149 * * * REMARKS OF THE SURGEON GENERAL * * *
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152 SURGEON GENERAL KOOP: Well thank you very
153 much, Bob. What you hear in the way of a voice this
154 morning is not the usual Chick Koop; that is a Swiss
155 virus. I thought it was going to be lethal, and then
156 I was afraid it might not be, but I did survive and
157 here I am.
158 I'm very happy to be here and to see the
159 workings of this Interagency Committee, because as I
160 am frequently asked, as I was in an interview this
161 morning before I came here, what have I set for my
162 goals, one of the things that I always mention--and
163 it might seem to you to be impertinent--is that I
164 would like to have a role in developing a philosophy
165 on aging in this country. And what I mean by that is
166 that aging is a part of living, and whether or not
167 one has to make a decision about his own aging, or
168 about a member of his family, or about society, I
169 think that that kind of a decision should be based on
170 information rather than upon prejudice, and even in
171 Government circles, as hard as we try, I find there
172 is still a lot of prejudice and concern that doesn't
173 have to be there. This doesn't mean that there will

174 ever be a document which says, "This is the
175 philosophy of aging," but the Office of the Surgeon
176 General, which has essentially no power, does have a
177 lot of moral suasion and I find that in certain areas
178 where I am asked to talk what I have to say is at
179 least listened to, and hopefully some of the things
180 that we discuss in the way of philosophy might
181 eventually take hold.
182 You might ask how comfortable I feel in
183 making an aging project one of my major initiatives
184 in Government after having spent a lifetime with
185 children, particularly with very young children. And
186 the answer is I feel very comfortable about it
187 because there are a lot of things that are very
188 similar about the dependence of elderly people and
189 the dependence of children. And I don't feel that
190 I've taken a giant step in any direction at all. It
191 just seemed to be a very natural evolution of the
192 things that I was concerned about in protecting
193 people who required protection.
194 My first real effort in reference to aging
195 was a total failure. And that is, at the time of the
196 White House Conference I tried to convince the
197 President that it would be a marvelous gesture if he
198 provided Dr. Butler with the six research beds he

199 wanted at the Clinical Center and a very fine gesture
200 to the Conference about his own concern about these
201 things. I almost thought, with some of the
202 information that Dr. Gibson and Dr. Butler provided,
203 and the response from the White House, that that
204 might have happened, but as you know, it didn't. I
205 hope that my next venture may prove to be
206 more effective, and I'll say a little bit more
207 about that later.
208 Let me just tell you, from the point of
209 view of the Surgeon General, functioning in the
210 capacity that I do now as Deputy Assistant Secretary
211 of Health as well, how I think all this fits into the
212 perspectives of our general Department's efforts. As
213 you know, Secretary Schweiker is very much interested
214 in health promotion and disease prevention, and you
215 will be seeing something almost weekly now about a
216 new initiative in the field of prevention. We are
217 committed to this as a major health policy and I
218 think this has been clear from the confirmation
219 hearings of Secretary Schweiker right on down to his
220 most recent press releases. In general, what we're
221 following, are the guidelines set forth in the
222 Surgeon General's Report on health promotion and
223 disease prevention which was entitled "Healthy

224 People", and in the follow-up document which was
225 called, "Objectives for the Nation". And you are very
226 familiar with these things. In these two documents we
227 really have isolated five separate categories or
228 objectives which are goals for prevention and health
229 promotion that we hope our society can achieve by the
230 year 1990. They include such things as trying to
231 lower our infant mortality rate from its present
232 almost 12 to 9 per 1,000 live births; to assure some
233 kind of longterm, successful control of high blood
234 pressure by at least 60 percent of persons with the
235 disease, and that of course impinges very definitely
236 upon your concerns; to reduce the proportion of
237 smoking adults to less than 25 percent of the
238 population--the kind of effort that the smoking
239 lobby, or the tobacco lobby is making against it at
240 this time, that seems problematical. They have
241 already spent in advertising this year more than our
242 entire budget on smoking and health, and that is only
243 25 percent of this year's budget for lobbying against
244 the things that we think are proper; and other such
245 things as trying to cut down on infant fetal alcohol
246 syndrome and such things as that, which are not part
247 of your aging concerns.
248 But we believe that interagency cooperation

249 is absolutely essential for attaining any of these
250 goals, and the kind of a meeting you're having this
251 morning is certainly evidence of the fact that you
252 understand these things as well. We need the
253 Department of Housing and Urban Development to help
254 achieve safety and sanitation goals for improved
255 living environments. We need the Department of
256 Agriculture to improve nutrition, especially in our
257 initiatives with pregnant women and children, and as
258 you see it, with the aging population. We certainly
259 need the Health Care Financing Administration to help
260 to fund demonstrations in new health care
261 technologies and to encourage the application of the
262 results and so on. And I'll say a few things about
263 that in a moment.
264 So, many of these goals may not appear at
265 first hand to be specifically targeted at the
266 nation's elderly. But we also have a separate program
267 devoted to the specific problems of longterm care
268 which cuts across all age groups and effects all
269 social and economic groups as well. So often longterm
270 care is assumed by the listener to refer only to the
271 aging population, but I certainly in my former
272 incarnation realized that a lot of longterm care went
273 into very young children indeed, and they had to have

274 it for much longer periods of time than do the aged.
275 You are aware of the fact that Assistant
276 Secretary Brandt appointed me as the Chairman of a
277 Public Health Service Task Force on Longterm Care,
278 and we moved into that with some degree of enthusiasm
279 only to find then that we were sort of downgraded a
280 little bit by the whole Department of Health and
281 Human Services getting into the same act. And you
282 know that we shifted gears as rapidly as we could and
283 tried to comply with Assistant Secretary Rubin's
284 request for an inventory of what was going on in
285 various parts of the Public Health Service. And
286 inasmuch as what Dr. Butler and Dr. Gibson are on
287 that task force, I won't have anything more to say
288 about that.
289 I've alluded to the fact that I would
290 mention something to you a little bit further about
291 another opportunity we might have, and I'll just
292 specifically mention it because it involves several
293 agencies here, and that is a longterm concern that I
294 have had about incontinence. One of the most
295 fascinating diseases of childhood is Hirschsprung's
296 disease, or aganglionic megacolon, and for every one
297 of those that you see, you see perhaps 35 or 40
298 children who are thought to have that disease but

299 merely have the symptoms of it without the pathology,
300 and all of these children tend to have problems in
301 incontinence. And therefore I have been concerned
302 about the physiologic pathology, or the pathologic
303 physiology, of incontinence. And as I got into the
304 Public Health Service and recognized what nursing
305 home admissions consisted of, and realized how much
306 longterm care was associated with incontinence, and
307 began to get the statistics on this, I realized that
308 if we wanted to make a really cost-effective stab at
309 something in the future, incontinence would be a
310 marvelous goal. If you could do all the things you
311 wanted to do and you were 100 percent successful, you
312 could save as much as $8 billion dollars a year in
313 longterm care by conquering incontinence by one way
314 or another. And there are many ways that can be done,
315 not just by surgical means and mechanical
316 contrivances, but most effectively by the use of
317 biomedical feedback techniques.
318 And on one of the occasions when I was able
319 to corner the Secretary, I pointed out to him that if
320 he really wanted an initiative that would sing for
321 him in days to come, incontinence would be it, and if
322 we could have his support, I would be very happy to
323 try to work with people out here at NIA to spearhead

324 this and get some of the answers that we'd like to
325 have. As you know, Dr. Engle working at the Institute
326 in Baltimore has a very high success rate among
327 ambulatory elderly, between 65 and 90, with
328 incontinence. And my concern is, can he get the same
329 kind of an effective result with people who are
330 admitted to nursing homes, especially to do it
331 quickly enough before they get into the situation of
332 having bed sores which make their discharge
333 absolutely impossible from a nursing home?
334 And it is along those lines that I
335 approached the Secretary and got his support to go to
336 Dr. Carolyn Davis, and we have her promise of a
337 substantial amount of financial support as soon as
338 the new fiscal year arrives to try to set up a unit
339 in Baltimore which would be a typical nursing home
340 unit where we would not be dealing with a select
341 population, but the run-of-the-mill, across the
342 board, incontinent patient that comes to a nursing
343 home, and see what these biofeedback methods might do
344 in such a circumstance.
345 Now, I'm not naive enough to believe that
346 even if you had a marvelous result with that, that
347 you could teach the doctors of America to teach their
348 patients/to be incontinent. It's just not exciting

349 enough for them. But I think there is a way that we
350 can utilize another phenomenon in our modern medical
351 picture today, and that is the teaching nursing home
352 that Dr. Butler has been so instrumental in bringing
353 about. And we have met with people from one of the
354 teaching nursing homes here in Washington, and it
355 would appear that if we do it just the right way that
356 we could indeed put out a nursing initiative across
357 this land, suggesting that this would be a major
358 contribution and a very cost-effective one if nurses
359 would assume to themselves the role of teaching
360 elderly people who are incontinent how to use the
361 biofeedback techniques to improve their situation.
362 And as those of you who may not know as
363 well as I do, there is a constant friction between
364 physicians and nurses in hospitals over the value of
365 training, and who is going to make decisions, and I
366 think here is a place where we could ask the nurses
367 to step into a role of teaching and responsibility
368 where they would not have any competition from
369 doctors and where, because of their own particular
370 skills and compassion, we might achieve the ends that
371 we'd like to achieve far better than if we put this
372 in the hands of physicians. And I say that in spite
373 of the fact that I, myself, am one.

374 Finally, I've just returned from the World
375 Health Assembly, where I did not have as much time to
376 do the things I wanted to do on the side as I had
377 hoped, but I did meet with Dr. Caprio and Dr. MacFadyen,
378 who are responsible for the aging
379 initiatives of WHO. They are very enthusiastic about
380 the upcoming World Assembly on Aging to be held later
381 this summer in Vienna. I think that they believe that
382 there will now be 31 ministers of various countries
383 who go as chief delegates to that, which I think is
384 very important, because it means that it has a high
385 profile and a sense of importance in those countries.
386 And as you know, it has a very high profile and a
387 very important role in this Department because our
388 own Secretary is going to lead the delegation to
389 Vienna in late July. And at the moment it appears as
390 though both Dr. Butler and I, among others, will be
391 accompanying him. And that might augur well for the
392 future.
393 And I might just say in closing that it was
394 very gratifying to be part of the Public Health
395 Service in Geneva and to realize in what tremendous
396 esteem the National Institutes of Health are held,
397 especially the National Institute on Aging, but most
398 especially your leader Dr. Butler.