



**Physician Policymaker Interview Series:  
C. Everett Koop, MD, ScD**

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*This is one in a series of interviews that will examine the careers of physician policymakers, the state of the healthcare system, and how students can affect policy discussions. If you have suggestions for future interviewees, comments, or questions, feel free to contact [bryan.d.harris@vanderbilt.edu](mailto:bryan.d.harris@vanderbilt.edu).*

Dr. Koop graduated from Dartmouth College in 1937 and received his M.D. degree from Cornell Medical College in 1941. Following his internship at the Pennsylvania Hospital, he pursued postgraduate training at the University of Pennsylvania School of Medicine, the Boston Children's Hospital, and the Graduate School of Medicine at the University of Pennsylvania, where he received the degree of Doctor of Science (Medicine) in 1947. Dr. Koop became Surgeon-in-Chief of the Children's Hospital of Philadelphia in 1948 and was named Professor of Pediatric Surgery at the School of Medicine of the University of Pennsylvania in 1959, and later Professor of Pediatrics in 1971. He was the Editor-in-Chief of the Journal of Pediatric Surgery from 1964-1976. In March 1981, Dr. Koop was appointed Deputy Assistant Secretary for Health, U.S. Public Health Service (PHS) and was sworn in as the U.S. Surgeon General on November 17, 1981. He was also appointed Director of the Office of International Health in May 1982. He resigned as Surgeon General on October 1, 1989 and continues to be very active in public health and health education. Dr. Koop is presently the Elizabeth DeCamp McInerney Professor as a Senior Scholar of the C. Everett Koop Institute at Dartmouth.

**Q: What motivated your decision to take a leave from medical practice to pursue politics? Were you active in politics, policy, and advocacy in medical school, residency, and/or post-residency practice?**

A: I didn't ever make a decision to leave medical practice to pursue politics. I was in my 65th year approaching the time when, at the University of Pennsylvania, one submits his resignation in June. But before that, on Valentine's Day to be exact, President Reagan designated me as his choice for Surgeon General.

**Q: Did your career as an academic physician provide a unique background that facilitated your work in public policy and specifically as Surgeon General?**

A: Many people have asked me how I managed to shift from one on one care of patients (particularly children!) to being the guide for 247 million people (at that time). It really wasn't hard at all and I found that so many of my interests from the days of pediatric surgery were replicated in the various things I was asked to do in government, that it seemed very natural.

**Q: What role do you think physicians currently play in politics? What role should they play?**

A: Except for the occasional physician who has been bitten by a political bug, I don't think many doctors really have a great interest in politics, they are just too busy. I think they should take a more active role in local and national politics, but I think especially they should take a more active role in medical politics. As a matter of fact, I think medical politics is sufficiently important to the future of this country that I would like to see medical schools and schools of public health, offer this as a short required course so that they would be better prepared for the things that lie ahead. It is also the reason that I suggest that medical students align themselves early on with the student American Medical Association so that they will be prepared to guide the future of medicine rather than to gripe about it after actions have been taken of which they don't approve.

**Q: What is your impression of current physician involvement in the health policy decision making process?**

A: I think the current physician involvement needs some doctoring. One of the ways I think this might best be accomplished is to have medically oriented and medically supervised town meetings that parallel the political town meetings such as we had in so many parts of the country preceding the primaries of the 2008 election. The public has a great investment in health and they also are extraordinarily interested in health, but we have to get their focus off the esoteric things like transplants and conjoined twins, and down to the nitty gritty of policy changes that will benefit the body politic.

**Q: What do you feel are the largest challenges that the US healthcare system faces today? How do you believe these issues should be addressed by the public and by physicians?**

A: The largest challenges to the US healthcare system today are associated with the dilemma that comes from the realization that we have the best health care available in the world, but it does not reflect itself in the best health of Americans as compared to other peoples. Following that general principle, we have to make it clear that whether one can or cannot find in our founding father's papers a plea for a right to healthcare (we can't!) we do have to insist on a moral right to healthcare and proceed to make that universal. A third pillar of the future has to be a greater reliance on preventive medicine and the promotion of health rather than just treating a patient's current illness or accident/injury and bringing him back to his old state of health. We should be interested in what true managed care should accomplish, and that is getting a patient not only back to where he was, but beyond and to give him the tools to practice preventative medicine and to keep him at that new level.

**Q: How would you recommend increasing physician political involvement, and should we expect physicians to increase their involvement despite all of the time pressures of maintaining a practice?**

A: There are many ways that one can face this issue of the competition for the time of physicians. In group practices, in academic medical circles and in places where doctors have come together in loose coalitions, such as community hospitals face this question corporately. Groups of physicians should assign time off for certain physicians and then make it possible to take that time off and to represent medicine in local law-making as well as in legislation emanating from the state, but also taking part in national medical politics by way of state medical societies and the parent organization, the AMA.

**Q: How can medical students get involved in policy and systems change and balance it with our already busy lives?**

A: As mentioned above, I urge any medical students with whom I have any influence to get involved early on in the student branch of the AMA because the earlier on they understand medical politics and the quicker they can take a role in it, the more natural it will seem and the better effect they will have upon a change in the future.

**Q: Do you see the rather dramatic increases in medical student debt as acceptable or problematic? Do you have suggestions to improve the current situation?**

A: When I was trying to assist the Clintons in their efforts to produce universal healthcare in the United States, I was able to add to the Clinton Plan a solution to two problems we face in America: the "shortage" of primary care physicians and the burgeoning debt of medical students for their education. The principles are simple, and compared to other costs in medicine, the costs are low. I suggested that when a young physician just finishing his training could prove to the powers that be that he was a bona fide primary care physician and had intentions of practicing that brand of medicine for the foreseeable future, that his accumulated debt for medical education would be forgiven. That remained in the plan to the end. There are a lot of things that can be done economically about the burgeoning cost of care. One is work-study programs, especially in the last two years of school, which could eliminate only a small portion of the debt problem, but at the same time, increase the abilities of the young physician to sample various roles in medicine. Indeed, it could act as the old two-year rotating internship used to, and being a product of that system, I have great respect for it. When you consider the fact that our huge medical centers, which include in many instances a medical school, lump their expenses together, they not only are huge, but the portion of the total expense that is paid for by medical student tuitions runs around four percent. That small amount compared to the colossal figures we are thinking about should be managed in some way to the betterment of students' economic situations when they leave school with absolutely crippling debt.

**Q: How can we promote discussion of the challenges facing the healthcare system among our classmates?**

A: Discussion concerning the challenges facing the health care issues among medical students can be promoted by having mock houses of delegates to debate the issues. This also a great opportunity to combine the thinking of faculty and students as medical leadership teams are built up in a competitive way.

**Q: As you know, the medical school curriculum is dense. Do you think medical schools can and should provide an in-depth education on health policy?**

A: I think that, as mentioned previously, there should be squeezed into the curriculum a few hours backed by a new department in medical school of medical politics. This is the general subject of the free literature that physicians are very apt to read rather than to sit down and fall asleep over the Journal of Neurology. Most of those free publications speak in the jargon of medical politics and are the most up-to-date reports available to busy doctors. The department of medical politics could translate and interdigitate such material into the larger field of medicine.

**Q: You have a free forum here to directly address hundreds of future physicians. What do you want them to know?**

A:

1. I'd like medical students to appreciate that they are members of a very select guild and that theirs is a privilege few other professions can claim, when they are able to affect, as they do, not only the complaints of their patients, but also the economic, social and spiritual problems that are associated with that complaint.
2. I would like them to think that there is no relationship more sacred than the one between doctor and patient and they should do everything within their power to preserve that relationship.
3. I would like medical students to remember that the bodies they work on are a trinity; they are souls who have a spirit and inhabit a body. All three of those aspects of their personalities, hope and aspirations have to be considered to provide therapy for the whole patient for his/her entire problem.
4. I would like medical students to consider the armamentarium that all patients bring with them and to use that armamentarium to accomplish their goals in healing. If they have a scientific bent, use science; if they have a spiritual bent, use spirituality.
5. The Hippocratic Oath and the traditions that surround it are espoused by nearly every religion and philosophy. Protect it and practice according to it.