Interview

David Satcher Takes Stock

The former U.S. surgeon general reflects on growing up in rural Alabama, health disparities, anthrax, and public health in America.

by Fitzhugh Mullan

Choosing Medicine

Fitzhugh Mullan: Tell me about where you grew up and how you got into medicine.

David Satcher: I was born and reared outside of Anniston, Alabama, on a small farm. More than anything else, my family’s experience with health care, or the lack of it, led me to a medical career. My mother had nine pregnancies and, as far as I know, never saw a physician. Her babies were delivered at home by a midwife—not a nurse-midwife, but a midwife who had been trained by her mother, who had been trained by hers. At the age of two I came down with whooping cough, which became pneumonia. Dr. Jackson, the black physician who came out to the farm to treat me, died when I was very young, but by the time I was six years old I was telling everybody I wanted to be a doctor like him.

Mullan: From whooping cough to Case Western Reserve Medical School is a long way. How did you get from Anniston to Cleveland?

Satcher: Just having the goal of being a doctor was a major motivation. I did well in school and got a scholarship to Morehouse College in Atlanta. One of my professors was a friend of a department head at Case Western Reserve University and promised him that one day he was going to send him a Morehouse student. I ended up going to Case Western’s M.D.–Ph.D. program in cytogenetics. I graduated from Case Western in 1970 and went to the University of Rochester to do a mixed medicine-pediatrics residency. After two years the opportunity came to join one of the real founders of community medicine, Al Haynes, in Los Angeles at the new Martin Luther King Jr. Hospital and Charles R. Drew Postgraduate Medical School that was being developed in Watts. The hospital opened in 1972 and since 1982 has been known as the King/Drew Medical Center. It had special meaning to me since I had worked with Martin Luther King Jr. on the sit-in movement while I was at college in Atlanta. I applied for and received the hospital’s first National Institutes of Health grant, which provided funding to start one of ten national sickle cell research centers. I headed the center for six years, managing basic scientists, clinicians, and outreach programs. This provided my first administrative job and gave me experience juggling a lot of things.

Mullan: Even though you trained in pediatrics, you got involved in the family medicine movement too. How did that come about?

Satcher: My commitment to family practice went back to Alabama’s Dr. Jackson, who was the only black physician for hundreds of miles...
around. Even though I didn’t know how it was going to play out, I knew that the concept of the family was consistent with my training in cytogenetics and dealing with familial genetic diseases. So those two things led me to be excited about family medicine. I actually completed the family practice residency program at the University of California, Los Angeles, in 1975. I then ended up developing King/Drew’s family practice residency and serving as chairman of the new department and the interim dean of the school.

**Leading Meharry Medical College**

**Mullan:** In 1982 you stepped onto the national stage taking on the presidency of Meharry Medical College, a school in Nashville, Tennessee, that had trained many of the nation’s African American physicians. It was also an institution that was financially embattled and had a very uncertain future.

**Satcher:** That was probably the toughest thing I ever tried to do. I was excited about Meharry because its mission—getting more physicians into poor communities—was consistent with my reason for going into medicine. In the early 1980s some 75 percent of Meharry graduates were practicing in underserved communities. The school had trained almost half of the black physicians and dentists in the country. I had no ambition to be a college president, and, in truth, Meharry’s financial struggles were overwhelming. The traditionally black institution had been shut out of public hospital facilities throughout its history. I stayed at Meharry until 1993. During that decade we were successful in moving Nashville’s public hospital from a decrepit plant to Meharry’s Hubbard Hospital. In doing this, we upgraded medical care in the city, renovated and improved Hubbard, and stabilized Meharry’s finances and clinical programs, which were heavily dependent on the hospital.

**Minority Health Issues**

**Mullan:** You have lived a life of leadership in what we now call minority health. I suspect that when you were in school, the operative term was probably “civil rights.” How would you assess minority health in America?

**Satcher:** The circumstances of minority health are tied to two things that we as a nation have not been willing to change. One, of course, is poverty. Minorities are more likely to be poor, and you can just tick off from that: They are more likely to have environmental health challenges and all the things that go along with poverty. We haven’t solved that problem, and I don’t think we’re necessarily committed to solving it. The second thing is the health system itself. A health system of the kind that we have—where health is a commodity traded in the marketplace, often to the highest bidder—is not good for people on the bottom.

It’s no accident that Cuba has a much lower infant mortality rate than we do, even though it has more poverty. I certainly don’t agree with a lot of things about Cuba, but you have to be impressed with what they’ve done with basic health care. The difference is commitment to access to care for everyone. We don’t have that commitment. One of the reasons the whole issue of universal care is so critical, especially to eliminating disparities, is that it’s the only way we’re going to deal with some of the generic health problems that disproportionately impact minorities.

When we improve those basic things for the overall population, the rural and inner-city poor are going to benefit more than anybody else because they are less able to defend themselves against infectious diseases or other environmental health challenges. That’s why for years AIDS has increased among African Americans and Hispanics, even though it didn’t start that way.

**Mullan:** As you have watched minority pro-
grams rise and fall, and affirmative action come and then become embattled, what is the likelihood of continued special support for minorities? Despite kind words, the president requested no money in his 2003 budget for the Minority Centers of Excellence and the Health Career Opportunity Program, the staples of health professions education for minorities.

Satcher: It's a political game, and a short-sighted one at that. With the diversity of our population, it's in our interests as a nation to make sure that all of our people are as healthy as they can be. To do that, we need more physicians, nurses, and social workers from minority communities. But because of the market mentality of the current system, commitment to universal access is not very attractive. I've struggled for years moving the chairs around on this deck. The fact is, until we make that commitment to universal access, we don't have a lot of incentives to produce the kinds of physicians, nurse practitioners, and physician assistants that we need to treat our whole population. We have the opportunity to develop the best health system in the world—one that continues to build research and technology while emphasizing health promotion, disease prevention, and a more balanced community health approach than we have now.

From Academia To Government

Mullan: In 1993 you were invited to head the Centers for Disease Control and Prevention [CDC]. What was it like coming from academia to take over a government agency?

Satcher: I was not expecting the job. The assistant secretary for health at the Department of Health and Human Services [HHS], Phil Lee, called me and asked if I'd be willing to do a preliminary phone interview for the directorship of the CDC. I'd always identified a little with the CDC because of my near-fatal experiences with whooping cough and pneumonia, but I'd never thought seriously about working there. The day of the call I was volunteering at an elementary school in Nashville, something I did from time to time to provide the students with a positive black male role model. At the school that morning I smelled tobacco in the hall and asked where it was coming from. The students told me that the teachers had a smoking room. When I asked a teacher about it she said, “Well, yeah. They're supposed to have a system in there that takes the smoke out of the room, but it doesn't work.” I was mad. When I arrived back at my office it was time for the interview, and I was still fuming. During the call Phil and the others started asking me questions. I told them the story about the school and the smoking teachers and, whatever they asked, I kept coming back to that. The next day Phil called and said, “David, that has to be the best interview I've ever heard. Not only did you have the right answers, you had passion.” I thought he was kidding. But I was invited to Washington to meet HHS secretary Donna Shalala. When I walked into her office, she said, “David Satcher, I want you to be director of the CDC.”

I went into the job thinking that I could bring to it my own brand of leadership. I was an outsider. I had not been in government or gone through the Epidemic Intelligence Service program, which is a rite of passage at the CDC. When you go to a new job, the first thing is to find out the strengths of the institution that are worth preserving and make sure that, like a physician, you “do no harm.” We set some major external goals, like putting violence on the national agenda as a preventable condition and raising immunization levels. We also pursued internal goals such as enhancing career mobility programs by providing tuition and release time for staff to go to college.

Mullan: How did the surgeon generalship offer come about?

Satcher: After the 1994 election the administration got heavily into “downsizing,” which affected both the CDC and, as it happened, Phil Lee's job as assistant secretary for health. Phil was intending to retire from government and began talking to me about the possibility of my coming to Washington to take on the combined jobs of assistant secretary for health and surgeon general. I didn't know the extent to which they had gutted the authority of the assistant secretary to manage the agencies of the Public Health Service [PHS], and I don't
believe Phil did, either. He thought that the job would be something like an undersecretary, which it wasn’t. I had also watched the departure of Joycelyn Elders from the surgeon generalship and the blocked candidacy of Hank Foster for the job and had real concern for the future of the position. Eventually Donna did offer me the joint jobs. I saw the move as an opportunity to have a national stage for some of my ideas, and I thought that the visibility would be good for people of color.

**An Agenda For Change**

**Mullan:** What was your agenda when you came to Washington, and how did Secretary Shalala or the White House react to it?

**Satcher:** I had been talking behind the scenes to Donna for a long time about increasing funding for disease prevention and health promotion. She ended up trying very hard to get more funding for prevention centers. At the time only 1.6 percent of the health budget was going to population-based prevention, so that was one of the major themes that I was going to work on. The other one was the disparities in health between minority groups and the population as a whole. Donna bought into my agenda and many of the things that I stood for. Additionally, I felt that by bringing together the surgeon general and assistant secretary for health positions, I would have some influence on the agencies, which turned out to be true. The disparities issue, in particular, gradually became an important theme throughout the department.

**Mullan:** Elaborate on the problems that developed for the assistant secretary for health when the position lost its managerial function as head of the PHS agencies in the downsizing.

**Satcher:** I was at the CDC when the management role of the assistant secretary was eliminated. I began to report directly to the secretary, a change that, like all of the PHS agency heads, I welcomed since it gave me direct access to a higher level of government. What I didn’t fully appreciate then was the resulting absence of any coordinating authority over the PHS. When I got to Washington, I saw things very differently and was troubled by the inability to provide real coordination of budget and policy for PHS programs. If I were reconstructing HHS now, I would have an undersecretary of health who was close to the secretary and through whom the PHS agencies would all report. I think it has to be someone with a public health background and experience to whom people in or outside government can look for leadership. The undersecretary has to be an identifiable person who’s not a politician but a public health leader. I would have a separate undersecretary for the Centers for Medicare and Medicaid Services [CMS].

**Mullan:** Do you feel that the problems related to the absence of that kind of authority were borne out by your experience?

**Satcher:** I think people outside certainly felt that there was confusion about the role of the assistant secretary. The fact that I served in the combined positions masked some of the problems with the position.

**Being Surgeon General**

**Mullan:** Was the surgeon generalship a bully pulpit? As you put the garment on, literally and figuratively, what was it like?

**Satcher:** I felt empowered by the credibility that the American people attribute to that office and by being able to speak directly to the public. I’ll give you the best example of how I viewed being surgeon general, as opposed to being assistant secretary for health. When I was CDC director, we funded research on needle exchange programs to prevent the spread of HIV, and I submitted the report to Phil and Donna. When I arrived in Washington, this issue came to a head. We got all of the agency heads together to talk about the position we were going to take on the needle exchange program. It was very clear, based on our work...
and that of the Institute of Medicine, that the needle exchange program reduced the spread of HIV and that there was no evidence that it increased drug use. That was our position.

The day before the press conference to announce this stance, word came from the White House that the administration position was going to be against the use of federal funds to support the needle exchange program. By the time of the press conference, that was the message from Donna—that we didn’t feel comfortable enough with the research. Basically, though, the problem was that the Clinton administration didn’t think backing needle exchange was politically smart for them. As assistant secretary for health, I had to support the secretary, but as surgeon general, I continued to speak in support of the needle exchange program. I never heard from the White House because I think the president didn’t want needle exchange to be used against him. But he also realized that needle exchange programs were good in terms of the HIV epidemic. So when Donna later testified before Congress on the issue, she said, “I’m going to respond by sharing with you a letter that I just received from the surgeon general.” This was a letter that she had asked me to write that detailed the proven benefits of the needle exchange program. The administration knew what the right thing was, but they also tried to play the politics.

Mullan: The Clinton administration used the surgeon general position to get a more independent voice, one that they may have actually agreed with but couldn’t embrace politically.

Satcher: Yes. Exactly.

Mullan: Many people have said that the two positions, if fully empowered, are not compatible because one is managerial and political and the other is representational and needs to be above politics.

Satcher: I would agree.

Toughest Issues

Mullan: While surgeon general under the Clinton administration, what were the toughest issues that you had to deal with?

Satcher: As has been the case too often, getting confirmed was one of the toughest parts of the job. When then Sen. John Ashcroft [R-MO] decided to work against my confirmation, he searched very hard to find anything negative that had ever been said about me. He came up with five issues: my making firearms and violence a public health problem; my support of the needle exchange program; my advocacy for comprehensive sex education, including allowing communities to provide condoms; my support of President Clinton’s decision to veto the partial birth abortion ban (I believe that such decisions should be made by the physician in conjunction with the family, not by government); and certain CDC-funded research in Africa on low-cost HIV prevention. My impression was that in opposing my nomination Ashcroft saw an opportunity to establish himself as a leader with the conservatives. He did a good job. He collected information on me but refused to meet with me. After I was confirmed he wrote to me saying, “As you know, I did not support your confirmation, but I hope that you will prove me wrong.” Nonetheless, I think he used my confirmation for his own ends.

Another challenge was sexual health, which was a really political game. When I was up for confirmation I remember going to see Carol Mosley-Braun, who was the only black person in the Senate at the time. She said to me, “I hope you understand that your confirmation is really important, especially to people of color. You can really make a contribution here.” She added, “Promise that you will stay away from sex. The worst thing that could happen would be for a black man in Washington to be talking about sex. Don’t give them an excuse to lynch you.” And I didn’t until my third year. At that point, after reviewing all of the public health data and the AIDS epidemic, which I’d been quite involved with, I decided to undertake a surgeon general’s report on sexual health.

Strategy For Effectiveness

Mullan: What was your thinking about using the surgeon general’s report as a vehicle for making policy?
Satcher: The surgeon general’s reports were an instrument to make the office effective. It’s one thing to render an opinion on your own about masturbation, as Joycelyn Elders had done. It’s another thing to put together a public health report on responsible sexual behavior. I felt that if we could use a public health approach for dealing with suicide prevention, mental health, or sexual health, we would have credibility in all of these reports, whether people agreed with us politically or not. So using the surgeon general’s report to raise difficult issues became a major strategy. Suggestions for the subjects of those reports could come from Congress, the White House, the secretary, or somebody outside of government. For example, it was the Suicide Prevention Advocacy Network [SPAN] that spurred my interest in that issue. The Association of Suicidology invited me to speak at its annual conference. Kay Redfield Jamison was on the program before me, and by the time she finished I knew that suicide prevention was important. I later met with SPAN, and the rest is history.

From Clinton To Bush

Mullan: Tell me about the change in administration, from Bill Clinton to George W. Bush. You were one of the few senior people in government who had a mandate that carried through the change in administrations.

Satcher: My intent all along was to serve out the four-year statutory term, unless a situation were created where I felt that I couldn’t be effective. I wanted to make the point that the surgeon general’s position is not political, that the surgeon general is responsible directly to the American people for making recommendations that are based on the best available science. The surgeon general will not always agree with the president and Congress. One way to underscore the position’s independent voice was to serve in both Democratic and Republican administrations and to continue to be productive. I understood that the Bush administration would want their own assistant secretary for health, and, as I expected, they relieved me of the job. The assistant secretary is a political position, and I am an independent. The change gave me the opportunity to focus more attention on the role of the surgeon general. I lost some of my resources, because as assistant secretary of health I had a $100 million-plus budget, while the surgeon general has virtually no budget.

September 11 And Anthrax

Mullan: During fall 2001, with the terrorist attacks and then anthrax, did you feel you were deployed effectively, both as an individual and as an office?

Satcher: It was a difficult situation. We had been training for bioterrorism, but when it actually came, nobody was prepared for the experience we had with anthrax, especially with its appearance so soon after September 11. It was such a shock. We had a new administration. HHS secretary Tommy Thompson was still getting on board, so he first responded by saying that he thought that the initial case probably just got anthrax randomly. He reassured the American people without seeking appropriate counsel. The press took hold of his statement and referred to it repeatedly as a source of embarrassment. Tommy was used to being a governor and felt that he should be the department’s spokesperson. He brought with him the idea that “I’m going to manage this department, which has never really been managed.” That instinct didn’t always serve him well.

Mullan: As time passed, different spokesmen showed up. You and others became more visible. Was there an evolving strategy?

Satcher: What unfolded happened in part by chance. Shortly after the creation of the Office of Homeland Security, director Tom Ridge invited me to a White House conference, where I
was able to respond to some difficult questions. When Thompson’s people saw me on television, they decided that I did a good job and started trying to get me to do more with the press. In a two-week period I held more than thirty TV interviews. Tommy's strategy seemed to be to rotate spokesmen in order to maintain his leadership role. The people who spoke for him included Jeffrey Koplan [CDC director], Tony Fauci [director of NIH’s National Institute of Allergy and Infectious Diseases], and me. That was his approach. His feeling was and probably still is that he is the chief spokesman on this issue.

Mullan: During the crisis, was there any sense of the PHS's Commissioned Corps, which is under the surgeon general’s authority, responding as a health defense force?

Satcher: The Commissioned Corps, which consists of about 5,600 mobile health professionals, was very active from September 11 on. Its members investigated just about every anthrax outbreak, even though there wasn’t a lot of press reporting on them. I activated the Commissioned Corps Readiness Force on the morning of September 11. Some of them were deployed almost immediately to New York City. Others were prepared, but since that city had so many resources of various kinds, they were never asked to go. We detailed some to the U.S. Navy hospital ship that was deployed to New York Harbor.

Reflections On The Larger Picture

Mullan: Do you think that September 11 and anthrax brought public health onto the national agenda in a lasting way?

Satcher: I tried to make the point during and after fall 2001 that to deal with bioterrorism you need a strong public health infrastructure. That infrastructure has three major components: the public health agencies at the federal, state, and local levels; health care providers, including physicians, pharmacists, and nurses; and the public. I talked about the role of each and how the lack of team training for those components was a major weakness of our response. By public, I mean the people to whom we say that if you have an unusual occurrence, see your doctor; wash your hands after opening the mail or dealing with a foreign object; thoroughly cook meat and wash fruits and vegetables; take antibiotics as prescribed, or you’re going to contribute to drug resistance. Those are very important parts of a strong infrastructure against bioterrorism. We depend on the public to hear those messages. The weakness in our response was at all three of those levels, but communication among the levels was especially weak. We had more than 400,000 physicians participating in satellite conferences after September 11. We should have been using that technology earlier. Before the planes hit, we had fewer than 5,000 physicians in the whole country who had been through bioterrorism training. We need to nurture the public health infrastructure and provide ongoing training.

Mullan: How do you feel about the money that has come into public health? One of the criticisms is that a lot is simply being used to purchase and stockpile vaccines.

Satcher: I’m pleased that the crisis brought attention to the importance of public health. But I’m also disappointed that while we are now preparing to respond to an infectious disease crisis, ongoing support for health promotion and disease prevention is still low on our agenda. There's an imbalance.

Mullan: What is your prognosis for the U.S. public health system?

Satcher: Everywhere I go, patients, physicians, and payers are all complaining about the health system. It’s tough. I still have hope that sooner or later we’re going to come to our senses. Somebody is going to say, “Let’s take this on” and make some real change in our health care system, meaning both increased access and strengthened infrastructure. We
need the infrastructure for a community health system that balances health promotion, disease prevention, early detection, and universal access. That same system, by the way, would be able to respond to a bioterrorism attack better than anything we have today. Suppose we were to take a balanced community health approach to diabetes, for example. We would invest in programs of physical activity instead of saying we can't afford physical education in K–12; we would understand how exercise relates to the whole health system.

**Leaving A Legacy**

*Mullan:* You sat atop the public health structure of the country for four years. As you look at the job and the country today, what would be your valedictory?

*Satcher:* I have served in government for almost nine years; that's a long time if you are not a career government person, but I wouldn't trade the experience for anything. Balancing politics with science under constant scrutiny is difficult but interesting work. The surgeon general tries to say to the American people, “This is what the public health science says. This is the way we should go.” I am now writing a book on my life in government and my views on how to improve America's health.

*Mullan:* Tell me about your new role at Morehouse School of Medicine [MSM] and the reason you chose a primary care center for your next stop.

*Satcher:* It was not an easy decision, even though I will be returning to Atlanta, where I'd lived as CDC director and as an MSM faculty member. I worried that in going to Morehouse, another historically black institution, I would be seen as competing with Meharry, the institution that I had once led. It was my wife, Nola, who said, “I think we should go back to Atlanta. That's where you belong, that's where we got married, and that's the thing that's most consistent with what you're about.” In the end I knew that it was the best decision for both me and my family. At Morehouse I hope to play a major role in strengthening the front line of health care in this country, with a real emphasis on training primary care providers and health care teams. The first initiative that we hope to have is a research center on health disparities. I also hope to have a program to bolster the role of the primary care provider in the early diagnosis and treatment of mental health problems, especially depression.

*Mullan:* Would it be fair to say that you don't see a distinct line between public health practice and health service delivery?

*Satcher:* What we need is a unique partnership between public health and medicine. Medicine means treating individuals, one at a time. Public health means working with community institutions like schools and worksites to promote good health and prevent what illness we can. Physicians and other health care providers need to bring more public health into their offices by offering prescriptions to change lifestyles, cease smoking, and increase physical activity. Public health also worries about cultural competency and barriers to access to high-quality health care. These concerns need to be reflected in the offices of physicians as well. Public health informs health care and vice versa; it's a partnership. That partnership is what the universal system of the future will need in order to succeed.