

Dr. Lester Breslow  
In his office at 1100 Lyndon  
West Los Angeles  
Interviewed by Frances Lomas Feldman  
June 20, 1990

#### ABSTRACT

Dr. Lester Breslow, frequently referred to as “Dr. Public Health,” was a pioneer in many aspects of public health in California and nationally. Following military service and work in Minnesota in public health, he entered the California Department of Public Health by the “back door,” and established himself as a leader in various divisions of that Department before becoming Director of the Department. During the Reagan governorship, he left because of philosophical differences, joining the School of Public Health at UCLA. There he sequentially assumed chairmanship of various departments in Public

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FELDMAN: Dr. Breslow has long experience in the field of health and welfare, especially health. I will ask him to just start and tell us about that.

BRESLOW: I understand that you might want me to start with the story of how I got into public health as a field. It begins, really at three years of age-I won't take you into details of my

childhood. At that time I began to stammer quite severely, a condition that persisted through my school years until in high school, my family put me in the hands of a therapist who undertook to help me overcome that disability. She did so, and in the course of it, introduced me to what was then known as mental hygiene. From that I took an interest in becoming a psychiatrist as a high school student. I finished high school with all the pre-medical courses, went through a medical school. In my junior year, during the summer, I decided the time had come to really become a psychiatrist. I therefore spent in the Fergus Falls State Mental Hospital, really properly called and insane asylum.

FELDMAN: Where was that?

BRESLOW: Fergus Falls, Minnesota. I was going to school in Minneapolis. The situation of people with mental illness was so terrible that I could not contemplate a life of that sort. Of course, people became psychiatrists and did other things. But I was concerned about those people who were really seriously ill in hospitals. So I returned to the campus at the end of the summer, very disheartened.

FELDMAN: About what year was this, Les?

BRESLOW: This was in the summer of 1937. I was then 22 years old, getting to the end of medical school. Here I devoted the last years of high school, college, medical school, anatomy, biochemistry--all those things in which I really did not have interest--in order to become a physician to become a psychiatrist. Now it was all laid apart.

Personally, I met a friend, a young instructor in the medical school, who had taken some interest personally in me. He said, when he heard my despair, that he never had thought I should be a psychiatrist, but that I should go on to public health. Because now I was a medical degree, and that my social and political orientation was such that that would be the proper field for me. So he introduced me to the new, just arrived professor of public health, who was just starting a school of public health in Minneapolis. That's how I came into the field of public health at the age of 22 before I finished medical school. Well, to go ahead, I finished medical school and also the master of public health program at Minnesota, entered the Minnesota

Department of Public Health, and then spent a few years in the Army of the United States during World War II the last year of so in the Pacific theater. I came back to enter public health work in California, the California Department of Public Health, as it was known in those days. I stayed there for 22 years, then came to UCLA, where I have now been also for 22 years. So that has been a quick outline of my career. I said I've only been able to get two jobs in my whole life.

FELDMAN: (Laughter) But those were very prestigious jobs. Did you enter the California program as Director of Public Health?

BRESLOW: Oh, no. I entered the California Department of Public Health in January of 1946, having just returned from overseas. The director of the Department at that time was Wilton Halverson, a great figure in public health, not only in California, but nationally. Halverson had been picked by Earl Warren, governor from the early years of 1940, along with a lot of other distinguished professionals in the health and welfare fields. He picked carefully, outstanding professionals, to get the departments dealing with prisons, welfare, public health, and other fields of that sort. That was a mark of Earl Warren. He not only picked outstanding professionals but gave them strong support. I didn't know that at the time, but I came to know that in the ensuing years.

My first encounter with the Department came through an introduction to Dr. Halverson. It had been given by a distinguished person in public health in those days, K. F. Meyer, at the Hooper Foundation at UC San Francisco. Halverson saw me because K. F. Meyer called him on the telephone to see me. Halverson, however, didn't like my ideas of public health. He listened for a few minutes to my great notions of introducing a chronic disease program on the public health scene in California, and after only a very few minutes of listening, advised that I should go back to Minnesota and try out those ideas. It was quite evident that he had no use for them in California. Well that was a bit disheartening, and after a brief vacation--that was in November, December of 1945--I came back. Through a great physician on the staff of the Department in those days, Jesse Veermer(?)--whom I saw just recently; great shape, head of

maternal and child health of the Department--got me in through the back door somehow, and that's how I entered the California State Department of Public Health.

I entered as the Grade I Medical Officer; the lowest rung for a physician, because they had need for someone to do the project on encephalitis, which I had some prior experience, although I made it very clear I had no interest in that. I took the job only because the immediate superior, a great figure in my career, Robert Dyer, said that he would read my memos (meemos as he called them) about chronic disease. That seemed a fair deal. At least I would have a chance to convince him to do this. That was a new idea in public health in those days. He was still concerned with the traditional things that people perhaps even still think are the guts of public health named the Communicable Disease Control, Maternal and Child Health, Environmental Sanitation and the like.

Well, once I got in, and having found the way with Dyer's support and Federal money to get started in the chronic disease field, by the middle of 1946, I entered into a wonderful opportunity in that department. Halverson, as I mentioned earlier, was a great leader in public health, a Seventh Day Adventist, but a broad-gaged man who organized and led a wonderful group of people in the Department. He gave everybody a great opportunity and was a great mentor for all of us in the Department in those days. He was quite conservative in his views about the nature of public health, as evidenced by his reactions of my notions of introducing chronic disease into the public health agenda. He also, like many leaders of public health in those days, had no time for medical care, even for indigent medical care as we called it in those days, as a teacher of public health. He would personally have nothing to do with it. He would not take part in any of the movements in those days in the beginning, admittedly on the fringe of public health. I was very much interested in those things.

Earl Warren wanted to introduce state health insurance. He had five daughters and had considerable amount of medical care experience with his family. He had the notion, in those days, that he wanted to leave as an important mark of his career, a state health insurance program. Halverson, however, the State Health Director, would have no part of it. But he

allowed me--not with any public notice--to assist the Governor's staff in the development of programs, the writing of speeches, and things of that sort. I used to travel occasionally to Sacramento to meet with the Governor's staff and people that were doing the planning and writing, to offer what help I could, because I was personally very interested in touch nationally with what was going on toward getting a national health insurance program underway in those days.

One very early experience indicates, I think, some of the tensions in the health field of that period. The very first thing that we decided to do with cancer control monies, which is all we had for chronic disease programming, beginning in the late summer of 1946. What we decided to start with was a tumor registry. I had visited New York, Connecticut, Massachusetts, some other programs where tumor registries had been started, and I decided that that's the way we should start. An important aspect was, at that time, to get the support of the Cancer Commission of the California Medical Association. We included people who became leaders not only in California medicine, but of American medicine. John Kline, for example, became president not only of the CMA, but also of the AMA; a cancer-interested surgeon. Then there were others: pathologists, radiologists, people that were just starting up in the clinical cancer field in those days. The time came, having talked with the chairman, informally, and one or two other members about our plan to start a state tumor registry, to meet with the Commission. The time was dinner at a famous restaurant; Jack's Restaurant in San Francisco. On my way to that dinner at six o'clock, I noticed the headlines in the newspapers on the stands on the corner. They were a surprise to me, not in substance, but in timing, as they were, I learned to the members of the Cancer commission. The headlines were that Governor Warren had introduced his health insurance bill. When I arrived at the meeting with the nine members of the Cancer Commission, they were so exercised, excited about this terrible thing that the Republican Governor of California was doing, that they immediately transformed the whole idea of the cancer registry into a scheme by which the cancer patients were to somehow be fed into a state medical machinery that Earl Warren was proposing to set up. It was even in those days, not just

in retrospect, the most bizarre notion. Here were these people, very distinguished leaders in California and in even American medicine, who had this short circuit.

FELDMAN: This kind of parallels what was happening among similar groups with mental health.

BRESLOW: Yes. Well, the situation was so unnerving for all of us, that I literally did not stay for dinner. There was just no way that any of would be able to eat. If I were still present, representing this terrible thing that Governor Warren was doing--of course they did not have any knowledge that I was otherwise working with Governor Warren--but the tumor registry had nothing to do with the case, of course. Well, as we walked out of the room, the Chairman of the Commission, a very nice radiologist from San Diego, put his arm around me and said, "Lester, don't worry too much about this. In two or three months, I'll call you again. That bill is not going anywhere. They'll forget about it, and things will die down. This is a good thing to do, and you'll come back, and we'll start the tumor registry." This is precisely what happened. But that indicated the feelings of people, and also, the attitude of the Public Health Director, who, while he might not have totally agreed with the leaders of medicine, still adopted a policy that would protect the relationship with them, even though it was not supportive of the Governor. The Governor did not mind that. He wasn't dependent on his health director to get his health insurance notions put forward. But that's the way it was.

I had a wonderful experience in the Department, and, as I say, learned a great deal over the years. We started the chronic disease program and put a lot of emphasis, in those early days, on the tumor registry. We started with nine hospitals in California, scattered among some of the major hospitals: some teaching, some non-teaching, some public, some voluntary. In those days we didn't have...

FELDMAN: Throughout the State?

BRESLOW: Throughout the State. I think three or so of them were in Los Angeles. We didn't have proprietary or profit-making hospitals in those days. We did have a lot of other hospitals that were substantial numbers of cancer patients. Those hospitals have maintained

their cancer registries to the present time. Over the years the idea of tumor registries is taken very strong root in California and elsewhere, too, but particularly in California. We developed a county-wide registry for Alameda County in 1960, and subsequently that became a Bay Area-wide registry, and very recently, it's become a state-wide registry, undergoing some metamorphoses during these years, but essentially the same as when we started back in '46. It's provided, of course, a wealth of data.

Well, we dealt with a lot of other problems in those days.

FELDMAN: Excuse me. Did the cancer registry, then, serve as a prototype for others kinds of registries?

BRESLOW: Only in subsequent years. Never to the same extent. We do have registries now, for example, of children born with birth defects. That came along later. There are registries of other fairly rare conditions. Nothing as extensive, that I know of, as the cancer registry. Various people around the country and the world have tried to develop such registries. There's always been some debate about the worthwhileness, even of the cancer registry. But it seems to have taken strong root, now, not just in California, but elsewhere as well.

In those very early years, I could recall any number of experiences. But let me just mention a couple. One was the great polio-myelitis epidemic in Los Angeles in 1946. That was the year I mentioned earlier that I entered the Department and was assigned to work on the encephalitis study. That June of 1946, I was called off the encephalitis study and assigned, as Halvorson said--he'd somehow discovered me in the Department, not having admitted me through the front door, however--sent me out, as he put it, to take charge. Those were his words, "take charge," of the polio-myelitis epidemic. That summer we had over 2,000 cases of recognized polio-myelitis in Los Angeles. Lord knows how many unrecognized cases occurred. There were various efforts made to deal with the epidemic.

FELDMAN: Was this a more expensive epidemic than the one in the mid-Thirties?

BRESLOW: Well I wasn't here in the mid-Thirties, and I only heard vaguely about that. But it was a very sizable epidemic. What we mainly did from the State Health Department, was to

handle the public relations aspects of it, giving support especially to the people of Los Angeles County, who were endeavoring to provide medical, hospital, and later on, rehabilitation services. A wonderful program was developed here by the people in Los Angeles County, including care for, I remember, over one hundred patients at home with what in those days we called the “iron lung.” That was a very elaborate contraption, very heavy, which had to be supported by stand-by generators in the backyards of the people in case the electricity should fail, and they would be without life support if they should be without that stand-by generator. That was an important feature of dealing with an epidemic that of course we may no longer, hopefully, will ever see in this country, and hopefully in the near future, not in the world. But that was a feature of our work.

I also recall, during those very early years, being assigned to join the Berkeley City Health Officer in vaccinating people against small pox in the face of an epidemic in the late ‘Forties. The epidemic actually never materialized as such, but there were a fair number of cases that occurred in the Bay Area, and to abort that threatened epidemic, health officers rounded up people to come for small pox vaccinations. This man needed physical assistance by a young doctor, so I had that experience of standing at the head of the line of hundreds of people lined up around the block in Berkeley, to receive the small pox vaccinations. Of course now days, small pox has been eliminated from the world. In my memory, we still had the public health challenge of disease.

Moving ahead a little bit in years, another great health problem that we encountered in California in the early 1950s, was air pollution. During the 1953 or 1954 gubernatorial campaign, when Goodwin Knight, who had succeeded Earl Warren as the Republican Governor when Warren went to the Supreme Court, Goodwin Knight was running against the Democratic candidate for his first election as Governor. In the midst of that campaign, the summer of--I’m not sure if it was ‘53 or ‘54--a very severe episode of air pollution effected Los Angeles County. It became a factor in the political race. Unfortunately for the Democratic candidate, he lost his voice about three weeks before the end of the campaign.

FELDMAN: Because of the pollution? (Laughter)

BRESLOW: I don't think it was because of that. But at any event, Goodwin Knight was running, I guess, as the politicians say, "scared." On the first of October, before the election early in November, he called upon the State Department of Public Health, headed by Halvorson in those days, to find, as he put it, "when smog becomes a killer." That was his charge. When does smog become a killer. The fear in those days arose from experiences in England, in lower Pennsylvania, other places, where there had been episodes of a considerable number of fatalities as well as severe illness from the smog.

FELDMAN: That was called the "yellow fog?"

BRESLOW: It had a lot of names. It was more brown than it was yellow. That's right, it had a lot of appellations. Knight wanted to, I suppose, get out of some of the political heat by having called on his Department a month or so before the election, as having taken all the stand that he could by calling his Health Department into the situation. We were instructed to bring in a report by the first of March, when he would hopefully, and he was, elected Governor of the State. We did that, and the report, I recall, was called "Clean Air for California." It was, I suppose, the state-of-the-art, but it did indicate that public health in those days, entered quite substantially into a political thinking. I believe in a way that that is more thoughtful, substantial, than the way, let's say, the AIDS epidemic has entered into politics. The Governor called on the Health Department to prepare a scientific report, and we did the best that we could. And as a matter of fact, even the phrase that we used in that report, "Clean Air for California" has become a kind of a slogan of an ocean of clean air as the concept for air pollution control. So we were fairly proud of that report. Unfortunately, it didn't have a great deal of impact because the election was over, and air pollution became quite powerful in especially some parts of Los Angeles, almost every fall during the 'Fifties and into the 'Sixties. We could go back to air pollution perhaps a bit later, or should I go ahead and complete story.

FELDMAN: Why don't you.

BRESLOW: All right. So we did that work on air pollution during the early 'Fifties. When

Pat Brown, some of us say, "The real Governor Brown," came into office in 1960--'59, I guess it was--he dispatched a couple of his high lieutenants, very bright attorneys who had been with him during the campaign and helped get the administration underway, came down to see a couple of us in the State Health Department; John Marga, public health engineer, and myself on the medical side. I think they came right by Dr. Merrill, who was by that time a successor to Halvorson, and the head of the State Department of Public Health. They knew the names of the people that they wanted to talk to. So they came to us and said that they wanted to have another report on air pollution. This time, one that would set the standards, the chemical standards for the ambient air, that is the air that people breathe out of doors everywhere. What amount of carbon monoxide and sulphur and other materials would be allowed in the air, ozone nitrogen oxides. Not only would the report do that, but since they were convinced, these two bright attorneys, that air pollution came largely in California from the exhaust pipes of automobiles, that we should further specify what limits should be placed on automobile exhaust. John Marga and I thought this was an off-the-wall idea. It was a marvelous concept, but we felt totally unfeasible. How could we possibly do that? But there were the instructions. We had to do it again in a quite short time-table, because the Governor wanted to have this accomplished early in his administration.

FELDMAN: Did he get this idea out of his experience and head, or were advisors suggesting it?

BRESLOW: I don't know where it came from. It certainly didn't come from us in the Health Department. It might have come from such attorneys, or he might have thought it himself. He, of course, had experience. He'd been the San Francisco District Attorney, but he'd been around the State. He knew as State Attorney, before he became Governor, what was going on in Los Angeles and a few other cities in the Southland. Where the idea came from, I don't know, but it clearly came from his office and was carried.

John Marga and I then scratched our heads and went to work, assembled an expert committee, including several Californians and several people from across the country who we

found to be the most expert at this question: “What standards should we allow for the ambient air, and how can we translate those standards to the number of automobiles and how much should be allowed to come out of the tailpipe?” With the very substantial help of this expert committee, we then proceeded to do precisely what we had been asked to do. We went to the State Board of Health some months, or maybe a year or so later, no longer than a year, when Roger Egeberg was by that time the Chairman of the State Board of Health. The Board had the power in those days to adopt such regulations. It didn’t, in those days, have to go through the Legislature referred to an initiative to the people to vote on. It was done in regular, governmental, well-established channels in which people had confidence because those channels were working as they did in this case. The Governor asked his agency, which called upon best experts it could find, locally in the State and nationally, took those expert opinions and studies, formulated a report with recommendations to the Governor. And we did. The Board had the power, being appointed by the Governor and its broad statutory authority, to adopt those regulations, which it did. It did so in a public hearing which I remember very well in the small auditorium of the Department in Berkeley, in those days, which was filled with people from the automotive, oil industries, who were intensely interested in this proposition. You can imagine what the situation would be like nowadays, where this would be handled in some obscure way in Sacramento with lobbyists and legislatures, in some of their, I must say, nefarious negotiations, making the decisions. This was all done with a style that I’ve just outlined to you, and done in a public meeting with the experts as well as the legal talent of the big industries; oil and automotive industries, brought in to see what was going on, to object and to challenge it, as is quite appropriate, of course, if they felt that there was a basis for a challenge. They listened to the report. They were given an opportunity to make comments, to ask questions. They had none. The Board adopted the recommendations, and they were never challenged in California--at least in those early days the way we formulated them; that first basic set of recommendations. That became the basis for the air pollution control program--not just in California, but in fact, across the country. Everyone is familiar, of course, with generally what

has been happening with efforts to get Detroit, as the automotive industry is called, to establish proper controls on air pollution in California and elsewhere in the country. So those were exciting days and opportunities in public jobs.

I emphasize the style and the matter of the work as being so different from what it is nowadays, what would happen nowadays.

FELDMAN: From the perspective of the Governor as well as departments and the public.

BRESLOW: That's right. And the industry.

FELDMAN: And the industry.

BRESLOW: Now of course our relationship has been all turned topsy-turvy, and everybody is dissatisfied. The industry, the public, I suppose the politicians, the experts, nobody is happy with the situation. In that respect, I suppose, I am pleading for what people might say at my age I look upon as the "good old days." I think, however, that these are our cycles in political styles and actions which will come around again. California is gone, I think, to an extreme, evidenced for example in a good outcome, I would say, recently in Proposition 99 where the elected officials would not do what the people wanted to have done with respect to control of tobacco use. And so an initiative was passed, by no means perfect, but certainly substantially what the people wanted; sixty to forty. Now the State has implement and is implementing an initiative that the people have passed, but they did it only because ultimately became totally frustrated with the system. There was no way of dealing with a problem like tobacco control, which is so important to health in California as well as elsewhere in the world nowadays. Well, enough of that. Let's go back to somewhere else.

FELDMAN: Okay. Let's go back to public health, and your role in it. That is, the Department.

BRESLOW: The Department. We did develop the Bureau of Chronic Diseases, as well called it. The Tumor Registry that I mentioned gave it a start, but we moved into a number of other fields. We had an interest in the control of hypertension, in diabetes and other conditions. One of the early ideas that we introduced in California was what became known as multi-phasic

screening. I had gotten the notion that in Public Health we were doing a lot of screening for specific diseases in the 1940s; even before that time. Surgeon General Parron(?) of the Public Health Service had popularized the serologic test for syphilis, and that was applied during World War II days. It wasn't quite as good a test as we have nowadays, but it was state-of-the-art. It was a reasonably good test for syphilis. We also had some new gadgetry for detecting tuberculosis. Instead of having to take regular large films that people are used to for chest x-rays, we were able to reduce the size and the cost and the time involved in screening masses of people for tuberculosis. Then someone in Oxford, Massachusetts Public Health Service was able to find a way to screen people for diabetes. So we had these separate screening tests and thought that the big expense in part of this whole screening notion was getting the people assembled to come through and get the tests. Of course it was some problem to line the test up and keep the records, and so on and so forth, but to manage all of that for separate diseases at different times seemed to us a rather inefficient way of going about it. So we introduced the idea of what became known as "multi-phasic" screening. First in a factory where cannery workers were employed in San Jose, California.

The name came about in a very interesting way. People have often asked me how it came to be called "multi-phasic" screening. I said that that term was applied before the San Jose trial of this idea because sitting around with a colleague one day, wondering what we should call this--we thought we ought to have some....

FELDMAN: Catchy name.

BRESLOW: Catchy name for it. I suddenly remembered that in Minnesota, a professor there had introduced the Minnesota Multi-Phasic Personality Inventory, very well known in psychological and social and medical circles. It was a personality test called the MMPI-Minnesota Multi-Phasic Personality Inventory. I guess it's still used.

FELDMAN: It's still used.

BRESLOW: That word, somehow, clicked into my mind, and so we called it multi-phasic screening, because it involved searching for more than one disease. Well, it was a very crude

way of doing things. For example, for the diabetes testing, we had to get the blood sugar of people. To do that, we had a gadget, oh, perhaps three feet wide and ten feet long with a chain on the outside into which in two places on the chain, we would insert test tubes. As the chain moved around, this oval apparatus, clinking, literally clinking all of the time, various chemicals would be inserted automatically. It was pretty advanced for those days. At certain times, after thirty seconds, such and such; after two minutes, such and such.

FELDMAN: That's very innovative considering the time.

BRESLOW: We didn't invent it. We bought this machine. It cost a relatively lot of money. It also had to go through at one point, for several minutes, ice water. At some places it was heated, and other places somewhat cooled, and then we had to go through an ice bath. So the principle problem we had logistically with multi-phasic screening was keeping enough chunks of ice around to keep that water properly cold. That indicates something about the technology that we had in doing things like multi-phasic screening in those days.

The idea took hold a bit. It was adopted a little bit later by the Kaiser Permanente Medical Group a very few years later. That happened in this way: A couple of people on the staff of the ILWU--International Longshoremen Warehousemen Union, led my Eric Bridges--Pacific Maritime Association, PMA-ILWU, PMA Health and Welfare fund had been established, and that fund provided medical care through a contract with the then just developing pre-paid health plan that Kaiser had elaborated, having had experience during the war years in the shipyards at organizing medical service. So Kaiser had the notion that medical care ought to be organized. He was an industrialist.

Henry J. Kaiser had established this pre-paid health plan. It was just getting off the ground when one of the very first large contracts was with this ILWU-PMA Fund. The contract called for examinations of the men. The story we heard was from these two women who came to see us from the staff of the Fund, that when they had asked the Kaiser doctors how to schedule these physical examinations, the Kaiser doctors responded--faced with six or eight thousand of these examinations, and it would practically have overrun the plan, they had very little to go on

in those days-- as to how to schedule them, the doctors said, "Well, just send the men over," knowing very well that if you talk to people to go for medical examinations, a trickle will show up. All the staff people said, "Just tell us how you want them scheduled."

"Well, what do you mean, 'scheduled'?"

"Well, we'll send the men over. You see, we have 'gangs' of twenty men who work on the shifts, unloading and loading the ships, and they work on the job until it's finished. It may take six hours, it may take twenty-six hours. Then they go on a rest, and they'd go to the bottom of the list, and then when the job comes up in time, they go back on the job. And when they're in this rest period, we'll send them over."

"Yeah, but they won't come," the doctor said.

"Oh, yes they will."

"How do you know they'll come? People don't do this."

"Well, that's part of their assignment. If they don't show up for the job, they go off the list to the bottom. If they don't show up for the examinations, the same thing; they go off the list to the bottom. They'll come."

Of course then, the Kaiser doctors had to have a second think. How were they going to tackle this? While they were thinking about it, these staff people heard of what we had done in San Jose. So they came to see us, to seek our help. Wouldn't that be a good way to approach this problem? At least find out whether people have tuberculosis and syphilis and diabetes and high blood pressure. At least do that much. And so we said, yes, we thought that would be a good way to go. "Well, why don't you go over and tell the Kaiser doctors how to do this," they said. (Laughter)

FELDMAN: Who didn't think you'd be welcome just because they didn't expect the men to come. (Laughter)

BRESLOW: We said, "No. You're in touch with the Kaiser doctors. You tell them that we're available to provide assistance." Well, we worked it out so that Dick Weinerman in those days-- a great figure in public health, unfortunately, killed in a terrible airplane crash, later, too

early in his career--on the Kaiser side, and I on the public health side were trying to get this think in place. We had a few problems. What it was when it got right down to it, Harry Bridges, this great old courageous allegedly revolutionary labor leader got cold feet. Maybe the men wouldn't like this scheme.

FELDMAN: Had the men been asked?

BRESLOW: Not yet. It was all being negotiated by staff, including staff of the Union and the Pacific Maritime, the Employer's Association. Bridges wanted us to send a postal card to the men asking them if they would do this. We said no, that wouldn't be of any help, because what a person put on the postcard had little to do with what would happen when the time came. Well, Bridges said, then you have to come over and tell it to the men. So Dick and I went to the Union meeting on the appointed day in the San Francisco Auditorium, and at each entrance to the auditorium, there were people with long rosters of names, checking off. We were, of course, admitted, because we were to be on the platform. What was all this business about the lists and the checking and so forth? The system that the Union had in those days was that every member had to come to these meetings of the ILWU. If you will, that was an enforcement; democracy. At least they had to be in the room where the decisions were being made. So we asked a few questions. "Well suppose you have to go to your aunt's funeral that day?" That's too bad; you get fined \$25.00, which in those days was a pretty stiff fine. But suppose you're in the hospital with a broken leg? Sorry, you just have that additional \$25.00 to pay. There is no excuse. That was the way Harry Bridges....

FELDMAN: Very arbitrary.

BRESLOW: Around the Union. So he had really good participation. So Dick and I found ourselves on this platform in front of six or eight thousand men with Harry Bridges sitting way in the back. (Laughter) We were up front making our little speeches and actually answering questions. It was my first experience with microphones in the isles of a large auditorium. There were, I guess, six microphones down through the auditorium.

FELDMAN: With eight thousand people, did they actually come forward and ask questions?

BRESLOW: They lined up very quietly and orderly behind these microphones, and a moderator would go from one microphone to the next, very systematically. There must have been thirty people or more who had questions. It went on for quite a while. Not all of them were questions; some of them were comments cursing the medical profession and other things. Some of them were quite sensible questions. What was the meaning of all this and why not have doctors listen to your heart and so forth? So we had to explain what this was all about, and apparently the explanation was satisfactory, because they voted overwhelmingly to go ahead with this scheme. So that's how Kaiser got started in using multi-phasic screening.

Over the years multi-phasic screening has taken a variety of forms and a good deal of criticism, justifiable, I must say, even though I was an originator of it. But it's now come down to a number of--what shall I say?--evolutions to the point where at the present time, I guess the term most used for it, and more related to individual evaluation rather than screening of people for particular conditions, called "health risk appraisal." I guess that's a very common term. The Centers for Disease Control developed, and now the Carter Center, nearby the Centers for disease Control in Atlanta distributes a form of the health risk appraisal, which people can fill out themselves. So many people do know their blood pressure and cholesterol level, and so on, that it's possible, nowadays, to get some of the same idea of the multi-phasic examination. A lot of people would object to my formulation of this, but they aren't seeing the connection. But if you lived through that forty-five years, I could go through the details of how it has progressed over the years to the various forms, including this health risk appraisal, which individuals can take by themselves.

FELDMAN: And people are more sophisticated now about what goes on in health as far as they are concerned.

BRESLOW: Exactly. And they're more knowledgeable about what can be done about these various things if they are found. They are more concerned, I think, also, with health as a goal, not just the avoidance of certain diseases, or finding the diseases to treat them early. That's a very primitive form, which we had in the late Forties. That's all we had of dealing with health

in this new way apart from what physicians do with you when you have different symptoms.

FELDMAN: Reminds me of a time when Roger Egeberg, then Dean of Medicine at USC, came to talk to one of my social policy classes. This would have been in the late Sixties, I think. He strolled up and down in his special way and announced that more had been found out about medical needs and care in the years between World War II and that year, than in all of the history of medicine before. And you're really referring to some of the same kind of things.

BRESLOW: There was tremendous technologic development. I mentioned the primitiveness of what we did in 1946 simply to emphasize the point you're just making; that there was tremendous technologic developments. And of course we're all benefitting from it. I wouldn't say that the technology has all been applied in the fashion that I would prefer, but at least the technology has been developed. I think I was responsible for recruiting Roger Egeberg, whom I knew was dean at USC, to be the President of the State Board of Health, to which post he was appointed by Pat Brown.

Well, I should mention one other thing early on. In 1952, before this air pollution thing started, in 1952, as Chief of the Bureau of Chronic Diseases--that was my title in those days--I received a telephone call from Russell Lee. Russell Lee was very well known in California in those days, and throughout the country for having developed the Palo Alto Medical Clinic. He also had several famous sons, including Pete Lee at USC and Phil Lee, now in San Francisco, and two other sons and a daughter, all of whom were in medicine. Russell Lee called me up and asked me to come down and see him. Well, that was a great honor, so of course I went down there. He told me that he was a member of the Truman Health Commission--1952, fairly early in the year--that the Commission was obligated to make a report to Truman before the end of the calendar year. He and a couple of other members of the Commission, including Lowell Reed, who was then either the dean or became the president of Johns Hopkins. He'd been the dean of ??? before he became president of Hopkins University. And another man who was head of the Machinist Union in those days, three of the dozen or members were dissatisfied with the choice made by the Chairman of the Commission for a study director, a staff leader. So the three of

them decided that I should be the staff leader. Since Russ Lee was the closest to me, he was given the charge to recruit me. Well, I was immensely flattered but explained to him the several reasons why it was utterly out of the question. Number one: I was working for the State Board of Health, the State Department of Health, and the Department of the Board would give me leave for the whole year to go off on some federal deal. Number two: I had a family, young children and no way that I could pick them up and move them to Washington and all of that, and I wanted to see them. Another was that while I wasn't getting a lot in the State Department of Health, this job didn't pay enough, and it absolutely was leave without salary from the Department. It wasn't going to pay enough to keep me in any kind of an apartment in Washington and still keep my family in Berkeley. Another was that just at the time at the end of the year when they would be getting the report ready, I was going to be at the American Public Health Association Meeting. I was determined to be a public health professional, and I had to be at that meeting. Well, I gave these several reasons to Russ Lee, and he had a little envelope, he was writing down on the back of the envelope. So we parted very amicably. About ten days later, he called me up, wanted me to come down and see him. Well, what about this time? Well, he wanted to talk some more about the job. Well, we talked about that and it's just not feasible. "I think it could be worked out. You have to come down and see me. It's very important." So I did. He had that same envelope. The first thing he handed me was a letter from the President of the State Board of Health, granting my leave for the year. The next thing he handed me was a set of travel requests. You may remember them. In the olden times, the Federal Government didn't pay your way. They gave you a so-called travel request, and you signed into some machinery, and then you got the ticket. But you got those for a particular assignment. You probably had several of those. He handed me not one of those but a whole book. There were twenty-five or more in that book. He said he understood about families, and whenever I wanted to see my family, any day of the week, I could just go down to the airport and turn one of these tickets in and go and see my family.

FELDMAN: That was really unusual.

BRESLOW: Then on the salary, he had a contract which he said, "It's true they don't pay very much, but in this job you're going to have to work not five days a week, but seven days a week. In some super salary, seven days a week, it's going to cover things for you." And that was true. "Now about this American Public Health Meeting. That week, I'll personally go back and sit at your desk." (Laughter)

FELDMAN: They really wanted you.

BRESLOW: (Laughter) Faced with all of that, I, of course, did go back and spend about ten months on that assignment. We wrote a report called *Building America's Health*. Truman had wanted that because like Earl Warren in California, Truman nationally wanted to something about health, felt totally frustrated during his years succeeding Roosevelt, and after his own election in 1948, and so decided he would have at least a Commission report. Well, the Commission Report, when it came to Eisenhower's desk--in fact there is somewhere a picture of this being on the desk when Eisenhower walked in to be President. In any event, nothing ever came from the Report, although I still use it from time to time, because some of the ideas that we advanced, are only now beginning to get some attention. Very small people know about even the existence of that report.

FELDMAN: But it suggests that there is always a time.

BRESLOW: That's right. There are often political people like Warren and like Truman, who have a sense of what needs to be done, but are totally frustrated in getting the political where-with-all to get the programs through. There were times, of course,--and Roosevelt and Social Security is perhaps the outstanding example of this century in this country. Bismark, in another century and another part of the world, likewise, and for different political motivations, perhaps, accomplished some forward-moving health and welfare goals. So those were quite frustrating, although very interesting experiences. You're quite right. Not only must they be good ideas to meet real needs, challenges, but they also must be timely with respect to public understanding and possibility of public commitment.

FELDMAN: Do you have available a copy of that Commission Report?

BRESLOW: I have a personal one at home. That's about all. There are not very many around. It came out in four volumes. The first volume was a summary, and I use it not infrequently to indicate one of the most modern things, and one which I'm now heavily committed to and that his health promotion. The formulation of health promotion in that report is still a very good one. I didn't invent it, let me assure you. I took it from Henry Siegerist(???), whose ideas about health and what to do about it were extremely instrumental in the minds of many of us who were on the left in the health movement in the Forties and the Fifties. So we didn't give Siegerist credit for, I'm sure he wasn't looking for the credit. But the whole report is based in Siegerist's concept of health which begins with health promotion. And we even dealt with the issue of the relationship between the individual and social or community endeavor for health, which has become, as you know, quite prominent in debates over the past decade or so about health--what to do about it, who's responsible for it, and the like. I feel the formulation of that report which we took from Siegerist--we didn't quote him and we didn't use his exact words...

FELDMAN: But he's getting credit today.

BRESLOW: Today, in this interview.

FELDMAN: And it's on record.

BRESLOW: On record. (Laughter) It's no secret to anybody that were there any scholars in the field, or anybody that knows about the concepts of what to do about health, the contributions of Siegerist to thinking about health in this country, in all of my work over the years, and the work of many, many people in the public health field. Although he's known to scholars, and especially in the history of medicine, which was his particular point of scholarship, he's not very much known in public or even professional circles. My guess is if you asked the faculties or student bodies of medical schools in this country, with the possible exception of Hopkins, which is where Siegerist was a figure for many decades, but even there, I suspect that not very many people would know what Siegerist did. Not very many people would even know his name. But he deserves a lot of credit.

FELDMAN: Well, you brought me up to Merrill being the director.

BRESLOW: Yes. Merrill was the director and for those interested in state/county government relations, a contribution made by Malcolm Merrill may be of considerable interest. Merrill had come into the California Department of Public Health before Halvorson did. Merrill came in during the late 1930s.

FELDMAN: I didn't realize that.

BRESLOW: He was a laboratory person, and he developed a laboratory service. He also was especially interested in venereal diseases. When Halvorson became the director appointed by Warren, selected by Warren after a very careful search, Halvorson brought Merrill in--he was already in the Department. He found him there--to organize and lead the laboratory services, which Merrill did at the beginning of Halvorson's career. When I entered the Department in 1946, that was still part of Merrill's responsibility. But Halvorson drew him in quite quickly as his deputy, so that Merrill became the Deputy Commissioner of Public Health. Both of those men, by the way, Halvorson first and Merrill later, and the succeeding Director of Public Health over the period of what I call "the long influenced era" from the early 1940s to the late 1960s, twenty-five years of public health work--there were only three directors of public health. All of them, for whatever it may mean, were presidents of the American Public Health Association. So California really was a leader, and Halvorson and Merrill really set that pattern.

Merrill then was a deputy of the Department and was well trained in some aspects of public health, but principally in the laboratory side. He decided that he should get broader training in public health. He went to the Berkeley School of Public Health to get a degree, going part time over a few years. His thesis--I'm not sure he got a doctoral degree--but his thesis was that the State should enter into partnership with the counties in California to advance public health. He had certain very concrete notions of how a partnership should be affected and carried out. Two of the essential ideas were that there should be a state subsidy to county departments of public health, enough to make it worthwhile to get the subsidy. To do so, the counties would have to meet a certain standard. They would have to have a certain standard of public health

service; personnel and service and such requirements. Further, that the counties should organize themselves, and as their health officers, leaders, become a Conference of Local Health Officers. They should advise the State, have virtual veto power--I'm not sure whether that's actual or literal veto power--but it had to be by consensus between the State and the counties represented by this California Conference of Local Health Officers, CCLHO. That was Merrill's idea which he developed as a student, of course a mature public health person already, but in that capacity as a student. He not only developed it as a thesis, but in the Department, he carried it out. Halvorson saw the merit of it, and the two of them persuaded Earl Warren that it was a good idea. The Legislature saw the merit of it, and it became law in California. The Legislature, of course, had to appropriate the funds and otherwise create a statutory environment.

FELDMAN: Did that then involve the local county departments carrying out certain specific functions that had been carried by the State?

BRESLOW: No, not really. What it did was to standardize, if you will, not in the sense of standardizing to some point of mediocrity, but having a certain minimum standard, standardized in that sense of service such as, you would have a maternal and child health service, and they would have to have various other features of a reasonable local health department.

FELDMAN: To me that's especially interesting because that parallels the pattern that came into public welfare when the Social Security Act was established and the relationship between State and county operations. It had some of the same flavor.

BRESLOW: That's right. Merrill and Halvorson--and Merrill took the lead in this particular thing, this was when he was deputy of the Department--they carried that through and it had a tremendous influence on the course of public health work in California. It was later largely undone. We can perhaps talk about that a little bit later. But it was a profound contribution, and I think that still, when we get our politics a little better under control in California and elsewhere in this country, that it is a pattern that might be considered again, I'm sure in some different format. Of course there are people that would insist that it exists in the present time, but not the way it was originally established or intended.

Merrill was again a great leader in public health. Both these were really very fine men. Halvorson was a Seventh Day Adventist--I think I mentioned that. Merrill was a Mormon. Their own lives were lived not with any extreme rigidity in following those particular faiths and their doctrines, but quite well, I guess. They were both certainly well known and accepted in their respective circles. It was rather interesting to me that they had these religious notions. They were both quite conservative, politically. I don't know, but I certainly presume, that they both voted Republican every election of their lives. I may have been wrong, but that was certainly my assumption. They knew very well that I never voted Republican. Well I'm not certain about that. I can't remember when I ever voted Republican. They had to have toleration for somebody who would work in the environment that they established for public health in the State.

I recall one instance--going back to Halvorson for a minute--that will illustrate their way of expressing their convictions. Halvorson asked, because I was in those very early days in tobacco use control, and we did some of the early studies in California, several of the studies that constituted the basis for the Surgeon General's report on tobacco and health, the report in 1964 that was really the watershed, nationally and around the world, on tobacco use control and utilized the whip, with a lot of other work of course, too, but some of the work that we had done in California, which we started in the very early days; the late 1940s. So Halvorson knew of my interest and that of course was quite consistent with Loma Linda University and their views of health. They had a medical school and a School of Public Health. Halvorson induced me to go down and talk with those people. They invited me to come to their annual alumni event. They'd bring in graduates with the people on the campus, faculty and students, and they would have a weekend or so of discussions. So on one occasion, early on, Halvorson went with me. He was on the platform behind me as I spoke about some of these matters and at the end of my talk-- maybe a hundred people there--one man got up and began really attacking my point of view, which was that we should encourage people not to smoke, that we needed to do things in society to change the conditions in which learned and kept on smoking, and so on as you might

expect. And a few other things about alcohol and the like. Although I did not favor and still do not favor necessarily abstinence from alcohol like we favor absolute abstinence from tobacco. I think these are different things and that's pretty generally accepted. In any event, the gentleman got up and lambasted me. The principle issue being that people who use tobacco or alcohol, were essentially sinners and that that was a way to tackle the issue. Enough of this medicine and health education. These people were to be blamed. I was a little bit fidgety, wondering how I was going to deal with that issue. (Laughter) Halvorson came up from the back of the platform. When he came up, he more or less pushed me aside, and he took after this fellow in a public meeting, like I have rarely seen anybody attacked in public. The upshot of Halvorson's remark was, "You're a doctor, and when a poor patient gets typhoid fever, how do you deal with him? This way?" And he went on to let this fellow have it, that religion was one thing, but medicine and health were something else, and we shouldn't mix them up.

FELDMAN: And probably nobody else could have done that.

BRESLOW: Except Halvorson. I mention this to indicate his forthrightness, and his ability to seize hold of what he thought was an important issue. The only difference between us was that we didn't agree on what all of the important issues were. He knew very well my role, for example, in finding the medical care section of the American Public Health Association. Even during the time that he was a leader of the Association, he was bitterly--I don't mean mildly--opposed it. Merrill was much milder.

Well during those days, I was the Chief of the Bureau of Chronic Diseases. It was necessary to develop relationships with the voluntary health agencies: with the American Cancer Society, with the American Heart Association, the American Lung Association, and so on. Those days it was the NTA, the National Tuberculosis Association, and there were groups forming: The Crippled Children's Society, the Diabetes Association, and so on. They were obviously a very important element in public health. The Government wasn't going to be able to do everything, probably in our society, should not try to do everything. But we needed to cultivate popular public not only interest, but participation in the development of services,

including education and other more direct services to people. I regarded the voluntary health agencies as truly important partners with State government. Soon that interest and attitude--these agencies would often invite me to serve on committees, either councils or boards--so I was quite active in some of those voluntary health agencies. In the National Cancer society, for example, being on the National Board for a little while, in fact, Chairman of the Committee of Etiology of Cancer, which I thought was a bit bizarre even decades ago when I had that responsibility. But nowadays, it's even more bizarre, considering the nature of cancer research and the way it had become so, I would say distorted, sort of towards the so called basic medical science approach to cancer, without sufficient emphasis on the epidemiologic aspect of cancer, when the most important things we've learned about how to control cancer have come from epidemiology.

There was a glimmer of grasp of that notion two decades ago in the American Cancer Society and elsewhere, but it's been too largely snuffed out, hopefully to recur. I wouldn't say it's been totally snuffed out, but certainly, it's not been given the support over the years that other aspects of cancer research has been given. That's a sideline on this notion.

You may recall I worked with you and other people in the study of cancer needs in patients in California. That must have been...

FELDMAN: That's when we first met.

BRESLOW: That's when we first met. That must have been in the early 1950s or something like that.

FELDMAN: Around 1957.

BRESLOW: Okay. The late 1950s. So, I was very close to those associations. I had one perhaps funny trouble with them. That is that there were so many of them, I would have to go and visit them at semi-annual or annual meetings, or whatever, that I of course couldn't keep track of the boards or the council or the committees, or the people that I had met six months ago. Of course, being from the Government, and therefore, kind of a special creature, they would remember me. But I had a hard time remembering them. I had a very good secretary in many,

many ways. A Japanese woman whose family had been in the camps, carted off there by Earl Warren, one of the things he rarely did, in my opinion, in the early war years. She, herself, had been an interpreter for the Army and escaped the camps, but her family were in those camps. In an event, she came to work in the Department, and she was a wonderful woman. She would keep a roster of all of these organizations and all of the names of the people who had just been elected the president or the chairman or this or that. Just at 11:30 when I was leaving to go to the luncheon, she would hand me this list. (Laughter)

FELDMAN: Marvelous.

BRESLOW: She was terrific. Otherwise I would have been a terrible...

FELDMAN: I can imagine with yours the only department of its kind, how important it would seem to all these organizations. When they're set up like the Cancer Society, I think they then had 33 branches.

BRESLOW: Well, I met some marvelous people, including Frances Feldman. Others, too. One man stands out in my mind, however. That was Larry Arnstein, Lawrence Arnstein. Larry Arnstein was a fur merchant in San Francisco, who retired early--he was only 55--in quite modest circumstances. He wasn't wealthy. He always lived in a very modest house in a very modest lifestyle. When he retired, he went to see a few people to inquire what he should do now. He wanted to devote himself to good works. So one of the people that he saw was Bill Shepard, then the medical chief (I'm not sure of the title) of the Metropolitan Life Association Insurance Company, whose office was in San Francisco. Larry went to see him. Bill Shepard said, "Larry, you should enter the voluntary health agency movement. I've got just the job for you. That's to be the executive of the American Social Hygiene Association." Well, you smile, Frances. Ah, but whoever listens to this will not know, probably, that the American Social Hygiene Association was a euphemism for the anti-venereal disease association, concerned principally with syphilis and gonorrhea. Well Larry was in this job, the executive of the American Social Hygiene Association. I never did know whether they paid him anything.

FELDMAN: I think not. I think his expenses were covered but that was all.

BRESLOW: He worked, however, full time. Not only for the American Social Hygiene Association, but for every other aspect of health and welfare in the State. Beginning at age 55, he knew nothing about this field except.....(end of Tape I)

BRESLOW: Larry Arnstein was probably the greatest volunteer in the health and welfare movement that I have ever known. I've known some other marvelous people, including one of my own colleagues here, right now, and others over the years. But Larry was something exceptional. He looked across the whole field of health and welfare. To him there was no division. He couldn't understand the difference between welfare and public health. For example, he worked for Crippled Children's Services. I don't think he ever had a position with that voluntary agency, but that was one of the very special interests. I guess he was more in close connection with the Health Department than he did with welfare agencies. He really was a marvelous figure in California. He did a lot of great things. He was utterly selfless and very careful in what he did, depending on expert advice, never presumed to be a professional in the field, only a volunteer who would try to find what the expert consensus was on a topic. Then if he felt it was important, he would see it through. He did a lot of great thing. He was very effective in Sacramento because people knew that he had no self interest. He was the most utterly selfless person I think I have ever known. He was also careful, so the Legislators knew that what he said, they could rely on. He ranged across the whole field. People knew that he would show up whenever there was an important issue in health and welfare, in Sacramento or in the offices of some Legislator, or whatever. I learned two things about him which I've never been able to follow, I must confess, Frances. His was the ideal, and I've often thought I wish I could be like Larry Arnstein.

One thing he taught me was, never have a meeting, never call a meeting unless you know not only what is going to happen, but who is going to say what at the meeting.

FELDMAN: Good community organizing.

BRESLOW: So, he would think, and he could call any meeting he wanted to. Anybody would come to a meeting if he called. He had that respect in the community. If he called a

meeting, it was for something significant. But he would call a meeting only when he decided what the issue was that something could be done about. He would never call a useless meeting. Only if he thought there was a good opportunity in assembling a certain group of people, whom he would carefully select. And then he would visit each one, both to ascertain what their views were, and I suppose some might not have been included, but he would not just keep people who agreed with him. He would really try to find what the range and what the consensus is and get the full body of expert opinion. Not only to find out what they thought, but I suppose, insert some of his own notions. Then he would call the meeting.

FELDMAN: He would of done most of the work ahead of time.

BRESLOW: Ahead of time. I don't think many people call meetings and participate in them in that way nowadays.

FELDMAN: I think that is unfortunately true.

BRESLOW: I had another mentor in public health who had a different approach to meetings. That was the first person for whom I worked. He was the health officer--Chester, Robert Chester--who was the Health Commissioner of Minnesota. I spent a few years in the Minnesota Department of Health before going into the Army, and then, as I said, coming on to California.

Chester's idea of meetings was, let other people call. He'd only go to meetings that other people arranged. Then if he didn't like the meeting, his pattern, and I saw this several times, would be to arrive late, after the meeting had been started and then the doldrums or stuttering for half an hour or so. He would arrive with a stuffed briefcase--he really carried around such a lot--and then in the midst of the meeting, as he came in, he would take something out of the briefcase, some document or paper, which he would hand to this person. Then he would see someone else who was there, and he would have another paper--not a copy, but some other document. He would do this to two or three people. Then he would grab the document away from the first person to whom he had given it, and pass it over to somebody else. So he would be sort of standing up at the meeting, criss-crossing and passing around all of these documents, not saying a word or paying any attention to what was going on.

FELDMAN: Really operating the meeting.

BRESLOW: And completely dominating the situation and disrupting the meeting. Whoever had called it, no longer (laughter) controlled it.

FELDMAN: How frustrating. (Laughter)

BRESLOW: (Laughter). Well, those are two ways of operating of meetings that I had mentors for. But I must say, Larry's notion was somewhat more appealing.

While I'm on that subject, let me digress once more to mention what Lowell Reed taught me during those years when I was at his ??????. One year, in 1952, when I was working with the Truman Health Commission Study Director with some wonderful people, both on the Commission and the staff. We went on to great things.

When I began to write the reports, the draft reports and so forth, Reed said the most important thing in convincing people on a Commission like this of the correctness of the document that you write--"I see," he said, "that you're writing documents, and you have some of your own ideas. That's fine. But the way to convince the people is to take some of the exact words that they use in their discussion and put those words into the report. You can find a way to do that. It doesn't have to be on your most important points. But you find a way for giving the precise words that the various members use."

FELDMAN: They'd recognize themselves.

BRESLOW: They, even though they don't recollect themselves maybe consciously, they get a sense that this is just right. (Laughter)

FELDMAN: Very interesting strategy.

BRESLOW: (Laughter) I've used that all my life. I use it today. I use it with staff people here, and with everybody. It's the best tool that I've ever encountered for convincing people in a group of what to do. Just listen very carefully to what they say. They all will have some ideas, and say it just right. And you can put it into the report. If you can't do that, then you're not doing a very good job. If you write the whole thing totally separate out of your own mind, not paying any attention, literally, to what they have said, obviously there's going to be trouble.

FELDMAN: It's not part of them.

BRESLOW: Not part of them. So anyway, that's a little tool that may be useful to some people. But coming back to Larry Arnstein, he taught me, as I've told you, his idea of how to organize a meeting, and he did it over and over again that I saw. He told me one other thing. He told me several times, maybe because he saw the need for it. He said, "Lester, you can accomplish anything in public health provided you really don't care who gets the credit."

That's a pretty hard lesson.

FELDMAN: Yes it is. In any field.

BRESLOW: In any field, to learn. But he had learned it. He practiced it, while I've never encountered anybody that approached him in the ideal lengths to which he went to carry out this notion. I think it's a very good lesson. A lot of the failures in public health--I don't know about welfare, but certainly in public health--have been, in my opinion, in considerable part attributable to difficulties over credit.

FELDMAN: Oh, I think it's equally true in the welfare field. All aspects of it. Maybe this would be a good stopping point, and only if you set another time.

BRESLOW: Okay, we can talk about that. Yes, I think it is because it brings us to 1960, more or less, and the rest of it we might cover in....

FELDMAN: What you have not dealt with yet is when you became the director.

BRESLOW: Well, that was later, so that was in the 1960s.

FELDMAN: Yes, so we'll pick that up then.

BRESLOW: We'll pick it up in 1960 with Pat Brown. How's that?

FELDMAN: All right. That's good. But that doesn't mean it can't include other things, because California is so interrelated with the rest of the world.

BRESLOW: We're one tenth of the United States, at least.

FELDMAN: You were talking about the Department of Public Health when we left off. You had become the director, the Chief of the Division of Preventive Medical Services. Now

considering that the health officer, when you came, really wasn't interested in prevention, how did you get that in?

BRESLOW: Well, as a matter of fact, the health officer was interested in prevention, as he would define it, and that was limited largely to control of the communicable diseases and difficulties in controlling child health. He was in favor of prevention in those aspects of public health. What I tried to say was that he was not at all interested in chronic disease control, including the prevention of chronic diseases. In that period, that is when I first encountered him in 1946, he, of course, was in the mainstream of public health, which had not, up to that time, given any attention, any substantial attention, anyway, to the potential for prevention of chronic diseases or for their control, and particularly, did not have any sense that they should be included in the framework of public health. But by 1960, when I had already been Chief of the Bureau of Chronic Diseases, as they called it in those days, for fourteen years, along with others across the country, had begun to cultivate the field--public health approaches to chronic disease--there was beginning to be some recognition that possibly, it belonged with public health. By that time, also, 1960 of course, that first health officer whom I mentioned last time, Dr. Halvorson, had died, and his successor, Dr. Merrill, had been the leader of the Department for fifteen years or so and had invited me to become the Chief of the Division of Preventive Medical Services in the Department in 1960. Pat Brown had--by the way, the Division at that time, included not just the Bureau of Chronic Diseases, but all of the other medical bureaus in the Department; those devoted to maternal and child health, communicable diseases, occupational health, crippled children.

FELDMAN: They were all in....

BRESLOW: They were all in the Division of Preventive Medical Services. So I moved from being a Bureau Chief, which was the hierarchically lower unit to the Division, which was the higher unit. But that brought me into what you might call the "Cabinet" of the Department, which consisted of the five or sometimes six, Division Chiefs. So we would meet quite frequently with the Director, and with the other Division Chiefs. It was a wonderful

Department, a great experience, and really a great joy. I was happy that they paid me for it, too. (Laughter) It was such a pleasure to work there.

Well, I started to mention, I think, that Pat Brown had become Governor by that time. He was very interested in the aggressive aspects of public health, including medical care. He had a substantial interest in medical care and, in fact, renewed in a very important sense what Earl Warren had started twenty years before and had been unsuccessful in carrying through all that he wanted before he was appointed to the Supreme Court. During the intervening years, in the middle of the late Fifties, not very much had been done by Goodwin Knight and the Republican successor to Earl Warren. But Pat Brown renewed that aggressive spirit in public health, and a lot of other aspects of mental health and welfare, and brought in some very good people to State service as heads of department.

Among the things that he did, for example, was to initiate a program of medical services as a part of the public employees retirement system. That covered all State employees. The program was essentially the same that has been introduced for the Federal government employees. It provided that employees could select a health care plan in a very progressive manner comparable to that of a situation in the best private employment situations. He linked it to the public employees retirement system for reasons of administrative control. The Board of Administration was given responsibility for administering the health program. It provided, as I say, opportunity for employees to select for themselves and their families, really quite good programs. Bob appointed me to be a member of that Board at the beginning of this new program in 1960. He did so because he wanted somebody that he regarded as well suited medically, who was close to, as a matter of fact, in a state government, that, I suppose, would be carrying out his general philosophy in that program. The Administrative Board, the Board of Administration appointed three people. As a matter of fact, Brown appointed three new people to the Board in accordance with the legislation. These three new people were to have special responsibility, but within the framework of the entire Board for decisions about this new program. The Board did defer, really quite substantially to the recommendations that the three

of us would make. Since the other two were non-health professionals, although interested in this topic, they turned to me quite a bit for recommendations on the implementation of this new program. That was a very interesting responsibility, because we had the opportunity there to really inaugurate something that in a sense, established a kind of a pattern, not just for public employees in the State, but also, so some extent, to private employees who looked to the model that the government would establish for its own personnel. The principle decision was to determine which of the health maintenance organizations, or as we called them in those days, "pre-paid health plans," would be admitted to participation. Of course, the Blue Cross-Blue Shield plans were included, a major private insurance company was included, but the real question was, which of the many, many health maintenance organizations, or pre-paid health plans in those days, would be admitted. There were a lot of upstart organizations, pre-paid health plans, in those days, that had followed on the success of..

FELDMAN: These would be like Ross-Loos and Kaiser?

BRESLOW: Correct. Now those were the two, Ross-Loos and Kaiser were the longest established, the Ross-Loos Clinic going back way to the Thirties, and the Kaiser pre-paid health plan having been started immediately after the end of World War II. Based on Kaiser's experience with industrial employees, he converted it to a pre-paid health plan. Those two were clearly going to be admissible, and they were admitted at the very outset. The other question was how to deal with these many others that had tried to copy, in a way, what Ross-Loos and Kaiser had been doing. By that time, Kaiser was the predominant organization in the field. So we had quite a struggle to hold down the participation of other organizations, because many of them were really quite poor. Gradually, some of the good ones that had been admitted to participation--one, at least, admitted during the period that I served on the Board during those early years--but that did set a pattern for quality of work in state government and was typical of what Pat Brown and the then quite progressive legislature wanted to have for the State. So that was quite a bit of fun.

There were other bodies established. Pat Brown appointed a Commission on Medical

Services just as Truman, I mentioned last time, had had such a Commission in the early 1950s, so Brown appointed one in the 1960s, and again I had the opportunity to serve as the study director in that particular investigation. During that period of the Sixties, we also continued that had been started, and which I believe I mentioned last time, namely, air pollution control. By the time that Brown came in, and John Marga (??) and I and the Department had done the work, I think which I described last time, and the State Board of Health had approved the regulations for standards of the ambient air and for automobile exhaust. There was established an Air Resources Board, I think they called it, in which again an effort was made to maintain quality of scientific work in approaching the air pollution problem.

While these things were going on, of course, things began to happen in California and elsewhere during the 1960s. In the middle of the 1960s, there was a very strong social movement in the inner cities, especially led by Black people. You may recall, and I'm sure you have otherwise described in your series of tapes here, the so-called Watts riots of 1965.

FELDMAN: I worked in that, so I know it quite well.

BRESLOW: So you know it quite well, okay. Then I don't have to give you any detail about it. But there was one thing that came to the Department of considerable interest. In 1965, immediately after the so-call riots, I had been--perhaps I should back up here and make clear that I served as the Chief of the Division of Preventive Medical Services from 1960 to 1965. In the latter year, Malcolm Merrill, who had been the Director of the Department during the Brown Administration and a bit before, I think, left to head the medical aspect of AID in Washington D.C.

FELDMAN: Not today's AIDS.

BRESLOW: No, not today's AIDS. This is Agency for International Development, an agency of the Federal Government for allocation of certain funds of the Congress appropriates for international assistance, principally economic, but to some extent, social and also there was a medical component, which Malcolm Merrill went back, at that time, to head. That left an unfinished term to which Pat Brown appointed me. So I became the Director of Public Health

in 1965. That was the year, you'll recall, when the riots took place during the summer, and I won't need to describe them here because you've otherwise covered that.

You may recall that a commission headed by McComb, called the McComb Commission, investigated the matter at the initiative, I think, of the Governor. The McComb Commission came in with a report which advocated the development of health services in the Watts area, as it's come to be called, although it covers a great deal more of Los Angeles, a whole segment, a rectangular segment, of the very middle of South Central Los Angeles. The McComb Commission, in recommending those health services, I think specified a hospital to be developed. At least that came to be quite an important aspect. Sherm Meloncoff,(?sp?) who was the Dean of the Medical School, who was, I believe, a member of the McComb Commission...

FELDMAN: Yes, he was at UCLA.

BRESLOW: Right. Sherm Meloncoff, the Dean of the UCLA Medical School, a member of the McComb Commission, had been, of course, an important party to that part of the McComb Commission Report. After the report was submitted, perhaps even before, Meloncoff called on a member of the faculty of the School of Public Health, Milton Romber, to participate in the investigation which led to the recommendations, specifically for a hospital in the Watts area. Well that recommendation in very early fall of 1965, came, of course, to the State Department of Public Health, of which I was then the Director. So I called in, as the first step, the people who were responsible in the Department for the hospital planning and construction program. Some decades before, in the 1940s, I believe, the Congress had established a program in which Federal funds were given on a matching basis to states for hospital construction. That program was started by two Congressmen, Hill and Burton, Senator Hill and Representative Burton--or were they both Senators?

FELDMAN: Burton was a Representative from California.

BRESLOW: From California? Well, I'm not sure. Was that Burton.....

FELDMAN: Oh, no. This was the Burton from New York. He pre-dated the Burton from

California.

BRESLOW: Pre-dated the Burton from California, yes. In the late Forties, the old Burton program allocated funds to the states because it was recognized that we were way behind in hospital construction in the late Forties. The program was still going in the middle 1960s, and the implementation in California called for the funds to be one-third Federal, one-third State--there's the State Appropriations--and one-third local, which could be either public or private, non-profit. Of course the funds would not go to any proprietary hospitals. So, with that program in mind, and with our planning board having gone on with the advise of a body of citizens representing various segments of California society, it was obvious that the thing to do was to see how that program related to this particular recommendation. The data came in to me, and the staff first pointed out that every area of the State was equitably being covered. When we looked specifically at the Watts area, which is that rectangular piece right in the middle of South Central Los Angeles, it was a fascinating document, because there were, in fact, hospitals on the periphery of that rectangle, not all the best hospitals, although there were some reasonably good hospitals outside the area, and with some reasonable proximity to that area. But within the area, there were no hospitals. Zero hospitals. In this huge rectangular piece of South Central Los Angeles. What happened, of course, was that that area had been, as the politicians would say, "gerrymandered." So each of those pieces of the rectangle was quartered off so that each of the pieces were attached to adjoining larger areas in which larger areas, there was a hospital. So looking at the lines as they were drawn at that time, yes, that area was as equitably covered as any other part of the State. But the people in Watts talked about saying they were ten dollars sick when they had to go to the hospital, because to them, the hospital was not any of those adjacent hospitals where they were not admitted, but rather, to them the hospital was what we now call the USC, Los Angeles County Medical Center.

FELDMAN: With no means of getting there.

BRESLOW: No means of getting there. The bus traffic, I think took three or four changes. So when they said, "ten dollars sick," that meant a ten dollar taxi cab ride, and ten dollars was

quite a bit of money, especially in those days. Well it seemed to me that that was really not an equitable distribution of hospital services. So I asked for a pencil, and we began drawing some new lines. We created a new hospital district right then and there. But I would emphasize that we did so, not on our own initiative, which I wished we had been able to do, but rather in response to the fact that a bunch of young people went out on the street, and a lot of them got killed because they were seeking reasonable rights for themselves and their families.

Some of us felt very strongly about that situation, so it didn't take very much effort to get the appropriate approvals of the State Hospital Council, which was the planning body, and I think we also needed approval of the State Board of Health to make a rather quick adjustment on the map for allocation of funds for hospital services. So we did that quite promptly in 1965 in response to the McComb Commission Report, and what Meloncoff and Romber had found to be at least one way to deal with the problems of that part of Los Angeles. So we announced then that there was a new hospital district with zero hospitals. That immediately went to the top of the list for allocation of Federal and State funds; two-thirds of the amount necessary to build a hospital. The question then was, where were the local funds to come from? The first initiative came from the very enterprising, I would say entrepreneurially oriented physician in Los Angeles, a Dr. White, who proposed that he would organize the hospital. It was never entirely clear, however, that it would really in the long term be a non-profit, voluntary hospital, as we called it in those days. It also seemed that he and the few people that he had with him, were not adequate to the task of organizing, building and operating a hospital of the kind that was obviously necessary for these many, many tens of thousands of people. So, not very much later, a request came from the Los Angeles County Board of Supervisors, which was initiated and led by Kenny Hahn, then and still, the Supervisor. So Kenny Hahn took the lead in getting Los Angeles County to apply, and of course to agree, to put up the monies. That was the way it turned out to have built, in Los Angeles, the Drew Medical Center, or as it's now called, the King Drew Medical Center. The hospital was named for Martin Luther King, and the medical school affiliated with it, for Charles Drew, the eminent Black physician. And it would be, and

has been, a County facility with a medical school as a part of the enterprise. That's how we now come to have the King Drew Hospital.

That's been a very interesting development over the years. The academic arm of it has evolved into a medical and science university, still named of course for Charles Drew. It has in it not only the School of Medicine, but also the School of Allied Health. I'm not certain about other schools. The medical school, at the onset, was sponsored in part by both USC and UCLA Medical Schools. There was a strong participation by the Deans of those two Schools, and by members of the faculty, who helped build up the faculty at the Drew Medical School. Over the years it has become more of a UCLA affiliate because the academic program, the selection and teaching of undergraduate medical students has been for the Drew a joint enterprise with UCLA. That turned out to be the only way in which they could get State approval for funding at the school, and also for getting approval to turn out doctors of medicine from the Drew Medical School. So it continues to be strongly affiliated now with UCLA. I don't think that USC participates so much, or even at all.

FELDMAN: No, I think it's diminished. Some, but not...

BRESLOW: Still has some attachments. I know that the current dean, and I know several faculty at USC have substantial interests at the Drew and in South Central Los Angeles generally. So I know its still supportive. But the legal thing had to be switched to UCLA.

Well that was one of the more interesting features of the middle 1960s. Then in 1966, there was the very interesting campaign for the Governorship in California. Pat Brown was running for his third term on the Democrat ticket, and Ronald Reagan had been selected by a coterie of Republicans with strong political influence and a lot of money, to become the candidate for Governor. Of course, in that election in the fall of 1966, Reagan was elected. That had tremendous repercussions on health and welfare in California. I'm sure that you and others will be recording what happened on the welfare side, but I can mention a few things, perhaps, on the health side that may be of interest. I'll have to personalize it a little bit.

FELDMAN: Oh, do.

BRESLOW: That's the way I think of it.

FELDMAN: That's why you're the one who's being "interviewed."

BRESLOW: Reagan came into office as an arch conservative. I'm sure that even he would have to accept that term. The people surrounding him were determined to break the tradition of California of progressive State government. It had been established by Earl Warren and carried forward by Pat Brown. That was very clearly the campaign determination of the incoming Reagan Administration. You may recall that to be sure this happened fully, Reagan took office ostentatiously at one minute after midnight of January, 1967, when he was officially the Governor. He did a lot of things during those early months of his Administration. So far as public health was concerned, and the Department of Public Health, he sent, or at least allowed his lieutenants to come to the Department to ask for my resignation. I had been appointed to fill out the unexpired term of Malcolm Merrill. You may recall that by arrangement established by Earl Warren and Halvorson, as the Director of Public Health appointed by Warren in the early 1940s, the Director of Public Health was an unusual position in government, because although appointed by the Governor, the term overlapped an incoming Governor by one year. The idea was that the Governor and the Director of Public Health would get used to one another and want to continue. That way, the Governor could make an appointment based not on politics, but on qualifications for the technical job that had to be done. That was Warren's idea, and that prevailed until Reagan came into office. We had been through Republican and Democrat Administrations, and that principle prevailed for those twenty-five years. But when Reagan came in in early 1967, he and/or his Lieutenants decided that they wanted a different arrangement.

I was starting to tell you about the first steps that Reagan took regarding the Department of Public Health. It didn't come very high, I'm sure, on their priority list, but I subsequently learned that a group of physicians centered in Kern County had been adamant in the support of Reagan as the candidate for Governor, that he would do something to the Department of Public Health. Let's put it that way. I was no longer eager to continue as the Director of Public

Health, to complete the term, even, because I was no more happy to be serving in the Reagan Administration, which had already made clear its colors, then they were to have me. But I advised the people who came to see me that while I was true, I was no longer eager to serve, as they not interested to have me serve, that this was a term, and that some of the major parties of interest ought to be consulting and that I would do that. So I consulted the public health officer leadership, the California Medical Association and the California Hospital Association leadership to ascertain their views on the matter. All of them insisted strongly that I should complete the term. That was true even though in the course of public health work, one has sometimes to come into conflict with the medical and hospital worlds. And I had done so. But they still insisted that this principle was very important to public health in California, and therefore, along with the health officers whom I consulted, they insisted that I should stay on and not accept this demand from the Reagan Administration to leave.. When I reported that quite firmly, the Reagan people backed off. Meanwhile, they appointed a man named Spencer Williams to be the head of the Health and Welfare Agency. That was the Cabinet post to which the Department of Public Health reported.

FELDMAN: Social welfare and mental welfare.

BRESLOW: Correct. So Spencer Williams was my boss, so to speak. I did not have anything to do--I didn't have much to do with any others in the Reagan Administration. Spencer Williams and I got along quite well. In fact, in a few months, by early fall in 1967, he was going about the State praising the Department, and me in particular, proposing that I be re-appointed the next term.

FELDMAN: So Spencer Williams wanted you re-appointed.

BRESLOW: Right. I talked with him and remonstrated, in fact, that that wasn't going to happen. It didn't take any political insight to realize that was not going to happen and that he wasn't doing me any good, and he wasn't doing himself any good by making such proposals. But he didn't back off very much. I don't know what he did in private in Sacramento, but publically, he was very supportive of me.

Well the year progressed, and the Administration began looking for a health officer. They called a few people around the country. I know because such people called me, and I explained the situation, the history of the Department, that it was a good Department, that even with the Reagan Administration, with somebody whom the Administration would trust, that still the job could be done in the Department. So I in no ways discouraged anybody from taking the job but did explain that I was not credible with the Administration. It got down to the last week of the year, by which time I had, of course, been looking around and had decided and was committed to come to UCLA to the School of Public Health. But that had not been publically announced as yet since it didn't seem desirable to do that until quite close to the end of the term. It was clear that I wasn't going to be re-appointed. The newspapers of the State--I guess because news is slow between Christmas and New Years--picked up on that and various stories appeared in the major newspapers of the State. Ultimately, of course, the Administration, not having any other health officer to appoint as of the first of January, asked me to stay on, but on a day-to-day basis, perhaps month-to-month. Well that was no way to be the Director of Public Health, and so I left and came to UCLA.

I remember one cartoon of the period. The newspapers had been very interested in the matter, and, as I say, gave it quite a bit of coverage in which they asked for Reagan's views on the matter. He responded that I was a competent public health official, but that our philosophies differed. It came around to me. Newspapers always to get to the other side, so to speak, and asked me what I thought about that. I said that the Reagan Administration and I had had some substantial differences during that year of our overlapping administrations, but that in that, I thoroughly agreed. We did have a profound difference of philosophy. The cartoon in the matter was a picture of a painter in a building at glass door of an office, and he had just painted out by crossing over, Department of Public Health, and he just finished repainting below, Department of Political Philosophy. (Laughter) I think that expressed very well the newspaper views of the situation. The press had been very favorable to the Department for many years. It was difficult for the health officer to do anything wrong. You would have to have done

something very scandalous, probably, to have gotten the newspapers turned against the Department. So this was something typical of their support of both the Department and whoever was the Director.

There were a lot of interesting experiences along the line. I remember one other little episode while I was Health Officer during the Brown period. We had an epidemic of influenza, probably 1966 or 1967, I'm not sure which, and the press picked it up, counting the number of cases every day, and so forth. It finally came to the Governor's attention, and the first thing he did was say, "Where's my doctor?" He used to call me and still calls me, "My doctor," when he meets me on social occasions. Brown sought me out and found me by telephone in a hotel in Sacramento, deathly sick of influenza. I'd come to Sacramento to work and simply couldn't drive home. I had to rest for a couple of days and holed up in this hotel room. Well that got out to the press and wasn't published, but they knew about it. A couple of days later, we had a press conference about the influenza epidemic in the Department. In the presence of all the press and a lot of questions about the epidemic, someone asked, "Dr. Breslow, have you had the flu?" And I said, "Yes. I just had the flu a few days ago." "Dr. Breslow, did you have influenza vaccine?" While I was waiting to give the answer, which was going to be embarrassing, and everybody knew it, and the press were there just waiting to have fun. I doubt if they would have published it, but anyway, they were going to have fun with me. Bob McGlaughlin (?sp??), a very witty member of the communicable disease staff spoke up. He said, "Dr. Breslow did not have vaccine because he was in the control group." (Laughter)

FELDMAN: (Laughter). Oh, that's a marvelous answer! (Laughter)

BRESLOW: That was--it was really just hilarious, and everybody had a good laugh about it and nothing appeared in the press.

We had some other interesting experiences then. I could go on for hours, but I'll just tell one more. One Friday at four o'clock in the afternoon, we had a telephone call, anonymous telephone call, that somebody had just dumped a large amount of LSD, which was a popular psychedelic drug in those days, into the Marin County water supply; a big tank reservoir. Such

calls always come at four o'clock on Friday.

FELDMAN: Especially if there's a long holiday to follow. (Laughter)

BRESLOW: So, we had to deal with that and with just that amount of information, we had an urgent conference. It happened that the key people in the Division of Environmental Sanitation, as we called it in those days, were present, along with some medical and other people, and the press person. We decided on this course of action which we followed out amidst a lot of debate. I remember that someone tried to make a point of the fact that in Marin County, you probably wouldn't be able to tell the difference. (Laughter) This was a liability on some people of Marin County. But, in any event, we decided on this course of action: first, to dispatch a team of engineers and other experts in water supply over to the site to make an inspection, to see if there was any sign of entry or anything happening over there, and the report was that there were no signs of any entry. There was a gate that had been locked and no evidence that it had been broken. But still, one could not be sure. So the second decision was that even though there was no evidence of this, we would run two thirds of the water to waste and fill the tank two thirds with fresh water so that at least it would dilute whatever LSD might have gotten into the water supply. In those days we had no easy chemical way of making a decision, so we had to make it on rather gross grounds.

FELDMAN: Where could you dispose of such water if it did have LSD in it?

BRESLOW: We just ran it into the sewer.

FELDMAN: And the effects would not be carried over.

BRESLOW: I suppose that some could escape from the sewage discharge, but that would be again, so diluted, that it wouldn't have any effect. Well I doubt that LSD was ever dumped into the Marin County water supply. I don't think that very many people in Marin County were ever aware of our consternation of that particular Friday afternoon and into the evening. We had a lot of experiences with that sort of thing.

The first of January, 1968, I came to UCLA and was thereafter out of the main channels of development of the State.

FELDMAN: Who became the Director of Public Health? Do you recall?

BRESLOW: Yes, a man named Louis Saylor, who had been a member of the staff at the Department, having joined, I think, the Bureau of Communicable Disease Control. I'm not certain, but one of the medical bureaus, after having completed a career as an Army Medical Officer. He was selected to become the first Director.

FELDMAN: It makes you wonder whether there were problems or difficulties trying to recruit a qualified person from outside.

BRESLOW: Thereafter, the Department has had a whole series of Directors, but the Reagan Administration systematically dismantled the old structure for public health that had been built up during the 1940s and sustained almost through the 1960s. For example, they abolished the State Board of Health, which had been an extremely important structural element of public health during all of those years, both a sounding board for and the authority for adopting rules and regulations about public health. Thereafter, of course, they became highly subject to political whims that they themselves were not always very consistent with. There were whims this way and that way, even in the same Administration among different people, with the same people on different days, so that you had no consistency, no stability in public health. That has been a very sad feature of public health sent progressively down to essentially the present time, that the leadership, the authority of the Director of Public Health buttressed importantly by a State Board of Public Health, has been systematically undercut, and that was the mission that the Reagan people adopted for their approach to this field. Jerry Brown, when he came into office, did nothing to turn that around, because although of the different political philosophy, if he has one, he did not change the fundamental approach of the Reagan Administration regarding public health. Mainly, it was something to be decided not by people who were competent in the field, with a body of citizens and enlightened professionals who were appointed over a term to look after the public health, but rather decisions would be made by political Lieutenants at various levels in the Administration. That continued during the Jerry Brown Administration, as it has, of course, during the succeeding Deukmejian Administration. One would hope that, as has been

recommended in important documents over the years, most recently in a report by the Institute of Medicine of the National Academy of Sciences in a report called *The Future of Public Health*, recommendations made that essentially state that the boards of health and the commissions of public health be re-established as a means of strengthening the public health structure throughout the country. I think we may have returned, but in California that will depend as elsewhere, on the results of the upcoming election. At least it will depend in part on that. Which way the various candidates will go is, I guess, not yet clear.

FELDMAN: You then came to the School of Public Health. Les, while you were in the Department of Public Health, is that when the health care for migrant workers became a program?

BRESLOW: Yes. I can't tell you the years, but a physician named Paul O'Rourke, and a medical social worker, Foustina Silves (??Sp) were most common in the leadership of that program, and both were highly interested in the health of migratory workers and their families. Both were very familiar with the problems of those people in California. They made many visits to camps, literally, where those people lived. We even called them "camps" in those days, and that's what they were, quite literally. So during the Brown years, and I don't remember exactly when, some efforts were made and some funds appropriated to extend the services of County Departments of Health to those camps. Quite specifically, it was a special program somewhat comparable to that for other segments of the population such as crippled children or pregnant women and their infants. So that was a special program, and a very good one at the time those people, especially Foustina Silves and Paul O'Rourke did a very good job.

FELDMAN: We happened across an interview with Foustina Silves, which picks this up too.

BRESLOW: Right. I remember one occasion with Jerry Brown. I don't remember the total background of it, but Paul O'Rourke and I were presented to then Governor Jerry Brown some proposals for maintaining and even strengthening those programs that had been established during his father's day. We weren't appealing on that paternalistic basis, but the previous Governor, and picking them back up again and continuing them after the Reagan years. So here

were Paul O'Rourke and I trying to persuade Jerry Brown to do what I've just told you. But Jerry Brown would have none of it. Finally, exasperated, I suppose, with our persistence, he turned on us and accused both of us of simply wanting to get back into State public health service, which was such an outrageous statement (laughter) that Paul and I just were astounded and made very angry. Neither one of us had thought of such a thing, nor would consider it. But Jerry Brown was so different from his father as Governor.

FELDMAN: Yes. He was more like Reagan.

BRESLOW: That's correct. They were both, in my view, essentially anarchists. Neither one of them was the quintatypical anarchist in the perfect mind--at least a few decades ago. I don't know what people think of as anarchists now, but a few decades ago, people used to think of anarchists as some kind of a wild, Eastern European with a big beard and carrying around a bomb which he was about to throw somewhere. Well, Reagan and Brown, Jerry Brown, were not that kind of an anarchist, but philosophically, they were essentially anarchists in that neither one of them believed in government. Government was something to be torn down.

FELDMAN: Well, they did their share. Each of them.

BRESLOW: They did their share. Each of them. That's right. But not enough people have come to understand, as you obviously have, what I think is true, and that is they were essentially similar, and their fundamental characteristics, characteristics exhibited by both of them was a disbelief in government. They just do not think that the government is a way to advance the public interest.

FELDMAN: Both of them, I think, were really more modern-day social Darwinist, that the people who really had the God-given ability would make it. You don't do anything about the others. They're going to perish, anyhow. I think that's characterized both, and the actions of both of them, not just in public health, but with mental health and social services were very similar.

BRESLOW: Right. That's right. Well, what I've said about public health, I know full well, but you can express it and others, a lot better than I as applied to social welfare.

FELDMAN: It was a philosophy, as you pointed out, and it didn't stop with the health.

BRESLOW: That's right. That's right.

FELDMAN: So then you went into public health in an academic setting.

BRESLOW: That's right. I've been very happy in that. Briefly, if you want to hear my career....

FELDMAN: Yes, I do.

BRESLOW: My career in public health has been that I came here, as I mentioned earlier, in January of 1968, having served for twenty-two years in the Department of Public Health in the State of California. I came as a professor in the School of Public Health at the invitation of the then Dean, Steve Gerkie, who had been the founding Dean of the School of Public Health at UCLA. Gerkie had been Chief Medical Officer in the Los Angeles City Department of Health Services, originally under George Uhl, who was the health officer. Then Steve, after serving for some years in that department, moved to the University when Stafford Warren started the School of Medicine at UCLA about 1950. Steve came sometime early in the 1950s. He came in as the founding Chairman of the Department of Preventive Medicine in the School of Medicine, which graduated its first class in 1955, so it must have been admitted in 1951. Thereafter, Steve established what was called in those days, the Southern Branch of the School of Public Health in the University of California. The School of Public Health, itself, was headquartered located in Berkeley, on the Berkeley Campus. The Dean of the School of Public Health at Berkeley was quite worried that the rapid growth of the UCLA Campus, and particularly, the Medical Campus: School of Dentistry, School of Nursing that were being planned, would eventuate in a separate School of Public Health, which he was obviously going to be dead set against. But Steve Gerkie was very astute and successful in developing the Southern Branch at the School of Public Health into a separate School of Public Health at UCLA, which was recognized--I think it was 1960--and began to develop slowly but not in a very strong fashion. During the early 1960s, some very important people came to the Campus, in those days. Among the was Milt Rommer, whom I mentioned. He was a national leader in medical care studies. He still is. Others were

also attracted to the School. It wasn't a very big school, and it didn't have a very big faculty, and it wasn't very strong. But by 1968, it had begun to get a little momentum and seemed like a very attractive place for me to come.

Steve had kept the Chairmanship of the Department of Preventive Medicine in the medical School, at the same time serving as Dean of the School of Public Health during the early and middle 1960s. In 1970, a couple of years after I'd come here, Steve became ill. He had some cardiovascular trouble and decided that he had to give up one of the positions, whereupon the Dean of the Medical School, still Sherman Melonkoff, conducted a search and invited me, thereafter, to come to the Medical School to be the Chairman of the Department of Preventive Medicine in the Medical School. That was in 1970. Steve kept the Deanship of the School of Public Health. Two years later, however, Steve got further sick, and in 1972 had to give up the Deanship, whereupon the Chancellor conducted a search for the Dean of the School of Public Health and ended up by asking me to be the Dean of the School of Public Health. I talked with the Dean of the School of Medicine and with the Chancellor to say, "Look, this is getting a little silly. I come to the School of Public Health, and you recruit me to be Chairman of Preventive Medicine and then back to be the Dean of the School Public Health. It appears that this is a fairly close-knit situation. Why don't we just recognize it and put it all together?" which was done. The Medical School Dean allocated the faculty and the space in the Department of Preventive Medicine to the School of Public Health, in return for which, of course, the School of Public Health was to function and has functioned, essentially, as the undergraduate teaching department in the School of Medicine. So it has been all put together and has continued to the present time.

FELDMAN: So it comes under the umbrella of the...

BRESLOW: Dean of the School of Public Health. So that the Dean of Nursing, Dentistry, Medicine, Public Health, are the heirarchical level with the Chancellor. Each of them reports directly to the Chancellor, but just as the Medical School takes responsibility for teaching certain of the basic sciences in the School of Dentistry. So the School of Public Health takes

responsibility for teaching Epidemiology, Social Medicine, and other aspects of preventive medicine to the medical students.

FELDMAN: It's a very integrated kind of relationship.

BRESLOW: That's right. And that's quite a healthy thing, we believe. It certainly has served everyone at UCLA very well; faculty and students, administration, all of them happy with that. I hope that it will flourish. It seems to be flourishing now, after we've gone through a complete rotation and new sets of deans, it's still strong. Quite different from what happened when Reagan became the Governor. What happened to the infrastructure.

Anyway, I then continued as Dean from 1972 until 1980, when I retired and began to dwell on my benefits, having served those many years in the department State service and in the University, which is for retirement purposes, a continuation of State service if there's no break in the service. So it became just too attractive for me, since I wanted to leave the Deanship--I was then 65 years old and thought that it was time to leave. After a year or two of persuading and the usual kinds of delay in such circumstances, I was relieved of being the Dean at my request and have continued, however, to be re-employed by the University in an arrangement that the University of California has for re-employing, without tenure and on a year-to-year basis, such faculty by mutual agreement with the University and the faculty member, should be re-employed. So I've continued, since 1980, to serve at the University in two capacities: one in health promotion, the other in cancer control work.

FELDMAN: Are those within the framework of the School of Medicine, Public Health, or are they totally discreet?

BRESLOW: It's mixed. I'll try to explain it to you. The health promotional work that I do is principally related to a health promotion center that has been established at UCLA in the School of Public Health. So that's in the School of Public Health in a Center which the Dean of the School of Public Health asked me to take the lead in organizing. I can give you any amount of detail on that that you might want to hear. The other is a Cancer Control Division of the Johnson Comprehensive Center at UCLA and that Center, the Comprehensive Center, of which

our Cancer Control Division is a part, reported to the Chancellor directly until a year or two ago when the Chancellor divested himself of all such connections..

FELDMAN: What was the rationale for reporting to him?

BRESLOW: The rationale in the first place was that it was a multi-disciplinary and multi-school element of the campus. It had, of course, strong participation. I would say predominant participation from the School of Medicine. But there was also strong participation from the other Health Science Schools: Nursing and Dentistry, and of course, Public Health. Likewise, from Letters and Science and various other elements of the Campus. The Molecular Biology Institute, which is a part of the Letter and Science College on the Campus, has a great many disciplines in the Cancer Center, so the Chancellor thought, and several of us who served on the Policy Advisory Committee--I chaired it for a number of years--advised that it report directly to the Chancellor, and that was the case for many years. But about a year or so ago, the Chancellor decided that too many people had persuaded him of that and that he was going to divest himself of all of those things and do the best he could with allocating the responsibility back to the Deans. So what has happened then is that the Cancer Center of UCLA reports to the Dean of the School of Medicine. He has avowed to maintain the Multi-school Advisory Committee on the Cancer Center. The answer is that now the Cancer Center reports to the Dean of the Medical School.

FELDMAN: It's a complex organizational arrangement, but there's a lot of logic in it. It's too cumbersome, otherwise. So your title now, your titles, now....

BRESLOW: My titles now are the Director of the Health Promotion Center, School of Public Health, UCLA, and I think it's still officially something like Associate Director, or something like

that, of the Cancer Control Division. The history of that, just very quickly, is that it was started by a very strong good person ten or plus years ago and was getting a very good start when he decided to return to the National Cancer Institute, where he'd had a good opportunity, and another one seemed to be looming. When he did that in the early 1980s, the Director of the

Cancer Center in those days and still, Rick Steckel, Dr. Richard Steckel, asked two of us who were in the Division, Helene Brown, who is very active in the National Cancer Advisory Board and other cancer circles, and me to take the responsibility as co-leaders of the Cancer Control Division. We did that with the intent of trying to keep building up the Cancer Control Division, but also to finding someone who could really take the lead in a way that either Helene or I felt we should or wanted to. That has happened in that Ellen Gritz, a psychologist, has come into the leadership of the Cancer Control Division. Both the things that I work with now, the Health Promotion Center and the Cancer Control Division are located on this floor of this building.

I didn't tell you much about the days when I was the Dean of the School of Public Health. That was also a very interesting period for me, personally. I'm not sure how relevant it is to your whole series.

FELDMAN: It's relevant.

BRESLOW: They were very fulfilling years for me. I was very happy to have the responsibility of succeeding Steve Gerkie, who had founded the School, and of keeping it going and running it. The greatest thing that I did for the School, probably, was not so much my effort as it was simply to bring to the attention of then Vice Chancellor, Saxon, who later became the President of the University of California, to bring to his attention a very great need for more faculty in the School of Public Health. Steve had been one to build things. That's often the case with the founding leader. So one of the ways that he built things was to build a student body, and he did so with some Federal funds that were available to assist the development of schools of public health around the country. Somewhat comparable to (end of tape II)

FELDMAN: We're with Dr. Breslow--a continuation from cassette number II, side B.

BRESLOW: Similar to the Federal funds for building the hospital infrastructure for the country, and on occasion to the States, the Government also allocated funds to universities for schools of public health. The UCLA School, as well as the Berkeley School, of course, was benefitting from those funds. With those and other support that we got from the University and the Campus, Steve was rapidly building a School and was successful in getting the building,

parts of the UCA Medical Center to be devoted to the School of Public Health. Just about the time that I arrived, the School was going to be moving into that building. But when I took over, the student body had outrun the faculty in size, and I brought that to the attention of Vice Chancellor Saxon, who had the responsibility for such academic affairs on the campus. He immediately allocated a fifty percent increase in the faculty of the School of Public Health, that is to jump from thirty members in the faculty to forty-five. That was quite a....

FELDMAN: That's a substantial increase.

BRESLOW: You've been in academic life, so you appreciate what that means. Now, how far did we get?

FELDMAN: You were talking about the structure of the School of Public Health, the increase of fifty percent in faculty.

BRESLOW: Oh, yes. That made UCLA quite a notable School of Public Health, nationally, because the other Deans quickly became aware of what had happened here. To have State-funded positions increased by fifty percent in one jump was a remarkable achievement. So they sort of wondered what was going on here. But that gave a great boost to the School, both locally and internally, as you can well imagine, and to the national reputation of the School, which has continued to grow over the years, I think it's fair to say. Now, of course, the School is considerably larger. I think they're up to sixty-five or some number like that of faculty. They need a lot more. I hope that's recorded.

FELDMAN: (Laughter) We have that. We have a record of that now. (Laughter)

BRESLOW: Even though I'm ten years out of the Deanship, I can affirm, vigorously that we really do need more. But the School is doing very well. So I'm happy to have been a part of that development.

Some goofy things happened in the course of my Deanship' one that's sort of personal, but it may be interesting for people to hear, sometime. The Association of Schools of Public Health, in those days, met annually during the summer at one of the Schools, and in 1972, the fall, it was meeting in Los Angeles. That was just a few weeks after I became the Dean at

UCLA. The number of schools at that time was something like 12 or 15 around the country. Now it's up to 25 or more. So, as the host Dean, I had, of course, visitors come to my home for a party the night before the official business meeting opened. At that party in my home, a small group of the deans--I guess, originally two or three of them only--decided that I should be the candidate to be the President of the Association of the Schools of Public Health, not because I was such a great candidate, but because the person who had been in line to succeed into the presidency of the Association was someone that they didn't feel was the appropriate person to be the President of the Association. Of course I knew absolutely nothing about this. I didn't know who the officers were.

FELDMAN: A person would ordinarily have followed a...

BRESLOW: A sort of a line, correct. And so right in my home that evening, this conspiracy, I suppose some people might call it, was carried out. Only at the end of the evening did the leader of that particular group tell me what they proposed to do. In fact he did so after essentially all of the other people had left, and there was no opportunity to respond. He was simply telling me; he wasn't asking me or consulting me. The next day, of course, they did that--question the discomfort of the other man and much to my embarrassment. I was stuck. There wasn't anyway I could say I wouldn't do it or get out of it, and they were determined, and they had decided right during that party with the other man present, but, of course, not a party to the conversations that took place. That's the closest I ever got to politics in public health, and as you can see, although it was physically close, I was unaware of what was going on. (Laughter)

FELDMAN: (Laughter) And this other man was in the group, too.

BRESLOW: Yes. Well, there were a dozen or twenty people milling about. Some wives were here, and so forth.

FELDMAN: So you did become President?

BRESLOW: I became President.

FELDMAN: While you were Dean of Public Health, do you recall any specific situations of influencing the State Department of Health Services? Was there much interaction? I was just

wondering about the irony of now being in a position of special recognized international expertise in relation to the Department you were heading. It's really a matter of personal curiosity on my part.

BRESLOW: Well I'm just looking, as a matter of fact, at my C.V. for those years, beginning in 1972, which is, I think, the years of which you are speaking. Reagan was Governor from '67 to '75, is that right? To '75. So I was during that period, '72 on, a member of the Medical Advisory Committee to the Air Resources Board. I was--this was during the time of Jerry Brown, I guess--Chairman of the Task Force on Quality of Care on Pre-paid Health Plans. Then also during that middle period, the so-called Little Hoover Commission of California, which you probably know about as a body that consists of people appointed for a long period of time--I think it's six or ten or more years--to have a kind of a watch-dog look at what's going on in the State Government. I served, beginning in '75 and continuing to '76, as Chairman of a Task Force on Operations and Organization of the Department of Health as a part of that Commission--so-called Little Hoover Commission on California State Government Organization and Economy. Then I served in various other capacities every year or two down to the present time.

Now the School has also, of course, had--you asked about the School during my Deanship--also has had contacts with State Government. I recall that some of our faculty, for example, had worked on various State committees and commissions and bodies, doing the kind of work that faculty members, especially in such a field as public health, should be doing. I did not have a great part in it until very recently. Again, I have been drawn in to activities in connection with Proposition 99 in the implementation of Health Education Account in the allocation of funds from the revenues derived from the increased tax on each package of cigarettes in California. The total of those revenues in a year is estimated to be something like six hundred million dollars. Most of it goes for medical, hospital, some research activities. Twenty percent of it, however, is earmarked for education, prevention of tobacco use among young people. I've served on a State Health Directors Advisory Committee for that Health

Education Account; what to do with the money. Now I'm appointed to the official Statutory so-called Oversight Committee. I'm appointed to that body by the Speaker of the Assembly, Willy Brown. So my principal interests in State government the last year or so has been in that connection.

FELDMAN: This matter--this interest in cancer and tobacco control has been a continuous thread in your professional and voluntary activities, has it not?

BRESLOW: That's right. I started--that's very perceptive. It's been a continuing thread. I started in it in August of 1946 when, I think I remarked on the earlier tape, we received funds for cancer control from the Federal Government, allocated to the various State Departments of Health Services, and with that allocation to California, we built the Bureau of Chronic Diseases. Not limited to cancer, but that was the core of the initiating force. We developed cancer control activities between a registry, which has just now become State wide, and other activities in cancer control. A lot of studies of cigarette smoking as a factor of lung cancer, occupational factors in cancer, other investigations and activities for control, we carried out in the State Department of Public Health. Since coming to the University, I have continued it. Since 1980, have emphasized that aspect of the work so that this year, for example, I served as a consultant to the American Cancer Society on their review of their orientation; what they're going to be doing, and give a talk at their leadership a few weeks ago. They wanted to hear my views on what society should be doing. I've been very active in the cancer control activities of the National Cancer Institute, served as the founding chairman of the board on cancer prevention and control, which led to the formation of the new division and a great strengthening of that division in recent years in the National Cancer Institute. I've also been in touch with some new development--very new developments--in the Centers for Disease Control, which has an interest, now, in smoking control and in serving some breast cancer in women. So I'm involved with that body. Next month, we'll be going to Hamburg, Germany, for a meeting of the International Union Against Cancer, which has asked me to serve, and I am serving as the chairman of a small committee to carry out some demonstrations of the development of a national cancer program.

So they are seeking funds and using some of their own funds to carry out some investigations in a small number of countries in different parts of the world on how such countries should develop national cancer control programs. I guess I was asked to do that because I also, a couple of years ago, finished a book for the World Health Organization on cancer control policies.

To jump way back, let me say that most of my time in cancer control, however, was not state or national or international, but is in Los Angeles, where our cancer control division, with substantial program research support from the National Cancer Institute, is intensively engaged with the Los Angeles County Department of Health Services to strengthen that Department's cancer control capacity. I've enjoyed that work over the last four years, and that's continuing.

FELDMAN: So that cancer prevention and cancer control has been kind of a continuing crusade for you over the years. Has there been any other particular dimension of the field of health that you've been as consistently involved in?

BRESLOW: I'd mention two things in response to that. They're hardly answers, but they're responses, I hope, to the question. One is that I've had a continuing interest in the whole of public health, although I have devoted myself to certain aspects of it, particularly, cancer, as you point out, and some others, but that's been a leading one, you're right, and a continuing one for forty-five years now. I've had an equally a strong interest in what I would now call the whole of public health. That has taken the form of participation in the American Public Health Association, certainly as it's President, for example, in 1969--the first year I came to UCLA, and other activities in the American Public Health Association. Also, in working with the schools of public health, as I mentioned in a peculiar way during my first year of Deanship, as the President of the Association of Schools of Public Health, an opportunity to look at the whole of it and try to influence it as you can with the deans of public health academia, at least. More recently, I served as a member of the Institute of Medicine's Committee on the future of public health and was a party to the report of that committee, namely, The Future of Public Health, in which we lay out what we think is the future of public health, beginning with the definition of public health. So I would say that I have had that interest in trying to defy and delineate and to

as best as an individual can, exemplify an approach to the whole of public health. That has, of course, meant, at various times, advocating things which were outside the accepted domain of public health as, for example, medical care administration which to my mind was a part of public health. The Institute of Medicine Report defined the mission of public health as “fulfilling society’s interest in assuring the conditions in which people can be healthy.” Well to me it’s perfectly obvious that one of those conditions is access to medical care when you need it.

FELDMAN: And better prevention.

BRESLOW: Better, still, prevention. Absolutely! I simply wanted to mention that that definition was public health, although was not my words

FELDMAN: That’s an interesting definition. I haven’t heard it, but I accept it philosophically.

BRESLOW: That’s right. And I was very happy to be a party to that philosophy as expressed in that report. So that’s been an interest. The other, and more recent interest of mine--perhaps I should take a minute to tell you about because it’s the other response to your question--what besides cancer control has been a long, continuing theme. And so my first response was the whole of public health. The second response is health promotion. It seemed to me for some time that in addition to assuring conditions in which people can be helped, and as a matter of fact, as a part of assuring those conditions, it is necessary to take account of the fact that people in many societies do have choices about what they do that will affect their health. For example, every day you and I decide, so to speak, whether we’ll smoke cigarettes, whether or how much alcohol we’ll drink, how we’ll drive our automobiles, how much and what kind of food we eat, what exercise we do, all of the things that we know effect our health. Now you would say, “Well I don’t decide that every day. I have certain habits. I don’t smoke cigarettes, I drink very moderately, if at all, and so on.” That’s true, but you and I could decide any day what we’re going to do about those matters. Everybody can. But that of course if only half of the story because you and I know very well that those decisions are not make in a vacuum. They are dependent upon your social life, the history of oneself, family, relationship to others,

peer groups. It's the social influence as a whole on people, and that social influence is one of the very important conditions in health and in assuring which one can say is extremely important for health.

In any event, going back to the time when I was the Study Director for the Truman Health Commission in 1952, you may recall the episode. I'd been interested in the question--or pursuing the question--of the relationship between personal and community or social action for health. You may recall there was a period--oh, ten or twenty years ago--when suddenly it became popular to speak about individual responsibility for health. Some of my colleagues attacked me because they thought that I was a part of that movement. Well I was to the extent that I just explained to you, that there are such individual decisions, and to the extent that we can, we should try to influence those decisions.

FELDMAN: We were talking about your interest first in cancer control in public health and then health promotion and the role of individual responsibility.

BRESLOW: And social responsibility in public health. Right. Well as I see it, one can look at this as an instance of systems, and one can take it at any level, the level of the individual if you want to regard the person as the system, and you certainly can, interfacing with an outside world, including the social conditions of that world. You also can look at the system of the community in which there are individuals interfacing with social as well as physical conditions of the community. So it's a question of what your focus is at any particular time, as long as you recognize that these are interfacing systems. I do affirm the importance of individual actions for health promotion, but also insist that one cannot take these as isolated actions, that they occur in the system of a community. If you want to influence an individual, you can deal with the individual. That's what physicians do, and nurses, and clinical social workers, and all of the people who deal with people and their individual health problems; try to assist individuals as best they can, to assume and take responsibility for their own health. There are limits of that, of course. The other focus is to concentrate on the social conditions in which the whole

community of individuals must act and to assure, as the Institute of Medicine Report affirmed, that we assure the conditions in which people can be healthy. That's the point of public health.

Well I've been interested in this matter of individual and social responsibility for health and how over the years, it has evolved into what we now call health promotion. It is getting to be a popular term. Most people never even think of it in connection with this interface between the individual and society, with respect to the conditions that people must live in and in which they must make decisions about their health. One doesn't decide to smoke cigarettes in 1960 because there were no cigarettes in those days and one doesn't decide, typically, to smoke cigarettes if you're raised in a family of some religious sect that eschews the use of tobacco, or one doesn't decide to smoke cigarettes if you have a college education and enough understanding to realize the damage to your own and other people's health that can follow the use of tobacco. On the other hand there are some other conditions in which people are induced to smoke cigarettes, and one of those conditions is the advertising milieu to which we are subjected very overtly and very subtly. So in public health, we are concerned with all of those conditions that influence people's smoking or other habits that pertain to health. That's a typical way of thinking of health promotion, and I have been involved in that also on a continuing basis for some years. But going back to that 1952 report of the President's Commission, which to my mind, still is one of the best formulations of this issue.

But now, in the last five or ten years, I've been thinking about another meaning to health promotion. That is something more than the prevention of disease. When we speak about prevention, we think about disease. That means to prevent all those terrible plagues that we had in the past and also to prevent cardiovascular disease and cancer and other diseases, which inclusively we had the knowledge to do. We can prevent those diseases and increasingly are getting down to that task. That's disease prevention. But there also is such a thing as promoting health. It's not the same as disease prevention. To me, promoting health is enhancing the capacity of people to live in the environment to which they are subject. Now some of us, like you and me, happen to have very favorable environments. So our health has

got a pretty good chance, and we think about it probably more than people who are living in circumstances which do not permit the same kind of health because they're tougher against health than the conditions in which you and I live. But health, for either set of people, is the capacity of the people, the reserves of people to stay in balance with, to maintain health in the presence of the conditions of where they are living. So I think of health promotion of being not only this central movement to assure conditions under which people can make healthful decisions, but also I think of it as an individual matter in which people can really build their own health by maintaining proper blood pressure, keeping a low blood cholesterol, maintaining proper weight by keeping up appropriate exercise, and so on. That builds the reserves of the body to deal with whatever the conditions are that you might reach.

I'd like to illustrate this with a story of a friend of mine, the Dean of another School of Public Health. He told me this story. He said that as a scuba diver, he was once, a few years ago, fifty or sixty feet under water. They go way down, and they have tanks and all kinds of equipment. Well the equipment failed so that he was not delivered oxygen. He was not drowned, inundated with water, but he simply did not have oxygen for some minutes. It isn't clear how long, but it was several minutes.

FELDMAN: Scary, in any event.

BRESLOW: In all probability, sufficient to have either killed him or left him a vegetable with his brain wiped out because the brain is more sensitive to the temporary lack of oxygen. Other parts of your body can keep going. But although the exact number of minutes isn't clear, it was evident that most people would not have come out of it. In fact, it's extremely rare for a person to come out of that exposure, to lack of oxygen and completely retaining his brain power, with the exception of memory loss from that event. He couldn't remember the event of the scuba dive, but that's the only cerebral impact. How did it happen? How could such a person have that degree of resistance, reserve to deal with that extreme condition? The explanation he advanced, and I think it's probably true, was that he'd made a habit for years of swimming under water. In addition to scuba diving, he was an under water swimmer. There are people that do

that. I couldn't do it, but he did it. So he would customarily swim for some minutes--that's a long time--under water, even a very few minutes. And he had trained himself, somehow, to do that. Well I mention that as an extreme anecdote--no science to this--but it illustrates the point that if one has the capacity to keep blood pressure down and all other systems of the body in a healthful state, then one can say that you are healthy and that you have been promoting health. So I like to think of health promotion in that sense: not just preventing disease. That's just one side of the coin. The other side of the coin is to build, in a positive way, the capacity, the reserves of the human organisms to live. That's my interest in health promotion.

FELDMAN: That, I think, is a very good point for a closing of--I really want to thank you very, very much for a very stimulating couple of cassettes and few hours, and if you think of other things you wish you had said, let me know?

BRESLOW: I will. I've probably said too much.

FELDMAN: No, no, never. Thank you.