical education -- this operates, I'm sure separately. Is this looking at the residencies?

COOPER:

It is now called the Accreditation Council for Graduate Medical Education.

WEEKS:

The liaison committee?

COOPER:

Yes. It used to be the LCGME but now the name has changed. It's called the Accreditation Council on Graduate Medical Education. The old liaison committee on continuing medical education is now called the Accreditation Council on Continuing Medical Education. It approves residency training. The residency review committees make recommendations to the Accreditation Council on Residency Programs.

WEEKS:

I heard a statement the other day that there's no longer a shortage, that the residencies are being filled now where before there were some vacancies.



COOPER:

Yes.

WEEKS:

And that this in turn has had an effect on the foreign medical graduates because they're becoming second in the choice of residencies. Is that a fair statement?

COOPER:

Yes. Well, residencies are not supposed to have been established to serve hospitals. Residencies are educational programs in which the learner does participate in patient care. So somebody saying you don't have enough medical graduates to fill the residencies, that is not the purpose of residencies.

I am also the president of the National Residency Matching Plan and have gotten involved with this whole business of residency programs and what residents are in them. There are slightly more residency positions in the United States than graduates of U.S. medical schools. The excess numbers are smaller than they were years ago because of the expansion of medical school class size which almost doubled during the decade. But there are about eleven hundred residency positions in the United States to which no U.S. graduate has ever applied. These are largely in inner-city hospitals, particularly in New York and New Jersey, where U.S. graduates don't really believe that there is an educational opportunity there and that they are really being used as labor. If you take those out, it's very close. Too close really for comfort. You need some slack, if you're going to give students any opportunity to choose among the various disciplines of medicine.

The U.S. foreign medical graduate has complicated matters because the

proprietary medical schools in the Caribbean have increased the numbers seeking residency training. With the new written examination foreign medical graduates are required to pass a hands-on examination being developed to evaluate their clinical skills, which will be difficult for them because they have very poor clinical education programs in these schools. I think you will see a decrease in the numbers qualifying for residency training here. Not only because there are not enough positions but because they will not be able to fulfill the requirements of the ACGME to enter them.

ACGME -- you may not appoint a resident to an approved program unless they are a graduate of an LCME accredited school or they have ECFMG certification.

WEEKS:

But you are going to try to strengthen the exam by getting the clinical aspect there.

COOPER:

As well. But the other exam has been strengthened. Only about two percent of the U.S. FMGs passed the new exam.

WEEKS:

Is that right? What are the foreign medical schools doing about it? Are they willing to increase their clinical training some way?

COOPER:

They have some clinical training. Not the quality we have. We have the highest quality of clinical training in the United States. Do you mean the one for U.S. foreign graduates or the ones in Europe or Italy?

WEEKS:

I was thinking more of the Latin American schools.

COOPER:

That isn't the biggest problem for residency. The biggest problem is Pakistan, India and the Philippines. They have schools that just turn out students by the thousands and far too many for any opportunities they have in those countries. Usually as poorly trained as...

WEEKS:

Does the government consult with any part of the medical education structure as to whom should we give visas...

COOPER:

No. They are required to have an exchange student visa if they are coming as a non-immigrant. There can be some control over exchange student visas but things have changed recently. More and more are coming in and marrying to get family preferences for a permanent immigration visa. Then you don't need to get that exchange student visa and that gets them into the country easier. It's a problem.

And we don't see why American medical schools should be asked to reduce their class size when all they would do would be stimulate the number of more poorly trained U.S. graduates of foreign medical schools to come into the country to be physicians.

WEEKS:

So actually the problem is, in many ways, due to the hospital saying we need to fill these residencies.

COOPER:

Right.

WEEKS:

Rather than saying to the hospital, we've got some residents that need

training.

COOPER:

The United States does have a responsibility to educate and train students from abroad, particularly, as I said, in the specialties and subspecialties for them to go home and help improve the quality of their medical care. But the problem is there are too many casuals that have come to this country with no intention of returning. They want to stay here. And we are already, as many people claim, producing too many physicians to meet our own requirements. Why do we need to import them?

WEEKS:

What is your opinion about the number of physicians we're training?

COOPER:

That is entirely dependent on what fraction of our resources policymakers decide should be spent for health care. Right now they are deciding it will be fewer. If they continue to cut back on resources, then we have too many physicians. However, if we took care of the twenty-five million people who are not getting adequate care and take care of the elderly who require more care and who are growing in number, we may have the right number or not enough physicians. But unless resources are provided for medical care, we may have too many physicians.

WEEKS:

Do you see any answer to the problem of distribution of physicians? We have, we'll say a greater gross number of physicians we need, but we don't have them distributed in the places...

COOPER:

Oh, the distribution has improved tremendously. Tremendously. Rand has

done a study on the availability of care for people every place, except on the top of Pike's Peak. Most of our people are now within a short distance of even specialists. There are a lot of board certified surgeons in towns of 5,000. It's not perfect, but the improvement is tremendous.

WEEKS:

I can think of a study we did in a town of 5,000 on progressive patient care where we had a medical staff of about thirty-five and they were all GPs. Some of them had certain skills in general surgery.

COOPER:

That's changing.

WEEKS:

Yes. But now that same hospital has quite a few specialists. They have internists, they have everything. But possibly this is due to the fact that we are training so many of them that they have to spread out.

COOPER:

That's right. Exactly. And the other thing is some physicians just decided they didn't want to hassle with the big town.

WEEKS:

You can be, like my father used to say, a big frog in a small puddle.

COOPER:

That's right.

WEEKS:

This National Commission on Accreditation is still another umbrella...

COOPER:

National Commission on Accreditation? Which is that?

WEEKS:

I picked this up some where.

COOPER:

There's an Educational Commission for Foreign Medical Graduates.

WEEKS:

I have that noted here somewhere.

Somewhere I read about the National Fund for Medical Education and I came away with the feeling that it was not so much for students as it was for schools.

COOPER:

Right. It was started under the impetus of the AAMC and the AMA, as a mechanism in the early fifties to try and get more support for medical schools from industry. It has always had on its board of trustees a preponderance of people from business. It was really designed to try and attract business contributions to medical schools, it was not meant, specifically, to support medical student finances.

WEEKS:

Weren't there one or two fellowships?

COOPER:

They had that.

WEEKS:

But it's incidental.

COOPER:

It changes its programs depending upon where they think the opportunities are.

WEEKS:

I see.

We were talking about the residencies. Is there a national residency matching program?

COOPER:

Plan, yes. It was started by the AMA, AAMC, American Hospital Association, Catholic Hospital Association, Protestant Hospital Association. There was a terrible problem with the number of people that were -- there was a disparity. There were many residencies and few graduates. And there was a very unprofessional way in which residents were being solicited for positions. It was a very unprofessional situation.

WEEKS:

Was this to be sort of a clearinghouse?

COOPER:

It was set up as mechanism to try and regularize the appointments to residencies and to set times when students had to finally give their commitment. It was established to prevent a kind of shanghaiing of students by program directors. It's been very effective. It is now going beyond the first year residents, it's beginning to match residents in years beyond the first year and it's also beginning to do some matches for fellowships. It just stops undesirable actions to try and get an advantage over somebody else.

WEEKS:

I can understand that.

We did speak about the VA and the research hospital and the radioisotopes.

COOPER:

I was one of the few people, I guess, that directed a VA radioisotope unit as a consultant not a full time employee. First I was director at Hines and then I organized and developed a unit at the VA Research Hospital, which is on the Northwestern campus.

The VA actually was responsible for developing the use of radioisotopes in the diagnosis and therapy of disease. It was a very effective program. I have had a very close relationship in other ways with the VA for many years. I am now on the VA Special Medical Advisory Group to the administrator. I have a deep commitment to the VA. I think it serves a very critical and important purpose for a great number of veterans. This Association now testifies vigorously for support for that system and for maintaining the high quality of care that is given on VA because of the affiliations to American medical schools. That was started by Paul Hawley and Paul Magnuson, who was a chairman of orthopedics at Northwestern.

WEEKS:

Is that right? I noticed you mentioned the VA Administration administrative scholars. I was wondering, is that the program that George Bugbee was interested in?

COOPER:

I don't know. It's abolished now. It was established for people who were interested in administrative posts, really in the VA, although they were not required to serve in the VA. It gave them a fellowship that involved course work at George Washington's School of Business and work in VA's central office. They did a thesis and so on and really became more knowledgeable about administration of health care systems generally and, specifically, about



the VA. Many of them have gone into the VA.

WEEKS:

The reason I brought this up -- I didn't think it was George Bugbee's but George Bugbee was hired by the VA, after he retired from the University of Chicago, to conduct, I think, quarterly seminars for second-level administrative people. He called it the VA Forum. That was his name for it. He has resigned from it. I don't know whether they continued to... George is now eighty-three, I guess.

COOPER:

Great man.

WEEKS:

I am very fond of him.

You had some WHO experience too, didn't you?

COOPER:

Yes. I have always been very interested in international medical education. I helped found the World Federation for Medical Education with Van Zile Hyde. It is no longer operating because when Dr. Hyde, who used to head the AAMC division of international medical education, retired there was no one who could get the necessary financial support for it.

I also have worked with WHO in a number of ways. The last one, and very interesting one, was to serve on the working group for tropical disease research. My role in that was to participate with the group that was identifying institutions in developing countries to build them up so that they could carry out more effective and better research on the tropical diseases to which their people were afflicted. It was a good program and I think it did greatly improve their abilities. The program part which I did not participate

directly in also gave grants to carry out research in tropical disease. Because the interest in tropical disease after World War II fell very rapidly in the United States. But the WHO program revived interest by grants, peer reviewed grants, to investigators not only in developing countries but in the United States.

I made a lot of trips around the world for the programs.

WEEKS:

Speaking of foreign countries, I noticed Russia and Poland here.

COOPER:

I just got back from China too.

WEEKS:

Did you?

COOPER:

I had a great time. I was on missions, State Department missions to Egypt and an HHS mission to both Poland and the Soviet Union. I spent six weeks in the Soviet Union. Very interesting -- to study medical education and health care. I learned a lot about their system, and was more impressed than ever about how great our system is.

WEEKS:

Is it true what we've read that they have more female physicians than male?

COOPER:

Oh, yes. That was true in many areas because the Russian men were decimated in World War II. They lost millions and millions and millions of men, and women had to do a lot of things. They are balancing things out a little more but at one time it was a necessity to have women doing more.

There was nothing else Russia could do.

WEEKS:

I think a woman is the natural person to take care of a sick person, child or...

COOPER:

I just got back from six weeks in the People's Republic of China which was very exciting. I was the guest of the Minister of Health who sent a young physician to meet us in Guang Zhou or Canton. He accompanied my wife and I on the trip. I visited five medical schools, talked about medical education, gave speeches, and worked with the deans and the faculty and saw a lot of China. It's a remarkable country, remarkable country.

WEEKS:

Are they leaning toward western medicine?

COOPER:

Oh, yes. No question. As a matter of fact, in Guang Zhou Medical School, a hundred of the students are taught only in English, not in Chinese.

WEEKS:

How do you spell that?

COOPER:

Guang Zhou. It used to be called Canton.

WEEKS:

This is the former Canton?

COOPER:

Yes.

WEEKS:

I display my ignorance here on another thing. I have heard others use

the words "visiting committees," like at Harvard or Duke. What does a visiting committee do? Act outsiders viewing the internal operation?

COOPER:

Yes. It's a review group that looks over the programs and what the dean is interested in having considered. It can also make independent recommendations. It sort of gives the dean and faculty an outside view of how they are doing.

WEEKS:

This is what I thought it was but I wasn't sure.

And the Health Care Policy Center at Georgetown -- what do they do?

COOPER:

That was an organization started to help state governments develop better staffing and better understanding of health care issues. I'm very proud I served on that. President Jimmy Carter was a member at the same time I was. It has changed its organizational format and no longer is as visible.

WEEKS:

May I ask you a few general questions?

COOPER:

Sure.

WEEKS:

I've been concerned about malpractice insurance like many other persons have been, I'm sure. I talked to Jim Neely, who used to be head of the Pennsylvania Hospital Association, and learned that they, while he was there, formed their own insurance company trying to get the rates within reason. Also I talked with a Canadian just a couple of weeks ago. I don't know whether you know Chaiker Abbis or not. He is a former judge who has been

interested in AHA and the Canadian Hospital Association. Anyway, in Canada they have no contingency fee that the attorney can work under. Would this be the answer in this country?

COOPER:

I think it certainly would help. But I think there's got to be some sort of more rational approach to the awards that are being made. The problem is that medicine is not a perfect science. There is some malpractice given by inept physicians, those who are drug addicted, those who don't keep up, those who are really not competent physicians. I think we are doing better in getting rid of those physicians.

There are also mishaps that occur that are not due to the inadequacies of a physician. They are just the fact that you can't be perfect in medicine. The problem has occurred that people expect medicine to be able to do more and more than it used to. We have more powerful drugs, more technology that may present more hazards. But at the same time that medicine becomes more of a hazard, it also has done more things for more people. It is just becoming impossible for physicians to practice when you have malpractice annual premiums of \$75,000 or \$100,000 a year. The physician has to earn that much before there is one dollar to put in the office costs and before there is another dollar to feed and house yourself. Something has to be done.

The AMA has been working very effectively. So has the AHA. We've got a lot of off-shore insurance companies, we've got self insurance, we've got a lot of things going on. But something has to be done legislatively or medicine is just going to be even more expensive -- defensive medicine costs a lot.

WEEKS:

This is another thing. Defensive medicine, and I love the new term "imaging costs." With all the new technology, the CAT scanners and magnetic resonance and so on.

COOPER:

CAT scanners actually save costs. It has been demonstrated that the total cost for the patients for which it's appropriate are much reduced. The noninvasive techniques that reduce hospitalization, reduce medical care costs. There is no question that CAT scanners have saved money. And I think NMR will do even more.

WEEKS:

I think you used the term appropriate and I think that's the key word.

COOPER:

Right. Now if you come in with a headache, I'm probably going to do a CAT scan on you even though I know you probably have got a tension headache. But you might have something else and then when I get on the stand and the lawyer asks, "Now doctor, why didn't you do a CAT scan?"

WEEKS:

This is the whole thing. The same is true with x-rays or laboratory tests or anything.

COOPER:

Right.

WEEKS:

I have a note on the multihospital systems and investor-owned hospitals. Are investor-owned hospitals affecting the training of medical students?

COOPER:

They are participating very little in any either medical student or residency training. They have bought some of our teaching hospitals. At Creighton and some others. You know, the projections for hospitals are not very good. There have been projections that at least ten percent will close, mostly community hospitals, by 1990. And the whole movement outside of the hospital into ambulatory surgery and into other sites is going to make the hospital business not the best business in the world. I don't think that the high investor interest in proprietary hospitals will continue and that they will not have this ease in raising capital.

Now, the claim is made that proprietary hospitals are better managed. Every study has shown that they are no better managed than the not-for-profit. And actually their costs are higher than the not-for-profit hospitals. There are more ancillaries used. The ancillaries have higher costs. We have big not-for-profit hospital systems. And there is going to be a lot of vertical integration. Hopkins has already purchased some smaller hospitals. They may purchase some more. They have an insurance company. They just announced last week the Hopkins Health Plan.

So there will be vertical integration for the teaching hospital to care for patients.

WEEKS:

The old regionalization idea?

COOPER:

Via the hospital. It won't be so much regionalization. It will be institutionalization, vertical integration.

WEEKS:

But they are going to ship people around to the place where the facilities are right for that patient.

COOPER:

Right. I don't think there is any question that that's going to happen.

WEEKS:

What else will they do? Will they save money?

COOPER:

There will be a lot of mergers.

WEEKS:

Well, do we have more beds than we need in this country?

COOPER:

Yes.

WEEKS:

Have you read recently about Blue Cross in northern Ohio and their putting out requests for bids to hospitals in their Blue Cross territory and those who did not warrant a contract didn't get a contract.

COOPER:

Oh, yes. I remember that. And preferred provider organizations for Blue Shield. There's all kinds of things to restrict freedom of access. As one person said there is the development of a lot of what are called organizations to limit care, HMOs, PPOs, and managed care.

WEEKS:

Such an HMO as Kaiser Permanente claims...

COOPER:

Some call them care avoidance organizations.



WEEKS:

That's a beautiful sounding name.

Kaiser made their biggest show in reducing the number of admissions per thousand patients. Do they carry it too far, I wonder? Apparently...

COOPER:

It claims that we over-hospitalize and that may be true. Although it may be that other countries and other systems under-hospitalize. It's very interesting. A study was done by an anesthesiologist where he compared us to England first and said they hospitalize half as much and then he talked about this country over-hospitalizing and a lot of unnecessary surgery. The interesting thing is that he then studied the claim that physicians were recommending too much surgery. He did a study of surgical use by families of physicians and lawyers. Now, you would expect a physician's family, if there is over-surgery, to have less surgery because a physician would not permit over-surgery on his own family. He found a higher rate of surgery in physicians' families.

Some say that if people were better informed they wouldn't have as much surgery. Here's physicians' families. How can you be better informed?

WEEKS:

I read research about access to care and it was based entirely on the number of times persons went to a physician in a year. It gauged the quality of care on the number of visits to a physician. I thought, what if you feel well and what if you don't go for an annual check-up and what if you don't have any aches and pains?

COOPER:

No, more important than that is how effective is the visit? I am

convinced that the total cost of care in an academic medical center is cheaper than it is elsewhere because I think the care is more effective. You get the problem solved by identifying properly what the problem is and solving it. If you add up all the return visits and fooling around that's done in other settings, I think the care is much more expensive. So it is not only the number of visits, but the quality of the visits.

WEEKS:

That's a good point.

COOPER:

You could have a guy come back as much as you want.

WEEKS:

This is something that people say is going to happen if we have too many physicians. Will he ask people to come back more often?

COOPER:

Well, who's going to pay for it?

WEEKS:

I guess that's the question. An interesting case in Massachusetts where Blue Cross is refusing to pay.

COOPER:

They tried that in Maryland too. That's all going to happen every place.

WEEKS:

It will just have to shake out somewhere.

COOPER:

We'll go through a curve and break out.

WEEKS:

And we'll know some day what we are going to have.

You haven't said anything about your work with the National Academy of Sciences.

COOPER:

Well I'm in the Institute of Medicine in the National Academy of Sciences. I have been on some of their committees. It is really no more than most of the other members are participating.

WEEKS:

I would like to close with asking you what you foresee for the future?

COOPER:

I think medicine is in for a real tough time in maintaining the high quality and standards that have characterized American medicine and to keep the personal kind of relationship between the physician and the patient, which is probably as important in satisfying the patient and in preventing or curing the disease as many of the other things in the physician's armamentarium.

I think the commercialization of medicine is very unfortunate. I think that it's changing the whole concept of medicine from the traditions. A physician does not discharge his or her responsibilities to a patient unless they can apply all of the modern things we know about prevention, diagnosis and therapy, no question. But that isn't all. There has to be caring. Because there is still the attitude and the feeling in patients that physicians must retain some of the priestly and shaman functions that have characterized this profession since it started. This kind of personal relationship is critical to good medicine. I think this is being threatened by the new approaches that are being taken in reimbursement and in the cries of business men that medicine should be more like a business.

Now if medicine is considered a business, it's going to be judged on the

basis of other businesses. Cost/benefit analyses, not quality of care. It's going to change the whole complexion of medicine. It's very unfortunate. Both for the physicians, the profession, and for the people.

WEEKS:

What do you think is really the motive of most of the students entering medical school?

COOPER:

I think the vast majority still have a deep commitment in service to people. No question. And I meet a lot of students. Let me tell you, they are not the perverted, money-grubbers like Joe Califano, for example, claims they are.

WEEKS:

Well, medicine, particularly the AMA, got a pretty bad picture during the pre-Medicare days when they were fighting anything that they thought might be socialized medicine.

COOPER:

Maybe they weren't as wrong as we thought they were at the time because it has been this that is changing medicine.

WEEKS:

Maybe it's been a good buffer. The fact that if any one of us has freedom of action we may do things that we wouldn't do if we had to consider the buffering effects of something else.

COOPER:

That's right.

WEEKS:

The curious thing to me -- I never met Morris Fishbein...

COOPER:

I knew Morris very well.

WEEKS:

I have talked to people who worked with him.

COOPER:

He was dogmatic. I mean, to him there was no gray. It was all black and white.

WEEKS:

But there was another side to him apparently because Bob Cunningham...

COOPER:

A very good friend of mine. A magnificent man.

WEEKS:

Isn't he though? And Bob Sigmond. Do you know him?

COOPER:

Yes. I know Bob very well.

WEEKS:

Both men told me that in one time in the early part of their careers they worked on a commission, each on separate commissions, that had to write reports. It happened that Morris Fishbein sat on each one of these committees and invited each one of these young men, separately, out to his home for lunch and then he would go over their manuscript and Sigmond said he taught him how to write.

COOPER:

No question. He was a very bright man.

WEEKS:

And furthermore, on a one to one basis, he was a very nice man.

COOPER:

Oh, yes. Charming.

WEEKS:

Except as you say when he got on to medicine.

COOPER:

On medicine he was dogmatic.

WEEKS:

I have another story that Nelson Cruikshank -- did you know him?

COOPER:

Very well.

WEEKS:

I hope he is still alive. I haven't talked to him in several months. He debated Fishbein one time on radio. After Fishbein had returned from England. Fishbein used to write for the JAMA. He used to write a column called Dr. Pepy's Diary. He was telling what he did in England. At another time, Cruikshank was able to show from another source that he wasn't doing that at all. It embarrassed Fishbein to the point that he lost some of his credibility because he was, in one place, telling about how he had dined with the King's physician and all that sort of thing. And the other time how he got away early and went to France and read a mystery novel on the way. There was nothing wrong about it except that he had two different stories. It made it embarrassing.

Is there anything that you would like to add?

COOPER:

No. I think it's been very interesting.

Interview in Washington, D.C.

July 25, 1985

INDEX

- Abbis, Chaiker 79
- Academic Medical Center 85 See also University Medical Center
- Accreditation Council on Continuing Medical Education 67
- Accreditation Council for Graduate Medical Education (ACGME)  
    residency training 67
- Accreditation Council on Residency Programs 67
- "Advancing the Nation's health Through Medical Education" 39
- Agency for International Development (AID) 16,27,66
- Allan Gregg Lectures 61
- Allessandri, Herson 12
- Alumni awards 59
- American College of Physicians 41
- American Council on Education 66-67
- American Hospital Association 54,80  
    award 54  
    malpractice insurance 80  
    residency matching 74
- American Medical Association 32,35,37,38  
    award 54  
    Council on Medical Education and Teaching Hospitals 34  
    malpractice insurance 80  
    residency matching 74
- American Medical Association-American Hospital Association relations 54



<u>The AMA and U.S. Health Policy Since 1940</u>	35
Argentina	14
Argonne National Laboratories	8
Argonne Universities Association	9
"Association of American Medical Centers"	45
Association of American Medical Colleges	11,12,14,31,33-34,35,38,39,41, 50,53-36,59,60-61,66
budget	57-58
chairman	46
Commission on Medical Education	36
Council of Academic Societies	41
Council of Deans	41
Council of Teaching Hospitals	41,45,47
data base	58-59
Evanston staff	45
expansion	39
finances	57-58
founding	31-33
Latin America	26
longitudinal studies	58
National Board of Medical Examiners	36
organization	42-44,46
representation	54-56
residency matching	74
student representatives	44
Veterans Administration special scholars	75

Association of Anatomy 41  
Association of Latin American Faculties 12  
Association of Midwestern Universities (AMU) 9  
Atomic Energy Commission 6-9  
Avoidance organization 83  
Bahia, University of 25  
Battle of the Bulge 4  
Bavaria 5  
Bellevue Hospital and Medical School 35  
Bellows, John 5  
Biddle, Dr. 3  
Biochemistry 2,3,6,7,21,63  
Biology  
Bloese, August 35  
Blue Cross 85  
Blue Cross-Blue Shield of Northeastern Ohio 83  
Bogota, Colombia 13  
Boston 10  
Boston University 19  
Brazil 14  
Brazil, University of 15  
Brill, Henry 3  
British Commonwealth 14  
Buenos Aires, University of 16  
Bugbee, George 75-76  
Cali, Colombia 25

Cali, University of 25  
California, University of, Los Angeles 79  
Campion, Frank 35  
Canada 14,37,61  
Canadian Association of Medical Schools 37  
Canadian Hospital Association 80  
Canton, China 78  
Caracas, Venezuela 13  
Carcinoma 7  
Carnegie Foundation for the Advancement of Teaching 34  
Carter, Jimmy 79  
CAT scanner 81  
Catholic Hospital Association 74  
Chagas, Carlos 15  
Charity care 53  
Chemistry, organic 20-21  
Chemistry, physical 21  
Chicago 3,6,24,66  
Chicago, University of 9,76  
    College of medicine 39  
Chile 12  
China 77,78  
Churchill, Colin 64  
Coalition 49  
Coggeshall, Lowell 39  
Coggeshall report 37,39

Co-insurance 50  
Colombia 14,26  
Colorado, University of 39  
Colwell, Nathan P. 35  
Commercialization of medicine 86-87  
Commonwealth Fund 17,19  
Community-based medical school 51  
Community college 10  
Congress 50,60  
Continental Illinois Bank 11  
Contingency fees 80  
Cooper, Jane 15, see also Stratton, Jane  
Copper injury to the eye 5  
Council of Deans see Association of American Medical Colleges  
Council of Teaching Hospitals see Association of American Medical Colleges  
Creighton Hospital 82  
Cruikshank, Nelson 89  
Cummins, Tilden 11  
Cunningham, Robert M. Jr. 88  
Darley, Ward 11,31,39  
Darmstadt, Germany 6  
Defensive medicine 80-81  
Dicoumarin 64  
"Dr. Pepy's Diary" 89  
Duke University 27  
East Lansing, MI 51

Educational Commission for Foreign Medical Graduates (ECFMG) 69

Egypt 77

Electrophoresis apparatus 3

Elvejehm, Conrad 64

Endocarditis 4

England 89

Europe 69

Fahs, Ned 24-25

Federation of Associations of Schools of the Health Professiions 39

Fermi, Enrico 8,19

Fileman, Gary 24

Fishbein, Morris 87-89

Flexner, Abraham 33-35

Flint, MI 50

Flook, E. Evelyn 62

Food and Drug Administration (FDA) 63

Foreign medical graduates 68-69

    Americans 69,70

Foundations 60

Fritchard, Frank 34

France 89

French language 18

Genetic engineering 48

Germany 4-5

Goodyear Rubber Company 1

Grand Rapids, MI 50

Gregg, Allan 30,61  
Gross, Samuel 31  
Guang Zhou, China 78  
Guang Zhou Medical School 78  
Harper-Grace Hospital, Detroit 50  
Harvard University 23,79  
Hawley, Paul 75  
Health Administration Press 62  
Health Care Policy Center, Georgetown University 79  
Health Maintenance Organization (HMO) 52,83  
    seniors 53  
Health services research 62  
Health Services Research journal 65  
Henry Ford Hospital, Detroit 50  
Hesburgh, Theodore 61  
High technology industry 10  
Hopkins Health Plan 82  
Horning, Ben 25  
Hospital Research & Educational Trust (HRET) 64-65  
    advisory committee 65  
Hungary 6  
Hunt, Andrew 50  
Illinois Department of Public Health 10  
Illinois Governor's Science Advisory Council 10  
Illinois Legislative Committee on Atomic Energy 10  
Illinois, State of 9-10

Illinois, University of 8,10  
Imaging costs 81  
India 70  
Institute of Medicine 86  
Internal Revenue Administration 64  
Investigational new drugs (IND) 63  
Investor-owned hospital 81-82  
Italy 69  
Jefferson Medical School 31  
Johns Hopkins Hospital 46  
Journal of Medical Education 31  
Kaiser-Permanente 83,84  
Kalamazoo, MI 50  
Kefauver, Estes 63  
Kellogg Fellows 25  
Kellogg Foundation 24,25,26,61  
    Medical advisory board 25,26  
Kellogg, John Harvey 35-36  
Kellogg, William Keith 30  
Kerner, Otto 10,11  
Las Cruces, NM 1  
Latin America 11,12,13,14,15,16,24,25,69  
Latin American Advisory Committee 25  
Latin American medical schools 11-12  
Liaison Committee on Graduate Medical Education (LCGME) 37,67  
Long, John 26

McMahon, John Alexander 54  
Magnuson, Paul 75  
Malpractice insurance 79-80  
Markle Award 59-60  
Marston, Robert 65-66  
MCAT test 38,54  
Mead, Margaret 16,66  
Medical education accrediting groups 58-59  
Medical residencies 67-68  
Medical school closing 49  
Medical schools  
    female students 56-57  
    Latin American 69  
    Number in the United States 52  
    proprietary, Caribbean 69  
Medical schools-university medical centers 46-48  
Medicare 44,51  
Mergers 83  
Mexico City 11  
Michigan, University of 8,35  
    Hospital 50  
Miller, J. Roscoe 4,6,22,23,40,65-66  
Millis, John 36,37  
Minnesota, University of 8  
Minorities 56  
Mississippi Supreme Court 1



Montevideo, Uruguay 12

Morris, Emory 28-30,61

Moscow 18

National Academy of Sciences 10,20,86

National Board of Medical Examiners 36

National Center for Higher Education 67

National Fund for Medical Education

National Institutes of Health 3,22,38,65-66

National Residency Matching Plan 68

National Science Foundation 38

National University of Colombia 14

Nazis 5

Neely, James 79

Nelson, Russell 46

New Mexico 11

New Mexico A&M College 1,2-3

New Mexico state chemist 2

New Trier High School 18

Northwestern University 1,2,3,5,6,16,17,22,24,40,75

    Evanston campus 3,19,22

    integration program in medical education 17-22

Northwestern University Medical School 33

    Director of Admissions 31

Northwestern University Press 61

Notre Dame University 61

Office of Naval Research 6

Office of Scientific Research and Development 38  
Ohio medical schools 49  
Pakistan 70  
Panama 13  
Pan-American Federation of Associations of Medical Colleges 24  
Passavant Hospital 7  
Patino, Jose Felix 13  
Pattullo, Andrew 61-62  
Penicillin 4  
Pennsylvania Hospital Association 70  
Peoples Republic of China 78  
Petoskey, MI 50  
Philadelphia 31-32  
Philippines 70  
Physics 19  
Physician glut 49  
Podiatry 3  
Poland 77  
Political action committee (PAC) 55  
Portugal 15  
Portuguese language 15  
Preferred Provider Organization (PPO) 52,83  
Prior, Moody 17,18  
Progressive Patient Care 72  
Proprietary medical schools 31-32  
Protestant Hospital Association 74

Psychiatry 61  
Puerto Rico 8  
Radiocarbon 7  
Radioisotope 6,7,8,10  
Radium 7  
Rand Corporation 71-72  
Rappeleye, Willard 36,37  
Regionalization 82  
Residency stipend 51  
Rio de Janeiro 15  
Rockefeller Foundation 11,12,25,30,61  
Ruch Medical School 33  
Russian language 18  
Sammons, James 54  
Sanazaro, Paul 62  
San Diego, CA 26  
Sherman, John 66  
Sigmond, Robert 88  
Silicon Valley 10  
Sites, Fred 10  
South America 14  
Southern Illinois University 51  
Soviet Union 77  
Spanish language 11,15  
Specialities in medicine 50,71  
Store front clinics 52

Stratton, Jane 4 See also Cooper, Jane  
Student data base 59  
Student motivation 87  
Student unrest 23  
Subspecialties in medicine 50,71  
Surgeon General 4  
Surgery, use of 84  
Sweden 3  
Symmetry 19-20  
Texas 1  
Tisehus, Arne 3  
Toronto 12  
Tripartite committee 6  
Tropical disease research 76  
Ultraviolet radiation 64  
U.S. Department of State 15,24  
U.S. News and World Report 54  
U.S. Public Health Service 62  
Union of Soviet Socialist Republics (USSR)  
    female physicians 77-78  
University medical center  
    separate corporation 48-49  
Vanderbilt University 4  
Venezuela 14  
Vertical integration 82

Veterans Administration 74,76  
    Fellowship at George Washington University 75  
    radioisotope unit 75  
    Special Medical Advisory Group 75  
Vina del Mar 13  
Viosterol 63  
Visiting committee 79  
Wakeman General Hospital 5  
Washington, DC 11,40,54,55,66  
West Virginia 5  
Wisconsin, University of 3,63,64  
Womer, Charles 46  
World Federation for Medical Education 76  
World health Organization (WHO) 76-77  
World War II 3,8,38,77  
Yale University 13,23,78  
Yale-New Haven Hospital 46  
Yankee imperialism 13  
Youmans, John B. 4,5  
Zappfe, Fred 33

