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Charlie E. Prather (CP): Say to our audience that we're privileged to have you here, Dr. Bob Windom of Sarasota. Dr. Windom is a former lot of things. He's an internist from Sarasota, but that's not the reason we have special interest in him today. He's former president of Florida Medical Association and was in that position over a period of some crisis moments in the movement of Florida's public health activities.

He's also a past president of the Florida Heart Association and has some very notable things there, and I can't separate that experience with the Florida Heart from public health history. But, notable also, he's a former assistant secretary for health with the HHS for the federal, oh shoot, public health service.

Robert Emerson Windom (RW): Health and Human Services and in that was the public health service.

CP: Yeah. Thank you, thank you, thank you. During the Reagan administration, does it comes with great experience in public health and has been a witness to significant events in the public health history of both the nation and of Florida. Dr. Robert Windom, it's a pleasure to have you here. Tell me, how it is you got interested in public health as a title?

RW: Well, first of all, Dr. Prather, it's a privilege for me to always be in your presence because you have been a shining light in Florida in public health. Don't let anybody deny it, and don't you deny it. And I respected you for many years, so it's always an honor just to be with you and to chat about old times.

CP: Thank you, Dr. Windom. I remember that I served in your administration as the president of Florida Medical Association. That's a highlight of my career.

RW: That's right. We had good times together.

CP: Yeah, we did.

RW: But you asked how I got interested in public health. Well, first of all, you mentioned that I am an internist by training from Duke University and came to Sarasota, where I had gone to high school. Came back there in the '60s to practice internal medicine.

And in the time of the early '60s, I also knew our health officer, at that time, the director of our local public health unit, health department, a fine gentleman who was very active in our local county medical society meetings. And he would bring up issues that we would discuss.

And, of course, we all remember the Sabin vaccine Sunday[1] and the time that public health and the doctors got together and volunteered their time to work on a community wide basis. And that was the realization to me that, as a physician, taking care of a patient, one must look at a physician as he looks at the whole community in which he resides. So that was sort of an interesting aspect that I became aware of.

And then, in the late '60s, I never shall forget the Constitutional Revision Board and the act[2] that they took when they said, We're going to take the Department of Health away and put it into this superstructure.

CP: In essence, they were going to abolish public health, as we know it, in this state.

1Sabin Sundays occurred on three consecutive Sundays in 1960 when millions of families across the United States met at schools and churches to be vaccinated against polio with the Sabin vaccine.

2The 1969 Reorganization Act revised the state constitution to consolidate 200 state agencies and boards into 23 departments. The next year the Florida Legislature created the Florida Department of Health and Rehabilitative Services (HRS) and the state board of health was abolished. County health departments were transferred to HRS under the Division of Health.

RW: That's right. And during those years, up to that point in time, I had been aware of how outstanding our state department of health was and recognized how well it was. And how well it worked with our counties and the state office.

And then, in the early '70s, I became president of the Florida Heart Association in 1972. Well, working in that organization, working my way up, it became very clear to me that I was seeing, in these meetings of committees that we all get together, a lack of physicians there but a large number of lay people.

CP: Thank you for that, go ahead.

RW: It was lay people who were there for one reason. They weren't doctors, nurses, or anything. They had a vested interest in that particular problem, either from themselves having heart disease, a relative having had it, or so forth.

But that interest that they had made them come together with the idea that they want to enhance education about heart disease, so I served with them. I tried to get one of my colleagues to be a part of it. But again, there's even a reluctance of many doctors to take time to participate. And I'd say to them, "Well, you've got to work on committees. You can't be president when you first walk in the door."

It takes time. Work your way up. And you can do it in the Cancer Society, or you can do it in the Lung—any association, but take some volunteer agency, and you'll be so pleased to see the support that people put into it.

CP: And a lot of personal satisfaction. Once they get in it, they recognize it. I'm sorry. I'm sorry. This is your talk.

RW: Not at all. I want you to interrupt all the time, you can. But what they were doing, Dr. Prather—I'll call you Skeeter, if I may.

CP: Please do.

RW: Skeeter, we've known you as Skeeter.

CP: Yes.

RW: Skeeter, what was pointed out to me was that if this is a group of people in a community interested in one specific aspect and trying to educate people about that, it's important to get people in all phases to become involved, the citizens in the community, because if you don't have the citizens, the ones you're serving, how can I, as a physician or any physician, change somebody's habit if they aren't educated as to why?

CP: That's public health, Dr. Windom.

RW: That's right. That's right.

CP: Go ahead.

RW: That's right. And you know as well as I do. And it happens today, it happened eons ago. The public does not think that the doctor spends any time in prevention.

CP: That is so true.

RW: But I will tell you that is not true, though. That's what they think, but it's a falsehood of what they are thinking. And back in the '60s, as I said, in early '70s when I was active in the Heart Association, in my office every patient received a pamphlet on heart disease, lower cholesterol, exercise. We gave them out. The Heart Association had them by the bushels.

CP: That was before cholesterol became a—what's the word?

RW: Widely popular, popular. But at least in the medical professional we knew the importance of it.

CP: Yes, we did.

RW: And so we would hand these out. And we'd tell the patient, Now, this is what we'd like for you to do, but here's a way to take it home and remember it better, learn it better. And the patient would go home and tell the wife, "Oh, how did the doctor—what did he

say?" "Oh, I'm fine, just fine. He gave me this piece of paper." And never looked at it again.

You see? The problem of treatment prevention education does not fall on the fault of the physician. It falls, primarily, on the fault of the recipient wanting to accept what is a change in a lifestyle that these people don't want to change or have difficulty changing.

CP: So true.

RW: That is so true today as it was then. So anyway, back in those days of the early '70s when this change had occurred already in our health department in Florida, there was still a health officer, Dr. Sowder[3] as you—

CP: Yes.

RW: We all—

CP:—love, love.

RW: His history we love.

CP: Love, love, yes.

RW: You've already recorded all about Dr. Sowder[4]. But anyway, his power and his base was changed what, in 1968 wasn't it or '70?

CP: In '69, effective July 1—no, January 1, '69.

3Dr. Wilson T. Sowder was a prominent figure in Florida's public health system for over 30 years. His dedication to Florida's health began in the 1940s, when he served as a venereal disease control officer with the US Public Health Service. Under his tenure as a Florida state officer, he developed health departments in each of Florida's counties. Dr. Sowder was interviewed as part of the Florida Public Health Oral History Project on June 24, 1997.

4There is an interview between E. Charlton Prather and Dr. Wilson T. Sowder in the USF College of Public Health Oral History Project collection.

RW: So, after that, he was still in leadership to a degree, but he was enmeshed in a hierarchy—

CP: Large bureaucracy. And he reported to a secretary. And the secretary was a nonprofessional in the sense of things medicine or preventative medicine or public health or any of what was called HRS[5]. He was a mathematician.

RW: That's right. Lost all the power and respect—not the respect, but the power he had. So anyway, during the '70s, after I was president of the Heart Association in '72, in '76, I became secretary of the Florida Medical Association and became more involved in its activities.

And around '74 or 5, I was working in that area, toward that area, became aware to me and to another very distinguished colleague, Dr. Gerry Schiebler. Do you know him?

CP: Oh yes.

RW: Dr. Gerold Schiebler. Dr. Schiebler was the, as you know, professor, chairman of pediatrics at the time at the University of Florida. He was also past president of the Florida Heart Association. He followed me as president.

And he was very interested in rheumatic heart disease[6] as it affected young people. He's a pediatrician, and that's what his focus was. I, at that time, was active in the Florida Medical, understanding this importance of rheumatic heart disease.

And so we said we needed to form a coalition or a task force to look at this problem, and how we can improve it or try to correct it. So we got together; they had Florida Medical; I represented Florida Heart; Dr. Schiebler, Dr. Sowder, at that time, in his position as health officer for the department, as it was. But it took us four years.

5HRS, the Florida Department of Health and Rehabilitative Services, was created to promote and protect the health and safety of all residents through the establishment and maintenance of high quality public health standards.

6Rheumatic heart disease is an inflammation and scarring of the heart triggered by an autoimmune reaction to the virus that causes rheumatic fever. It was one of the highest risks for young people between the ages of 5 years to 15 years old.

My point is, at that point in time when we introduced our program, to get his hierarchy and his bureaucracy to accept what he wanted to do and for us to get it all maneuvered together, it took about four years to get the legislature to adopt a rheumatic fever control program.

Which meant that we would identify Streptococcal infection in the doctor's offices, report them, treat the patient properly. And we could eradicate rheumatic heart disease; wipe it off the map.

CP: Yes, we could. Theoretically, it's possible, yeah.

RW: And it wasn't expensive. It wasn't expensive. But once you got the patient, who developed rheumatic heart disease with the valvular compromise[7] and then later on all the costs of that, it was a tremendous saving.

So anyway, we got it started. But the sad part of it is that after it got started, it took so long to get going because the public health program was weakening. And then Dr. Sowder was even lessened in his position. And subsequently, today, that residual of that program is very limited. Some reporting is still going on. But it is not this coalition of Florida Medical, Florida Heart, and the Public Health.

CP: You need a spotlight to keep it lighted with a special program, and that was lost.

RW: But I'm optimistic, though, when we have this new department of health today. That this will go back and revitalize this and bring it up and really work as a preventive program.

CP: Oh, yes, yes, yes, yes. Okay, good.

RW: Well, that's so, then that again was another reason and another example of my going from practice per se, every day at practice, to focusing on some areas that related to public health.

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7 Valvular compromise occurs when the valves of the heart do not receive dedicated blood supply, which allows bacteria to attach to the surface of the compromised valve and render the body's immune system ineffective.

CP: Very distinctly, and it took a public health approach to do something about that. You and your private office could really never have an impact on the prevalence of rheumatic fever in this state.

RW: No way, in fact, and I was doing internal medicine and adult medicine, the instance of strep infections is limited compared to that of pediatric AIDS, so the family practitioner and the pediatrician were the primary doctors who were seeing so much of these streptococcal diseases. So anyway—and also we had the support of a Dr. Ayoub[8] who's one of the world's leading infectious disease experts at the University of Florida. So we're not—

CP: Yes, with a special interest in rheumatic fever, too, and strep disease.

RW: Exactly. So not only do we have organized medicine, we had the voluntary health agency, the State Department of Health, as it was, and the academic centers.

CP: The universities.

RW: So you've got great coalition there. And I'm hoping that—

CP: That's the recipe for successful programming.

RW: That's right. And what we're seeing today, Skeeter, in the programs that are going on and looking at bringing together these two disciplines of public health and organized medicine again, I think we're going to come back. The future was going to be very good for what we had before.

CP: Yeah, it is. Yeah, a return to the future.

RW: A return from the past.

CP: Go back to the future.

8Dr. Elia Moussa Ayoub was a pediatric infectious disease specialist and professor emeritus at the University of Florida's College of Medicine. He was best known for his research of rheumatic heart disease and Streptococcal infections. He passed away on April 4, 2004.

RW: Go back to the—yeah.

CP: Yeah, that's great. Yes, yes, yes. I recently saw that the New York—uh, no, the Academy of Medicine, is taking on Florida as an example of the uniqueness of the cooperation for the public good between organized medicine and the public health organizations.

RW: I attended that task force meeting just a few weeks ago, the last, sort of the wrap up of their year session of where they've had interviews around the state like how to bring public health and organized medicine together. And, at that session, just a few weeks ago, I understand that the New York Academy of Medicine, which is putting together—they had some 600 types of input around the country of how programs were working.

They were able to take only 20 of those, and Florida was one that they were going to use as a site as a prime example of how revitalization of public health, and then the relationship of the private sector, is working.

CP: Oh, it is so important. You know, the public health folks have known all along that without the cooperation of the physicians who see the patients, public health programming is suffering without the willful cooperation and vice versa. You know, you who have an orientation to the public's welfare, the public's health, you're stymied unless you have the cooperation of the organized public health department.

RW: That's right.

CP: And our goals are the same, we use a different language to—excuse me, I'm talking too much. But I'm just agreeing with you. I'm just appreciating what you're saying.

RW: The goals are the same. But, you know, Skeeter, what happened in the past to cause this separation in Florida more, was when they went to the regions of the state and separated the liaison from the region to the Department of Health as far as a good, direct line. So that really—

CP: Oh, there was not a direct line?

RW: There's no direct line. And so, if you go to your local public health unit, as they called it, and you had problems, well, they'd have to go to the region, to that doctor, who was under another administrator and go to the HRS, so that doctor who was enmeshed in another administrator—it was frustrating.

CP: Before you got to the experts in the matters of the public's health.

RW: And that points out their whole purpose of public health: to provide health for the public. If we have an epidemic, a sudden outbreak, or whatever, how could you mobilize any forces when you had that type of obstruction?

CP: Almost impossible.

RW: Impossible. But now, we had that in 1960. We had a wonderful liaison. We're back to that today, starting to get back to it with a new department of health, the direct line to the physicians at the public health department and to, then, the county societies.

You and I have talked about this before. And this is sort of a little pet peeve we both have: the importance of the county health officer. And I say that that should be a physician.

CP: I agree.

RW: There are circumstances where—

CP: And I think he must be a formal part of the county medical society.

RW: That's right. And I don't want to lessen the impact of the other public health people who may serve in that position because of what's happened over the years. But now, I think once we get back into what it used to be, we need to reform the program so that that physician—man or woman—and then that person who goes to the public health, I mean, to the county society meetings.

The doctors in the community then hear, and then also that public health doctor will go to the hospital and will talk to the doctors there because a lot of opportunities where they do work together, particularly in the community clinics, that they need to have a liaison with and know what medicine is, how to deliver it.

CP: As the state epidemiologist for your state, I had complimentary staff appointments to a number of hospitals in Florida. I was there, and I was notified of all their staff meetings. And I went to their clinical rounds and as many staff meetings, but I had, at one time, I was on the complimentary staff of like 19 Florida hospitals.

RW: See, isn't that wonderful? And those hospitals benefited and got to become more knowledgeable about epidemiology.

CP: Yeah, they did. Yeah, they did. And it was great. But that, to me, is the relationship between public health and the practicing physician. The practicing physician is the eye of the public health organization, in terms of disease prevention.

RW: Right, exactly.

CP: Well, you and I agree. We're preaching to the choir.

RW: Choir, right. You're the director of the choir; I'm just singing with you. But the other thing we've got to realize is that the public health service or the health department over the years, because of however the system evolved, got into the delivery of healthcare.

And I think that they're spending their time—it was thought maybe this is an indigent health service. And they were having doctors taking care of patients in the area who were indigent. Well, that takes away from public health. What is their primary role?

And so, when they take away their primary role and put it into seeing sick patients then we're compromising the public health of the whole community by the fact that we're not doing the immunizations properly, as well; we're not doing surveillance, epidemiology, sanitation, all those things. So I hope, and I think that we will see that changing—

CP: It already has.

RW: It already has. So if we separate the delivery and put into communities clinics separate from the health department, maybe a liaison, but separate and let those be funded independent from what we'd have to do with public health.

CP: I'm agreeing with you. I'm just sitting here anxious to use—one of my pet peeves is that, I know all the explanation, but I won't waste your time and tell you, but I would like for you, when you're talking about care of the sick, I want you to use medical care. When you're talking about care of the well, talk about health care. We have confused the American public by talking, by including everything healthcare—

RW: It's sick—

CP: Do you go into a hospital for healthcare?

RW: That's right, that's right, it's sick—

CP: No, you don't.

RW: It's sick care.

CP: That's one of my favorite peeves.

RW: Well, I share it with you, and I hope that whatever little effect what we're talking about will have, that those who come behind us will recall the importance of this—

CP: Oh, I totally agree.

RW: Yeah, yeah, yeah.

CP: Well, you had a good introduction into public health in the sense of you recognizing the need for a community, combined approach to a problem, that's public health. And you came through it through a very interesting—I didn't know that piece of history, but I loved that. And it ultimately ended up with your being, kind of, the chief health officer for the nation in a funny sort of way.

RW: Well, it did come out as a funny sort of way, and it was a very happy way for me, anyway.

CP: Yeah, talk about that some. Talk about your appointment to the public health service.

RW: Well, as I was involved in the ’70s and ’80s—’60s and ’70s, with these things we’ve talked about. I was very disturbed in ’65, ’67 when Medicare/Medicaid came about. And we heard from the great orator of medicine, Dr. Ed Annis[9]. Our great doctor from Miami who still is just as viable at 82 years old.

Dr. Annis, in his presentation to the country from Madison Square Garden[10], pointed out that if we go with this type of government program, Doctors, you’ll find, that the government is going to tell you when you can admit your patient. The government is going to tell you how long your patient can stay in the hospital.

The government is going to tell you what you can do to your patient. Don’t accept this program. Accept the one where we support those who need the care, not just categorically to everybody just because they’re 65 years of age. Well, that was his message. And, in giving that message, he failed. Congress did not go along, and the Great Society Program intervened.

Well, that was ’67, ’66. From that point on, I was seeing then government intervening in our practices, government requiring more. So I said, “You know, you can sit back and accept all of this government direction, but if you’re starting to interfere with healthcare, nobody is going to do anything. They said, Talk to those people who are making the decisions, who are writing the laws.”

CP: As an aside, who was directing the governmental effort? Was it doctors?

RW: Oh, excuse me, back with the government?

CP: Yeah, who was directing—

9Dr. Edward R. Annis (March 27, 1913 – September 14, 2009) was a Florida surgeon who was a influential critic of the Medicare program in the United States. He served as the president of the American Medical Association and the World Medical Association.

10After President Kennedy’s speech on May 20, 1962 concerning the benefits of the King Anderson bill, a bill that would authorize the use of Social Security taxes to pay for health care benefits for retirees, the AMA rented the Gardens for Annis to debate with Leonard Larson, then president of the AMA, concerning the bill and its passage. The debate was televised on prime time television and made Annis a popular figure in the medical field.

RW: Oh, no, no, excuse me—

CP: It was accountants.

RW: Oh certainly, these people that were in the management of the Medicare/Medicaid program were not physicians is right.

CP: No, and their goal was not the healthcare, the medical care, folks. Go ahead.

RW: Yes, it was just the monetary aspect. It was just the monetary aspect. But, to start off, you know, it was really very nice to many people. I remember, in my office, a patient would come in prior to Medicare and I'd say, "You'll come back next year or two years, we'll do another checkup. That's what we need to do then. You don't need to see me just for everything."

Medicare comes in, here's a patient calling in the next week after they've been seen before, "Oh, doctor, I've got this little problem." "Well, you don't need to come in for—" "Well, don't worry, doctor, Medicare's going to pay for it. You're going to get paid. Sure, don't worry about it." So we were besieged.

CP: That's not the point.

RW: We were besieged by people wanting to seek care, take our time, for services that they could handle themselves so much of the time. So then that was when Medicare was very gracious. Also, wonderful Great Society[11] program, it's only going to cost six billion dollars. That's all, six billion.

CP: Just six billion.

RW: Lyndon Johnson said, "(unintelligible) throw in the extended nursing home care, that's only three billion more. That's not nine billion. We can afford that." Now, we're up to over 250, almost 300 billion with those two programs.

11The Great Society was a set of domestic programs instituted as a way to combat poverty and racial injustice by President Lyndon B. Johnson in 1964-1965. The programs were expansive and expensive leading to elimination or reduction of many of them, but several are still active.

CP: That's correct.

RW: Ed Annis was right. So anyway, we saw what happened coming up, government couldn't afford that. They went to DRGs[12], cutting back. They're now controlling the resource base, the value studies, and all that. So, a long story short was, I was seeing government intervening along the way in the late '60s and '70s.

CP: And increasingly.

RW: Increasingly so. So, as I said, we need to talk to those who do write the laws. So I got involved in supporting, in the sense of trying to meet our congressmen. There was an organization of a senatorial group, which I joined, to go to Washington about three or four times a year to meet with the senators of the Republican party. There are two parties, as you know.

CP: Well, yes, that's right.

RW: That's right. And so I happened to choose one. And, at that point, you went to those meetings. So, from the mid-70s on, I got to know quite a few Republican senators.

I want to point out one thing right now. People say, "Well, you buy your way. You influence them by buying into it." You don't. I can tell you, guarantee that nothing that they did ever was based upon the money I had donated.

CP: I found that distinct legislature.

RW: It is based upon getting to know the person, that they'll know you're a human being.

CP: Rapport and respect.

RW: Right.

12DRGs are diagnosis related groups, a patient classification system developed in the 1980s to identify the products that the patient received.

CP: And trustworthiness for your factual information is critical.

RW: My whole point has always been, all I ever wanted to do, is to give the elected person the best knowledge I had about the medical issue of which they were discussing. I want them to be truly informed because, as you know, a politician serving in a state or county government, state, federal government, there's no way that person knows everything about everything.

CP: No way.

RW: They do need the input. So, therefore, I would hope to give them the best input. They go ahead and make their decisions, they pass a law is against what I said, but at least I know that they had the input, and they had the right to make the decision. I guess what I wanted. You know that. So anyway—

CP: But I want them to have good information. I want him to have fair information.

RW: That's all.

CP: And balanced information.

RW: That's right.

CP: And I got an obligation to see to it that he gets my unique expertise piece of that.

RW: That's right.

CP: Go ahead. I'm liking what you're saying. Go ahead.

RW: And not to say that I own you, and I've put my money into it, so forth. So, anyway, over the years of having become a friend of a number of the senators, I said, "If there's ever an opportunity where I could provide some of my expertise in the federal system, I would like to be considered." And so my name was in, some of these people said, Okay fine.

So they put my name into the [Executive] Office of the President and the Office of Personnel [Management]. And that sits in a file. And it's there for a period of time, maybe for several years. Nothing happened. But then, in 1986, in December, no—excuse me, in '85, December '85, Dr. Otis Bowen[13] was selected as a secretary of HHS.

Dr. Bowen, as you know, we know, a family practitioner from Bremen, Indiana, 3,000, 2,000 people. He went from general practice to state legislature to Speaker of the House of legislature, governor, governor twice. And during his term as governor, Dr. Bowen, in that leadership role, was able to make their legislature aware of the fact that they had to put a cap on professional liability[14].

And they put a cap at $100,000 on professional liability for pain and suffering. And this is what has been a model for the nation; today still exists. As you know, what we've done in Florida fighting that issue, we still have not accomplished as what we need to. California has a $250,000 cap.

So, anyway, Dr. Bowen, a great man of public health and legislative health, was appointed. So, in his job, December of '85, January of '86, he has to go through a list of people and so forth that are on the presidential list. Plus, he has other people.

So in February of '86, I got a call to come up and had a visit with his deputy. And they said (inaudible). I said, "Okay." We'll talk to you later. A couple of weeks later I got a call and it said, "When can you come up? We have something important to talk to you about. Can you come up this week?" I said, "Well, I can be up there tomorrow."

So I got on a plane, went up there tomorrow, got up there, and sat down. And I met with, like I said, the deputy, and he said, "I want you, (inaudible) we like your interview, and we'd like for you to come in and meet Dr. Bowen." So we walk in, and we sit down, and Dr. Bowen's in his big desk there, and I sit down in front of him, "Hello, Dr. Bowen." I had never met him personally, but I certainly had known of him.

CP: Oh, everybody knew him.

13Dr. Otis R. Brown (February 26, 1918 – May 4, 2013) served as the governor of Indiana from 1973 to 1981 and as Secretary of Health and Human Services from 1985 to 1989. He was the first medical doctor to serve as the Secretary of Health and Human Services with the Reagan administration.

14Professional liability caps are agreements, which limit the amount for which a client in the event of any negligence or a breach in contract may sue a professional.

RW: He said, “Yes, Dr. Windom, we’re glad you’re here. And we would like to offer you the job of—” I said, “What job?” “Job of assistant secretary for health.”

I said, “Dr. Bowen, are you sure you know what you’re talking about?” And he said, “Yes. We want you to, if you will, accept the job of assistant secretary for health.” So, I said, “Well, thank you, and that’s a mighty great challenge and offer. And let me think about it because I have to talk to my wife.”

So we had a little visit, and I left and went out to meet his chief of staff, whom I never met. And we were talking there, and the chief of staff said, “You better call your wife.” So I called and broke the news to her and shocked her a little bit because she didn’t want to leave too much from our little small Sarasota to go to big Washington. So, anyway, it worked out, and she accepted it.

I called back a couple of days later and said, “Fine.” So that was in about February of ’86. So to go through the process once I accepted his appointment, which came from his —he had to have my name accepted and approved by the president before he could make anybody’s appointment. So that had been already cleared. President Reagan had accepted his choice of me.

Well now, I’m not in the job yet. So, I have to be confirmed by the United States Senate. There are about 550 or maybe 600 now in the federal government, there are that many presidential appointees that have to be approved by the Senate. So that takes about three months to go through, because I had a lot of learning to do.

CP: Oh, I’m sure you did.

RW: So I started going up on a basis of about three or four days a week from February, on until June when I was through the hearings. I went to the Senate hearings, and I was introduced to the Senate by Lawton Chiles[15] and by Paula Hawkins[16]. And they both made their little speech as you’ve seen them make for everybody.

15Lawton Mainor Chiles, Jr. (April 3, 1930 – December 12, 1998) was a Florida politician who served in the United States Senate from 1971 to 1989 and as governor of Florida from 1991 to 1998.

16Paula Fickes Hawkins (January 24, 1927 – December 4, 2009) was a Florida politician who served as United States Senator from 1981 to 1987.

And then, I had the whole health services committee, Health Welfare Senate Committee [Labor and Human Resources], and President Kennedy, not President Kennedy. Senator Kennedy was chairman[17]. And he had the routine questions. Senator Kennedy, who was very adamant in a way of saying, "Well, how much public service have you had?"

So I tried to give a little history. "Well, that's not much. What kind of administration have you had?" "Well, president of the Heart Association." "Well, that's not much." So really, he said, "You know, Dr. Windom, I'm going to approve you, but I really don't think you've had that much experience in public health, but since President Reagan is," and so forth, "I'm going to approve you."

And the whole committee unanimously approved me, thank goodness. So, after that, he and I got to be friends. We'd see each other, and I think that by the end of the three years I was there, he acknowledged the fact that I had learned a lot anyway. On-the-job training, I guess.

So that meant I had to leave my practice. And I had been in practice at that time about 30—let's see, from '60 to '86—26 years. And it was a big decision to make because I was 56 at the time. And my question was to whether to continue in practice and relax and enjoy life that way, or make a major change in closing down everything in Sarasota and going up there for three years.

But I wouldn't exchange it for anything in the world. And my wife, she did enjoy it. It was a great experience. And I'll point out one thing that is a disadvantage to that type of an appointment: that once one gets in, you have to have a learning curve.

CP: Oh, I'm sure.

RW: So it takes you months, or so forth, or to a year to really get you a good feeling. So, by the time you're in a position to have some knowledge of how this person is doing something wrong to get in there and really work on it, you are about ready to go out. But you are just getting on the crest of, the crest rather—

CP: Of how the system works.

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17 Senator Ted Kennedy was Chairman of the Senate Committee on Labor and Human Resources from 1987 to 1995 which evolved into the Senate Committee on Health, Education, Labor, and Pensions.

RW: Of how it works, and how you can really implement some things you want to do because you know how it works. Boom. You've got to appointment somebody else. A new administration comes in, and they get somebody else.

CP: I've heard that a lot, particularly in the federal, higher-level, federal positions, and how come the long-time bureaucrats are so influential. You have to trust them until you know for sure you can't.

RW: Well, I'll tell you what, that was interesting in my knowledge of the HHS, Health and Human Services, the largest department in our federal government, just like HRS was at one time. It was largest in Florida government in many states. But—

CP: It was the largest department of state government, of all states—

RW:—in the nation. That's right. Because HHS had the Social Security, had the HIPAA[18], had family services, and public health was only, at that time, a 12 billion dollar budget out of 600 billion. So, you see, we were just like pocket change. But my division, as the assistant secretary of health, ran the whole public health service. And I want to point out, as we're talking today, next year, 1998, will be the 200th birthday of the US Public Health Service.

CP: That is correct.

RW: It started 1798, under President Adams. And his reason for starting it was that our various businesses at that time, industry, had some shipping up and down, and sailors taking ships up and down the eastern seaboard. And a lot of these seamen were getting sick and so forth, and they set up the marine hospitals at that time. Little small areas where, along the eastern seaboard—

CP: Really, infirmaries.

RW: Infirmaries, right, to take care of the sick sailors. And, it's interesting, after that got started, they had to pay for it. And so they said, How are we going to finance it? It was in the Department of Treasury at that time, the Marine Hospital. And they said, Okay, we'll just take 25 cents out of every sailor's monthly check.

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18 HIPAA (Health Insurance Portability and Accountability Act) regulates and creates uniformity for dealing with patients' privacy and the security of their medical information.

So, every sailor, 25 cents a month went into this fund to help take care of the sick sailors. That's our first prepaid health program in the history of this country.

CP: Yeah, it was.

RW: Isn't that something?

CP: Ah, I love it.

RW: Twenty-five cents.

CP: I love it.

RW: So those are the great days of public health. It changed, of course, in many ways. But one thing I'd like to point out today is that, for many years, they were treating sick people.

They had more hospitals around the country, public health hospitals, but in the early '80s, under President Reagan, he felt that the public health should not be in the delivering health care. And they closed down these hospitals[19]. They were all closed down by '83 or 4, and the Public Health Service is out of patient care and doing the things that public health should do.

CP: Supposed to be doing.

RW: Research, prevention, epidemiology, surveillance, sanitation, and all that. And now, we are hopefully seeing that public health in Florida will get out, as much as possible, of direct health care and do the things that they do well.

CP: There's others who are better prepared for providing medical care. And that's their motivation. That's what they want to do, you know.

19In order to combat what President Ronald Reagan perceived as rampant governmental spending, funding for public health and state run hospitals was cut dramatically during his administration.

RW: That's exactly right. So—

CP: It's misconceived that, since we're already funding those doctors and nurses that the health department has, just tell them to take care of the sick. It was a cost avoidance move, which was contrary to the best interest of Florida, as far as I'm concerned.

RW: You and I remember days gone by when I was first in the early '60s in the medical society at home. We did spend time taking care of charity patients before Medicare. In our offices we would see them. In the hospital emergency room, you would see them, and you'd never get paid.

And then Medicare, of course, came in and started paying, but in public health we, then the department, started taking over because doctors were doing their own thing again. But we can go back to say, Keep the funding we need for public health in this direction and have another funding for the clinics we may need—

CP: Totally separate pocket over there.

RW: You can't have all doctors volunteer all the time. They're doing a lot of that in Florida, as you know.

CP: The Sarasota special clinic[20]. You got a special clinic for senior.

RW: Okay, now, I'll tell you—

CP: Who did that? Now, you were involved with that. That's good public health from a medical practice point of view.

RW: In 1978, Dr. Irwin Portner, P-o-r-t-n-e-r, came down from Philadelphia. He's a family practitioner. And he had Legionnaires' disease[21]; acquired that in Philadelphia in a hotel[22]. And he saw a lot of those patients, and he got Legionnaires' disease. And he was probably, at that time, in his early, late 60s.

20The Community Medical Clinic in Sarasota County, Florida, provides specialty care and referral services to residents of Sarasota County who are uninsured, underinsured, and/or demonstrate significant financial need.

And he came to Sarasota to sort of convalesce. And in Sarasota, at that time, we had a program called Senior Friendship Center[23] candlelight dinner. So this was a group formed by a Bro. Bill Geenen. Brother Geenen was of a church discipline, was not a Catholic, it was, I forget the name of it, was it—

CP: Episcopal?

RW: Well, wasn't Episcopal, it was another—Father Bill Geenen. But anyway, his whole mission was to help the underserved. And they had a community candlelight dinner for people in the community who couldn't afford a full meal. They came in.

Well, Dr. Portner met Brother Geenen and liked him very much. And Dr. Portner said, "You know, these people also need healthcare, sick care. They are senior citizens who aren't getting the benefits of anything, Medicare or anything. They're not in that qualification, they are too much or too below."

So, anyway, so we need to form some kind of health program. So they agreed to that, but Dr. Portner, in his wisdom, said, "You know, you're not going to get this through unless you work with the county doctors in Sarasota who will support this because they don't want you to be taking quote, patients, from them, Eddie." They get worried about that, so they said, Okay.

Well, Dr.—Bro. Geenen knew me quite well as a friend, too. He said, "Why don't we get Bob Windom because he is very active in the Florida Medical, and he's been president of our county society here." So they called me, and I met with the three of them. And the idea was wonderful.

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21 Legionnaire's Disease and Pontiac Fever are both names referring to an infection caused by the bacterium *Legionella pneumophila*, spread through the air via aerosolized water and then inhaled. Symptoms of the disease include a high fever, chills, and a cough.

22 In 1976, an outbreak of pneumonia at an American Legion Convention in Philadelphia led to the first identification of the infection.

23 Friendship Centers are non-profit networks of centers in Southwest Florida with services to meet the needs of senior citizens in the communities that they serve. The organization has been active in addressing the health and wellness needs of older adults since the early 1970s.

And so we talked to Henry Morton. Who, at that time, was our health officer. Dr. Morton, a pediatrician who was doing the health office job at that time. And we went to the county medical society.

And I presented it to them, so that they would hear their viewpoints and everything, and assured them that this was going to really help them because it was going to be taking care of people that weren't in the system already, secondly, couldn't afford the system. And it gave these doctors who were going to be involved the opportunity to continue their expertise.

CP: Yeah, these are, for the record, retired physicians now living in Sarasota with their focus on medical.

RW: That was it: to get the retired physician who wanted to be involved. And Dr. Portner, of course, did. He said, "Well, I'm not going back to Philadelphia." And he's going to stay down here and run this program. So he got the county doctors to do it.

Then Henry Morton with I, we flew to Jacksonville and met with the Board of Governors of the Florida Medical Association. And they gave their stamp of approval, so we knew that the state doctors in organized medicine accepted it. Then we went to doctor—who was it? Dr. Sowder then, I believe, to explain it to him.

CP: You went to the board of health.

RW: Board of health.

CP: You met before the board of health.

RW: That was it.

CP: I remember yours and his presence there.

RW: Right, and then we explained it to them what we wanted to do. And that got their sanction so we covered all our bases and the pro—first of all, we had to figure out how to get them licensed. These were retired doctors in Sarasota who had left their practice and were licensed elsewhere.

So, they set up this program of licensing through the state, to the county health department, through the state so that the doctor had his sovereign immunity[24] from the state.

CP: And he worked on the auspices of the county health department.

RW: And he worked under—

CP: —jurisdiction of the county health department.

RW: That's right, and he only did work in that particular clinic environment. So, really, was no threat to anybody. And it gave them the opportunity to do the things they wanted to do.

CP: And competent physicians. Just being—oh, yeah, that was a marvelous program.

RW: And now, over time, today, they have about 50 physicians, I believe, in the program. Of course, they may work only half a day or a day a week, but then they're away for summer. But they still have a cadre there, year round. And this expanded down to Fort Myers and to Naples and over in the East Coast, and it's throughout other areas of Florida.

CP: And the nation.

RW: The nation gave the—

CP:—the example, that the example has been picked up. There are several locations in Texas, for example, and retired places that I'm personally aware of.

RW: In 1988, when I was in Washington, I wrote a—well, I had a regular article I put in the JAMA [The Journal of the American Medical Association] every month from the

24Sovereign immunity is a legal privilege that prevents an organization or individual working on behalf of the organization from being sued. In the case of doctors operating on behalf of the state, this protects from medical malpractice suits.

assistant secretary of health. And one of those articles was about this type of thing. And I got tremendous inquires around, “How did you do it?” and so forth.

So, from Sarasota, even today, the wonderful woman, Jane Isley, is running that program as a director and she’s been there probably 15 more years. And she has sent out voluminous material to all these areas in the country who are inquiring about how we can do it. How can we simulate your program?

And, in the last couple, three years, we’ve had the president of the American Medical Association, at that time. And when he was in office would come down and speak to our county society, but each time they wanted to go over and visit this center. So, here is a remarkable way of doctors keeping their mind alert, keeping their interest in practice, to a degree.

CP: And doing a great—

RW: In a remarkable way, a great service—

CP: —public service, both to organized medicine and to the image of the public. It’s a service to both of those.

RW: And when the patient would be sick enough that required care beyond what they could do in their limited environment, the medical doctors in the community knew about it, and they would refer to this doctor, surgeons, whatever the need was, or hospitalization. They would refer to this doctor, and he would put them in this hospital.

CP: And growing out of that is the FMA’s [Florida Medical Association] program, We Care[25]. The FMA is a direct result of that. Do you want to speak to that, for the record, the fact that it’s now a statewide activity?

RW: Yes, in fact the We Care program started in Alachua County, in Gainesville. And, I don’t recall the exact year, but it began because the doctors in that community realized there was a need to help the underserved. And these were also, primarily, practicing physicians who were just donating their time.

25The We Care Program is a cooperative between the Florida Medical Association’s county subsidiaries and the health department to provide free medical treatment to residents in the county who are unable to afford healthcare or wellness services.

This was not a retiree program to start with. It was a volunteer program that the county medical society established. And the doctors there realized there were a lot of people underserved, so they said, We'll go and set up a clinic, and we'll set up a—"

They had a wonderful system. They had a coordinator. And this person was hired, and her job was to relate from the patient seen in the doctor's office. The doctor would see the patient in his office, at no charge.

And if the patient required hospitalization, the hospitals already were set up to accept this type of person. The patient could go right there; admission was automatic because they knew they weren't going to get paid. It was a volunteer program, and you didn't have to go through all this bureaucracy.

CP: All the paperwork.

RW: Paperwork—

CP: And I can't pay.

RW: That's right, so that worked very well. And the patient was in and out of the hospital quickly as possible, and then back into the active life again.

CP: And the hospital care was cared for through volunteer physician efforts.

RW: That's right. And the payment was through the hospital's indigent fund program. So that started and was very successful. And they presented a program to the Florida Medical Association, and it was accepted in other counties. And a lot of places now are doing—I'd have to say most all counties are doing it.

CP: Yeah, it's my impression it's going on in almost all counties.

RW: Right, to some degree. And I recall, I believe, the last time I heard, it was 20 million dollars a year saved in Florida just from the free care.

CP: Free service.

RW: Free services for people who otherwise couldn't get it or didn't know how to get it, weren't in the system.

CP: Yeah, they were too rich to pay for it and too poor for Medicaid.

RW: That's right. There's a sort of that niche in there. It was that area where they weren't covered.

CP: Yeah, that's a good program. I want to think that it kind of grew out of the attitude in Sarasota.

RW: That was the beginning.

CP: Yeah, the beginning, kind of the beginning of it, and that's good. And you were partial to that, too. While you were president of the Florida Medical Association, I know you did a lot of talking before the legislature on matters of the public's health in other places, speak to some of that.

RW: Well, as the year I was president in 197—no, '82, we were having a very significant concern about physicians and the cost of their malpractice insurance. That was the number one issue that was confronting the doctors, having to pay so much. Doctors in Miami, for example, were paying, I guess, over $100,000 for their premiums.

And so this, they were saying, "Florida medicine, what are you doing for us? What are you doing?" So much of my year of '81, '82, during my presidency and president elect, spent a lot of time going around the state talking to the county societies, explaining that we were trying to get a program through the legislature, and how we needed their help to talk to their elected representatives.

And then we presented to the legislative committees proposals that the state hopefully would follow. To enact laws that would limit the cap, put a cap on pain and suffering. That's all we needed was a cap on that one thing. People would get all the medical care they needed and all that, that's no problem, but the pain and suffering—

CP: Those were the big awards, and they continue to be the big awards.

RW: That's right. But we lost. We didn't get what we wanted at all. We didn't get anything. So that was a frustrating result of my year of president, but since then, that was '82, in '87, I believe, when I was in Washington, they were down here in Florida, set up the Proposition 10. That may have been '88 or '87.

But, you know, the big effort throughout the state to have a constitutional amendment, Proposition 10. And I understand, I wasn't here at the time, but I understand the public response was very good. But, in the last hours before the voting, the trial lawyers came out with their campaign on TV of a big bus accident and all these children were either killed or—

CP: Yeah, I remember that.

RW: —badly injured. And, Do you want your child in this situation, who's going to be incapacitated for life, to not get the award for pain and suffering that you should get? So, boom, Proposition 10 lost.

CP: I remember that.

RW: And yet, in Indiana, Governor Bowen was very able to get that through back in the 1970s for a cap of $50—

CP: $100—

RW: $100,000. So, it just shows how it varies from state to state. But the state of California has a program that's been in effect for a number of years now, where their cap is $250,000 and a state that size accepted it, but we couldn't get through in Florida.

CP: We're going to come again on it.

RW: I think we are. Florida Medical Board of Governors is looking at it again, but it's a costly thing. It's expensive to put a proposition out.

CP: I know.

RW: To get the vote, to get all the people to sign up and all that, it's a—if you don't, you've got to have your whole membership wanting to do it.

CP: With the (inaudible).

RW: Yes, sir.

CP: I'm aware that you've accepted the position of historian for the Florida Medical Association. And, I need not remind you, but I want you to speak to it in your new capacity, that the history of Florida medicine is intrinsically accountable, if I may, for the history of Florida public health organization.

RW: It is.

CP: It was one of your former presidents and a dominant member from Tampa—as a point of interest, a physician from Tampa, now a legislator—who, in 1887, was responsible for a particular constitutional insertion for a board of health for Florida, and when he was president of the Florida Medical Association. And then, two years later, as a legislator, managed to get it activated. I just want to remind—

RW: That was Dr. Wall, wasn't it?

CP: Right.

RW: Dr. Wall.

CP: Dr. Wall from Tampa.

RW: And he had a brother, also, who was in the Senate.

CP: He was in the Senate, yeah. Oh, I'm having trouble with Dr. Wall's initials, but Dr. Wall was in the House. The Dr. Wall who was, his brother was not a physician.

RW: Yes, he wasn't.

CP: Yeah, but the physician was in the house and from Tampa, but I'm constrained quickly to tell you that they were born and raised in my home county of Hamilton County. I have to say that with pride.

RW: Well, I'm sure you will. That exemplifies the reason why you became such an important person because the genetics of that county were in your body.

CP: There's no question about it.

RW: It must be in the water up there.

CP: Well, speak to your new job as the historian. And I'm all excited about that because I'm aware of the fact that you're interested in history and that you're one of those who, if we don't understand how we got here, we're going to having trouble getting yonder.

RW: That's right. You don't want to repeat and reinvent those wheels and everything.

CP: No.

RW: Well, thank you. I'm glad to be appointed this year by Dr. Cecil Wilson, who is president of the Florida Medical Association, to be the historian. And we are now in the process of looking at our records that we have for our annual meetings, for example.

These need to be, by our statutes and by our organization's rules, to be maintained and so forth. We're trying to figure out how best of way to preserve them. What to take out that won't be necessary or needed to preserve.

So that's a process right now, which is going to take some funding for us. And we're working to take that history and get it documented in a better fashion. Yeah, and then I want to go back and review a number of the historical issues of our *Journal of the Florida Medical Association* over the years, that have been published on various special issues of public health.

CP: Yeah, and you used to have an issue every year called the historical issue.

RW: That's right. And William Straight of Miami was editor of that for a number of years. So we need to put that back into—Dr. Shea, now, is editor of our journal. And we hope to get more in the historical message out to the public, I mean, to our members, and even to the public in some ways, or even to understand what we did do in the past. So we got to put all this together.

CP: Yeah. I'm not aware that there is a written, quote, history of the Florida Medical Association.

RW: I don't believe so either, and that's what we're trying—

CP: And it's been passed down by word of mouth. You know, you're very knowledgeable of it. I have some familiarity, and it's very colorful. The importance of that organization to the health and welfare of this state cannot be underestimated.

RW: Exactly.

CP: And I'm just now thinking of it, there's not, this hasn't been written down anywhere. And it needs to be, Dr. Windom.

RW: And to take advantage of you and all the others and Dr. Sowder and different ones who are still active and able, still living, and be able to give us vital information. And I'm hopeful that in Jacksonville, the house of the former building of the Regional Department of Health, right?

CP: Yes, the Julius Street [Julia Street] building. The public health home.

RW: Will be revitalized and be a museum.

CP: The repository for a while.

RW: Right, right. So we're working on that too, so.

CP: Marvelous.

RW: There's a lot to do in the area of history, to put it together. But I think the Medical Association is knowledgeable of the need to do it, so I hope I can help get it started.

CP: Well, under your leadership it'll get done.

RW: Help get it started.

CP: It'll get done. That's great.

RW: Right, right.

CP: It's been stymied. I've been kind of partial; I was on the history committee for a number of years.

RW: Right now, we have no committee, which we're putting together in your name—

CP: I don't think you need one. Use an ad hoc committee.

RW: Ad hoc, and we'd call up on people.

CP: If you need me, call me.

RW: You're on the list. You're on the list.

CP: But if you need Dr. Sowder, call him.

RW: That's right.

CP: We need one person to spearhead it.

RW: Exactly.

CP: I agree with no committee. But, the point being, I remember the committee was frustrated when we'd go to the Board of Governors for consideration of some money. You know, not a lot of money, some money.

To hire us a staff person on a part-time basis, or let Tom Jarvis, is a specific name, let Tom Jarvis spend some time, but we got to pay him to do it. Your predecessors were regularly frustrated with the lack of wherewithal to get some of this stuff. So, I'm excited about your being the historian.

RW: Well, thank you.

CP: I've now gotten in my kicks, too. I hope you noticed.

RW: Yes, yes, you certainly did. And that's so important, what you're doing here in this program, right here, in public health. You're putting together a documentary for historical perspective.

CP: Yes, it is.

RW: And so this is very important.

CP: And for future research and for future use. That's the reason for this.

RW: Right. And I think that this avenue would be excellent in medicine, too, since today so much of our education is through video, this medium.

CP: You know, you mention Dr. Annis, the innuendos and the—we know a lot about Dr. Annis. We know a lot about him. But there's a lot about Dr. Annis that's very—who's the man, back of this, that caused this person to be such a great person in organized medicine for this world?

Annis. You know, we need to get him on tape. Let him talk some. Tell about what went in —like you've done today, Dr. Windom. You've introduced us to the man, that you can't read about that anywhere.

RW: No. He's the most eloquent speaker today. And it's interesting that the tape of his presentation in Madison Square Garden was revived, and the Florida Medical Association got it. And I have one of those copies, that excerpt.

And it is most heartwarming to hear him, see him on video, talking to an empty Madison Square Garden with debris of cups and so forth all around because, for those that don't know, this occurred the day after President Kennedy had addressed the full Madison Square Garden, the whole nation, about this wonderful program of healthcare that the government was going to provide.

And so the American Medical Association said, We have to have some defense to counter that. And who can do it? Somebody knew Dr. Annis because Dr. Annis, in his early training, was a debater. And he knew how to talk on both sides of an issue. But he is so wonderful in his eloquence, presentation. And so they called him, and he agreed to come up.

And the people putting this on tried to figure out what kind of environment; you just can't have him in front of a camera. And they thought about it, See, you know, let's not have the people at Madison Square Garden, the maintenance people, clean up that auditorium.

We want it to be completely like it's just been used by hundreds and they left, which it was. And here he is speaking out to the nation, to an audience and no one's there. And he had, I think, more viewers even than the night before, when the president was on, because they knew something unusual was coming up to counter this. And so I can't believe—

CP: He wasn't president of AMA at the time, was he?

RW: No, he was just a—

CP: He was just a Joe Blow physician.

RW: Physician in Miami, Florida, who had been known as a speaker. He was not active—I mean, as a leader—in Florida medicine at that time. But AMA was so impressed, as was the general public, about this man's ability. So, within a short time, they got him involved right away in some committees, and the next year he was president of AMA. He's the only one in the history of AMA to become a president at that—

CP: Without coming up through the ranks.

RW: Sure, at that sudden way. But then he became president of the World [Medical] Association. And so, but to see him, that was in the '60s, mid-60s, and to see him today, of course, he hasn't practiced for all these years, but he has been a spokesperson and out before the public.

CP: He's on my list to come here, by the way.

RW: So vital, so vital. So I'm glad you're going to have him because your audience and the audience of people for years to come who will watch this history will be most impressed to hear him.

CP: And our approach is different, and I wanted to do that.

RW: And his book that he wrote is really the, sort of, the bible, in a sense, to know what has happened over the years with the government involvement, the intervention of certain personalities.

CP: I haven't read that book.

RW: *Code Blue*[26].

CP: Yeah, I need to get it. I need to get a copy.

RW: I would hope that every physician, every public health official, would put in his or her library an issue of *Code Blue.* It's not very big.

26*Code Blue: A Healthcare in Crisis* was written by Edward Annis, M.D., in 1993 and published by Regnery Gateway. The novel explores the development of socialized healthcare in the United States during Dr. Annis' years of involvement.

CP: Yeah. I'm aware of the book, knowledgeable of it. But I have not read it, and I don't have a copy, so I shall get me one.

RW: And there's no history represented in any other publication in the detail that he has there and the nuances and the innuendos and everything that went on. And it points out very clearly that the personality of the person in that public office in Washington, that personality and that knowledge that person has, is what causes the changes.

And they weren't all aware of what Dr. Annis was saying at the time, enough of them, to understand that his predictions were going to be true. But, after that, he also became a member of the American Chamber of Commerce, Board of Directors.

CP: He did? I don't think I knew that.

RW: American Chamber knew his wonderful ability to present and educate. And so, he would sit at the meetings, and maybe here it'd be the president of General Motors and here's the president of IBM, for example. And he would talk to them about health issues. And these presidents would say, "You know, Dr. Annis, if I had known that, I would have never supported what the government did," or "I never knew this."

It boils down to one basic factor, Skeeter. As physicians, our obligation is to do everything we can to give our best knowledge and information to those people who are in elected positions to know what it is and get businesses involved. Business figures.

CP: I'm reminded of my professor emeritus of medicine when I was in medical school would tell us, "Your first obligation is to educate." He would tell us that. Your first obligation is to educate. And I remember that so well. And this, well, professor emeritus is still lecturing, he lectured, he had a course on the art of medicine in my medical school.

And I remember more that that man had to say than all the rest of my professors put together for my four years of medical school. Dr. Johnson, every Saturday morning, seven o'clock to eight o'clock, first two years of medicine. Medical school, the Art of Medicine, Dr. Wingate Johnson.

RW: So important.

CP: Your first obligation is educate. Oh, and it's so true, Bob, so true.

RW: This brings up another interesting point about that. As I told you about my interest in the Heart Association and how the Heart Association, with all of its volunteers, wants to educate others about heart disease just like all the voluntary agencies want to do.

CP: Yes, that's first thing.

RW: So, at one of the annual meetings of the Florida Heart Association, back in the early '70s, we had a guest speaker who was the retired emeritus professor of business, economics at the University of Florida. I don't remember his name, but he was just a wonderful speaker. So, the purpose of his coming was, how can we sell our message and educate the public. So he was talking about salesmanship. He used his palm of his hand.

He said, Okay, so now you're selling a product. 20 percent of the people here are going to buy your product if it's no good at all because you just are promoting it, because they got faith in you. They'll buy it if it's nothing. You got 20 percent of the people on this side who, if you were going to give them gold for five cents they wouldn't buy it.

So, you've 40 percent right here, I mean, 20, 10, 20. 40 percent of the people right here, you don't worry about. You don't need to worry about talking to the ones that are for you because they are going to support you. The ones against you will never change. What you got here in the middle, 60 percent of the people, these are the people who really analyze what they hear.

And, if you can present to them a legible—or not legible but understandable—a clean, clear, precise bit of information and it's important, you're going to get 60 plus 20, 80 percent to support your program. But, if you can't convince them or show them that what you have is right, what you're trying to educate the public is right, you got 80 percent of the people against you. And I think it holds true—

CP: Isn't it so true?

RW: —in everything you do in life. And if we're trying to educate the public, we need to look at that, and how we're going to do it. And focus on that 60 percent who will listen, and don't waste our time on the person who is going to be against us because they'll never change.

CP: Oh, it's so true, so true. Well, looking back on your very, very colorful, very, very productive career, what's the two highlights of your career, up to this point? You still got a long way to go, I'm just talking about up this point.

RW: Well, I would say it would probably—the main highlight was being a leader in Florida medicine. That was my first highlight, to be able to say that here I am in Florida as a physician, and I'm head of this great organization.

CP: Very prestigious.

RW: But it gave me the opportunity to, I think, exchange and deliver some the messages that I thought about. And the second highlight would be the opportunity to serve under President Reagan and to direct the whole United States Public Health Service, because not only did that give me a wonderful opportunity here in the country, but I also represented all of the biomedical research agreements that we did in the federal government with other foreign countries.

So I traveled and I met—see, I was the peer, as a minister of health of every nation, the same fate as peer here. I was minister of health of the United States[27]. So that opportunity to meet such wonderful people and to travel as I did around the world on several occasions in World Health Organization meetings that was a highlight I'll never forget.

Because it just pointed out to me, to see so vividly, that the people in all these countries, developing countries, developed countries, and everything, people in health have had the same basic background training, the same reason to go into health program because they want to help others.

You talk to them on health anywhere in the world. It's the only discipline, as I see it, as I've ever seen, that has a uniformity around. And it remains everywhere.

CP: The common denominator of language and motivation and goals to them.

27In the United States, the minister of health is the United States Secretary of Health and Human Services which is the head of the Department of Health and Human Services.

RW: You can’t take a county; laws differ. You can’t take any other profession. You look at any of them. They have differences.

CP: That’s right, that’s right. I hadn’t thought of that.

RW: And who touches more people in their lifetime than a physician? Because many people don’t go to churches. And that’s one of two true professions and law. Many people don’t—three professions. Many people don’t seek a lawyer’s help.

CP: Not anymore.

RW: Occasionally some. But over a lifetime, from birth, everybody’s kept a medical contact, not always with a physician, with a—but still. So the medical profession has the greatest opportunity to reach the masses.

And that’s why it’s so important for every one of us in the medical profession, public health and organized medicine, to take that opportunity, as we are seeing throughout the nation, millions of people every day, over and over.

CP: Oh, and we miss it.

RW: Throw in a little bit of education. Let them know. Pass this on. I use the acronym PR. We all need to practice PR. And what do you think about that when I say PR? What comes to your mind right away?

CP: Public relations.

RW: That’s right.

CP: Yeah. But I’m sure that’s not what yours is.

RW: My PR is prevention and responsibility.

CP: Very good.

RW: PR. You cannot, you can preach prevention to your mouth and you get hoarse, dry up.

CP: Until you phone home.

RW: You don't have the person accepting the responsibility to follow out what their direction should be—

CP:—save your breath.

RW: We're not going to create, maintain the health of our nation.

CP: No, we're not. No, we're not.

RW: That's right.

CP: Within the US Public Health Service, what was your highlight during your three years as the big boss?

RW: Well, the highlight was probably—I got in office, officially, in June 1986. I was sworn in. September 8 or so, we had a presentation. I spent, probably, three days prior to that September 8 with our leadership because we were presented with something that had never been presented before in science: a controlled study on the use of AZT in AIDS patients had been started.[28]

But this study was not at its endpoint yet. But the data, early, showed that out of 16 people that were taking AZT, 16 not taking it, there were 3 alive not taking it, there were 14 alive taking it. So the data was so strong, so the question is, Am I going to take the responsibility to accept this study being terminated and present to the American public?

28The 1987 AZT trial proved that azidothymidine (AZT) was effective in reducing mortality in patients with HIV/AIDS. The results were published in *The New England Journal of Medicine* on 1987.

So, on that September 8 or whatever it was, I said, Yes, we're going to go forward; we're going to terminate the study; we're going to announce to the American public that we have a drug, which has been shown to be effective.

And so we go downstairs, and the department of HHS is sitting in the [Hubert H.] Humphrey Building, and we have our media room there. And I can't believe it; at this microphone, at this dais, there were more microphones than had ever been before a federal presentation at that time. Microphones come up from all over. And here I was, I had only been there for four months—June, July—

CP: Two months.

RW: Three months. And so—

CP: You didn't even know who was on first base yet.

RW: That's right. That's right. I didn't know where the ballgame was being played. No, I did know that. And I respected the judgment from my scientist friends. And Secretary Bowen suggested go forward with it, and we did. And that was what I felt was probably the major thing that turned the table.

But then, after that, from '86 to when I left in '89, the AIDS education was a very important part of my administration because I was not able to devote as much time on the other things, in my own personal time, because you're trying to educate the public. We didn't have more than AZT. We had not much information for people to prevent the disease. We tried to.

And I got so frustrated, Skeeter, when people would say, Well, we don't know what causes AIDS. We don't know. Can you get it from kissing? Can you do it from this and that? And I said, "No, the information is out. We've told you."

No, no. So we sat down, I said, "There's only one way, I don't want somebody coming to me and saying that we haven't told you so." I said, "Let's send a letter, a pamphlet, out to every household in the nation."

We did. We took 110 million homes that had post office boxes or homes. 110 million, it's the largest ever in the country, I mean, the largest mailing, a mass mailing, it cost us 20 million dollars out of my budget.[29] And you got one, you remember?

CP: I got mine.

RW: It's about six pages. It has Chick Koop[30] on there. A wonderful man. The Surgeon General had great charisma with his beard and all that, Dr. Bowen, and I. But anyway, and all these pictures in there writing exactly what causes AIDS, how you can prevent AIDS. We don't ever need to take drugs because you can prevent it. Okay?

And now we enjoy, later on, talking to people. And they'd say, I don't understand. Did you get the mailing? Oh my goodness. They threw it away. It just shows the communication break is on the other end.

CP: Yeah, and communication is so tough, so tough.

RW: I wrote an article as the president of the Florida Medical Association, "The Communication Gap," because this was evident to me back when I was even president of Florida Medical. We would talk about issues, liability or whatever, doctors didn't understand, but we wrote articles and everything.

I said the communication gap is on the terminal point. That's where the gap is. We gave it out. But it gets down to the receiving end, and if it doesn't go across the barrier, for the person to retain it, communication is no good.

CP: So true. What have I left out?

RW: Not a thing. I think we've covered pretty much organized medicine, voluntary health agencies, community health, public health. I will point out again the importance of

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29In response to the AIDS hysteria of the 1980s, the US government planned to mail informational brochures to 108 million American households in 1988 to inform the public about the virus. Congress appropriated 21 million dollars for the brochure but the mass mailing was canceled in exchange for distributing brochures in other ways.

30C. Everett "Chick" Koop (October 14, 1916 – February 25, 2013) was an American pediatric surgeon and public health administrator with the Reagan administration. Koop is remembered for his work with abortion rights, tobacco, AIDS, and the rights of handicapped children.

voluntary agencies because I think that they are center of appeal to a person who's had cancer, lung disease, whatever it is, multiple sclerosis, you name it.

But those are people dedicated, so we need to then educate them more about other issues but to capitalize upon their involvement to help us if they commit.

CP: And their motivation.

RW: That's right.

CP: Yeah. Yes, yes, yes. Good point, that's worth repeating. And thank you for repeating that because that will be useful forever.

RW: Voluntary agencies, I'm sure, will always remain, but we need to get doctors more involved in them. The excuse that doctors used to have is, I'm so busy. Which was true in many times. You were working day and night; you had no coverage. But today, I don't know of any doctors practicing that doesn't have such a group that they're probably one night a month they're on duty or two nights, but, I mean, there is time.

CP: You can arrange if he's so motivated.

RW: I think that doctor practicing this needs to develop that motivation if he can. He should have it, but if they want him to have it, they should—if they're going into medicine, the motivation needs to be beyond just the one-on-one in the office.

CP: Another comment from Dr. Johnson that I'm constrained to remark, he would tell us young physicians, "Every patient that enters your office is only an index of something larger going on. It's your obligation to find it."

RW: That's a very good point.

CP: Isn't that the truth?

RW: Yes, sir.

CP: He went on several lectures on the impact of this is the breadwinner there, standing before you, and you're fixing to put him to bed for week? Think about those kids. Think about—you've got to think about the larger thing that's going on if you're going to be a good physician, he'd always say. Isn't that marvelous?

RW: Remarkable. But you know what has happened to maybe lessen that degree of feeling? Has been the invention of the technology we have today. A recent article came out showing, for one of the journals—journal of medical—*JAMA*. In the public news, in the newspapers recently, that doctors can't diagnose heart murmurs anymore.

CP: Oh, I saw that.

RW: Well, I don't think that is as true as they're saying, but the point is, doctors often do less because they can send you over and get a test here, get this here, get that there. In fact, I know doctors today who do certain procedures in that they might operate on this or that.

They won't even see the patient in the office first until they've been through this MRI or this study, then you come in and see me. So technology, I work on that tiny bit here. I do this, wonderful work, no question.

CP: Technically, yeah.

RW: It's wonderful, but we've lost our knowledge of the patient.

CP: Lost our patient contacts, but we're getting so much better medicine.

RW: We're getting better medicine for it, that's true, but you can't—

CP: We're getting better care, but I don't feel better about it. Dr. Robert Windom, it is truly a pleasure to have you here today, and for you to share your life and fun with us and future viewers, into the historical libraries of the University of South Florida. Thank you for coming, Bob.

RW: Thank you so much, Skeeter. And if you don't have fun at what you're doing, you're not in what you should be.

CP: You as well ought to go back to the desk.

RW: That's right.

CP: Put your head under the—

End of Interview