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Dr. Samuel Korper Oral History

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SAMUEL P. KORPER, PhD, MPH Oral History

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This interview is being held with Samuel P. Korper, PhD, MPH, who was employed at NIH for nineteen years. During that time, Dr. Korper held two positions: first as the director of the Office of Legislative Analysis (DLA), in the Office of the Director, NIH (March 1984–May 1987); and then as associate director of the National Institute on Aging (NIA) until his retirement in 2003.

NIH oral histories often include questions seeking general biographical information about the interviewee. In addition, the subjects are often asked to address specific aspects of, or topics related to, their responsibilities at NIH of historic interest to the NIH Office of History for preservation. In Dr. Korper's interview, that topic was the role of the DLA in the 1980's, as well as his general observations about legislative matters, relevant laws, and NIH interactions with the U.S. Congress.

Ordinarily, in constructing an oral history, the moderator and the interviewee, having previously reviewed the material to be covered, arrange a time and place for the dialogue. The planned discussion occurs, is recorded, and then the exchanges are created into a written transcript. In this instance, an oral interview of Dr. Sam Korper, suffering from a disruption of his vocal cords, was not possible. It was agreed that I, E. Gordon Margolin, moderator and volunteer in the Office of NIH History and Stetten Museum, would still ask the questions—but the answers would be submitted in written form and the resulting document would be presented in the fashion of other oral histories.

GM: To begin, would you give us some insight into your early family life and the nature and place of your educational endeavors?

SK: I was born in Providence, Rhode Island. I have a younger brother. My father worked in electronics and was a ham radio operator. He was also a skilled sailor, having raced Star Class sailboats before World War II. From a very early age I was taught to sail and went out regularly with him as crew. He was very strict and had very high standards, which I remember with a mixture of emotions. My mother was an interior designer, with a very active client base, had a shop, and was a founding member of the American Society of Interior Designers. She was very busy, much loved by her clients, and played an important role in my development. Lastingly, I remember her as a lady of many judgements, but that she was seldom judgmental.

My earliest grades were in Providence at the Moses Brown Quaker School, then a few years later, I attended a one-room school in rural Matunuck, Rhode Island. Sometime around the fifth grade my family moved to Connecticut, and I was subsequently enrolled at the Hopkins Grammar Preparatory School (Grades 6 - 12) in New Haven.

Following graduation, I completed two years at the University of Pennsylvania, after which I returned to Connecticut to finish at Fairfield University, graduating with a BA in 1964. I was fortunate to have completed high school courses in what back then was called "mechanical drawing" and was able to work every summer through secondary school and college as a draftsman at the Sikorsky Aircraft plant and later at another electronics firm to supplement my earnings for college.

GM: How did you become interested in Epidemiology as a major, early focus in your life?

SK: Actually, not so early.... This was not a straightforward decision. As so much of my career has demonstrated, timing and luck has played a major part. After college graduation, I applied and was accepted as a volunteer in the U.S. Peace Corps and after several months training at Harvard and the University of North Carolina, I was assigned to a public health program concentrating on tuberculosis (TB) transmission in rural Africa. Thus, after this serendipitous selection, my initial interest in Epidemiology can be traced to my experience in 1964–65 Peace Corps program in Nyasaland—now Malawi—Central Africa. Beyond TB, and due to the remote setting, I also became involved in work with leprosy and environmental health and sanitation and became involved in a varied combination of disease-specific epidemiological projects and more general public health practice.

The location of my Peace Corps assignment had unexpectedly placed me in local events that were part of the global transition from colonialism to independence in the mid 1960's. In this case, the British Commonwealth was giving way to the creation of independent countries throughout Africa and elsewhere. I apologize for the digression—or perhaps too much history!

My Peace Corps experience in was not without some drama, which was certainly a demonstration of my place/time/luck argument. As I said, my work primarily involved TB contract-tracing and preventive vaccination in rural villages in what was then Nyasaland—now Malawi—and my village was caught up in an armed political uprising shortly after the county's Independence in 1964, when insurrectionists challenged the recently installed President of Malawi. Several local leaders who were involved in the insurrection were tracked down and captured by the government police force, and a number of villagers were killed in the incident.

Then came another culture change. After leaving Africa and the Peace Corps and returning to the U.S., things changed once again. It was the Vietnam era, and for the subsequent two years (1966–67), I volunteered for the draft and served in the U.S. Army. After completing Basic Training and Advanced Infantry Training, I was sent to Okinawa, south of Japan. Based on my public health training in the Peace Corps, I was ultimately assigned to the Public Health and Welfare Dept., U.S. Civil Administration of Ryukyu Islands (Japan) where I worked on traditional public health issues such as infectious diseases (leprosy) and venereal diseases, as well as environmental health and sanitation.

GM: Then, I gather, you returned to Yale to acquire advanced degrees related to the Peace Corps and Army experiences as you just mentioned.

SK: Yes. Both the Peace Corps and my military experience were important in that they provided hands-on practical public health-related experience as well as the opportunity to become immersed in foreign cultures. While I was away on military duty, my father had passed away, and upon completing my tour, I decided to return to my home in the New Haven, CT area (where my mother resided). Given these events and based upon both my Peace Corps and military experience with public health activity, I applied to the Yale School of Public Health in New Haven, CT for my graduate training, to which I was accepted.

Also, while in the Service, I had married and was starting a family. So, when I returned to New Haven, my new family responsibilities became intertwined with graduate school class requirements and the need to find part-time employment. So, due to my multiple responsibilities, my graduate education was somewhat prolonged. Throughout, my jobs were very relevant to my academic training, which took place at the Yale School of Public Health, receiving a master's in Public Health (MPH) in Epidemiology in 1969, a master's degree in Philosophy, and a PhD in Epidemiology from the Yale University Graduate School in 1976.

GM: Then in 1968 and 1969, after you finished your military service, and while in graduate school, I understand that you were the director of the Model Cities Program, Office of the Mayor, New Haven, CT. Please describe the nature of the position, its purposes, and your accomplishments. You might also tell us what is meant by "Model City".

SK: The Model Cities program was a federal program during the administration of President Lyndon Johnson (as a part of the "Great Society" programs) established in 1966 in hundreds of urban areas across the country to test and develop new anti-poverty programs and undertake urban physical renewal and expand low-income housing. As I had worked on a part-time basis for the City of New Haven's Model City program, when the position became vacant, I was asked to serve as acting director of the program. It was a period of active social change reflecting economic and racial disparities across the country, and during my time the New Haven riots involving the Black Panthers took place, in the summer of 1967, along with other types of civil unrest.

The office was responsible for planning and developing and programs initiated through the establishment of several local neighborhood organizations for housing renovation, urban services improvements, and other aspects of city life. Looking back, it is pretty clear that we were pretty naive, and though there was, indeed, local participation, we were much less considerate of the perceptions and concerns of the neighborhood residents than we should have been. By today's standards—shameful, I think. But there were also some great results as well. I'm thinking particularly of the creation of neighborhood health facilities and centers.

GM: Your work in the Model City program must have been an attention-getter, as it led you to the federal system where, from 1969 to 1978, you served as the part-time project director of the New Haven Health Information System for the Census Bureau's Center for Census Use Studies. You were also promoted locally during 1972–73 to be the director of Research and Evaluation at New Haven Health Care, Inc. Tell us about these positions and programs.

SK: Yes. These positions had to be worked in and around my graduate school studies; by then I was working on my PhD dissertation. They all involved working with data from local organizations such as hospitals and service agencies (such police and fire) to be linked with census-type data for specific studies and analyses of a wide variety of health issues and the resources that might be allocated to deal with them.

The part-time position with the Center for Census Use Studies occurred at a time when the U.S. Census Bureau was preparing for the conduct of the 1970 Census across the entire county. The City of New Haven had been selected as one of three areas in the country for a trial run of the upcoming census (called a Census Pre-test) and to develop new tools for survey conduct and analysis. Again, for me, a lucky bit of timing.

The use of small (local) area data in New Haven served as an experiment later taken nationwide to test the effectiveness of several Great Society programs. The Census Bureau, other federal agencies, and local governments and organizations developed methods to match state and local agency administrative records with census data at the block level to determine if these programs had reduced poverty rates and improved health outcomes in New Haven's program area and across the country.

Our small New Haven Census Use Study project developed computer software (ADMATCH) designed to match state and local administrative records with census data at the block level. We also introduced "Geocoding" to civilian applications and created the Geographic Base File/Dual Independent Map Encoding (GBF/DIME), a system to automate the creation of geographic information systems. Users found so much value in these experimental data linkages that the Census Bureau extended the GBF/DIME system to 80 other urban areas over the next ten years for the 1980 census. These methods have continued to be developed and are still utilized in the American Community Survey (ACS) as a continuing part of the current U.S. Census.

GM: Could you explain the "block system" in more detail?

SK: The Census builds a database starting with questionnaires and responses from individual households (addresses) into larger integrated files starting with each block face (one side of a block), whole blocks, and census tracts. They further aggregate these data into county, state, and, finally, national subtotals and totals. This is a method that is used in the conduct of the national Decennial Census.

GM: Tell us briefly about another project, the Experimental Health Services Delivery Systems Project, in which you participated at that time.

SK: This was, as I recall, another federal program begun in the 1970's. Faculty at the Yale School of Medicine and several community groups in New Haven were awarded a grant from the U.S. Department of Health, Education, and Welfare [DHEW, now the Department of Health and Human Services (HHS)] to plan and implement neighborhood health centers and to coordinate other health activities with the local health department and hospitals, etc. I was asked to participate as the leading research analyst and planning advisor.

GM: Your next venture, from 1973–78, moved you into the Dean's Office at Yale University School of Medicine, where you held several positions: assistant dean for Regional Activities; director of Office of Regional Activities; research associate (psychiatry); and lecturer in Public Health. How did you fill these roles? Was this where you were working under Dean Robert Berliner, and you were encouraged to consider NIH as a site for your work?

SK: Yes. This was, indeed, a fairly major career shift. In 1973 I was appointed assistant dean of the Yale University School of Medicine, in New Haven Connecticut. I reported to Yale Medical School Dean Robert Berliner (who had come to Yale after having been NIH deputy director for science in the late 1960's to the early 1970's), with primary responsibility for the development and expansion of the Yale School of Medicine's regional network of affiliations with several community hospitals in Connecticut for training opportunities for medical students and clinical faculty. Through these efforts, the network was expanded to some 14 hospitals and is, I understand, still providing clinical training opportunities to this day.

GM: During this latter period (1976–77) you were awarded a further training opportunity as a Robert Wood Johnson Health Policy Fellow, administered by the Institute of Medicine of the National Academy of Sciences, Washington, DC.

SK: Yes. It was during this time, probably 1975, that Dean Berliner recommended that I consider pursuing the then newly created Robert Wood Johnson Health Policy Fellowship (RWHPF) in the U.S. Congress in Washington. He thought that this would be an excellent opportunity to apply my training, and interests at the national level.

Having completed my formal training in epidemiology and having worked directly on community development and social policy issues, and adding experience in the university and medical school, and after lengthy discussions with Dr. Berliner, colleagues, and family, I determined that if I were to be awarded the Robert Wood Johnson (RWJ) Health Policy Fellowship, it would afford a significant learning experience in new and expanded dimensions. To my everlasting good fortune, the Fellowship was awarded to me, and I took a leave from my position at Yale to work with the U.S. Congress on health policy issues.

To explain a bit more, the RWJ Health Policy Fellowship is considered among the nation's most prestigious health Fellowship experiences, combining health, science, and policy in Washington, DC. Mid-career health professionals (about six each year) and behavioral and social scientists actively participate in the health policy process with assignments in the Congress (usually directly with members of Congress and their staffs, or on Committees) and at the federal level, to gain hands-on policy experience. In 1976, I was in the third group of Fellows, and by now, a total of more than 250 Fellows from across the nation have participated in the program since 1973.

So, the move to Washington took place. Once getting the children's schools resolved, and the family settled in, the RWJ Fellowship year in Congress commenced. After an intensive four-month policy and legislative "familiarization" period, Fellows begin negotiating and selecting assignments to work in a House and/or Senate Congressional office, either with a single Member of Congress or a Congressional committee for a year or a full Congressional term. There were also a few placements where Fellows worked in an Executive Branch office such as the Office of the Secretary of Labor. My assignment was with Andrew Maguire, Democrat of New Jersey, a member of the Health and the Environment Subcommittee of the Commerce Committee in the House of Representatives. My activities, which focused on health issues, were those of the regular staff, involving covering hearings, drafting testimony, briefing the Congressman, and responding to constituent inquiries.

In direct answer to your question, the Fellowship experience was truly an amazing—transformative—experience, expanding my interests and it certainly helped prepare me for participation in health policy at the federal level.

GM: So now you have moved into the federal government. Was that considered a major step up, or just a normal move for an individual of your interest and experience? From September 1977 until December 1978, you were in the federal system as a senior research manager for the HEW National Center for Health Services Research (NCHSR). What were your responsibilities?

SK: I was engaged primarily as a participant on the research staff in and working directly on various data analytic projects in the established intramural research program. These studies were focused on health care delivery, quality, and costs. Much of the work entailed gathering relevant data, undertaking analyses, and publishing the results in the open literature or as reports to Congress. This position was the beginning of my association with the NCHSR.

GM: I see that you served as associate director for Legislation, Epidemiology and the Environment at the Office for Health Research, Statistics and Technology in the Office of the Assistant Secretary for Health, DHHS, from April 1982 to February 1984. This position allowed you to continue to expand your research and federal advisory activities in health care. Is that right?

SK: Yes. During this time, I was asked to take a temporary assignment, called a "detail", to serve directly on the staff of the Deputy Assistant Secretary for Health. This temporary position provided a great experience with many of the organizations and senior officials of these organizations with primary responsibility for health issues in statistics, technology, and legislative activity related to these matters. This position expanded my role in the DHHS, especially at higher-level policy positions. It included serving as liaison to the National Center for Health Statistics, Health Care Technology and Health Services Research, and required briefing senior officials in the Department, the White House, and Congress.

GM: Obviously this position offered further expansion of your knowledge bank into health statistics, technology, and research. Now you were ready for even a greater add-on to your increasing involvement in these areas.

SK: I suppose, but at the time I recall being grateful for an opportunity to get back directly into research activity. I served as director of the Division of Intramural Research at NCHSR. It was a return to the NCHSR with far greater direct involvement in research projects and managerial responsibility. Along with the other senior staff—the Center Director and the Director for Extramural Activities—responsible for awarding grants in the area of health services research to universities across the country, we designed major studies such as the National Health Care Expenditure Study; the Hospital Cost and Utilization Project; and studies in several other areas such as long-term care, costs and financing of care, and the then-evolving area of health care technology and computer applications in health care. This was some 40 years ago, and the design of such systems and applications were in their early days.

Dr. Margolin, may I indulge myself in a brief moment to vent? Back in those NCHSR years, now so many years ago, I was always frustrated that the nation, through its policy-makers—Administration and Congress alike—placed so little relative emphasis on the health services research programs when compared to the biomedical research enterprise as reflected in the widely disparate scale of the annual budgets of the NIH and the NCHSR. For example, the budget of something over $40 billion for NIH vs. $300 million or so for NCHSR this past year. The imbalance continues to this day in a variety of areas ranging from epidemics to hospital care to occupational health, from racial and social differentials in health access and outcomes, the failure to appreciate the importance of better understanding approaches to the application and availability (access to) of the fruits of biomedical research to individuals and the larger community. And don't get me started on the failure to maintain the national public health infrastructure—all very wasteful, shortsighted, and potentially harmful to the population and particular sub-groups.

GM: Up until this point you were expanding your experience in administration in so many venues, as we have discussed, above; you had moved around and had become a recognized candidate for just the kind of position that became available at NIH. It was during this time, as I understand it, that you got a call from Dr. Ruth Kirschstein at NIH. What was it that enticed you to come to NIH in March 1984?

SK: One day I received what was very much an “out of the blue” surprise call from Dr. Ruth Kirschstein, who was then serving as the director of the National Institute of General Medical Sciences at NIH, asking me to come to meet with her to discuss and/or recommend potential candidates for the position of director of the Division of Legislative Analysis (DLA) in the NIH director’s office. I was going as a consultant, NOT as a potential candidate, so the whole thing was unpressured and quite informal.

As I recall, we met in her Institute office, and it was a very warm, cordial, and far-ranging discussion. I remember thinking she was very gracious. A day or so later Ruth called and asked whether I might be interested the position myself. This was really quite a surprise! Apparently, not only did Ruth reach out for recommendations, but several people in DHHS and in Congress had talked with Ruth about my possible recruitment to the position, which had suddenly become available. My initial reaction was quite lukewarm, as I was quite happy at NCHSR. However, after more reflection and additional conversations with Ruth and several other colleagues, friends, and family, I agreed to accept the offer. I think that I felt that with my additional experience, combining research along with legislative activity, I really did have something to offer in undertaking the DLA position.

GM: So, starting in March 1984, you served as the DLA director. What is the role of the DLA director? Can you elaborate on the background, history, purposes, and key functions of this division?

SK: Dr. Margolin, you have asked me a number of questions that I will try to address as we go along, but I apologize, as it may be somewhat meandering at first.

I explained how I was recruited to the DLA position by Dr. Ruth Kirschstein. Some of your other questions will take me into some essentially generic descriptions of process, but I will try to limit my digressions into political science. Your questions will also take us on a few detours into history and some illustrative anecdotal reflections from the period in which I served as DLA director.

There are a number of unique aspects or requirements of the role played by those trained in the health and behavioral sciences who choose to become involved in legislative activity either in Congress or in the Executive branch. Beyond the scientific training, some basic skill in public communication is necessary to be effective. Some training and experience in legislative mechanics and processes as well as an understanding of the historical underpinnings establishing the federal agencies engaged in health and biomedical research is a pretty much a prerequisite.

There are many helpful references. Here is one example. During my Robert Wood Johnson Fellowship year which we discussed earlier, the Fellows were fortunate to have available the then-recently published book, “The Dance of Legislation “ by Eric Redman, which was—and still remains, I think—perhaps the most readable description of the ins-and-outs of the legislative process. It is especially relevant to those of us in health-related fields as it deals specifically, as I recall, with the evolution through the Congress of the National Health Service Corps draft legislation. I have always—and still do—recommend it to anyone interested in the area. This and numerous other resources are helpful.

But, in the end, Congress is essentially another world. I recall that sometime in the late 1980's, *Newsweek* magazine did a lengthy piece on the Congress that carried the subtitle, "It's a fortress of unreality, with its own laws, logic and codes of behavior", and harshly called it "the last plantation". So true! And that's not to be taken lightly. The Congress has, essentially, a very full range of relationships with and over the NIH from creator, parent, budget allocator, and guidance counselor to potential executioner.

Earlier, looking on from the outside, and then later when I became an active insider, the relationship of NIH to Congress has always had complex and profound implications for the NIH's mission, its daily management, and its evolution into the future. This was really driven home to me, both when I was the DLA director when the relationship with Congress was my full-time fare, and then later, when I was at the National Institute on Aging. That latter role gave me both responsibilities for managing, along with many other staff, some mandated, formally (Congressionally) established, and ever-evolving, aging research-related activities of the NIA, as well as being responsible for the specific legislative responsibilities of the institute. Thus I was immersed in the responsibility for many of the same types of concerns, but compared with my previous DLA role, with a much more narrow aging research-related focus.

GM: I will try to get back to any overall perspectives this might have afforded you, but let's return to the overall NIH/DLA story you were beginning to describe.

SK: As an institution, the NIH is also an unusual and hybrid environment with a very distinguished past and is, as I have come to believe, greatly appreciated by the nation in a way that is not always the case with other federal agencies.

People often refer to the NIH buildings and grounds as a "campus" as if it were a university—and for many of the scientists and administrative personnel it might feel that way. The grassy campus-like appearance with its numerous institute buildings housing laboratories and the Clinical Center, along with a primary role to conduct intramural research and fund extramural biomedical research activity at universities across the nation, lends itself to this perspective. But despite appearances, the NIH is, after all, a very large federal agency, with numerous unique characteristics that differ from the universities and the private sector in many important ways. This does impact the way NIH must operate on a year-to-year basis with annual Congressional appropriations and changing authorities to conduct its work and has a variety of implications for the numerous NIH components and its employees.

I know that this interview is not the place for a high school civics lesson (and I would hope that everyone should be familiar with the basics, such as the U. S. Constitution and references such as "How A Bill Becomes A Law"), but many citizens are sadly unfamiliar with how their government works. As a practical matter, I found that awareness of the many aspects and implications of the NIH as a federal government employer is somewhat limited for many employees.

Things affecting government employment were changing in the period of my DLA responsibilities in the 1980's. Recall that the 1970's and 1980's saw the beginning of a national transition from lengthier careers to shorter terms and forms of flexible employment which is now more common. On June 6, 1986, President Reagan signed the Federal Employees' Retirement System Act of 1986 (Public Law 99-335) which established the Federal Employees' Retirement System (FERS) for employees hired after December 31, 1983. The "old" Civil Service retirement annuity era was abolished—and with it, longer-term "career" perspectives were giving way to shorter-term transitional perspectives on employment, and NIH was not immune from the impact on recruitment, hiring practices, and the perspectives of the younger scientists and administrative personnel.

This national workplace transition in career options and perspectives and the specific changes made during my era to the U.S. Public Health Service Commissioned Corps all had an impact on recruitment and staffing at NIH. Beyond their exploration of biomedical questions in the laboratories and clinical applications in the Clinical Center, most NIH employees are naturally concerned with employee personnel and career decisions and retirement matters, and less with the federal legislation under which they work, and even less in how the NIH was created and how Congress affects its function. Many are barely familiar with the details of the Authorization and Appropriations process, which is the basis of their organizational existence and the support upon which their scientific enterprise rests.

GM: What can you tell us of the growth of the NIH from the early 1930's on?

SK: So, a little history. In May of 1930, Congress passed the Ransdell Act which reorganized, expanded, and re-designated the "old' Hygienic Laboratory as the National Institute of Health. The act authorized $750,000 for the construction of two buildings for NIH and authorized a system of fellowships. (P.L. 71-251, 46 Stat).

For anyone interested in the overall growth and historical development of the NIH, the details can easily be found in the Legislative Chronology which is on the DLA website (http://www.nih.gov). I will always think of the legislative chronology as "Gertrude's List", as Gertrude Kelly was the one on the DLA staff who did the initial research and manually entered the early history onto the list and edited and maintained it for years thereafter. She looked for the NIH-relevant bills and laws as they were passed in each session of Congress and as they were printed in the hard copy of the *Congressional Record* and went through the legislative history and created this invaluable catalogue.

Briefly, starting with the National Cancer Institute in 1937, and in every decade thereafter, the Congress authorized (and appropriated the necessary funds) to establish new entities as the disease advocates pushed and lobbied for—and the science supported—their separate disease interests. The Clinical Center in 1946 or 1947, and then from earlier origins, the NIAID, NHLBI, NIDR, NIMH, NLM,4/25/22 NIGMS, NICHD, NEI and NINDS—and more—all followed into the late 1960's. Then, we get into the 1970's and 1980's where my own involvement in the story picks up.

While I am trying to limit myself to specific answers to the questions you have raised, but I think it is important to not forget that during these decades, beyond the creation of the several institutes, many dozens, really hundreds, of other important pieces of health legislation were passed which added numerous specific authorities and extended biomedical and public health activities, not only of the NIH, but of the nation. Here I am thinking of such things as the Hill-Burton Act that provided states funds for construction of hospitals and health centers; the Research Facilities Act; the Health Manpower Act (I think in 1968). Then there were many disease-specific pieces of legislation like the Cancer Act, MS, heart disease, the Sickle Cell Act, SIDS, and dozens more.

As I was starting my career in the early 1970's, there were several pieces of legislation that had a direct impact on my career as we discussed in our earlier talks, and from which I had learned a great deal, and they established the responsibilities and created the institutions in which I worked. While I was vaguely aware of the efforts that had gone into their creation, I was really only tangentially concerned with the specific legislative process(es) from which these activities had originated. For example, there was the support to schools of Public Health that made formula grants for traineeships for public health students that supported me for my MPH training, as well as several of the local programs in New Haven that I worked with such as the Census, the Experimental Health Services and Delivery Systems projects, and more, had all started with and were supported by legislation of the era.

Two more come to mind. First Congress passing the Research on Aging Act, PL 93-296 in 1974, which established the NIA, where I later worked from 1984 to1993, and more we will discuss later. Another is the Health Services Research, Health Statistics and Health Care Technology act (PL95-623) of 1978, which further supported the national centers when I first arrived in Washington to serve as a research analyst in NCHSR and later as director of Intramural Research there.

Surprisingly, all these historical legislative references, like the specific public law references and the jargon, are still stuck in—or crowding out—perhaps more needed material in my brain. I guess the older memories do survive best! And I still have old draft bills, notes, and references and other such detritus stored away in boxes in my basement— mostly unopened— for years.

GM: And for your specific NIH DLA activities?

SK: Back to my specific role as director of the Division of Legislative Analysis in NIH legislative activities in my era, the mid to late 1980's.

Basically, there were four principal responsibilities of the office: "1. Advising senior officials on legislative developments relevant to NIH. 2. Affecting changes in the statutory base of NIH activities. 3. Coordinating Congressional communications. 4. Developing new legislative proposals." These have expanded to a few more specific functions as stated in the current Mission Statement of the Office of Legislative Policy and Analysis, or OLPA as it is now called.

As a day-to-day matter, this took the form of tracking legislation; answering calls from Congressional Staff, the press, and the public; briefing NIH staff on current legislative developments; researching and drafting new legislative proposals; meeting with senior officials in the DHHS; coordinating responses to general inquires; arranging Congressional visits; and writing or coordinating the preparation of the numerous Congressionally mandated reports—endless reports.

The staff, numbering about a dozen, were each responsible for either general matters such as appropriations, or the unique legislative concerns of the separate institutes and specializing in a few individually held "portfolio" issues such as cancer, AIDS, Alzheimer's, arthritis, mental health, environmental health, etc. A very important ongoing function was following the developing annual NIH appropriation cycle (or in the case of Continuing Resolutions, several versions), which was for many years the purview of Anne Houser, and ascertaining the impact of the different versions on Institute functions. Fortunately for the NIH, several of the DLA staff remained in their roles for many years, expanding and regularly demonstrating their great expertise, providing continuity for the Institutes, and becoming well known to and trusted by Congressional staff.

I really do want to take a moment here to say how much my time in DLA has meant to me. From the outset, the staff was beyond cordial and over time we developed friendships, some of which continue to the present. These very smart, experienced, and motivated professionals taught me so much, and their gift of sharing and patience—in an often very frenetic office environment—remains very much with me. I still think back to the manner in which Kay, Anne, Roz, Gertrude, Tina, Doug, and several others managed their individual portfolios and often made difficult assignments look easy under very intense time pressure. I never lacked for great preparation, advice, and support.

Often the DLA role was simply providing assistance to the separate Institutes in the preparation and clearance through the DHEW/DHHS of their draft testimony, replies to Congressional inquiries, or in assisting the Institute staff in arranging Congressional visits to meet with the scientists directly in their laboratories.

But sometimes it was a little more thorny. During my tenure, we had a few incidents that required investigation of intramural laboratory staff, or response to Congressional investigations and their inevitable press inquiries. The most well-known of these were the highly publicized allegations of "scientific misconduct" in the academic research community. The Health Research Extension Act of 1985 (PL 9-158) established the Office of Scientific Integrity at NIH, and the Public Health Service issued a policy creating a framework of guidelines, definitions, and investigative procedures.

While there were several well-publicized "incidents'" alleged and investigated over the next decade, among the earliest and most highly charged of these was described in the manuscript of Walter Stewart and Ned Feder, two NIH intramural scientists, published as I recall in the journal *Nature* in the mid-1980's. National headlines and Congressional investigations ensued. Heated and very visible, the furor lasted a decade, with the men being removed from their NIH positions, detailed to Congress, participating in hunger strikes, and more. Ultimately, the reputation and status of world famous scientists and Nobel Laureates and international incidents were all part of the mix.

Looking back there were also humorous events as well. For example, sometimes as I was on the Hill for a Congressional staff meeting or member's briefing, and I would sometimes have a surprise encounter with an NIH Institute Director coming out of a Congress member's office door from a meeting that had not been "cleared" by our office or that of the Office of the Secretary as was then mandatory. Oops!

I recently had an opportunity to reminisce about my old role, and to talk about and compare, the current OLPA activities with my contemporary counterpart, the current Associate Director, Adrienne Hallett. While the NIH has grown in both budget and organization, and consequently some specific aspects of the DLA's role have expanded accordingly, it seems that by-in-large not all that much has changed in the day-to-day "atmospherics" of the office despite the passage of some 40 or more years.

Remember that I was in the position the 1980's. The D.C. Metro had only recently been created in the mid-1970's, and the Medical Center Metro stop on the NIH campus would not open until August of 1984. The advent of the Metro increased the ability of DLA staff to meet with DHEW/DHHS staff downtown and attend Congressional hearings and meet directly with Committee staff when necessary.

The Internet was much less well-developed, and cell ("mobile") phones were just coming into regular use. And there were phone calls aplenty, on some days numbering in the hundreds, and on some incredibly high-interest days my own personal call receipt record was over 80!

The days were also often pretty long, as the Congress tends to begin the day somewhat later in the morning, and definitely ends MUCH later than is typical for government agencies. Often, I was in the office past 7:00pm. And it was almost always the case that if I stayed late, any call received was invariably a member of Congress, a Representative or Senator, calling directly from their offices. Many inquiries from Congressional members had to do with legislation they wanted to develop or were already sponsoring. But often they were interested in a constituent "problem" such as getting a person admitted directly to the Clinical Center for a health issue despite the then-existing rules requiring physician referral, or sometimes requesting VIP admission for a family member. Such calls could become quite delicate. Saying "no" or suggesting that what they were requesting was not possible meant that the call could become a little tense.

GM: Do you have some more examples?

SK: Sometimes I received calls directly from Representatives or Senators who were unhappy with testimony presented by an NIH official (generally Institute directors) at a Congressional hearing earlier that day. They might ask about the individual, their salary and grade level and "the manner of their appointment", inferring that they might be asking for their removal.

More bothersome—or sometimes infuriating—to me and the staff, were the calls we occasionally received from (relatively) young Congressional staffers wanting an instant answer or some analytic assistance for an issue that was often impossible to answer in that instant or might take time to assemble. Their impatience and arrogance could be incredible! It used to remind me of the old adage: "Teenagers, leave home while you know everything."

Fortunately, more common were the calls from the press or the public for subject-matter information such a scientific perspectives from NIH scientists, advice on the drafting of bills that were of interest to their boss or discussing the likely NIH or Departmental position on a legislative initiative. These inquiries were very much the typical daily fare of the office.

Over time DLA received inquiries from many different members and their staffs in Congress, the most specific and detailed came from the established Health Committees and Sub-Committees working on both general appropriations and authorization issues as well as legislation which was being developed in response to pressure from the numerous disease or health-system interest groups (access, costs, insurance, quality, etc.). In particular, Senator Kennedy and Congressmen Dingell and Waxman (and members of those Committees) were, by virtue of their Committee jurisdiction, very often involved. But it was really very diverse, with numerous inquiries from Committee and Sub-Committees like Oversight, Aging, Veteran's Affairs, and others requiring attention—essentially the alphabet soup of Washington's Congressional and Executive Branches, the OMB, OTA OSTP, etc.

GM: Was there much daily NIH direction? How did this work? Did DLA receive direct oversight from higher levels in the DHEW/DHHS?

SK: The DLA was located both organizationally and physically in the immediate office of the NIH director in Building 1, and I was fortunate to have the access and support that I needed from the NIH director, James Wyngaarden, or his deputy. In addition, the assistance we received from other OD staff offices such as budget, planning, and communications was always available.

A few special mentions? During my time there, I really must credit the wonderful support of people like Bill Raub, Tom Malone, Storm Whaley, Phil Chen, Belle Ceja (the NIH director Jim Wyngaarden's Executive Assistant and "gatekeeper'), and Vida Beaven (NIH Assistant Director), and several other senior staff who were most important to me in affording advice and providing access to the director at critical times. I must also mention the extraordinary access granted and opportunity to discuss things as necessary with the NIH director during my time, Jim Wyngaarden. Calls at any hour, the ability to drop in to his house on the NIH campus if there was an "emergency" need to see him, and our private discussions to and from Congressional hearings all were important to me at the time.

To keep people informed of legislative developments, I was responsible for providing weekly legislative updates to the senior staff, as well as at the NIH Institute Director's weekly meeting. These ID meetings were a great opportunity to learn about current issues and problems, and they were sometimes were very intense, as these very gifted people seldom held back in letting their opinions be known. These meetings invariably surprised me for the candid nature of the discussion as well as those times when an "agenda" was either made explicit or kept under wraps.

GM: And what about from outside the NIH—DHEW/DHHS or the Congress?

SK: There was the "supervision" provided by the Office of Legislation and the assistant secretary for legislation in the Office of the Secretary (OS) in the Department. This was of a wholly different kind. At that level "supervision" or "oversight" took on a very different meaning!

The OS took the legislative liaison and monitoring role very seriously. I saved, and still have, several of these memoranda sent either directly from the Secretary or a senior departmental staff person (once even from the White House!) instructing us on quite precisely how Congressional interactions were to be conducted. In fact, at the time, I recall tacking them up on a wallboard in the office for our “instruction” and/or bemusement.

As I remember, we received what I'll term "Congressional Activity Directives", usually in the form of memoranda, but sometimes by telephone, directly from successive Department Secretaries. There was one from Secretary Patricia Harris which prohibited "meetings, calls, or staff contacts" with members of Congress or staff and a whole laundry list of additional offices and individuals. Similar memos were delivered in the following years from Secretary Otis Bowen and any number of Assistant (or Deputy Assistant) Secretaries for Legislation or Health, all requiring notification and/or coordination with officials at higher levels in the Department.

GM: It almost sounds like you didn't take these directives seriously.

SK: Well... for those who had been in government for some time, living through successive administrations, each thinking they had been elected with a fresh mandate, along with a felt-need to be “in charge”, it was somewhat repetitive. We of course understood the need for coordination and the importance of keeping the senior officials aware of what was happening and keeping them alerted to upcoming events and newsworthy achievements. But with each incoming group there was a fairly predictable learning curve and evolving awareness that, despite their enthusiasms, they didn't control everything. Often one got the feeling that they felt Congress was overly intrusive—in the way—or thwarting their plans. And there was, inevitably, the feeling that the hold-over permanent career staff (or permanent bureaucracy or, I suppose in today's parlance, "The Deep State") were not necessarily as responsive to the rapidity of change as they might like. Sometimes the recollection and pointing out earlier attempts at policy re-direction, successes, and failures, were met with deaf ears or repudiation rather than honest attempts to avoid the same sad experiences and outcomes. All are part of the way the process works as I experienced it.

These directives acknowledged the importance and potential visibility of these interactions, but all parties involved understood that when the Congress requested, asked, or demanded a response or attendance, it was almost invariably heeded. It was at times like these that one comes to understand that as a practical matter, the three branches of government are not created "equal". On some reflection, and with the distance of time, I realized that you can almost never "win" an argument or disagreement on a seriously-held policy issue with Congress given the political pressures brought by their competing constituencies. In general, often having the last word, Congress wins!

GM: Can you provide some examples of specific legislative developments that were of somewhat greater significance during your tenure in DLA in the 1980's?

SK: Well, a few come to mind. And, knowing you were interested in some specifics, rather that relying solely on memory alone, I "cheated", checking with Gertrude's List chronology on the OLPA web site.

There were a few important new laws that were passed about the time I was getting to NIH, just before my DLA responsibilities began. The Small Business Innovation Act, which required the "small business set-aside", opened up new opportunities to all kinds of firms that were not previously really competitive. About the same time there was the Orphan Drug Act (PL 97-414 of 1983 that encouraged research that was directed at the funding for research into less well-known or understood diseases. Sometime later we (the NIH) were required to support and participate in a Commission on Orphan Drugs.

Just before, or just after, I had arrived at DLA, the National Research Service Awards or NRSA's (now re-titled as the Ruth Kirschstein National Research Awards) were being authorized (or perhaps re-authorized). At that time I think the National Organ Transplant Act required the OD office of Medical Applications of Research (which was literally just down the hall from my office) to sponsor a conference on bone marrow transplantation for which our office provided assistance.

Legislation that also became law (PL 98-297) around the time when I first arrived at the DLA was the one that designated the former convent on the corner of the NIH property as the Mary Woodard Lasker Center for Health Research and Education.

Then sometime early on after my arrival, the Congress passed the Health Promotion and Disease Prevention Amendments to the Public Health Services Act (PL 98-551). While at NCHSR, I had been working with Congressional staff on these issues prior to my arrival at NIH, so I was in conversation with my contacts on the Hill providing input into the drafts of the bill that was working its way through development and conference. This was probably not exactly "approved' activity in the context I discussed earlier, but I was getting calls from Hill staff, many with whom I had developed close ties going as far back as my RWJ fellowship days, and I was not about to leave their calls unanswered.

This was also a somewhat "complicated" period for me, because when I had served in the Congress during my RWJ fellowship year, recalling our earlier conversations, I was involved in the legislative work surrounding the establishment of the National Center for Health Care Technology (NCHCT). Then, later I was a Departmental staff-person in the Deputy Assistant Secretary's office that had responsibility for the three National Centers (NCHS, NCGSR, NCHCT). Finally, a few years later, believe it or not, in 1981, I was among the Departmental staff assigned to close down the NCHCT when the Administration decided (on political grounds) to terminate the NCHCT. This decision was based on the close relationship of one man with the President of the United States and zeroed out the budget after just three years. In some ways this was a 'full-circle' Washington legislative and administrative experience, encapsulating—a bitter pill you might say—my early involvement at the Center's creation, but also participating as a pall-bearer at the Center's funeral. At the time I found this a frustrating and sad "Washington policy experience". For years, whenever I was teaching graduate students, it was, for them, a fascinating example of how the interactions and collisions between legislative policy and political reality can work and be part of one person's government career.

Around the middle of my tenure at DLA, say 1985 or 1986, there was PL 99-158, a massive piece of legislation that re-authorized, as I recall, the NIH Institutes and their major programs, and was also the vehicle for establishing several new components. This law, titled the "Health Research Extension Act of 1985" was one that really did occupy a great deal of attention and time for us. For the NIH, it really didn't get much bigger than that, and for DLA, this was the proverbial "all hands on deck" situation.

The new law was massive—something around eighty or more pages when printed in the Congressional Record—and contained numerous (and quite detailed) requirements for NIH advisory Councils; the responsibilities of the NIH director and the separate Institute directors; established a host of new positions, particularly in prevention; mandated a plan for developing laboratory animal research guidelines; focused attention on selected “orphan” and other diseases, and much more that is lost to my precise memory. There were also some highly politically charged, what you have called “hot potato" type items, included such as fetal tissue research and protection from scientific fraud. Oh, and the Act demanded numerous additional reports to Congress, many of which continue to be required (to uncertain reading) to this day I believe.

What I do recall was perhaps the broadest, most well-funded, and certainly most influential period of lobbying by disease and research groups that I had experienced up until that time. But the thing I well-remember was that the new law, through some re-organizing, also established new entities: the NIAMS, NIDDK, and the National Center for Nursing Research (now the National Institute for Nursing Research, NINR). The Congress opened up the NIH grab bag and they came!

Of these, another example of a “hot potato” you asked about Dr. Margolin, was the National Institute for Nursing Research (NINR). This was true both for the Department, which opposed the initial proposals, and for the NIH hierarchy, which was equally unhappy or of very mixed opinion about the creation of an institute dedicated to nursing research. As we talked about this during our earlier conversation, and I will not go back over it at this point except to say that I became very actively involved with the proponents of the new institute from the nursing community through the evolution (and the proposal carried in the somewhat earlier very influential report the Institute of Medicine of the National Academy of Sciences) and final adoption of the proposed organization from its initial designation as a "Center" through to the final realization of a Nursing Institute. But this also created some tensions and the potential (or the appearance of) conflicts, both personal and professional, for me.

All this made me somewhat uneasy due to the high regard in which I held for the nursing profession. I had previously worked alongside many wonderful folks in the nursing community both in New Haven, in the several community programs with which I had been associated, and at Yale when I was training in Public Health and as Assistant Dean of the Medical School. I had long held one particular nursing activity, the Frontier Nursing Service in Appalachia, in very high esteem. And I had two close associates at Yale, the Dean of Nursing, and a well-known professor of Hospital Administration at the School of Public Health, also a nurse. Finally, throughout my career, as a member of the American Public Health Association, and serving on many its committees, nurses were constant allies on public health matters. Enough said.

The few years we spent on the coming of the Nursing Center (later Institute) to NIH became a very important learning experience for me. It taught me about performing a role (and one, I think, to which lawyers are accustomed) requiring me to represent a client that has and requires acting on different values than I myself held. I believed firmly that it was more than time to recognize and institutionalize nursing research at NIH, but my employer did not.

Thankfully, however, given the persistence of many individual nurses, and their professional and academic organizations, in working with, pushing (badgering), and testifying before the Congress, the Center finally came to into existence.

The second lesson was essentially akin to the one I had learned in the Army: "Hurry up and wait." The initial effort to establish the Nursing Center had taken some time, but it finally happened, and Doris Merritt, M.D. was appointed acting director for a period. Then, about a year later the DHHS directed the "establishment" of the NINR, and Dr. Ada Sue Hinshaw became the first full time director.

Then came a series of government budget leveling and cut-back measures known as "Gramm-Rudman-Hollings".(PL 99-177) Over the next few years, NIH had to learn about managing reduced appropriations and the impact that these changes had on both the campus intramural research activities, and perhaps of much greater national visibility, reductions in the resources for grants made to university research programs across the country. It was a pretty painful period, and the monitoring of appropriations was critical and never-ending, provoking much scrutiny of the whole process. At that time, attending the various Institute Scientific Council meetings and reporting on the status of appropriations, along with the reports presented by the NIH Budget Office, became pretty depressing responsibilities. The concerns about the status of extramural grant funding, and the "Pay Line" in NIH jargon, was all-consuming.

I think I must briefly mention the Congressional recognition of the NIH Centennial Year running from October 1986 though September 1987. I became quite actively involved with preparation for, and activities of, the Centennial celebration, as I previously discussed, serving on the NIH Centennial Committee headed by program director Bonnie Kalberer. This involved two distinct roles, first in working with Congress on the preparation of the Congressional Joint Resolution acknowledging the celebration (PL 99-489) and as an OD staff member working with many wonderful folks on campus and beyond—historians, engineers, glass blowers and others—in creating the Centennial "atomic clock", preparing a time capsule for the next 100 year celebration, and more.

Two final bills I'll mention which I think fell into my time and tenure at DLA were, first, the Federal Technology Transfer Act Stevenson-Wydler amendments (PL 99-502) which authorized collaborative R&D agreements with universities and established royalty-sharing agreements for the inventions of NIH scientists. The second was the Alzheimer's Disease and Related Dementias Services Research Act (PL 99-660) of 1986. Little did I know how important that would become for me!

GM: What do you mean? Can you expand on that?

SK: Well, the Act, I recall, after the earlier PL 98-158, which focused on expansion of research on Alzheimer's Disease, contained major authorizations to NIH components, in particular the NIA and the NIMH, to take the lead in funding research related to Alzheimer's Disease (AD). The Act also directed the creation of the Secretary's Advisory Council on Alzheimer's Disease. The NIA was also directed to create public information programs that were important mechanisms for public education and scientific information transfer. The DLA became involved in meetings having to do with interpretation of the Act, working with the relevant NIH institutes such as NIA, NIMH, NINDS, NIGMS and others involved with AD research activities.

If you remain in government long enough, things often come back to find—or haunt—you. A few years later (1988 and beyond), sometime after leaving DLA, when I had moved to NIA as associate director, Alzheimer's Disease research grew to become a central activity of the Institute, engaging major components of the Institute's intramural and extramural programs, and ultimately consuming upwards of half of the NIA budget as I recall. I also served as the Executive Secretary to the DHHS Alzheimer's Advisory panel on Alzheimer's and Related Disorders. So, along with the other aging-related research topics, Alzheimer's-related issues loomed large in the NIA planning, analysis, and legislative portfolio.

Another example, coming somewhat later on in the 1990's, was my service as executive secretary of the U.S. Japan Commission on Aging.

Has this covered most of what you wanted to discuss regarding specific legislative developments NIH during my time as DLA Director?

GM: Yes, I think you have covered a lot of ground which has helped us to better understand the legislative function at NIH. Is there anything else you would like to add about the overall process or about the DLA you haven't touched on?

SK: As a summing up, I think it might be worthwhile to chat about a few things that I believe had an impact on the NIH legislative function and end with some general thoughts.

First, an observation born of experience: Almost whenever there is interest expressed by a member of Congress or their staff, the Department, an Institute Director, or an outside interest group in re-visiting, possibly abolishing or amending statutes, and, in particular, the basic legislative authorities for the NIH, there is the potential for serious and non-trivial alterations, mistakes, and just plain mischief. These large (and sometimes the smaller) legislative undertakings almost always become more politicized, complex, time-consuming, and mistake-prone than had been contemplated at the outset.

Recognizing that meeting new opportunities and challenges in health research is an important goal, and that making change (progress) depends on this often complex and unwieldy (and to me fascinating) process, be aware that frustrations abound. At some point we humorously adopted the mantra: "Never open up the Public Health Service Act" (the general powers of the Public Health Service going all the way back to 1944), as a way of expressing wariness about unintended consequences and worse.

I have tried to leave you with a sense of the history and function, but I really cannot do justice to the unique legislative cultural, language, and pace of work found in the DLA office. Add to this the relatively high public visibility attendant to Congressional activity, and it all adds up to something not usually found elsewhere at NIH. This sometimes led to clashes with the scientists in their laboratories—who were accustomed to a less frenetic pace—who sometimes felt that we were intrusive or combative. But tensions did arise. We tried our best, and were very respectful of their work, but the deadline pressures imposed by the Office of the Secretary, the White House, the Congress, and the press (literal deadlines in their case) were sometimes very difficult to meet without pushing people to the limits of their tolerance. Cultural clash.

And as is occasionally the case in every work environment, sometimes relatively petty things just drove us crazy. Especially vexing were the deadlines imposed on us by the Department for the numerous and never-ending Congressionally-mandated reports that were required year-after-year, or the deadlines which attended certain activities. Year after year, some of us were never able to go home early the evening before Thanksgiving as the budget submission deadline was always due "close of business" that afternoon. Then there were the infamous "close of business" requirements for reports and drafts of material to be delivered to the Office of the Secretary in downtown D.C. by 5:00PM on Friday. We finally responded to these demands by telling the requestor that we'd happy to do as they requested IF they would be there to receive it. Remember, much of our work was undertaken in the "Olden Days" before the active use of the internet or the availability of Metro, and messenger and hand-carried deliveries were common (I assume that seldom happens nowadays).

A larger question or issue that is raised by much of what I have described is the "Who runs the NIH?" question. There have been periods when this is mostly felt as a fairly light undercurrent. It has long been the topic of conjecture and mostly academic and administrative debate, but at times it has risen to quite intense, heated, and quite visible tensions between the Department and the Congress, with NIH directors and others caught up in the struggle. I know that might sound overly dramatic, but you only need to look at the numerous articles in then-contemporary scientific press and the news to get a feel for the relatively high drama. Pending legislation, possibly creating several new institutes and many new authorities for the NIH, pull the various participants in several competing directions.

The most senior members of Congress who chaired the major committees of relevant jurisdiction (Senator Orrin Hatch, Congressman Henry Waxman, and others), as well as very influential citizens (Mary Lasker) were deeply involved in the struggle. What seemed like the appropriate assertion of Congressional authority to some was labeled unjustified micro-management by others, and the give-and-take led to veto threats and great uncertainty for those of us charged with ultimate implementation of whatever resulted. There was a real period of turmoil that finally ended with the passage of the legislation I described earlier. It was, indeed, a real-time demonstration of the old adage: "Laws are like sausages. It is better to not seeing them being made."

Thus, as I have suggested, there was a mostly subtle, but sometimes real, potential for a "clash of cultures" as we did our work. To some degree, this mirrors, in a much smaller environment, the tensions that are inherent and exist between the three branches of government at the highest levels. As people who have worked there know, the NIH is a place full of tensions that are generally healthy, but sometimes less so, between the Institutes, generally due to competing budgets, and between laboratories and individual scientists. The DLA was occasionally caught between, and less frequently (I hope) a source of this tension in our relatively small way. We did our best. And there are stories here for another time.

Perhaps we should pause at this point. There is, of course, more, and I will inevitably think of things I have missed just after we conclude. But this will probably suffice to answer many of the questions you have posed and leave an impression of the impact that legislative activity and the role of the DLA had in the 1980's.

GM: Later you moved on to National Institute on Aging (NIA). What caused that to happen? Also to the Substance Abuse and Mental Health Services Administration (SAMHSA)? I do not see the connections here.

SK: After several years at DLA, I began wondering if there might be an opportunity to engage in a more hands-on health research-related position at NIH. I really felt that, although the DLA position was very rewarding. But, for sure, the intensity of the legislative role took a toll. As I have suggested, it was—and remains—a very different place in the NIH environment. During this period, I had developed a vague feeling that I wanted to be engaged in activities more directly tied to my research interests.

As I was pondering the options, and mentioning these feelings informally to my colleagues, then-director of the National Institute on Aging (NIA), Franklin Williams, M.D. asked me if I would consider developing (and assuming) a new associate director position at NIA with a very wide array of responsibilities (legislative, planning and evaluation, policy development, communications, etc.) that were not previously consolidated into a single office. Ultimately, I agreed to assume the role, and my SES position was transferred from the NIH OD to the NIA.

GM: You served as NIA associate director from June 1987 to August 2003, when you retired. During that time (July 1989–July 1990) you also were acting associate director of NIA's Epidemiology, Demography, and Biometry Program (EDB).

SK: Yes. During the course of my several years at NIA, I was asked to fill in other roles and positions, such as the EDB and SAMHSA assignments that we can discuss.

As such, I was "acting" in the position of director at EDB while simultaneously holding my "regular" associate NIA director role. I covered several bases. In this "temporary" position I was responsible for a large Intramural epidemiology research staff with numerous ongoing aging-related research studies (domestic and foreign) in progress. I was able to return to my duties once we recruited a new EDB director. We did successfully recruit a wonderful new full-time director and I was able to go back to my original, and primary responsibilities.

I believe that among other accomplishments, the recommendations and ultimately securing project funding for the Older Women's Health Study and several other women's aging research projects were among the most important achievements of the time. Recall that up until the 1980's, women were under-represented in not only aging-related research but in most health research such as clinical trials, health surveys and clinical applications.

GM: From February 1997 to August 2003, you were also senior advisor to the SAMHSA Office of Applied Studies (OAS). What were some of your key accomplishments in these areas?

SK: My assignment to the SAMHSA OAS was on a "Senior Executive Service Detail" from NIH at the request of an old friend and colleague (Dr. Donald Goldstone, the former deputy director of the National Center for Health Services Research, who was director of the Office of Applied Studies at SAMHSA) to consolidate and coordinate several small studies and the individual research activities of several researchers, as well as establish an OAS "Fellowship" program to interest and recruit young post-doctoral scientists to the field of substance abuse research (smoking and health, substance use in older persons, etc.). We had recruited about five to seven Fellows in a few years, each of whom produced numerous peer-reviewed journal articles. This was my final position at NIH (albeit on detail) before my retirement from NIH in 2003.

GM: This was not a surprising, considering you had spent 39 years in federal service. So, you retired from federal service and accepted a position as senior advisor to Aging Studies at the Westat Research Corp., located in Rockville, MD from 2003 to 2020.

SK: Yes. I went on to serve seven years at Westat, a large local survey research firm with numerous federal contracts across many areas such as health, education, defense, transportation, etc. I served as senior advisor for aging-related research, developed proposals for contract funding, and was a participant in several research studies. The last major project was the "NIH TOOLBOX", an NIH-funded tool for NIH grantee researchers across the country to access and utilize pre-approved (“normed” and “vetted”) survey research designs, tools and methods, survey designs and questionnaires for use in their NIH-funded research, saving time and money.

GM: Your professional life, in addition to your Peace Corps and military experience, was quite remarkable: working in New Haven at Yale, in Washington with the federal government and in Maryland at NIH. You started out in epidemiology as a grad student, expanded beyond public health into demography, federal census activity, federal program administration at the local and national levels, and ultimately segued into medical school administration. At NIH, you held several leadership positions and even in your retirement you’re working in the private sector advising on studies of the aging population. There is a thread here somewhere. Can you tie all of these endeavors into a single system and comment on the “Serendipity Model" of your life?

SK: A single system or thread? Hah! More like a tangled web. Well, maybe one thing. Thinking back through my career, and certainly subsequent to my academic introduction to public health and adoption of epidemiology as a way of participating in research projects, I have always asked the "Who, What, When, Where, How, and Why?" questions in assessing problems and issues. I still do. Of course, these six questions are also relevant to all manner of health and social research, and numerous other professions such as journalism, and literature (such as detective novels), and criminology, industry and more. Asking and answering these questions has served me well, as a research, management, and "life" tool.

I don't know. It is certainly hard to determine exactly how the various strands have been woven into the career that we have talked about. And it is beyond important to credit all the family, colleagues, and other individual and social impacts that undoubtedly played a part. Indeed, I look back and realize how incredibly fortunate I have been. Given my international exposure to multiple cultures and religious practices, perhaps much of this "serendipity" is better ascribed to, or described and accepted as, Karma.

I have been absolutely blessed with role models and colleagues—both women and men—all along the way. Timing was important, certainly. Never discount “right time, right place.” Some diligence and application—I guess. There is luck—for sure. If you are looking for any guiding principle, insight, or vision... I'm not sure if there has been a well-planned "theme" or script to it all.

GM: Would you agree with my assessment that your multiple positions were all joined so that moving through them, broadening your exposure at each site, led to your multiple contributions and to the outstanding legacy you have left behind?

SK: I suppose, but I am still uncomfortable attributing my career path to any single thing. Perhaps it is less complicated when considered retrospectively, but I was certainly much less conscious of that simplicity at the time.

GM: Thank you for sharing your historical overview, the details and examples of the DLA legislative responsibilities, and your personal story with us.