Biomedical Leadership: Cooper, Fredrickson Ready to Step In

"No government agency with a budget of $2 billion a year is going to go out of business," Theodore Cooper once said in response to cries from the biomedical community that people in the Administration were planning to so limit funds that research would be done in. Just recently, however, Cooper also said that if the Administration has its way, federal support of biomedical research through the National Institutes of Health (NIH) will come in at a bit under the present $2 billion next year rather than a bit above. Basically, Cooper believes that biomedical research will not suffer irrevocably if its resources are limited and, if and when he is confirmed by the Senate as the new top-ranking health official in the country—assistant secretary for health in the Department of Health, Education, and Welfare—one can expect him to be concerned with how research priorities are determined rather than with ways to provide more and more funds to NIH.

Donald S. Fredrickson is also realistic about the present limits to growth and says, "This time of great fiscal stringency is an exquisitely good time to reexamine our premises about biomedical research, discard those that we cannot defend and rearticulate the durable ones." If the Senate approves, Fredrickson will be the new director of NIH. (There is every reason to anticipate Senate confirmation of the President's appointments of both Cooper and Fredrickson.) Fredrickson says he believes the NIH director should assume the role of "architect and spokesman for research." And he believes NIH needs strong and stable leadership.

It has been a long time since there has been stable leadership at the NIH. It was at Christmastime in 1972 that Robert Q. Marston was fired. It marked the beginning of what has turned out to be a long stretch of uncertainty that has taken its toll of researchers' spirits.

Although people in the Nixon White House had decided they no longer wanted Marston around (he was a holdover from the previous Administration), they had no one who was ready and willing to take his job. So, for 6 months, John Sherman,* an old NIH hand who had been deputy director, subbed in as acting director. Sherman and others became increasingly gloomy as the search for a chief dragged on and on "downtown" in the White House and the Department of Health, Education, and Welfare (HEW).

In May, recruiters discovered Robert S. Stone, who had taken a year's leave as dean of the University of New Mexico School of Medicine to study management techniques at the Massachusetts Institute of Technology. By June, Stone was installed in the director's office, but it was clear from the start that it would take him a while to get settled. Stone was an unknown quantity to the biomedical research community and had little familiarity with NIH and virtually none at all with Washington politics. He never took hold as leader of NIH and was plagued by poor relationships with his bosses in HEW.

By November 1974, it was clear that Stone was on his way out (*Science*, 15 November) and that, once again, NIH would have to seek someone new at the top. In January, Stone's forced resignation became official.†

This time, White House recruiters were better able to cope. During November and December they had been doing their homework and, by mid-January, before Stone had even vacated his office, they had asked Fredrickson, president of the Institute of Medicine–National Academy of Sciences, to be NIH director.

Fredrickson said "Yes," but his acceptance carried with it at least one important condition. He had to know who would be his direct superior as assistant secretary for health in HEW. The post had just been resigned by Charles C. Edwards; Cooper was acting assistant secretary.

Fredrickson's appointment apparently met with uniform approval. He had HEW Secretary Caspar Weinberger's blessing, his scientific credentials are impeccable, and he is a registered Republican. Cooper also had Weinberger's blessing—indeed, he had his strong, active support—and strong scientific credentials. (He is a surgeon who also has a Ph.D. in physiology.) But Cooper is not a Republican. Like the majority of scientists in this country, he is a registered Democrat. Apparently, his appointment ran into trouble with conservative Republicans but now it looks as if everything is ready to go ahead as planned. On 2 April, a White House official called Cooper and Fredrickson to say that their nominations would be formally announced and sent to the Senate for confirmation within a matter of a few days. Both men are anxious to get the show on the road.

Although the day-to-day business of the health arm of HEW and of NIH is carried on reasonably smoothly in the absence of official leadership, it is difficult, if not impossible, to implement policy changes or do anything new. As acting assistant secretary, Cooper cannot do much more than just "mind the store," as he puts it. He lacks the authority to speak in his own right or to hire his own policy-making staff. Similarly, at NIH the absence of a director makes an already difficult hiring situation (*Science*, 17 January) even worse and leaves everyone up in the air when it comes to deciding policy in the allocation of diminishing resources. Congress, too, finds the many acting heads of federal health agencies discomfiting. At recent hearings, Senator Edward M. Kennedy (D-Mass) took pains to point out that four of the health agency heads who were testifying were merely "acting." If Cooper and Fredrickson can be put in place quickly, it is bound to help.

Experience Working Together

Cooper and Fredrickson, as a twosome, bring to the health establishment certain special qualifications that their predecessors lacked. Although it would be an exaggeration to say that the two men are personally close, there is plenty of evidence that they can work together satisfactorily—seven years' worth of it. Therefore, there will be no repeat of the situation that arose last year when former assistant secretary Edwards and former NIH director Stone, who knew very little about one another when they joined forces, discovered they could not work well together.

* Sherman left NIH in March 1974 to join the Association of American Medical Colleges.
† Negotiations regarding Stone's resignation secured him a position at NIH while looking for another job. Ironically, he is being paid as a "consultant to the director," when there isn't any.

Another potential benefit of the Cooper-Fredrickson appointments is that each knows NIH and its strengths and weaknesses intimately. Discontented researchers will, if they like, be able to criticize Cooper or Fredrickson for policies they disapprove, but they will not be able to accuse them of being uncomprehending outsiders.

Cooper received part of his training in surgery at NIH in what was then the National Heart Institute (NHI) [it is now the National Heart and Lung Institute]. Then, after doing research and teaching in cardiology and pharmacology at St. Louis University, Missouri, and the University of New Mexico School of Medicine, Albuquerque, he returned to NHI to head the artificial heart program. That was in 1967 when Fredrickson was director of the heart institute.

Fredrickson, reluctant to leave his NHI laboratory where he was studying the genetics of blood lipids, had agreed to serve as institute director for one year, to see how he liked it. "After exactly 365 days," he recalls, "I went to see Shannon [James Shannon, then director of NIH] and told him I was going back to research." So, Fredrickson continued his work, for which he has won international recognition and membership in the National Academy of Sciences, and also functioned administratively as director of intramural research in the heart institute.

Cooper moved up to be director of NHI, a position he held until April 1974, when he went to HEW as deputy assistant secretary for health. Shortly after that, Fredrickson left NIH to become president of the Institute of Medicine.

In an interview, Fredrickson explained his reasons for leaving NIH after 22 years, saying that even though there were still many opportunities to contribute in his field of research, he did feel the need to do something new, and that, frankly, the challenges of being director of intramural research had ceased to be stimulating to him. He has been at the Institute of Medicine, which he describes as a "terribly important experiment in providing neutral ground where people can discuss and possibly resolve issues of health care," for nine months. Did he intend to stay at the institute for so short a time? "Certainly not." Why then is he leaving to return to NIH? "The opportunity was too great to resist." In fact, Fredrickson said that there is no other job he could have been offered that would have enticed him away. But as director of NIH, Fredrickson sees a chance to have an impact that only that position can afford and he has a very strong loyalty to the institution. "Quite simply," he said, "I love the place." He cares about NIH as a distinct institution and would like to bring to the Bethesda campus some of the amenities of intellectual life that would restore morale and strengthen the intramural program. At the same time, he cares about NIH as the institution that supports research nationally. And he thinks that his months at the Institute of Medicine will help make him a better NIH director.

Theodore Cooper

The intellectual distance between the academic atmosphere of NIH on its tree-shaded acres in Bethesda and institutions in downtown Washington, be they HEW or the Institute of Medicine, is far greater than the 10 miles between them. Certainly, at HEW Cooper developed a broad view of the national health enterprise when he had to cope with problems with Medicaid, professional standards review organizations, and national health insurance proposals, as well as with biomedical research.

Similarly, Fredrickson knows that supervising the Institute of Medicine's diverse programs and studies having to do with such monumental problems as the cost of medical education and the way Medicare-Medicaid money affects the national distribution of physicians has expanded his view of the biomedical world. "I have ceased to believe in science for its own sake," he declared. "Research does have as its end the betterment of the human condition."

Does that mean Fredrickson believes only in so-called applied and/or targeted research? Not at all. He is too much a basic scientist and scholar for that, but he does recognize that "Biomedical research needs better defense. Our success in the past in dealing with infectious diseases has made things look deceptively easy. Now we are in a new era, one of chronic diseases that may not lend themselves as easily to molecular solutions. They are diseases in which genetics and environment and nutrition play a role."

Donald S. Fredrickson

Setting Boundaries

Fredrickson is concerned that NIH find the boundary between its mission and the delivery of health services. Uncertain just where that boundary lies, he nevertheless knows that NIH "cannot do everything," and that it needs to develop better ties with other federal health agencies. "It is necessary to see where research fits in the world of health. I see that now, more clearly, but not precisely. It is part of a continuum."

During the past few years, NIH has had less and less to say about what its boundaries are and how it should conduct its business. The reasons are several. Officials at HEW, expressly trying to consolidate and coordinate federal health activities, have insisted on taking a more active role in NIH policy-making. Office of Management and Budget (OMB) people, too, have stepped in more definitively than before. And, NIH has, to some extent, allowed this to happen. Recognizing "that the world

has changed a lot during the past few years," and affirming that NIH "must definitely remain a part of HEW," Fredrickson would nonetheless like to see it reestablish some measure of the independence it once enjoyed. He anticipates creating an office of analysis and planning to this end, one whose effectiveness may be proportional to its ability to see the world realistically. Among its jobs would be to consider the total biomedical research budget, including that of the administratively elite and comparatively very wealthy National Cancer Institute.

Cooper, for his part, claims that he is not unwilling to have NIH take more responsibility for its own destiny, as long as it is realistic. But he is not going to dramatically relinquish the power that has been building up in the office of the assistant secretary for health.

What any of this means is hardly clear. Even if Cooper and Fredrickson establish the best of working relationships, there remains the authority of the HEW secretary over them, and at the moment the lingering uncertainty about whether Caspar Weinberger will stay or leave. There is the OMB which, having been trained as an organization to involve itself in every aspect of government, is not likely to graciously step aside so that NIH can have the luxury of making its own choices. And, there is the Congress which likes to know what is going on, although it is more inclined to give money than to take it away.

Cooper and Fredrickson are optimistic. Edwards, apparently, thinks that may be unwarranted. In a "now that I'm out of office I'll talk" article in the 13 March *New England Journal of Medicine* he charges that nowhere in either the legislative or executive branches is there sufficient leadership in health. During his tenure as assistant secretary, he reports, there was an effort made to plan for health legislation in various areas in a way that would take into account the future consequences of federal involvement. The result of that effort was called the Forward Plan. It was intended to help government officials make decisions.

Edwards, somewhat bitter after his last year in office and fights about the budget for FY 1976, writes:

> Having been informed that the health budget would have to be substantially reduced as part of the President's economic strategy, we were able to make careful and defensible decisions about the most prudent way to curtail the Department's controllable expenditures for health programs. But the OMB is simply not receptive to the guidance provided by [HEW] on spending and other health priorities.

Cooper and Fredrickson will have to deal with the same problems that led Edwards to quit and saw Stone fired. Nobody in this arena has prevailed for quite a while. Perhaps this time.—BARBARA J. CULLITON

Health Education in California: The Grand Design in Trouble

Faced with a ballooning population and a growing dependence on other states for its supply of doctors, California set out in the late 1960's to dramatically expand its small but excellent system of public medical education. Under an ambitious 10-year plan that promised important strides toward medical self-sufficiency for the nation's most populous state, the University of California proposed to create three new medical schools in addition to making improvements at the two already established at San Francisco and Los Angeles.

No other state in recent times had undertaken quite so rapid an expansion of tax-supported medical education; but with the voters' approval of a $156 million health sciences bond issue in 1972, it seemed as if California might well succeed.

Three years later, however, California's grand design has begun to blur. Although three new medical schools are open and functioning—at UC campuses in San Diego, Davis (near Sacramento), and at Irvine in Southern California's Orange County—all three are still making do with temporary accommodations and the medical school at Irvine is still borrowing beds at a county hospital for its clinical facilities. Moreover, for several reasons, of which inflation is only one, it now looks as if the 1972 bond issue will fall $35 million short of providing the basic science and clinical facilities originally envisioned as permanent homes for the three new schools. As the university's regents struggle to divide a shrunken pie, there is gloomy talk about closing the medical school at Irvine, apparently because it has the smallest enrollment of the three and it is the only one where construction is not under way or imminent.

Officials at Irvine and at the statewide university headquarters in Berkeley regard closure of the Irvine medical school (which has 225 faculty, 281 students, and 449 residents) as a remote but not inconceivable resolution of the medical education system's worsening financial problems. The first suggestion for folding the school and merging it with the Davis campus came last December from the state government's influential legislative analyst, A. Alan Post. Ever since then, says one UC budget official, the university has been doing "absolutely all it can to avoid closure. We can't rule out the possibility, but we're turning over every stone to avoid it."

The future of the Irvine medical college ultimately rests in the hands of California's new governor, Edmund G. Brown, Jr., who must decide whether to budget money for development of permanent campus and clinical facilities as originally planned. Brown's father, who preceded Ronald Reagan in the governor's office, was an unflinching patron of the university, but the younger Brown's attitudes toward the financing of higher education have been something of an enigma. Though nominally a liberal Democrat, the new governor has defied traditional political labels; in his statements on fiscal matters he sometimes seems as conservative