Cornelius L. Hopper


Interviews conducted by
Germaine LaBerge
in 2002

Copyright © 2016 by The Regents of the University of California
Since 1954 the Oral History Center of the Bancroft Library, formerly the Regional Oral History Office, has been interviewing leading participants in or well-placed witnesses to major events in the development of Northern California, the West, and the nation. Oral History is a method of collecting historical information through tape-recorded interviews between a narrator with firsthand knowledge of historically significant events and a well-informed interviewer, with the goal of preserving substantive additions to the historical record. The tape recording is transcribed, lightly edited for continuity and clarity, and reviewed by the interviewee. The corrected manuscript is bound with photographs and illustrative materials and placed in The Bancroft Library at the University of California, Berkeley, and in other research collections for scholarly use. Because it is primary material, oral history is not intended to present the final, verified, or complete narrative of events. It is a spoken account, offered by the interviewee in response to questioning, and as such it is reflective, partisan, deeply involved, and irreplaceable.

All uses of this manuscript are covered by a legal agreement between The Regents of the University of California and Cornelius L. Hopper dated August 27, 2015. The manuscript is thereby made available for research purposes. All literary rights in the manuscript, including the right to publish, are reserved to The Bancroft Library of the University of California, Berkeley. Excerpts up to 1000 words from this interview may be quoted for publication without seeking permission as long as the use is non-commercial and properly cited.

Requests for permission to quote for publication should be addressed to The Bancroft Library, Head of Public Services, Mail Code 6000, University of California, Berkeley, 94720-6000, and should follow instructions available online at http://bancroft.berkeley.edu/ROHO/collections/cite.html

It is recommended that this oral history be cited as follows:

Dr. Cornelius L. Hopper, circa 1978
Photo by Kirwan Berkeley
Cornelius L. Hopper, M.D. is the Emeritus Vice President for Health Affairs for the University of California System. Born in Oklahoma, Dr. Hopper received his AB and MD degrees, respectively, from Ohio University in Athens, Ohio, and the University of Cincinnati College of Medicine. He served as a Battalion Surgeon in the Marines from 1961 to 1963. Later, Dr. Hopper trained in Internal Medicine at Marquette University and subsequently Neurology at the University of Wisconsin, Madison, where he remained on the Neurology faculty until 1971. In 1971 Dr. Hopper accepted the directorship of the John A. Andrew Memorial Hospital at Tuskegee Institute in Alabama and an appointment as the Institute’s Vice President for Health Affairs. In 1979 Dr. Hopper was recruited to the University of California System as Special Assistant for Health Affairs to the University’s President and in 1983 was promoted to Vice President. For twenty years, until his retirement in 2000, he served as the senior administrative officer for the nation’s largest university health sciences system, encompassing fourteen health professions schools on six campuses, an enrollment of thirteen thousand students, and a budget of over $3 billion. Dr. Hopper and his wife Barbara have been married for over 50 years, and have three children.
Table of Contents—Cornelius Hopper, M.D.

Interview 1: January 10, 2002

Tape 1, Side A

CHILDHOOD, FAMILY BACKGROUND, AND EDUCATION

Parents and Grandparents — Extended Family in Oklahoma — Segregated Schools — Schools in California and Florida

Tape 1, Side B

Leaving Home for Milford, Ohio, Age 16 — Influences on College Decision — Ohio University: Jobs, Influences, Racial Considerations — Work at Emergency Room, Cincinnati General Hospital — Cross Country Travels with Dad

Interview 2: January 23, 2002

Tape 2, Side A

Firsthand Encounters with Segregation and Church Influence — Retrospective on the Busyness of Life — Formative Years: Music Lessons; Community

Tape 2, Side B

UNIVERSITY OF CINCINNATI MEDICAL SCHOOL, INTERNSHIP, AND RESIDENCY AT MARQUETTE UNIVERSITY AND UNIVERSITY OF WISCONSIN

Jobs and Housing — Experience as the Third Black Graduate — Carryover Abilities to Health Affairs Jobs — Meeting Barbara Johnson

Interview 3: February 8, 2002

Tape 3, Side A

Internship at Marquette University — Military Service: Battalion Surgeon in Fourth Marines, Hawaii — Residency in Neurology at Marquette and UW, Madison — Multiple Sclerosis Clinics during Revolutionary Times

Tape 3, Side B is blank

Tape 4, Side A

Civil Rights Movement, 1960s — Black Studies Department — Multiple Sclerosis Clinics Throughout Wisconsin
Tape 4, Side B

More on Neurology — More on Civil Rights Discussions/Activity at Wisconsin —
Family — Discrimination

TUSKEGEE INSTITUTE, 1971-1979

History, 1882 — Booker T. Washington

Tape 5, Side A

Tuskegee’s Funding — Culture of Service

Tape 5, Side B is blank

Interview 4: June 19, 2002

Tape 6, Side A

Veteran’s Administration Hospital at Tuskegee — Issues Faced at John A. Andrew
Hospital — Area Health Education Centers (AHEC) — Nurse Practitioners and the
Mobile Team

Tape 6, Side B

Community Health Workers — Closing the Hospital; Beginning School of Allied Health
— Mount Bayou, Mississippi — Work in West Africa — Health Care in Rural
Communities; Local Politics of Tuskegee

Tape 7, Side A

Closing of Tuskegee’s White Hospital — Dealings with the Alabama Legislature —
Owner of Radio Station — Tuskegee Laboratory and Learning Center — Heritage Hills
Housing and Capricorn Apartments

Tape 7, Side B is blank

Interview 5: June 24, 2002

Tape 8, Side A

Importance of John A. Andrew Hospital to Black Patients in Rural Alabama —
Historically Black Colleges — Desegregation of Health Care Facilities — Segregation of
County Medical Societies

Tape 8, Side B

Disparity in Health Care
UNIVERSITY OF CALIFORNIA, 1979-1999

Decision — Health Sciences Committee — Hospital Directors’ Council and Regents’ Meetings

Tape 9, Side A

More on Health Sciences Committee Service

Tape 9, Side B is blank

Interview 6: July 23, 2002

Tape 10, Side A

Problems Similar to Tuskegee: Poor/Indigent Patients — Family Medicine and AHECs — More on Advisory Groups in the Health Sciences — Research Programs: AIDS, Breast Cancer, Tobacco, Geriatrics — Occupational Health Centers: Stringfellow Acid Pits

Tape 10, Side B

Function of Office of Health Affairs — The NIH Model for Research — Student Health Centers at Tuskegee and UC — More on UC Health Committees

Tape 11, Side A

More on UC Health Committees —

Tape 11, Side B

Interview 7: September 5, 2002

Disc 12

Strategic Planning Team for the Health Sciences — Clinical Activities, Budgets, Academic Planning — Family Practice Divisions — Memorandum of Understanding with Office of State Health Planning and Development, 1990s — Graduate Medical Education National Advisory Committee — Committee Membership — Medical School Council of Chancellors; Health Sciences Deans — More on AHECs at UC — Regents’ Committee on Hospital Governance — Reorganization of the Clinical Compensation Plan — Changing Directions in Medical Education

RETIREMENT ACTIVITIES
Interview 8: September 17, 2002

Disc 13

Report on State Schools of Medicine — Review of Charles Drew School of Medicine — Work in the Soviet Union, USAID and AIHA — Health Manpower Policy Commissioner — East Bay Community Foundation; Samuel Merritt College Board of Regents — Kaiser Arbitration Oversight Board — Ethnic Health Institute — Church By the Side of the Road and Other Community Groups

Interview 9: October 14, 2002

Tape 14, Side A

Commission for the Control of Epilepsy and Its Consequences — National Professional Standards Review Council — Tuskegee Syphilis Study

Tape 14, Side B

More on the Study and Its Aftermath — American Public Health Association — Work in West Africa — Affirmative Action — Regent Ward Connerly and the Cooks — Presentation to Regents on Medical School Admissions — Answering Mr. Connerly on Fairness Issue

Tape 15, Side A

SP 1 and 2 — Special Report on Medical School Diversity — Increase in Primary Care Training

Tape 15, Side B is blank

Interview 10: October 22, 2002

Disc 16

Special Research Programs — Continued Involvement with Established Programs — The University as a Sanctuary for Social Justice Principles

[End of Interview]
Interview History — Cornelius Hopper, M.D.

Dr. Cornelius L. Hopper came to the University of California in 1979 as special assistant to President David Saxon for health affairs. He became Vice President for Health Affairs in 1983 and by his retirement in 1999, had been the longest-serving vice president of the university.

The Regional Oral History Office (ROHO) tape recorded one interview with Dr. Hopper in 1997 for the University History Series, focusing on the Office of the President. It became obvious to this interviewer that the richness of his life experience warranted a full-life oral history. President Richard Atkinson agreed and provided the necessary funds as a retirement gift to Cornelius Hopper.

We recorded ten interviews between January and October 2002 in a conference room at The Bancroft Library. Unlike many of us, Dr. Hopper speaks in complete sentences, softly, clearly. He arrived at each session fully prepared for the topic at hand and gave the interviewer copies of reports, letters, meetings (most of which are deposited in The Bancroft Library with this volume). His story begins in Hartshorne, Oklahoma, the only son of a minister. People in his father’s church community recognized his extraordinary abilities, and encouraged the furtherance of his education. In the interview which follows, Hopper pinpoints his early interest in medicine, his choice of the University of Ohio and the University of Cincinnati Medical School, one of a very few black students in his graduating class. At the University of Wisconsin, he was one of the founders of the African-American Studies Department. He talks about his coming-of-age during the civil rights movement of the 1960s and recounts the various types of discrimination he encountered throughout his life. He chose neurology as his specialty, taught at the University of Wisconsin Medical School, and treated multiple sclerosis patients in the region before being lured to Tuskegee Institute.

His move to Tuskegee’s John A. Andrew Health Center was significant; he set up health care centers throughout rural Alabama, and saw real progress for his efforts. He recounted the history of the historically black colleges, and their unique contribution to American life. Dr. Hopper continues his advocacy of adequate health care for blacks particularly, emphasizing the subtle and not-so-subtle types of discrimination people encounter.

He describes his initial reaction to the invitation from UC’s Office of the President. Did they need to have a diverse pool or were they truly interested in him? It was a difficult decision. His wife Barbara had a booming real estate practice in Tuskegee, the three children were settled, did they really want to move to California? Where could they best make a contribution? Did he want to give up medical practice to become an administrator?

Vice President Hopper discusses the health sciences at the university systemwide, including the hospitals; the dental, nursing, and medical schools; funding for AIDS, breast cancer, and other research. He also talks about the workings of the Office of the President, the Council of Chancellors, and the Academic Council.

The tapes were transcribed at ROHO, lightly edited, and sent to Dr. Hopper for approval. He was at first shocked how the spoken word translates to the written, but with assurances from the
editor, he plunged into the editing process. He returned the transcript to ROHO with very few corrections.

He and Barbara are active parishioners at the Church by the Side of the Road in Berkeley. Dr. Hopper remains active on many boards, including Samuel Merritt College, the East Bay Community Foundation, the California Family Health Council, the National Epilepsy Council, and international groups too many to mention, as many people seek his wisdom and medical expertise. He has received awards from alma maters and other distinguished institutions. He writes poetry. He voices opposition to the recent trend of weakening affirmative action in California, writing a special report on Medical Student Diversity in 2000. He is a Renaissance man, one whom this interviewer is very grateful to have encountered through this oral history.

Germaine LaBerge, Interviewer
Regional Oral History Office
Berkeley, California
December 2004
LaBerge: Well, we always like to start at the beginning. I know you were born in Oklahoma, but why don’t you give me the circumstances?

Hopper: Yes. Okay. I was born in 1934 kind of in the middle of the Depression.

LaBerge: What’s the actual date?

Hopper: August 30th, 1934. I was born in a town called Hartshorne, which was and is a very small town in eastern Oklahoma near the Arkansas border. A small farming, ranching and mining town. I think it probably got its distinction from the fact that it was about fourteen miles from McAlester, Oklahoma, which is the home of the state penitentiary. During the years as I have tried to tell people where I’m from, even people from Oklahoma said, “Hartshorne?” I said, “Well you do know where McAlester is? You know where all of your not well appreciated citizens were sent off to spend a few years?” I was born in the same room that my mother had been born in, in a—

LaBerge: At home?

Hopper: Yes, at home. I don’t know all the circumstances surrounding that. But I suspect that an awful lot of the births at that time were at home by midwives. This was in the home that was owned by my maternal great grandmother and grandfather who had come originally from Alabama and who had migrated over from Alabama following slavery. Back as I understand it during those times, a long, long time ago, back in the 1800s this was part of the migration of Indians and blacks into the Oklahoma Territory. But very interesting history. But in any event I said I was born in the same room that my mother had been born in. My mother was seventeen when I was born. My father was I think around twenty-two or so.

LaBerge: What were their names?

Hopper: Father was named Claude Hopper and my mother’s name was Hazel and her maiden name was Pugh. As I said it was the middle of the Depression, and it was very difficult, as I understand it to get work at that point in time. So when I was three years old, my dad who always was a real go-getter moved the family to Kansas City—

LaBerge: Kansas City, Missouri or—
Hopper: Well, I think it was Kansas City, Kansas, but I’m not a hundred percent sure. No, I think it was Kansas City, Missouri, now that you mention it. Of course I remember none of that at all. My first memories are in Kansas City playing in a rain puddle walking around in and getting a spanking because of it. While in Kansas City my father became associated with or met and became associated with some ministers from a small religious organization, a Holiness church and became very much associated with it and very enamored with it and went on. By the early forties he had become a lay minister, and we had moved to Baltimore, Maryland. I’ve lived all over the country.

LaBerge: I knew that.

Hopper: As you’ll find out.

LaBerge: Before we go to that moving, what did he do before that?

Hopper: In Oklahoma he worked in the coal mines. I think he had a seventh grade education, and my mother only had a sixth grade education and he had to work from the very beginning.

LaBerge: I guess I didn’t realize there were coal mines in Oklahoma.

Hopper: Oh yes. Oh yes. You think of Oklahoma as having a lot of gas and oil. That’s another story because years later it turns out that my paternal grandmother inherited or somehow came into possession of land on which the Kerr Company operated. Often they took out a lot of oil and I got the magnificent royalties of about ten dollars a year even now, down from my father’s side on that. But in any event by the time we moved to Baltimore, which I think would’ve been around 1940 or ‘41, he was a junior minister in the church.

LaBerge: Is that what he did for his job or—

Hopper: No. This was during the war and what he did really was become a cement finisher. He did his ministering, his preaching, kind of on the side but was a superb cement finisher. As a matter of fact, he kept his union license, and it carried him through the years. But in any event in Baltimore he became pastor of a number of about three small churches around Maryland, and that’s where I remember going to school.

LaBerge: In Maryland.

Hopper: In Maryland, in Baltimore.

LaBerge: Let’s go back to your forbearers. What do you remember or what do you know about for instance your maternal grandparents and their story?
Hopper: Yes. My maternal great grandmother, Ma Crout we called her, who is my mother’s grandmother, as I said they—she and her husband, we always called him Pa Crout, and I have absolutely no idea what his real name was.

LaBerge: Was Crout their last name?

Hopper: Crout was their last name. That was his last name and of course her last name. The story within the family is of course that they migrated over from northern Alabama sometime following the Civil War.

LaBerge: So had they been slaves?

Hopper: No. No. They had not been slaves although my—I’m not so sure because there were stories that my great grandmother in fact had to plow in the fields in her bare feet back during the time that they were in Alabama. But I know very little about it and one of the tasks that my kids have charged me with in addition to going ahead and doing this thing that we’re doing now is in fact to go down and try to research some of that. Now my dad’s mother—I don’t know anything about my dad’s father—but my dad’s mother grew up either on or next to an Indian reservation, a Choctaw Indian reservation. Even though she’s African American when I first met her, my Grandma Susan, which would’ve been in around 1943 or ’44, she spoke Choctaw fluently. When she would get angry at any of the grandkids, she’d forget her English, and she would be after them in the Choctaw language. We didn’t know what she was talking about. But we understood the switch though. So I know very little about that side of the family except that she had five boys and one girl. So my father had four brothers and one sister, and they were all extremely close, strikingly handsome people. If you see picture of them, they look like they could’ve been movie stars.

To leap frog ahead, when I came here in ’79, shortly thereafter, I met the wife of one of my father’s brothers. He had died, not my father but the brother had died. Her name was Jean Carney. She worked for UC Berkeley for many, many years.

LaBerge: Oh really.

Hopper: Right. And I don’t know where she worked here on campus, but by that time she had retired. So that part of the family had migrated out here years and years ago. But anyway getting back to Oklahoma again. Again being born in the Depression and with things being very, very difficult my father tells the stories about how his mother, my grandmother, the one who spoke Choctaw was extremely enterprising. She could shoot, she could take a rifle and reportedly hit an incredibly small target from like three hundred yards away, and that’s how she fed the family hunting.

LaBerge: She raised—
Hopper: She raised—

LaBerge: The family on her own.

Hopper: The family on her own, absolutely.

LaBerge: Her name was Susan, Susan Hopper?

Hopper: Susan Lewis. Susan Lewis.

LaBerge: Did both of your parents grow up in Oklahoma?

Hopper: Yes, they both grew up in Oklahoma. Right.

LaBerge: Do you know how they met?

Hopper: All I know is the story that was told by my mother’s sister, who I had a chance to meet in the forties, I’ll get back to that soon because when we left Maryland, my dad was sent to open some churches out in the West, and we stopped in Oklahoma for my mom and I for about a year and a half. I met members of the family that I had never met before. But I’m sorry I missed my— [tape interruption]

LaBerge: How your parents met.

Hopper: Oh yes. Right. Right. So my Aunt Mary, my mother’s sister, said that my dad who was an incredible horse rider, that he came riding into town with his spurs and his saddle, a handsome young man and took a liking to my mother. After about eight months or so then they got married. So she was married at age sixteen, and I was born a year later. She was seventeen years old.

LaBerge: Do you have brothers and sisters?

Hopper: Yes. I have one half brother that’s my dad’s son, Charles who did come to live with us years later in Arizona. He’s dead now. But no brothers and sisters in my immediate family.

LaBerge: What else do you know about the whole family background that we don’t want to forget?

Hopper: Not very much. That’s why again as I said my kids—

LaBerge: Want you to—

Hopper: Want me really to, they said I’m the only one right now that has the time to do it, they assume, to go back and really research that more. I do know that my dad’s brothers as I said they were tremendously striking looking men who all
in their own way were very successful, not in business and that, but in terms of raising families with very, very strong family values. I met my Uncle Joe when I went back to Hartshorne back in the early forties.

LaBerge: Why don’t you talk about them, their names and what they did?

Hopper: Yes. Uncle Joe, he was a farmer. He stayed on the same land that my grandmother his mother, Grandma Lewis, lived on and kind of took care of her. He farmed, and he also was a handyman. I understand he was a good carpenter. He did painting. He did a number of things like this. But I remember mainly the farming part. He grew corn, and in retrospect that part of Oklahoma is really kind of hard scrabble land. When you’re a kid, you always remember things as being lush and green and so forth. But in subsequent years I came to understand that it had been land that had pretty much been farmed out. But again I think the connection with the Indian grants that occurred back when the Oklahoma Territory was opened up was that somehow that land had passed down to my grandmother. Of course over time as you went through generations it got parceled out, but for one point in time I guess it was a fairly substantial amount of land.

Now back at that time, back in the thirties and forties, as I understand it, the land had really not been explored for oil and gas then. That was something that occurred subsequently. But I do know it was a hard life. I mean I do know that for example my dad went to work in the coal mines there at an early age, which is why he was only able to go to the seventh grade. When he eventually died, he died of anthracosis, which is a disease of the lung. They call it coal miner’s lung. He had very, very severe asthma and lung problems throughout his life. But this was not something that he sat and dwelled on an awful lot. He was always a very forward looking person who once he became associated with the church, I mean there was two things. One was building a construction business or a cement finishing business on the one hand, and then using the funds from that to really support his church work. So we were never wealthy or well off although when you’re a kid you don’t really realize that sort of thing because so much of what he actually made, he invested in his church work.

But it may be that at a later time in all this I will be able to pull some additional memories, I have moved my mother out here with me now from Florida where she had lived for many, many years. She fell and broke her arm last year, and I have been trying to get her out here for the last ten years or so. I said that we were teasing that that’s the only way we ultimately got her out here. But unfortunately her memory of those Oklahoma years is really very, very poor. She’s reached, she’s eighty-four going on eighty-five right now. She had trouble remembering Aunt Jean and some of Aunt Jean’s kids. Aunt Jean being the one who worked here at UC Berkeley. So I am going to actually have to go to some of the courthouse records and do that sort of thing to trace some of this. Of course I’m interested in some of the same things that
you’re asking at this point in time. My own philosophy is that (we won’t get into that right now), but I don’t think that sort of thing is so critically important unless it’s important to my kids. The kids really want to know those things, like who am I? Where did I come from? What was that all about? I want to do that work for them because they have very little sense of what we went through as African Americans in this country at that point in time, which on the one hand is good that they are not subjected to all of that. But at the same time it does kind of generate a kind of wistful feeling that they don’t, they can’t really connect with what it was like, for example in going back and forth across the country and the South and not being able to go to bathrooms and so on. But we’ll talk about that too.

So again I’ll try to fill in some of the blanks about Oklahoma. Maybe as we go through this part of time. But going back to Baltimore, which is where I went my first couple of years in grammar school. The biggest thing I remember, I remember living on Leadenhall Street. My national fraternity had a meeting in Baltimore—oh, God, maybe about five years or so ago. I hadn’t been back since, and I remember trying to find Leadenhall Street, and I couldn’t find it. But there were some of the old timers there said, “Oh yeah, that was down there.” I got hit by—the other thing I remember about Baltimore is I got hit by a taxicab and was unconscious for a couple of days or so.

LaBerge: As a child.

Hopper: As a child in Baltimore and had a big lump on the back of my head and even now have a little bald spot back there from that. But in any event my dad was tremendously successful in this small church and kept being given promotions. Ultimately the senior bishop asked him to go out West and see about establishing some missions there, and so we left, in it was either ’42 or ’43 because I think in 1943 that was the year I spent back at home in Hartshorne, Oklahoma.

LaBerge: With your mom.

Hopper: With my mom, and I actually went to school at the same school that my mom had gone to, so that and this is a small community and actually I remember meeting the principal who was kind of a historic figure. It was Professor Hankins they called him, and he was still there, and he was still teaching. I met a number of my cousins on my mother’s side because that was a big family. That was a huge family. I met a number of them, and that was the year that I did something with barbed wire and cut my face, and I remember being taken to this doctor. I guess it was on a Sunday morning, and I remember thinking this guy smells like alcohol. So here I’m getting sewed up by this country doctor who wasn’t African American. He was not too happy in retrospect about being called out. But he did go to his office and sew me up. We were there for a year, and then we joined my dad. By that time he had
gone to Phoenix, Arizona, and had a job as a cement finisher and had already started to make some contacts in terms of trying to get a mission started.

LaBerge: What was the name of, what type of church?

Hopper: It’s a Holiness church.

LaBerge: It’s called Holiness.

Hopper: Holiness.

LaBerge: What kind of—how much involvement did you and your mom have in the church?

Hopper: Well, we were members because he was.

LaBerge: So did that mean he was in church all day Sunday?

Hopper: Yeah. Sunday morning and Sunday evening and then occasionally during the week like on Wednesday evenings. So it was fairly intensive. It’s an experience that had a great deal to do with who I am and my own life in a very positive way.

LaBerge: Do you want to say more about that?

Hopper: Oh, I’ll say a lot about that as we go on. But I’m just saying that the sense of extended family that you have—remember this is back in the early forties. As he got the churches there started and as people started to join a lot of them were migrant farmworkers who had come from Arkansas and as I think back on it again we were all kind of struggling. They were. They were working in migrant farm camps because Arizona has a lot of cotton, had a lot of cotton. I don’t know about now. I used to shine shoes because there was an Air Force base at Litchfield, Arizona. It was either Litchfield Air Force Base or Litchfield, Arizona. The officers would come into downtown Phoenix, and I had a little shoe shine box, and I made a lot of money. I made a lot of money during those years. Although that would’ve been more like ‘46, around ‘45, ‘46 or so, because I was a little older. I imagine I would’ve been probably about twelve or thirteen when I was doing that.

LaBerge: Let’s go back to schools you went to and what those were like, maybe starting with in Baltimore.

Hopper: In Baltimore I went to—

LaBerge: With public elementary—

Hopper: Public elementary school.
LaBerge: Segregated?

Hopper: Segregated school. All I remember was I didn’t learn anything. I can remember being hit by the taxicab. I can remember a lot of kids yelling and the classrooms being very noisy and had a lot of activity, but I don’t remember having a good teacher. Remember I was quite young at the time. I don’t remember having a good teacher. I don’t remember learning anything that really stuck with me afterwards. That was not true when I got to Oklahoma to that rural school.

LaBerge: Was that segregated also?

Hopper: Oh yes. But they were real taskmasters. You were taught to decline verbs. I’ve forgotten now but, and then in Arizona I went to—was it three schools all together? I went to school which is Dunbar named after Paul Laurence Dunbar a black poet, which was a good school. The teachers were very conscientious, and I ran track there. I got put into a city wide spelling bee that I won much to the, I guess amazement, of a lot of people back at the time.

LaBerge: Now that we’re in Arizona was this school segregated or no?

Hopper: Oh yes. Oh yes.

LaBerge: It was. We need to keep saying that because I think people aren’t going to know.

Hopper: That was segregated.

LaBerge: You don’t think of Arizona as the South.

Hopper: No, but at that time, it’s very interesting because it was in many respects it was segregated. There were many places that you—the schools were segregated. This changed after I left. I’m getting ahead of the game. But I went to Dunbar Elementary school, and then my last two years of elementary school I went to Bethune, the school named after Mary McLeod Bethune. Then I went to my first year in high school to George Washington Carver High school. I think the names of these schools can tell you, it was true at that time, that these were segregated schools. But again as I look back during those years they were segregated, but they were good schools. There were teachers who really, who cared about what it was that they did. They maintained a lot more in a sense of decorum and order in the school. Again I think I got a very solid foundation in the schools.

LaBerge: Were the teachers integrated or not?

Hopper: No. These were black teachers. These were all black teachers. I went to four different high schools in four different parts of the country by the way. But
my first year, my freshman year was at Carver High School in Phoenix. I remember a math teacher by the name of Flippen, who was again one of the very best teachers that I had ever had. Of course I’m not all that mathematically inclined, but he made all that stuff kind of come to life. I remember some of the coaches that we had, and it was a great year. Then my dad was sent to San Francisco. So I went my sophomore year to Commerce High School in San Francisco, which was the first integrated school that I had ever gone to. What I remember about Commerce—and by the way it was the old Commerce High School building on Van Ness Avenue that sits right across from the big municipal complex. What I remember about Commerce was I had a successful track career there. They had the teams separated into what they called the twenties, the thirties and the varsity. I was in the thirties because I was a sophomore and did very well. I also remember this was the first time I had Latin. It was a positive experience. It was I remember just being overwhelmed by San Francisco. The beauty of the place, and that was the year that I put my age up and went into the National Guard by the way.

LaBerge: Oh really. By putting your age up you mean you—

Hopper: I lied.

LaBerge: Let’s just say it, right.

Hopper: No, I mean because—I think the interesting thing is, I think about that in retrospect the people that allowed us to go into the National Guard knew full well that we were—

LaBerge: Too young.

Hopper: Under age, too young, but this was a way of providing some kind of structure and getting us off the street and this sort of thing and actually I went to summer camp at Camp San Luis Obispo and had my own little squad. I often wondered in later years when I was a battalion surgeon, I said I wonder if they ever, if the military has any way of coordinating these things and going back because for years afterwards I was scared because when I left—

[Tape 1, Side B]

Hopper: I remember fishing off the piers. I lived in what was even at that time I think was a public housing project, Double Rock it was called. It’s not too far from, it’s right off Third Street and the buildings are still there as a matter of fact. But I remember fishing off of the piers. I remember running track at Kezar Stadium. I remember Poly High School being Commerce’s big rival. As I said, in subsequent years I don’t think I’ve crowded as much living into the years as I did that one year. But then my dad was sent to Tampa, Florida. So he was the equivalent of like a troubleshooter.
LaBerge: So every time he moved did he then find a new job as a cement finisher too?

Hopper: Yes. Yes. He always—in fact to back up for a moment. For a period of time in Arizona he and another person actually had created a partnership and had their own like small company where they did—they would bid against some of the bigger contractors and would get the jobs because he had built a reputation as being a superb cement finisher. He was able to, for example—I worked a lot for him and with him. (I could carry about as many bags of the cement as a kid as some of his full-fledged workers.) But I remember he could do a flagstone design in the cement and would have in one flagstone, a segment of it, it would be colored red. The next one would be green, and the next one would be plain cement. I still to this day don’t know how he did it. But he was very much in demand; so there was never a problem. Once we got out of the 1930s, there was never a problem with his being able to have a job.

But so anyway, in 1951 when we moved to Tampa, Florida, again I was there only the one year, and then my family broke up at that point in time. My dad and my mother divorced, and I left home. I was on my own at the age of sixteen. I said on my own, but remember by this time I had a very broad national network of church people that I knew, and the nature of the church was such that you always had a home to go to. I caught a Greyhound bus and went to Cincinnati, Ohio and spent my senior year at Milford High School in Milford, Ohio, which was a small community outside of Cincinnati. There is Cincinnati. There is Loveland. There is Milford.

LaBerge: How did you decide to leave home, and then how did you decide on Ohio?

Hopper: It was clear that my family was breaking up.

LaBerge: Right. But you could’ve stayed with one of them probably.

Hopper: Yes, but I didn’t particularly want to. I mean that, I was old enough and I guess ambitious and adventuresome enough to not really want to watch that kind of disintegration. I knew people in Ohio. In fact the gentleman that I stayed with in Loveland, Ohio while I was going to Milford High School was one of the people that brought my dad into the church way back in the thirties.

LaBerge: What was his name?

Hopper: Richardson. Bishop Richardson.

LaBerge: So did you just arrive or did you call him and say I’d like to come or how did that happen?

Hopper: No, I called the senior bishop of the church who was in Coshocton, Ohio and said that I was going to be leaving. He called Bishop Richardson up and said why don’t you go there. So I did and so I went to—oh and by the way the high
school in Florida, Middleton High School in Tampa, Florida was segregated again but was an excellent high school and one of the best teachers again that I had in all these years. Her name was Ruffin. Again an absolute no-nonsense woman who taught English and who was very encouraging in terms of my own writing and my growth and so forth. By contrast to the teacher that I had in Milford, Ohio just a little small town in Ohio who I wrote a superb essay and she gave me a B. I went in, and I said, “Why is this a B?” She said, “It’s just a B.” So I went to the principal, and I said, “I don’t believe this is a B.” So he made her change the grade.

So when I started talking about trying to go to college, she says, “Well why are you going to bother doing that? There’s no future in that for you.” In retrospect it was, although not just in retrospect, even at that time it was clearly racist, but it wasn’t so different than the experiences that I had that it was earth-shaking. Here’s another example of how some people are.

LaBerge: This is school Milford was integrated.

Hopper: It was integrated, yes.

LaBerge: And she was probably white.

Hopper: Yes, oh yes. Oh yes. I mentioned to her somehow that I wanted to become a doctor. She said oh. Just pooh-pooh, don’t bother with that. There’s a second part to that story I’ll tell you in a moment from later on. But in any event, I happened to go to Ohio University in Athens, Ohio, not because I had any good counseling in high school. In fact had I had a decent high school counselor who had bothered to do an IQ test on me or look at whatever I probably could’ve gotten a scholarship to Ohio State or to Western Reserve or whatever. But basically I went down this list of colleges, and here was one down in Athens, Ohio that looked kind of interesting, and it was cheap. That’s how I happened to end up at Ohio University in Athens, Ohio.

LaBerge: Now when you were in school all these years, you obviously were a good student. You must have liked school.

Hopper: Yes I did.

LaBerge: Had you always thought you were going to be going to college? Where did that come from? Did your parents encourage you?

Hopper: No, my dad. My dad always—it’s interesting. I broke a lot of bones when I was back in Arizona.

LaBerge: While you were running track or what?

Hopper: Yes, well—
LaBerge: Look at that.

Hopper: [showing broken bones] Yes. This, this, this, that knee, and I was high jumping and came down on a rock and so forth. My dad of course was having to carry me to these doctors. Given the kinds of monies that he was having to pay out he thought that was a pretty good thing. I remember this one doctor in Phoenix, Doctor Wormley, and every time the poor guy would turn around here I was showing up with another broken limb. In fact one of the breaks that I had in my left knee didn’t get treated well, and I walked around for the better part of a year having to kind of sling my leg because they had not really repaired the knee cap, the patella. So I have a kind of deformed knee at this point in time. But in any event my dad though, said whatever you have to go through to get to be a doctor I think that’s pretty good thing that you ought to do.

LaBerge: So that’s where it was first suggested.

Hopper: Yes.

LaBerge: But you must have liked that idea.

Hopper: Oh yes. No. No. No. No. I liked education. I liked reading. I liked spelling, and the notion of medicine being, somehow along the line that got instilled in my mind. Yes, that’s a pretty good thing to do; so why don’t I become a pre-med. when I go into college, and I already knew that prior to finishing Milford High School. That’s what I said. I told this teacher I wanted to become a doctor. At Ohio University in Athens I met a number of people who were a tremendous influence in my life. I had to get a job, and I worked my first year in the library, which was like taking the rabbit and throwing him into the briar patch. I had to clean the library floors at night. The old janitor that I was working for, he would let me work about half the time that I was supposed to and the rest of the time I was wandering the shelves and pulling down books and reading everything I could get my hands on. So I worked my first year in the library, and then in subsequent years I worked in the women’s dormitories in the cafeteria, which meant that I could get my food, which was really great.

But probably the single most influential person back at that time was, his name was Rush Elliott, and he was a professor of zoology, and he also was the head of the pre-med. group. The stories were that if you can get past Rush Elliott, then you’ll get into medical school because he had those kind of contacts. He was very encouraging. Again in retrospect you don’t realize some of these things are happening until you think about them later on. He was kind of tracking me to be sure that I had enough to eat and that where I was staying in the dormitory was okay. Again this is important because in later years his son-in-law was graduating from medical school and became a physician. This was when I was on the faculty at University of Wisconsin. So I was able to provide an entrée for him at that time and had a chance to meet
Rush Elliott again. This is years and years later. I majored in zoology and
minored in English at Ohio University. In the summer times I worked—it’s
amazing, you always characterized these things as where you worked. But I
worked at the L and K Drive-in in Newark, Ohio one summer.

LaBerge: Doing what?

Hopper: I was the person who would when they would bring in—this was a hamburger
joint—they’d bring in the meat. I would have to cut up the meat and then
grind it and then put the bread crumb extenders in it and was very good at it.
In fact no, I’m sorry. That was the summer the L and K Drive-in in Newark
was the summer between—. After I graduated from Milford High School then
I went to Coshocton and then over to Newark. Coshocton and Newark were
both in the same part of the state. I got the job at the L and K Drive-in that
summer. I did so well until the guy tried to talk me out of going to college.
He said, “You could become a manager of one of these places if you—” I said not
on your life. So in any event that’s where I worked that summer. Then went to
Ohio U. and then the subsequent summer worked at the Newark Stove
Company, but what we were doing were making shells for the army. They call
it the stove company, but we were making these. I don’t know what
millimeter they are, but these big steel casings for shells. What I remember is
that there was an instrument that had like a fork, like a big fork. You would
stick the fork into four of these shells at a time, and then you would use a
chain hoist and hoist them up and carry them where they were supposed to go.
It was deadening stuff. That really increased my resolve that I was going to
get through college and do something else.

LaBerge: But all these jobs this is how you paid your way through college.

Hopper: Yes. Yes. Yes.

LaBerge: And you were essentially on your own.

Hopper: Essentially except again I think, in fairness to the church, the church
headquarters in Coshocton, Ohio, these were people that I knew. For example,
the summer that I worked at the L and K Drive-in I stayed with a lady who
then provided me meals and very cheap, just room and board and laundry for
that. I knew I had a kind of a support system there although it’s not quite the
same as having your own family. It was like an extended family. That was
very meaningful because I could’ve slipped between the cracks I think
without that. So one summer I worked at General Electric in Coshocton, Ohio,
and what they made were these the laminates. You’ve seen the laminated
countertops. That’s what they did there. I don’t remember what my job was. I
just remember that I didn’t like it. So in my senior year I took the Medical
College Admissions Test, and I had about a three-point-two or a three-point-
three GPA, which wasn’t bad considering all the stuff that I was taking and
the work that I was doing. I did apparently very well on the MCAT test and
got admitted to the University of Cincinnati just like that. Again I attribute that to a significant degree to the influence of Rush Elliott because he had a pipeline into Cincinnati. A number of his students always ended up at Cincinnati. Some of my good friends now from those years are people that I went to college with, and then we went to medical school together in Ohio, I mean in Cincinnati.

But jumping ahead, and then I’ll come back. I did have a chance to go back and after I graduated from medical school and before I left my internship I went back to Milford, Ohio and met this teacher.

LaBerge: And?

Hopper: In all fairness I’m not even sure she remembered me. It made me feel good, but I don’t think that it really was all that consequential to her.

LaBerge: Before we go on, we’ll leave medical school for another time I think. Let’s go back and talk about—

Hopper: Ohio U?

LaBerge: Ohio U. What in all these, well, first of all did you do athletics there too?

Hopper: Only intramurals. Only intramurals.

LaBerge: Because you had during high school.

Hopper: Yeah. Only intramurals. I was in competitive athletics in high school.

LaBerge: What was the racial situation on campus?

Hopper: We were very, very much in the minority. I would guess in fact, I would guess in 1952 when I came to Ohio U, there probably were no more than thirty-five or forty black students on campus. This would’ve been in a student body of maybe six or seven thousand. Some of this I’m guessing at this point in time. But we were very much in the minority. One of the saddest things about those years is that Athens, Ohio, which is a little town in southeastern Ohio in the Appalachians, in a very poor area, but there was a barbershop that was run by blacks. But they would not cut the hair of the black students.

LaBerge: You’re kidding.

Hopper: Because they said, “our livelihood depends on this, and if we started cutting your hair, then we’ll lose our trade. We’re sorry, but get out of here.” That sort of thing. So we had to go to a little town called Nelsonville in order to even get our hair cut. But there was no conscious, I don’t carry away a sense of any conscious discrimination on the part of my instructors with one or two
exceptions. It turned out that the one guy who I thought was an absolute racist was a teacher of physiology who after giving me a hard time gave me an A in his course. So those were very pleasant years. Those were extremely pleasant years. I subsequently went back and got an award from Ohio University as a matter of fact.

LaBerge: I know about a Drake award from Cincinnati.

Hopper: That was Cincinnati.

LaBerge: What was from Ohio University?

Hopper: This was the Ohio University medal, and it’s the one that’s given to outstanding alumni. I went back and had a chance to ride in a parade and all that sort of stuff. It was very nice. But the African American kids on campus in the 1950s turned out finally to be a fairly close knit group. They have reunions down there now, for black kids from the fifties. I planned to go to one of them and ended up going to Russia. It was the same time I had to go to Russia to do some consulting here a couple of years ago. So I missed that, but a close knit group and they did well. They all went on and had very successful careers. Beautiful campus.

LaBerge: What about housing and all, were things integrated on campus? I mean for instance you mentioned the barber.

Hopper: Yeah. I think for example I stayed in the cheaper housing which was on what they called the East Green. This was housing that had been developed right after the war. They were the barracks really because remember when right after the war when there was this huge surge of students coming back—

LaBerge: G.I. Bill.

Hopper: G.I. Bill, right. So we stayed in barrack rooms. As I think about it they were segregated in the sense that the black students all had black roommates. But I’m not so sure that this was by some nefarious design as opposed to people kind of choosing to live together. My roommate for the first couple of years was Norman Tibbs from Lancaster, Ohio. One of the bones of contention on campus (of course this was in southeastern Ohio) was the interracial dating problem or phenomenon. But as I said I have nothing but really very, very happy memories about Ohio University. The sense of, the sense of struggle, like am I going to actually do well enough to get into medical school, and of course that’s true with any pre-med. student. That’s probably even more so now than it was back at that time. When I left, to show you the continuity, when I left Athens, I hitchhiked down to Cincinnati, and this was in the summer before my freshman year in medical school. I hitchhiked down, and I got two jobs. I got a job at night in the medical records room, and I got a job during the day time at General Electric which was in Lockland, Ohio which
LaBerge: Is this in the hospital?

Hopper: In the hospital.

LaBerge: The university hospital?

Hopper: Yes. Yes. Cincinnati General Hospital was the university hospital for the University of Cincinnati Medical School. I was gotten this job by one of my old classmates, well a classmate one year removed who had been down there a year before. I remember it was an old pavilion hospital, and you always hoped that you could sleep at night, but then the medical record requests would come through these pneumatic tubes, and you could hear the things bouncing from it seemed like a mile away. You knew that it was going to go boom and hit. Then you were going to have to go find the medical records. But interestingly enough after the first couple of months of this, one of the what they called the “suture boys” at that time which is a highly desirable job that was set aside mainly for junior medical students. There were four of them. They were working every fourth night. One of them got sick and had to go home to Cleveland or wherever, and I went to Doctor Charles Kiely who was like the assistant administrator of the hospital and like an associate dean at the School of Medicine.

I said, “I can do this.” He said, “You haven’t even had a class in anatomy yet.” I said, “Yeah, but you know I spent a lot of time down there in the emergency room. I can do that stuff.” So he probably said, “oh what am I doing?” But he gave me the job, and I kept that job in the emergency room all four years of medical school, and it made all the difference because in addition to room, board, and laundry, there was some small stipend. Because again I’m not a chronic liar, but when I applied to medical school, they wanted to know, will you have the money to pay? I of course said yes and I had about a dime in my pocket at the time. But the job in the emergency room made all the difference. By the time I was a junior I had gotten so good at suturing lacerations that when policemen would get injured, would get hit in the mouth or something like that, they would come down and they would tell the emergency room people wake up that colored guy and have him come down here.

LaBerge: Because they knew you were so good.

Hopper: I was good. I was good. In fact the people at the hospital could not believe I didn’t go into surgery. I mean because but when you do something what felt like ten thousand times you become good.
LaBerge: It is pretty delicate.
Hopper: Pretty good at it. So medical school—
LaBerge: Well before we go. I don’t even think we should get into that.
Hopper: All right. Good. Am I talking too much?
LaBerge: You’re not talking too much at all. We’re going to start another tape unless you want to stop.
Hopper: Yeah let’s stop today and then let’s set some other times up.
LaBerge: Okay. Because I’d like to go back and talk about things we didn’t talk about during that time: World War II, what impact that had, your traveling across the country, and what the conditions were like—
Hopper: Yeah. Yeah. Yeah. I would welcome— [tape interruption]

In the summertime we would always go to the church convocation, and the church convocation was always back in Ohio. So we would have to drive across the country, and that’s where I really remember the discomfort in terms of not being able to go to the restrooms, and then in subsequent years while we were in Arizona part of his district that he had responsibility for was in Arkansas. So there’s a lot of course I know I haven’t talked about.

LaBerge: And I think we should go back and pick all that up.

[End of Interview]
2002 interview number two with Cornelius Hopper. We are going to backtrack a little bit today because when we ended last time, you were talking about the influence that the church had on your life. But we hadn’t talked about everything and one of the events, not the events, something important were the travels you made with your dad across the country.

Yes. Yes. Yes. As kind of a troubleshooting minister, I mean he was a tremendously ambitious, energetic person who I think as I mentioned before in addition to his working ministry was a consummate cement finisher and was a contractor for a while. When we were in Arizona and again we lived in Arizona from like 1943 to 1950. Certainly the 1950 year stands out, but I think my mom and I got back from Oklahoma in about 1943. Every summer we would go to a church convocation which was located in Ohio. So there was always this kind of annual pilgrimage, so to speak, which was a long ways way back in those days.

Did you have a car?

Did he have a car?

Yes.

Oh yes. Oh yes. He always had a very nice car. I remember the old air conditioners were the kind that sat outside of the window. I don’t know if you remember those.

No, I didn't know that there was such a thing.

Yes, they had it. Of course in Arizona which gets tremendously hot he had the first one that I remember ever seeing which was a little air conditioner that actually sat, it was a cylinder kind of thing that sat outside the window, the front window, and that kept the car reasonably cool. But the travels from Arizona to Ohio for the annual convocation would for the most part go through the South because he would stop in Arkansas where he had a congregation and gradually then make his way up through the Midwest and on over to Ohio. So that was an interesting, exciting time. As a kid you like getting in the car and going places. But again it was not my first exposure to segregation, but perhaps it was more apparent and more pointed because in Arizona even though they had segregated schools there were no signs that said colored can drink water here and bathrooms and so forth. So when we would leave the Arizona border heading over through New Mexico in to Texas. Once we got into Texas then it was very, very apparent that you had to choose very carefully the places that you stopped. We very often slept in the car, but the thing about kids it seems to me is that they’re very forgiving and
adventuresome in terms of things like that not being as devastating as they are in retrospect. In retrospect it was really humiliating and degrading. At that time it was like, hey, that’s how the world is. So let’s see how many more jackrabbits we’ll pass on the side of the road as we’re going this next sixty miles.

But the church convocations in Ohio were marvelous, marvelous events because people congregated from all over the United States. I would guess, and again this is in retrospect and just a crude guess, probably four thousand or so people. We slept on ticks in tents and so forth, but there was this tremendous sense of an extended family and people that you had not seen since the last time you were there last August. People would greet each other, and it was kind of like a marvelous camp out session in a sense for kids.

LaBerge: So everybody brought their kids?

Hopper: Oh yes. Oh yes.

LaBerge: So what did the kids do during the—?

Hopper: We would go to the church services, but then we, this was all on a big farm in Ohio in Coshocton, Ohio.

LaBerge: Can you spell that?

Hopper: C-O-S-H-O-C-T-O-N. Coshocton. It’s in mid-Ohio about seventy miles from Columbus, slightly northeast of Columbus. The kids would, they were on the farm, and they would roam the woods and have fun and pick persimmons and eat them and again just a sense of extended family. That kind of sense of extended family, again, as I pointed out before, kind of carried throughout my childhood and actually early adulthood as well. When I left home in Florida years later and went to Ohio, there was that extended family there who could provide at least some support system for me. So the church was an extremely influential entity in my early life. I think in retrospect some of the speaking skills, such as I have, and the ability to stand up in front of hundreds of people and say things and do things came from that kind of exposure as a kid.

LaBerge: Because that’s hard for a lot of people to do, very hard.

Hopper: Yes. I don’t think it’s ever easy. But it would’ve been a lot harder had I not had that kind of experience because you were expected as a kid to periodically stand up and really talk to the congregation about the things that were going on in your life, your observations and so forth. You got critiqued sometimes rather severely. The fishing trips, in Arkansas we would stop sometimes for two or three days. There were these great fishing places, and so things like that really built a set of memories about your parents, about your father in particular. In my case that probably transcends because as an adult we only
interacted periodically because there was a period of time from about 1952 until like about 1958 or ’59 when he was really not active in the church any longer. He was doing other things. But then the church was his first love, so he went back and then had a tremendously successful career after that. Of course by that time I’d finished college and was in medical school and was very much preoccupied with my own life. But so even though we were not close in the sense of seeing each other real frequently. From 1958 on I would say, we would manage to talk on the phone periodically. I remember when I first left the University of Wisconsin and went down to Alabama. He made a trip all the way out from Arizona, which is where he lived then, to spend several days with the family. I have nice pictures of, his coming which coincided with the only snow they had ever had in Alabama for probably fifteen years. So I have these great pictures of him with my kids and the George Washington Carver library and it’s really very special. He died in 1989 while I was here in California. I had a chance to go back to where he lived in Arizona. As I mentioned before he had an anthracosis of the lungs with a chronic pulmonary condition for many years. So Arizona was both a retirement but also a health location for him. So again in spite of my being relatively on my own since sixteen there was always the sense that my parents were out there. They were divorced by that time, but I knew where to find them. I rarely did but—

LaBerge: It’s that security of knowing.

Hopper: Yes. Right. Exactly.

LaBerge: Two questions to follow up on that. What did your father and your mother say to you if you can remember about the traveling, about the fact that you couldn’t go certain places or even your friends? Was that a topic of conversation?

Hopper: No, not really. Not until later. It was the way it was. It was the way it was. A lot of the church people that belonged to my dad’s congregation were migrant workers. They were used to that kind of life, and one of the things that I remember about that is that in spite of what in retrospect sounds like a degrading sort of an existence they had incredible fun. There was a lot of laughter. There was a lot of camaraderie. I remember picking cotton in Arizona with—I got pretty good by the way. I got to the point where I could pick one hundred pounds of cotton a day, which was pretty good. But it was kind of the way it was. So it’s not something that we talked about although I do remember in our travels in the South going to Ohio or back from Ohio my dad becoming very angry at times. Well the terms that he articulated it in were not nice. He didn’t use epithets, but he was calling people “dumb crackers” and so on that. But beside that kind of anger and that kind of sense of injustice and of course the discomfort of having to sleep in the car or having to pick places where you could go to the restroom or plan your trip so that you would hit a town where you knew somebody before nightfall, it was not in my
recollection a kind of a terrible, oppressive sense of injustice. It was like, yes it’s not right, but let’s get on with life. There are other things that, it was only much later that I began to think about and really resent it and become a lot more aggressive about it in terms of my writing, in terms of other things. But truthfully as a kid it just didn’t, childhood is a beautiful time in life. You look at pictures now of kids in Africa or in Asia who for whatever reasons are impoverished and terrible things have happened around them. But somehow they manage to project a little sense of adventure and the smiles that come through, and that’s kind of—I guess in some respects that’s the beauty of evolution. Evolution finds a way of protecting children so that they somehow achieve adulthood without being so terribly scarred that they can’t function.

LaBerge: Yes. Yes. Yes. How about the longer term effects of the church as far as your own personal beliefs and practice?

Hopper: I think that there’s certain things that you experience when you’re growing up that become really kind of an indelible part of your personality, and I have not been an active member of the church since about 19— I would say ‘58 or so. But I still interacted then and still even now interact with a lot of the people, not a lot but a significant number of people that I grew up with. They still call me unfortunately very often when they have cancer or when something else terrible is happening and they want some medical advice or I just want to share. But I think there are parts of your personality that really are shaped by those kinds of experiences that they don’t go away. The belief systems change, but the personality basically doesn’t.

LaBerge: I don’t know if we talked about hobbies and pastimes or if you had hobbies. You had jobs. You picked cotton.

Hopper: Oh and I shined shoes.

LaBerge: You talked about some of those, but I don’t know if we got all?

Hopper: When my dad was a contractor, I would shovel sand and carry cement bags to the cement mixer. Loved to fish. Fishing was always a pastime, and I still do that.

LaBerge: You told me that you go up to the Delta.

Hopper: Yes. Yes. Still like that. But I write poetry and have done that not in a serious way long but as kind of a past time and probably have twenty-five to thirty pieces that I have made a point to save that my wife keeps wanting me to publish. I say in absolute moments of clarity it’s not publishable except to your kids, grandkids. I might pull it off the computer one of these days and pass it on to them. But life has been, I’ll bring in a poem that I wrote on my wife’s and my thirty-fifth, yes the jade and coral anniversary, and it talked about the fact that we basically have been in overdrive. I was in overdrive
before we got married and have remained kind of in overdrive ever since then. There wasn’t really time to get into a different kind of gear. It was always that kind of climbing, striving. Really I guess earlier on there was kind of a sense of duty associated with that because again everybody keeps saying you’ve got to become a doctor. I gave you the story about my dad decided that was a pretty good idea after paying all the money to the—

LaBerge: To the doctors.

Hopper: To the doctors and all the broken bones that I had. But earlier on the striving was a kind of a sense of duty, and but after a while I think it became this part of who I was. Like I’ve got a make a good grade. I’ve got to get through the pre-med. course. I’ve got to show that I can do this job in the emergency room in Cincinnati General Hospital even though I hadn’t had a course in anatomy. I’ve got to overcome the fact that in medical school they had a white fraternity that I couldn't join. They kept samples of exams, and yet counterbalancing that were a number of friends that I had from Ohio University because we all kind of grew up at Ohio U under Rush Elliott who made sure that I had whatever they had. A number of them refused to join the fraternity.

LaBerge: Because you couldn’t?

Hopper: Well, I think in one case yes. Mike McCann. I think Mike refused because of their policies on that. Others just thought it was nonsense and a waste of time. Even though it would have had the practicality of providing access to not only past exams but also the kind of word of mouth things that said, “here is what Roger Craft really wants in anatomy,” and, “here’s what Gus Eckstein does with his birds, and you need to be able to weave the birds into the physiology exams.” But so that sense of striving, getting into a good internship and then following the internship being a Navy doctor for two years but choosing or certainly accepting being associated with the Marines during that period of time—because they were pretty tough people who climbed up and down ropes on ships. My wife and I talk about this occasionally. We go back and kind of look at the poem that I wrote to her, and it’s true. I only just now am beginning to kind of catch my breath so to speak. My kids don’t believe it yet. They call and say where is he? He’s out at this board meeting or that board meeting, but in actuality I think the furrows of my brow have kind of shallowed a bit. We both talk about, she also fantasizes about retiring from real estate and the kinds of fun that we’re going to have that we didn't have before.

LaBerge: That you’ve put off all these years.

Hopper: That we didn't have before. But again there are different kinds of fun. I think the sense of fulfillment even with the University of California is one. I just finished a letter last night announcing my resignation from the California Health Manpower Policy Commission (HMPC), and I was saying that, I was a
commissioner for twenty-two years, and this was second in duration only to the guy who almost founded the commission before I came. But how there now was a sense of inevitability about it even though the University seemed quite happy to have me stay on as a commissioner. But the level of interest in that work as contrasted to my college, my Samuel Merritt College and taking over a school of podiatry which we’re going to do shortly, and then my work with the hospital Alta Bates/Summit Hospital and with Meharry Medical College and a few things like that, the HMPC commission and its work has kind of receded into the background. It’s only fair to the university and the commission that I do this. But I was telling Barbara just last night that that was a not bad for a little farm boy to have been a commissioner for twenty-two years.

LaBerge: Absolutely. So you’re going to bring that poem in?

Hopper: Yes. Sure. I will. And I’m also going to bring, as I said my mom kind of distracted me today, but I’m also going to bring in the little excerpt or whatever one would call it that I wrote about David Saxon.

LaBerge: We have a piece you wrote about David Gardner.

Hopper: Yes right.

LaBerge: This is different.

Hopper: But this is Saxon. This precedes Gardner. Because see I came in as a special assistant to the president. It’s a title that I inherited from the person that retired when I took the job. It was Gardner who made me a vice president later on. But I’ll bring, because again looking back through the memogendas I think you go through a number of interesting experiences, and at the risk of sounding immodest, I said, ‘God, I could write pretty good back then.’ With some pretty insightful stuff and then going back into some of the things that I wrote and did in Alabama at Tuskegee Institute, I’ve had the same kind of reaction. See only now in really and really quite apart from doing this history only now am I kind of finding the time or being willing to take the time to go back and do that kind of retrospective kind of thing. It’s really kind of worthwhile. I think in the case of Tuskegee because I was there during a very formative period. There are a lot of formative periods in the life of an institution. But the ‘70s were a very special time in terms of—in a sense of both empowerment, which kind of arose out of the civil rights movement, and a sense of shared mission, at a predominantly black school that you probably would not have found anywhere else. So again, even though my record keeping back in the earlier years of my Tuskegee experience was not as detailed or as compulsive as it became later on, partially because of the exercise that we’re going through and partly because I want to, I do want to go back and revisit a lot of that.
LaBerge: You’ll have memories even though you don’t have memorandum from that time. Let’s go back, we have a few things to talk about before we get you to medical school because we really haven’t covered that. World War Two, do you remember where you were on Pearl Harbor Day and what was life like then?

Hopper: I don’t, I really don’t remember Pearl Harbor Day.

LaBerge: You were what? Five.

Hopper: I was only six. This would’ve occurred when we were in Baltimore I think because we were there from I think ‘41 until ‘43 or from ‘40 to ‘43. Let’s see—I had left Oklahoma. My dad moved us when I was three years old, which would’ve been 1937, and we were there from ’37, I think until ‘40. We would’ve moved to Baltimore in 1940 or perhaps early ‘41. What I remember about the Second World War was that my dad and his work. He was certainly able to find work everywhere. People were working, this was true of other church people because they had had some very difficult times in the Depression. Some of this is in retrospect, but I do remember people had jobs and there was a sense of kind of a positive sense about work, about life that as a six or seven year old you don’t think too much about that. But when we moved back to Arizona, this was in ‘43 and of course the War was still on. I was telling you that one of the things I did was I shined shoes with these officers from Litchfield Air Force Base outside of Phoenix and made for me lots and lots of money. One of the experiences that I remember when we first moved from Oklahoma to Arizona we stayed in a rooming house with a family by the name of Swindell, and this is an African American family. It was on the east side of Phoenix, which was somewhat the more middle or upper lower class economically. But I remember being taken to a concert where an African American singer by the name of Roland Hayes sung, and I remember being just tremendously impressed because he sang a song called Deep River. Even at that time I remember thinking there’s a whole lot of something truly deep and spiritual and compelling about that. Mrs. Swindell saw to it that I got enrolled in music lessons. I was taking cornet lessons and when we later moved to a different part of Phoenix, I was already a good candidate for the school band at that point in time. That’s something that kind of helped carry me through high school because every high school that I went to until I was a senior in Ohio I played in the band.

LaBerge: You played cornet.

Hopper: I played solo trumpet. Yes. That got me in with a lot of the girls.

LaBerge: I bet.

Hopper: I don’t remember the trumpet as a great instrument. It’s a great ice breaker, but in the early Arizona days from ‘43 on there was this sense of being not
only part of a church community but being part of a now what we call the African American community, but then the colored community. That even though segregation was not nearly as rigid and as visible and tangible in Arizona at the time, but the schools were segregated, and there were places that you kind of knew you just didn't go even though there was not a sign out there. But there was a sense of almost a kind of a renaissance sort of thing. There was music and people were working, which is always very important. People were working, and they had apparently some extra money to spend. They had cars. Even the migrant workers that made up a part of my dad’s congregation those were relatively good years for them. We did read stories about Negro history, I mean after all when you go to a school called Bethune, which is named after Mary McLeod Bethune, and then you go to a high school named after George Washington Carver.

[Tape 2, Side B]

Hopper: Being part of a group that had been set apart in a way but a group that had an incredible amount of internal vitality I think we’ve come to call it soul. I had no idea what that meant at the time but just a tremendous sense of vitality, spirit, laughter, respect for kids, for parents—the parents demanded it and got it—less in the way of diffuseness than you find in the African American community at this point in time. But again I’m kind of trying to piece together recollections from what a nine, ten, eleven, twelve, thirteen year old really thinks about back in the time. But again a very formative period, the people that you met and the kind of interactions that you had and the memories mean that they and the time were clearly formative in terms of what I ultimately did.

LaBerge: Do you think that people for instance you were mentioning Mrs. Swindell made sure you got music lessons, did people recognized that you had ability maybe?

Hopper: I don’t know. I suspect so. I always a little smart. I think that was true very early that, “well Cornelius can probably do it.” I think in her case it was like, here’s a kid who has some talent, let’s get him involved in some things that his parents probably wouldn't. They went along with it. My dad, I mean he was so busy trying to start churches and doing other things, but I went back to see her. They were still staying in the same home there many years later, when I was traveling from Milwaukee coming out to California as part of my military experience. I had been to the Great Lakes and had my basic training, and then I was given a period of time to drive across the country. I remember stopping in Arizona and looking them up, and they still had the same little rooming house. He was kind of senile at the time and didn't really remember it, but she was just as sharp as she could be. She remembered and remembered Mr. Edwards the guy that she sent me to who lived right down the street to get the music lessons.
LaBerge: So you were encouraged?

Hopper: I was encouraged. I was encouraged really every step along the way in terms of teachers, in terms of my own parents. Even though they didn't have very much education they knew that education was important.

LaBerge: Except for that one high school teacher who tried to—

Hopper: Oh yes.

LaBerge: What about reading. Did you read a lot as a child?

Hopper: Yes.

LaBerge: Or did you like to read?

Hopper: Yes. Yes. I read a lot. I read westerns. That was the currency that you could find. I read westerns. I read funny books. I had an incredible collection of funny books at one point in time. I’d be rich now if I had held on to them. But unfortunately again in terms of the kind of semi-serious reading that I was determined to have my kids exposed to I really didn't have growing up. I felt somewhat stunted because of that because those are years you never really recapture. When you read Jack London late you lose part of the real imagination, the mystery associated with it or Kipling. That’s why when I went to Ohio University and took the job in the library, it was like I had died and gone to heaven. Here are all these books.

LaBerge: Time, too.

Hopper: Yes. Right.

LaBerge: Let’s go on to medical school. Now when you started Ohio University you already had in mind you were going to go on to medical school.

Hopper: Yes. It was a dream. Like I had no idea that I was definitely going to get through a pre-med. curriculum. I think I mentioned to you before that I chose Ohio University by just happenstance. You run your finger down the page and oh yes there’s this place Ohio U. The tuition or the fees were very low. It was true luck. It was serendipity that I ended up in a place. If I had had decent high school counseling, I probably could’ve gone on to a “better” school. But who knows I might not have gotten into medical school from Western Reserve or some place.

LaBerge: I think we started in on that and how you got the job suturing—

Hopper: Oh yes in medical school, not Ohio University. That's the University of Cincinnati.
LaBerge: So we got that part that you moved to Cincinnati and to the University of Cincinnati, but we haven’t done any of what you did besides?

Hopper: Ohio U.

LaBerge: We went through Ohio U. But now medical school. So why don’t you start with the thing about the fraternities, which I didn’t know about and where you did live.

Hopper: I lived in the hospital. Again the beautiful coincidences as I look back on it as I said, I hitch-hiked to Cincinnati from Athens, Ohio across southern Ohio and good friends of mine from Ohio University a couple of them worked in the medical records room. I mentioned Mike McCann, Ray Lipicky are people who come to mind. They worked in the medical records room. So at night I would work and sleep. They had a little cot there, and then when somebody would come into the emergency room that had been a previous patient, they would send up the request for the medical records. You’d wake up groggily and go find the darn thing and send it back down. In the daytime, I had a daytime job that I got. I’ve had a lot of good people in my life actually. At General Electric in Lockwood, I was working in one of the laboratories. As I think back on it now it was kind of, to some extent, it was like make work. But it was meaningful in that I was doing chemistry that was yielding numbers that were useful even though I suspect they probably went back and looked to be sure that some of the stuff was correct. So I worked at GE during the daytime, and I worked in the medical records room at night until as I said one of the emergency room suture boys developed a family crisis and had to leave. I went to Doctor Charles Kylie and said, ‘Why don’t you let me do this?’ Again after I’m sure a lot of trepidation he said, ‘Yes.’ So halfway through that summer my night job was in fact then in the emergency room. So both of these jobs carried with them the ability to have room, board and laundry in the hospital, both the medical records room thing and certainly the suture boy thing. So for all four years I had room, board and laundry covered and with a small stipend associated with it. But it also meant that in the summer times I was able, like starting after my sophomore year, then I started working at other hospitals in town too during the daytime in the summer.

LaBerge: Doing what?

Hopper: Doing stuff that I shouldn’t have been doing. For example, there was a small Catholic hospital in downtown Cincinnati—I won’t be able to think of the name of it, but it will come back—where I was actually because of my experience in the emergency room at Cincinnati General Hospital starting before I actually started medical school. I was pretty darned good. So in my junior year I was actually covering the emergency room of this little downtown Catholic hospital in the ghetto.

LaBerge: They thought you were the doctor.
Hopper: The people who came in thought I was the doctor. In retrospect I don't think I made any real serious mistakes because they were sure that I had backup and the notion was I was supposed to really call if I needed. So I had jobs. I worked right through medical school and managed to save enough to pay my tuition.

LaBerge: Where did you find time to study or for fun or anything?

Hopper: It was, “fun” what was that? As I said I was on a treadmill.

LaBerge: That was the beginning.

Hopper: I was on a treadmill. Study, you study during the week. We were on every fourth night all night long. The other three nights you could study and get your work done. But it was deadly the day after your night on. God forbid that your night on was the night before a big exam because you could be up literally all night long and walk in bleary eyed. I did well. I didn't have a superlative record as a medical student, but I did well. I was in the middle of my class. One of the very sad stories about medical school for me (getting into the business of being a minority—.) When I graduated, I was like the third black graduate they’d ever had. The first one was a woman, Lucy Oxley who had graduated back in the late ‘30s. One of her classmates Dr. Francis Forster turned out to be my professor of neurology and my chief in neurology at the University of Wisconsin and who was the guy who sponsored me for the top award that the University of Cincinnati has ever given.

LaBerge: The one that you recently got. You mean the Drake award.

Hopper: The Drake award. Right. Frank Forster was the one who sponsored me for that. But anyway, he was a classmate of Lucy Oxley’s.

LaBerge: Were there any other minorities, Latinos, women in your class?

Hopper: No. There were women. There was a handful of women, but just a handful. There were six or seven women in my class. As a matter of fact, one of my anatomy partners, Pat Forney, the two of us named our cadaver, named him Bernie. You had to do these kinds of things to get through.

LaBerge: To get through.

Hopper: I saw Pat at the last reunion that I attended. But then, interestingly enough, the attrition rate—I don't mean in terms of passing medical school but in terms of dying—was so much higher among the women in our class. We’ve lost three of the six women, three of the six.

LaBerge: That’s a lot.
Hopper: Again that’s a much higher percentage than if you looked at the entire medical school class. I mean although that, those tallies are getting awfully scary too. Boy this is very interesting to think back through some of these things. I think they had their eye on me really closely for the first year or so. Even though they knew I was one of Rush Elliott’s boys and they’d all done well, it was like they were keeping a close eye on me. But I did okay. I did okay. So by the time I got to pathology in my second year, I had the sense that even though people knew that I was African American I mean that really wasn’t making any difference that I could see because, as I said, the fraternity was off limits. I knew that before medical school started. It wasn’t one of these things where I was saying, oh please sponsor me for the fraternity. First of all I didn’t have time, and I think at the very beginning, that summer before medical school, I had absolutely no idea that things like oral exams existed. So I probably was a better doctor because of it actually. I was a pretty darned good physician. My experience in the emergency room plus an absolutely outstanding training in pediatrics. See this is where Albert Sabin taught, if you ever heard of the Sabin vaccine.

LaBerge: Oh yes. Oh yes I do.

Hopper: That’s Cincinnati.

LaBerge: When did you do pediatrics?

Hopper: Well, we were given introductory courses in pediatrics starting in the sophomore year. Then the medical school curriculum wasn’t nearly as integrated as it is now. Back then it was the first two years were, you did basic science. You had maybe a little introductory course to clinical work to just kind of keep you interested after deadly stuff with the Kreb’s cycle and stuff like that. So it was in the junior and senior year that we did pediatrics and OB/GYN. One of the experiences that I had was, again Cincinnati General Hospital was a large public hospital. I remember there was a poor white woman who had come from northern Kentucky had come to Cincinnati General to have her baby. When I was a senior, when you are a senior in medical school, you deliver babies. You do it under supervision, and she didn’t want me to deliver hers.

LaBerge: Because you were a student.

Hopper: No, because I was black. Yes. I remember the professor of obstetrics just said absolutely not. He’s going to be in the room, and I appreciate that. That would’ve been kind of devastating too because I made good grades in obstetrics.

LaBerge: You were qualified.

Hopper: As qualified as any medical student is. Right.
LaBerge: So looking back now that you’ve been to all these other medical schools how would you characterize the quality of the education?

Hopper: I’d say outstanding. Outstanding because of I think the research reputation of Cincinnati—again this is all in retrospect, (who cared at the time?)—but I think of the research reputation of people like Richard Vilter, Sabin, the guy in surgery, William Altemeier. These were big names nationally. But the very, very detailed medical education and then the practical experience were just great. When I got into my internship, third year residents were calling me for pediatrics to give an opinion about something. It was that good. So again, number one had I had a decent high school counselor at Milford Ohio who had counseled me to go somewhere else to college where I might have gotten a nice scholarship, who knows, I may never have actually gotten into medical school. So all those crossroads that you reach in life you have no way of knowing sometimes even in retrospect why you took. Although I know it was pure chance that Ohio University got chosen. I knew nothing about Rush Elliott.

LaBerge: When I’m talking to people, I find that that happens to a lot of people that it’s just pure chance.

Hopper: I still think I would’ve made a better lawyer than a doctor though.

LaBerge: Oh really. You had so much success. You could’ve done both.

Hopper: Yes. Because I minored in English, and I remember the courses in economics and government, and I just ate that stuff alive. I loved it. My son’s a lawyer now. My son’s a deputy city attorney in San Jose one of them. I remember just devouring his books when he was in, he did his undergraduate work at UC San Diego and was bringing home books. I still have a whole big shelf of his books from back then. He was reading such better stuff than I was reading at that age. But I was a pretty good doctor too.

LaBerge: It sounds like you—didn’t you have to use some of—we’re going to come back, get to this later, but when you were vice president, weren’t you doing a lot of that kind of thing?

Hopper: Oh yes.

LaBerge: I mean finance. So you were using those kinds of things.


LaBerge: You couldn't have done that job without—

Hopper: This was a perfect, perfect job for me—
A good fit.

I mean this was a perfect fit for me, and I think the one piece of it that I regret but only at the margins was that when I came to UC, I gave up medicine, I gave up clinical medicine. That was part of the deal, although had I negotiated harder I probably could’ve carved out a half day a week at San Francisco or someplace, but in reality it’s a full-time job. I wouldn't have lasted very long, but I would say the ability to stand up in front of people and talk, the ability to negotiate, the ability to not be intimidated by powerful people. All of those things were extremely important in this job because from the very beginning I was thrown in front of legislators in Sacramento who were very angry with the university for whatever reasons.

The Regents too.

The Regents too, yes. That’s right. From the very beginning I had the responsibility of reporting at every Regents meeting on the hospitals. I could never get them interested in the academic side of the health sciences. It was always those damned hospitals that they were interested in. Quite frankly I think I told you the story before. I really didn’t think the University of California was serious about my coming.

You didn’t want to waste your time coming out here for an interview.

The first interview I had, I had with my feet on my desk down in my hospital in Alabama, at Tuskegee because I did what I thought was a favor for Shirley Chater. I said, ‘Okay Shirley you put my name in, but I have the sense that this was only so that they could claim a diversified pool.’ So when they asked me to come out for the interview, I was saying, ‘Oh come on. You’re carrying this too far.’ I didn’t say it in so many words, but I do have other things that I need to be doing. But I agreed to and then when they said, ‘We do want you to come out and talk.’ I said, ‘Well by now they know who I am and what I am. So why not?’ But in any event I’m saying all that to say that for the first couple of years in this job I worked very hard at it. My wife was still in Alabama because she was in real estate. She had her own real estate company there and had just started a subdivision.

So she couldn’t just pick up and leave.

Couldn’t just pick up and leave. So I was subsidizing Delta Airlines to an incredible amount of money for a couple of years, but one advantage was I could work sixteen-hour-days. So that after a year I knew what the issues were, I knew who the main characters were, and but even at that I was being looked at for the presidency of Tuskegee and I knew that. So if this didn’t work out and I really went after that job very strongly, I could probably have had it. There were options. So it was nice just under the sense of pride and the
challenge, I wanted to do a good job here, but I really at that point in time never thought I’d have a twenty year career.

LaBerge: Yes. Let’s go to your internship. How did you choose, how did you decide what you wanted to do and where you went?

Hopper: Well, with internships you match. The way they, you apply to a certain number of places and then these places look at the total number of people who have applied, and they go through it, and then they match you. So it’s a matching program. I liked Milwaukee County Hospital because it was associated with a university, with Marquette University at that time and the Marquette Medical School. But it was a county hospital. When I had gone to look at it, I thought I had died and gone to heaven. It’s this big, beautiful building, a county hospital. I had been in this grungy pavilion city hospital for so many years. So the notion of working in a place like that let me put this very, very high on my list. They had a general rotating internship. Back in those days unlike now when you are forced as a junior or a senior medical student to kind of make up your mind on a specialty. Back then they had a general rotating internship; so that you rotated through all the major services, internal medicine, surgery, OB, pediatrics and then a few sub-specialties as well, which gave you an opportunity to really make a more educated decision about what you ultimately wanted to do. So I did the general rotating internship, enjoyed Milwaukee, met my wife-to-be there, announced to her mother I was going to marry her on the first date. Both she and her mother thought that I was crazy.

LaBerge: Do you want to tell that story right now. Should we just—okay, how did you meet her? First tell me her name. Barbara what?

Hopper: It was Barbara Johnson. Barbara Johnson was her maiden name. She was the head of a small group of about twelve or thirteen young black women that named themselves the “Eligibelles.” She had gone to the University of Wisconsin and was back at that time working as a counselor at the Jewish Vocational Services and so—

LaBerge: In Milwaukee.

Hopper: In Milwaukee and so the other African American intern that year, Eugene Mitchell and myself and then there was an African American medical resident who went on to have a really distinguished career, but we were constantly on the lookout for dates. We had heard about this group and had a, it was really the second date because the first date was kind of a group thing where guys and gals get together and talk in something of an informal setting. Then I asked her for a date, and then met her at her home, and then proceeded to tell her mother that I was going to marry her. We dated two or three times after that, but she didn’t take me seriously.
LaBerge: But you knew—

Hopper: Well, I, yes I kind of did. I kind of did. It wasn’t one of these things where I was moonstruck and, “my God I’m pining.” I was getting ready to go off to Hawaii as a single guy. But I came back two years later, and did a year of internal medicine at Marquette, Milwaukee County Hospital.

LaBerge: What were you doing in Hawaii, the Navy or—

Hopper: I was a Navy doctor, but I was stationed with the Marines, the Fourth Marines.

LaBerge: But in Hawaii—okay.

Hopper: Battalion surgeon with the Fourth Marines. In fact the Vietnam thing started while I was in the service. I thought for a while that I might end up having to go. But when I finished in ‘63, I went back to Milwaukee and did a year of internal medicine.

LaBerge: As a resident, is that—

Hopper: Yes. As a resident. Resident, in internal medicine and I was doing that, again not thinking that I really wanted to stay in internal medicine, but with a sense that this was a good preparation for whatever specialty I was going to decide to go into. So Barbara and I hooked up again and started dating—

LaBerge: So this was a couple of years after—

Hopper: Yes. This was a couple of years after I had—

LaBerge: Did you keep in contact during—

Hopper: Not really. Not really.

LaBerge: No.

Hopper: No, no. Not really. I don’t think we exchanged even a letter. But she was still there when I got back. I guess whatever qualities had led me to make this great pronouncement to begin with were still there. So we started dating and got married in 1964.

LaBerge: She grew up in Wisconsin.

Hopper: She grew up in Wisconsin. Right. She was born in Wisconsin. The family was from Macon, Georgia. Yes, she’s a Wisconsin girl.
LaBerge: You had some comments about both the internship and the residency.

Hopper: The internship was like every internship. Again the setting was so much nicer than I was used to. The hospital where I was trained and where I worked in Cincinnati was again in retrospect a big grungy city hospital where you saw all the pathology in the world. I mean that’s why you left there, when you left the University of Cincinnati there was very little that stunned you. But Milwaukee County Hospital was in this beautiful park like setting. They had an actual dormitory for the interns and the residents.

LaBerge: Is that where you lived?

Hopper: Yes. Yes. You lived in the dorm which is right across the street so you would be handy. They could call you and expect you there in fifteen, ten minutes or so. What I remember about the internship is this wall-to-wall work. We would occasionally go downtown to a jazz club and look for girls. Eugene Mitchell who was my fellow intern was from St. Louis. He came from a wealthy family. His family owned a newspaper in St. Louis, very smart guy, extremely smart. Ultimately went on to do surgery and would ultimately came to a very unhappy end. But in any event what I remember about those years was work. That year was work, work, work. So going into the Navy went down to Great Lakes—

LaBerge: And how did you decide to do that?

Hopper: Well actually that wasn’t my decision.

LaBerge: Okay you had to.

Hopper: We had a military obligation at that time. I did have some choice once I got into the Navy of choosing to go with the Marines or staying in typical Navy billet. But no, this was a kind of a uniform obligation at that time, the two years. I had my preliminary training at the Great Lakes Naval Base in Illinois.

LaBerge: And where?

Hopper: It was Great Lakes Naval Base there. Then after, I think it was about probably, it couldn't have been more than like two or three weeks if that, then we were shipped out. But it was during that period of time where I could’ve, you were given a limited number of choices, and of course one of those was to go and be a Marine for all intents and purposes. That’s what I chose and ended up in Hawaii.

LaBerge: In Hawaii the whole time.
Hopper: The whole time. The whole two years. At Kaneohe Air Station, which is on the opposite side of the island from Honolulu.

LaBerge: So what were you doing?

Hopper: I was doing several things. As a battalion surgeon I had the responsibility for having sick call for the entire battalion. It wasn’t so bad. I had corpsmen. I had like three corpsmen who worked for me.

LaBerge: Who were doctors too or—

Hopper: No, these were trained corpsmen who later on were the kind of people who became emergency medical technicians. So after sick call in the mornings then in the afternoons I would work in the dependent clinic for the wives and children of the servicemen. Then every fourth or fifth night would do call in the small hospital, the infirmary hospital there, and I would have patients. I would admit patients there and take care of them. Then when they were too ill so that we couldn't really handle them on the base, we would send them to Tripler Army Hospital in Honolulu, which is a big well-equipped hospital. Again Hawaii was, those were two absolutely marvelous wonderful years. Even in the Marines when you spend it in paradise, it ain’t bad.

LaBerge: Now you were called a surgeon, but you weren’t doing surgery.

Hopper: No. No. I was not doing surgery, but you were called a surgeon. It was routine minor stuff. I was setting bones, setting fractures and suturing lacerations and treating relatively minor injuries. Eighteen and nineteen year old kids don’t have that much wrong with them. They get the flu and stuff like that. Some of the more challenging cases were actually in the dependents, and I remember learning to recognize, even though I had excellent psychiatry training at Cincinnati, which was one of the really old fashioned psycho-analytic programs there. Even with the medical students you got a taste of this, but even though I’d had that kind of training, it took me a while to recognize that a great deal of what I was seeing among the wives of these servicemen was depression. Their husbands were off on some billet some place on duty, and the pay was not very good so that they were constantly struggling, and so it took me awhile to realize this myriad of complaints I’m like, how could these young women—

LaBerge: Be so tired—

Hopper: Be coming up with all these symptoms. For a while I was running all these tests, and then I thought they were coming back negative, and I thought I’m going to have to adjust my—I remember the guy who was over us was a Navy captain Robie. In later years I thought he could’ve saved the Navy a lot of money or the Marines a lot of money if his orientation to us had included the fact that in the dependent clinic. But I think they wanted to give the
dependents every doubt, every sense of the doubt just to be sure because a lot of the enlisted men of course could’ve opted to get out of the service. So one of the things was “we’re getting medical care for our wives and kids.” So it was a good two years, an outstanding two years. I met some lifelong friends there, one of whom Frank Peterson became the first three star African American General in the Marine Corps. A guy with the unlikely name of Gary Cooper who was about six feet six inches tall and who was a squad leader at that point in time, but ultimately became a full colonel and then more recently was the ambassador to Jamaica. Carlos Campbell who became an assistant secretary of commerce, Gordon Fisher who became a full Navy captain and had his own ship for a while. We were, it was a real, I used to send them cards. I said we had a real gathering of the eagles back at that time. We kind of followed each other’s careers along. Frank would, when we got out of the service and was in Milwaukee, Frank and Carlos, Frank commandeered an airplane and flew all the way out to visit us in Milwaukee. So good years, those were two good years. Then the year of internal medicine, that was most memorable because that’s the year I married Barbara. We were nesting and enjoying early married life, and then I did a year of neurology there.

LaBerge: At Marquette?

Hopper: At Marquette.

LaBerge: Okay. I didn't realize it. Okay. How did you choose neurology?

Hopper: God, I think because it was so, I can’t believe I’m saying this. It was so logical because neuroanatomy back at that time was this nice, clear-cut thing that this function is located in the right hemisphere in this lobe. You could trace those tracks down through the spinal cord. That was so logical, and I had done well in neuroanatomy in medical school. It wasn’t so much, it was the challenge, see, because neurology with few exceptions was a diagnostic specialty because very few of the things that we could diagnose we could actually do anything about back at that time. You could treat myasthenia gravis using neostigmine. You could help the internist control diabetes for the peripheral neuropathies and this kind of thing. But one of our biggest functions was in fact telling the neurosurgeons that the tumor is more than likely located in the left parietal lobe here because the diagnostic tools we had at that time were so crude and dangerous. If you talk about sticking a needle in somebody’s carotid artery and injecting radio-opaque contrast material, so we were, it was primarily a diagnostic specialty, and therefore had a lot of intellectual challenge and curiosity. But perhaps the outstanding thing that I was known for at Marquette, back at that time—and when I went back to give the lecture, the big lecture recently, there was somebody there that remembered this— that I had made an exceptional diagnosis on the psychiatric ward—. At Milwaukee County they had a closed ward, and this young woman had come in with what was being diagnosed as some kind of psychosis. She was weak. She was out of her gourd. I remember and
somebody said and well she has a urinary tract infection because she’s urinating blood. I remember walking in and all I did was just test her reflexes, and they were gone, and I said this is porphyria. I don’t know where it came from. For weeks that was the talk that there was this doctor—. But the neurology program was a program that was being started kind of from scratch, and it really wasn’t all that great. So I applied to the University of Wisconsin and went over and was interviewed. I applied actually, during the time that I was in the year of internal medicine I applied at Wisconsin, and Frank Forster didn't have any space that year. But he says, ‘You’re a Cincinnatian and you come back.’ Sure enough the next time I applied they did have a space, and so I did my last two years of neurology at Wisconsin.

LaBerge: In Madison.

Hopper: In Madison and stayed on the faculty. In the last year of my residency I was the chief resident and had responsibility for about sixteen residents as I remember. Stayed on the faculty, got a National Institutes Fellowship to start a multiple sclerosis clinic. Demyelinating diseases became my thing within the department. I then developed a clinic there at Madison, a home base, but also then developed satellite clinics in LaCrosse and in Green Bay, Wisconsin as well. The scary part about those years is that I also worked with a slow virus research team that was dealing with something called transmissible mink encephalopathy. These organisms are called prions. In fact one of the guys, God forbid I’m not going to be able to think of his name, but one of the guys from UCSF fairly recently got the Noble Prize for his work with prions. But it’s scary stuff because it was related to a disease called Jakob Creutzfeldt and then to a disease that had been seen in New Guinea called Kuru. So this was an animal model for what was a very, very dangerous. I’ve often thought how fortunate I was to not—

LaBerge: Contract it.

Hopper: Contract that stuff because there were people who did who died later on. But I got through that. I enjoyed my work with multiple sclerosis. But this was during the revolution. This was in the late ‘60s when the Black Power Movement. There was all sorts of furor on the Berkeley campus, that extended to Wisconsin.

LaBerge: Yes, Wisconsin was really one—

Hopper: Oh I remember my wife and I, I had bought a house, and we were a good—oh maybe four miles from campus, and I remember being awakened early one morning, maybe three or four o’clock, and one of the buildings had blown up on campus. I think a graduate student got killed. But given all that was happening and I remember also we called Barbara’s mother at one point in time because—I think this was after Martin Luther King was killed, and there were all of the riots going on. I remember that the police had basically closed
down a portion of Milwaukee, and I remember that we called Barbara’s mother in Milwaukee, and she held the telephone out to the window, and you could hear the tanks going through the streets. But the sense I have was that something very monumental was occurring in the country and here I was teaching a sea of white kids about demyelinating disease and while there was so much that was undone in the country. One of the people that I had met that we knew, his name was Nathaniel Calloway who was an M.D./Ph.D., African American guy who kept talking to me about Tuskegee. As it turned out Nat Calloway was the son of one of the people that was a right-hand man to Booker T. Washington. Nat kept telling me about the Carver Research Foundation and about the John A. Andrew Memorial Hospital and all that and finally got me to agree to talk to the president at Tuskegee, and as I said I was frustrated because I didn’t feel that I was making any significant contribution. I was a darned good neurologist. I had started a clinic network. I had the respect of my colleagues. I had written a few papers, but the things that were going on elsewhere seemed so much more important than what I was doing. To make a long story short that led to my agreeing to talk with President Luther Foster at Tuskegee about the job of medical director of the hospital. I took it, and those were incredibly exciting years from ‘71 until ‘79. I can’t begin to describe, all the things that we were involved in in that community. It was a story all of its own.

LaBerge: Do you want to stop? It’s late. Do you want to start there next time?

Hopper: Yes. Why don’t we—

LaBerge: Yes. And we might go back and talk a little bit more about what was happening in the country.

Hopper: Okay. Okay. Okay and in the meantime I will try to pull out some of the key people and issues and events from the University of California too.

LaBerge: Fine. But we won’t get there I don’t think.

Hopper: No. All right.

[End of Interview]
February 8th, 2002, and this is interview number three with Cornelius Hopper. Well, last time we had you at the University of Wisconsin faculty. But what I wanted to go back to was your kind of growing consciousness of the Civil Rights Movement and how that affected your behavior then. What were some of the triggers that affected you?

Well, I think, the sixties generally was a time of real civil rights activity, and although much of that time I was in the residency program, and again very absorbed in trying to do what residents do, I clearly was aware of it. My wife and I joined a group of young, black faculty members at the University of Wisconsin. I even forget what we called them now. That will come back at some point in time. But where we would get together once every two weeks or so and try to identify issues even within the Madison community. Even as small as Madison is and as unique as it is, there was a small, deprived, predominantly minority community there in Madison. These were faculty members. These were in some cases people who were in city government, in state government. It was an outstanding group, and in fact, we’ve kept up with each other through the years. One of the people went on to become the athletic director at Michigan State for a period of time, and then another one—. Anyway, they did very well.

During that whole period, there was an awareness of civil rights issues. There we were in Wisconsin, being one of these very liberal campuses where there were lots and lots of things going on, but I think Martin Luther King’s death and the kind of national outpouring of both grief and outrage was something that affected us very deeply. I remember being asked by one of the radio stations to be interviewed about my feelings about it. I remember being very conflicted because even though I honored Martin Luther King, I recognized a great man and a tremendous orator. I was really not non-violent. That was not, and that’s frankly quite true of a lot of young African Americans of that time. We recognized the value of the movement, but the notion that this would require sitting at a counter and having people pour things over your head was just not—. But I do remember, I think I mentioned before that my mother in law from Milwaukee, when their riots were going on, held her telephone up to her window, and we could hear the tanks in the street of Milwaukee.

That was a period of time I think that we tend to minimize at this point in time. We tend to minimize the level of upheaval that there really was in the country, and there was a lot of drama. There was a lot of game playing, but there was a lot of very serious challenging to American stability. So in any event as time went on, as I finished my residency and was on the faculty, and I
told you about having the responsibility for the demyelinating diseases program within the Department of Neurology.

The other things that I did is I chaired a black studies department feasibility study. I remember writing to the person at that time who was—I think he was the vice chancellor. I can’t remember what Ed’s actual title was. But he was like the executive head of the campus. I said at the time like if you really are not serious about this, you really shouldn’t do it. You shouldn’t do this in a response just to the fact that people are waving flags and raising hell on campus because it’s a lot more serious than that. But in any event that did lead ultimately to the formation of a black studies program at Wisconsin. I didn’t teach in it. I happened to be handy and vocal, and therefore, the university maybe appropriately used me to try to get something started at that time.

But I mentioned that one of the people who had moved to Madison was a physician, an M.D.-Ph.D. whose name was Nat Calloway, Nathaniel Calloway. Nat, as it turned out, was the son of one of the people who had been very close to Booker T. Washington, the president of Tuskegee Institute, many years ago. Nat was on the board of the Carver Research Foundation at Tuskegee, and we had many, many good conversations, very wise, and he said you might really want to consider looking at Tuskegee. I said, “Well, what do they have down there?” So he went on to the hospital. There’s a nearby 1300-bed VA hospital that the institution is very influential with. There are Allied Health programs, a school of veterinary medicine, there are all sorts of things that might—but more importantly, there are lots and lots of people who have needs for health care that aren’t being met. So I did. I was invited to Washington to meet with the president of Tuskegee and some members of his senior staff.

LaBerge: Who was the president? Do you remember?

Hopper: Luther Foster, President Luther Foster and some members of his senior staff. I can remember a lot of those names as a matter of fact, but in any event, he was talking to me about the possibility. I mulled it over for a period of time, and I finally decided, well I really, it’s one of these kind of watershed periods both in American history in my life. There are others who can do certainly as well and maybe even better than what I’m doing in the medical school at Wisconsin. Whereas by inclination and temperament and interest, there are some things that I might be able to do at Tuskegee that would be unique. So consequently, I took the job with a great deal of trepidation on the part of my wife who thought that the South had not changed at all. She said, “Okay. Two years, we’ll do it for two years, and then we’ll—”

LaBerge: Come back.

Hopper: “Come back.” After I was there for about six months in fact, my department chair, Dr. Francis Forster, and the dean both called and said, “Now Con,
you’ve had your fling, so to speak, why don’t you come on back home because there are lots of things that you—” I also served on the admissions committee at the University of Wisconsin as well.

LaBerge: For the medical school or the whole?

Hopper: For the medical school. For the medical school. I forgot to mention that, and I really initiated their first minority recruitment program for medicine there. So the things that I was doing at Wisconsin were, in the neurology department, they were useful. For the school and the university, they were probably even more useful in some respects because after all there were not that many—. I think I was the only black faculty member in the school of medicine at that point in time. In fact, the University of Wisconsin graduated its first black M.D. while I was there in the sixties. The first student who had gone from a freshman through the medical school and gotten an M.D. degree. Walter Hardy, I think, his name was. But in any event, so in 1971 I found myself in Tuskegee, Alabama, and—

LaBerge: Before we go into that, before this idea to go to Tuskegee came about, did you think you were going to be at Wisconsin forever? What was your plan?

Hopper: I really didn't have one. I enjoyed finally having gotten through my residency program and having established myself, having bought a house and had two small sons at the time. It was a great life. Madison’s a beautiful community. There are lakes there. There are all sorts of things to do. I was enjoying being a neurologist. I was a pretty darned good clinical neurologist. I was respected, and so I probably would’ve continued in that kind of career. But again, the importance of what was happening in the country, and I think, the knowledge or the awareness that there were not—I think there were only about five black neurologists in the country at the time, by the way.

LaBerge: Did you know each other?

Hopper: Yes. Well, two of us knew each other, and the other two or three—there may have only been four. But Dr. Calvin Calhoun, who had gone to Meharry—this is another story we’ll get to later on—was at the University of Minnesota in neurology residency. This was a second career for him, and we would get together at the American Academy of Neurology meetings, and as I said, there were only just a real handful nationally of neurologists or neurosurgeons for that matter. But given that there were so few, not just neurologists, but I think few physicians who had grown up in an environment and realized where there were a lot of resources that could be brought to bear in an area of real need. Because as a kind of a developmental politician, if I can put it that way, I knew what was happening in the federal government. I knew that there was the Comprehensive Health Manpower Training Act of 1971, and it was going to create things called AHECs, Area Health Education Centers. A lot of resources that could be brought to bear in ways or in avenues that were really
not that relevant in Wisconsin, but they were tremendously relevant in rural Alabama.

So I don’t mean to make this sound noble or whatever, but it really was a kind of a life changing Aha! experience, like you really have got to do something else besides be a good clinical neurologist or a faculty member at the University of Wisconsin. There are other things you can do. So I made the transition. As I said, I was in Tuskegee only a short time before I did get a letter and a phone call from my old chair and the dean saying—I went back and gave a lecture. But frankly, what I was spending my time on that visit doing was setting up an affiliation between one of the departments up there and Tuskegee to take advantage of that connection in a positive way. Anything more about Wisconsin or are there other things to cover?

LaBerge: Yes. How about the multiple sclerosis clinic that you established.

Hopper: Okay. One of my interests during my residency was with the MS patients, and Dr. Forster, Francis Forster, grand old gentleman by the way, said, “Well”—he always called me Connie—he said, “Well, Connie you know, we have a clinic that’s not anything’s being done with right now. Do you have any interest along those lines?” I said, “Yeah.” So I first then took over the multiple sclerosis clinic there and in the Department of Neurology at the hospital, and within a short period of time, I said, “Well, we already—.”

By the way, the way the University of Wisconsin School of Medicine is organized, at that time at least, we had referrals from all over the state. It was like the premier institution medically in the state, and I thought there was a tremendous opportunity to really do some research in multiple sclerosis, and so started off with the National Multiple Sclerosis Society. There was a chapter of that in Madison. I met then one of the people who did the ground work for the state in terms of the Multiple Sclerosis Society. He traveled around and so forth. I wish I could think of his name. But in any event, I said, “I really would like to get to know some of the people in the movement in the state because it’s like a kind of a religion of sorts. People who have these kind of illnesses that they latch onto—just like breast cancer does that, which is another story we’ll talk about some time later. But it’s like an extended family sort of thing.

By that time I had speaking engagements in Iowa and a number of other places, so they invited me up to Green Bay to Brown County to the hospital there to both speak to the medical staff, but also then speak to the Multiple Sclerosis Society. One thing led to another, and they were saying, “We don’t have any services up here.” I said that’s not going to be real easy to do because typically community physicians, even though they would refer their patients to the University of Wisconsin, their constant complaint was they never came back. So there was a natural, I wouldn’t call it animosity, but kind of a tension between the university and these communities. I met with Dan,
and I’ll think of his name, pediatrician there, but who was one of the key people in the Multiple Sclerosis Society there in Green Bay. Dan introduced me to the hospital director and I said, “I really would like to establish a clinic where I come periodically, and we can decide how often that would be.” He immediately wanted to know, “Well, what about the financial arrangements?” I said, “Well, I think that what I’m interested in is whether you’re providing the service. I think if there are charges to patients that can legitimately be expected to be charged, the clinic can charge them. I’m not that interested in—I mean because I’m getting a salary from the university.

So after about six months of running that clinic, I had a large number of patients, who of course they preferred coming to the clinic rather than driving all the way down to Madison. Then this was kind of replicated to some extent at the Gunderson Clinic over in LaCrosse, Wisconsin. Again they had a multiple sclerosis, a local chapter, and the university had good relationship with the Gunderson Clinic and the hospital, and I’ll think of the name of it, but I did the same thing. I started a multiple sclerosis clinic there.

LaBerge: So you’re the one who did the traveling to each of these—

Hopper: Oh, yeah. I had a team. I had an EEG, an electroencephalogram technician and would actually take a neuropsych technician along because the, we were doing research on, number one, classifying the various kinds of multiple sclerosis and the levels of disability and then relating these things to mental function. Really that part of the country had the highest incidence of multiple sclerosis anywhere in the country at that point in time. So I had a large, large population of multiple sclerosis patients. I did research on the use of ACTH, which is adrenocortical simulating hormone, corticotrophic hormone, use of ACTH in the treating the acute episodes of multiple sclerosis.

It’s a fascinating disease in that if you’re twenty-two years old and you come in with sudden blindness in one eye and some numbness and tingling in the other arm, and our first obligation of course was to rule out that you didn’t have a brain tumor or aneurysm or something like that. When we finally had enough data to verify a diagnosis of multiple sclerosis, then the first thing you’d want to know is well, what’s my prognosis. What’s going to happen to me? The terrible thing about it was that we had absolutely no way of knowing because back at that time, at least, roughly one-third of the people like I just described after ten years would be dead. Another third would be alive, but significantly disabled, and another third would have an occasional neurological symptom but would be perfectly fine, and there was no way then of predicting for an individual patient which category you’d fall into.

We know there was a tremendous amount of emotional overlay. This was something that I probably recognized because it had been recognized before, but the fact that people could really be talked out of exacerbations. What I mean is that their mental status or their emotional status during times of crises,
during crises in their lives, would really play its way out in terms of their symptoms because the fascinating thing about multiple sclerosis in its early phases is that the actual nerve cells in the nerve fibers aren’t destroyed. What’s destroyed is the wrapping, the myelin around it. If you could imagine a telephone cable through which there run about a thousand separate wires, and each one of those wires has a little wrapping around it, insulation around it. Well, with multiple sclerosis what happened is that the insulation would be stripped away, but the fiber itself was intact, so that under certain circumstances the fiber could function. Anyway—

LaBerge: That was the best description I have ever heard. I can see you were a good professor.

Hopper: Yes. Yes. But having patients understand the relationship, in a sense or the kind of intuitive relationships, between their mental status or their emotional status and what was happening to them in terms of their neurological symptoms was very important. So I spent lots of time. I’ll give the University of Wisconsin Department of Neurology credit. We were not on a treadmill at that time. Now you go into a doctor’s office, and it’s tell me about your immediate symptom, and let’s do this in about ten or fifteen minutes, and then we’ll deal with your other stuff later on. I was able to spend, I would spend at least an hour and fifteen minutes with the first visit with a patient so that my history and my neurological examination, the baseline exams were fabulous things.

I’d love to be able to go back now and retrieve some of that stuff and look at it again. So in any event, as I said, and I’m saying now to say that the decision to kind of give that up although it wasn’t the decision to give it up. What I was giving up was the faculty position. I wasn’t giving up being a clinical neurologist because I think I fantasized that I could go on doing clinical neurology, while doing the other things that were required of me as a director of a hospital and a vice president for health affairs. For a while I did in Alabama. I was getting referrals from a number of places in Alabama, and I was on the clinical faculty at the University of Alabama at Birmingham. I had a place that I could refer patients to because I didn’t have all the sophisticated equipment.

But over the next eight years or so, the balance between clinical work and my developmental work shifted totally. So by the time, I think I mentioned to you before, by the time I came here in 1979, I was probably doing only 15 to 20 percent time in clinical neurology.

LaBerge: Well, did your clinics keep on growing when you left Wisconsin or what happened with them?

Hopper: They kept going for a while. Certainly the central clinic in Madison did, but the other clinics kept on going for another couple of years or so. You had to
have somebody who was really interested in doing this and who was willing to travel all those miles. Wisconsin is a big state. So I had the sense that, well, I had taken the case of—oh boy, this is nice. Ken Viste, is a neurologist that was in—oh Lord what is the community. It was a community just south of Green Bay between Madison and Green Bay. Ken and I had worked together for a number of years, and I had the feeling that Ken, for some reason that Ken picked up a number of the patients and tried to carry this on. In LaCrosse, a number of the residents who had gone through with me, a couple of them ended up in LaCrosse in practice. Dr. Keith Bogart, for example, was in LaCrosse, and I think he picked up some of that work, but the actual network I don't think lasted for more than two or three years. I’ll go back and check that by the way. That would be interesting to find out.

LaBerge: Could we just follow this thread a little bit? What happened, like has a cause ever been found and are you said there’s such an incidence in Wisconsin? Are there environmental factors?

Hopper: Well, that’s something that still has not been cleanly worked out. It’s a fascinating story. If you start at the equator and the further you move north from the equator, the higher the incidence of multiple sclerosis became. I mean, it was almost like a linear kind of progression. We suspect that this was also the case as you move south of the equator, but if you look what’s south of the equator, there’s not very much in terms of being able to really figure that out. But they looked at all sorts of factors, the heavy metals in the soil, various kinds of infections and whether or not this was a long term aftermath of certain kinds of infections.

It was both puzzling and frustrating in terms of like, but what was ultimately and I’m really not up on the literature, but what was ultimately determined was that it was an autoimmune disease because that wrapping that I described for you, that insulation around the nerve fibers, these are actually cells. There’s a specialized cell that does that. They ultimately believed that the body for whatever triggering reason would react against these cells in such a way that some of these cells would die, and therefore, the insulation would be lost, and then a scarring process would take over. Now until the scarring occurred, as long as you had the fibers intact even without the wrapping, then periodically this would all work and things, you could see. Like I mentioned, the young woman would come in and would be basically blind in one eye for a period of weeks. But then the vision would return almost to normal. So you know that the basic neural fibers, the transmission was there, but over time within that, then scarring would occur. The scarring would move in and actually disrupt the fibers.

So the treatment that we were giving back at that time which was as I said, adrenal cortical stimulating hormone, which is a form of cortisone. You were stimulating your own adrenal glands to produce lots and lots of cortisone as an anti-inflammatory. We were giving it although we didn’t say it quite that way,
but we were giving it for the same reason that they were giving rheumatoid arthritis patients large amounts of cortisone because it’s anti-inflammatory. It interrupts that inflammatory process. But as I said, there was evidence much later that this was an autoimmune disease, and they started to attack this using drugs not terribly successfully even now, but using drugs that you use in autoimmune disease processes.

One of the tragedies that—and I’m kind of skipping all over the place. I’ll have to depend on you to bring these threads back together. But when I got to Alabama, one of the first things I did was recruited a group of very bright, energetic, young health service administrators, African American they were. One of these was a young man by the name of Henry Snelling. Henry and Avon Henderson were both from Pittsburgh, University of Pittsburgh, but Henry had gone to the Sloane School at MIT to do his master’s work, brilliant. He was the one who helped me organize the telemedicine system that we put in place in Alabama. He was into computers long before most people. The linkage I’m making here is about a year after I left, Hank came out to Stanford and got a law degree.

[Tape 4, Side B]

LaBerge: Okay, Hank came out to Stanford.

Hopper: Yes. Hank Snelling came out to Stanford. The step that I had missed was he had also, before he went to the Sloane School at MIT, he had gotten an engineering degree from some place. I forget now. But in any event, after he had spent the better part of the seventies with me, he came out to Stanford and went to law school and did well there. The linkage is that in about 1984, I got a phone call from him. He was having symptoms that were clearly neurological. So I said, “Hank, I think you really ought to be seeing—.” His was a different kind of, his fell into the category of the chronic progressive type that starts off with numbness and tingling in the legs and difficulty walking and stiffness and gradually moves up. He right now is tremendously disabled. I’ve often thought about the irony that I would hook up with somebody with my multiple sclerosis background who had this beautiful mind. He ultimately ended up, doing forensic engineering because his background as an engineer allowed him to. So even after he started in with all the symptoms, he still had a very productive career, and so anyway that’s the multiple sclerosis story.

LaBerge: It must be, somehow you have to keep your spirits up when that’s what you’re working with because it’s—

Hopper: It’s what?

LaBerge: It’s not good news.
Hopper: This is true of a lot of neurology. This is true of neurology at that time, with the exception of myasthenia gravis, and some of the sort of neuro-muscular diseases. It was primarily a diagnostic specialty because the vast majority of the time, the things that we would diagnose, we were either pointing to where the neurosurgeon ought to be looking when he went into the brain. Or we were diagnosing chronic neurodegenerative diseases that all you could do is palliative kinds of things. It’s not that these people died quickly. It was that they were long slow processes, and it’s even now there are people who say why did you choose neurology? I said, “As opposed to what, law?”

LaBerge: As opposed to OB/GYN.

Hopper: Right. Right. Surgery, which is what the people back at Cincinnati always thought that I was going to do. Again I think it was the intellectual challenge of being able to pull together sometimes obscure symptoms and signs and weave them together into a pattern and a diagnosis with a recognition that some of the things that you found you do some treatment for. The rest of it you really provided supportive services. But now much of what we did at that point in time has been superseded by CAT scans and MRIs. Now, you go into a doctor’s office with a headache and he doesn’t do a neurological exam. He sends you over for an MRI.

LaBerge: If any of that comes back, if there’s more you want to say on it at any point—

Hopper: Yes, okay, because I’m sure again, there are lots of things at Wisconsin.

LaBerge: And there are lots of linkages no matter—.

Hopper: Oh, yes. Oh, yes. Oh, yes. Right. Right. That small group of African American faculty members, not in the school of medicine, these were faculty members and graduate students in other departments. But the fact that we really did develop a kind of a kindred spirit, and therefore, had managed to stay in contact through all these years, like the Bentleys. Eugene Bentley is somebody who went on. He majored in, and got his Ph.D. in water chemistry, I think it was, and he went on to become a founder of an engineering company, and that company was one of the ones that cleaned up the Cuyahoga River at Cleveland. Remember the one that used to catch on fire? And has been tremendously successful, and so we’ve had a chance to go to their kids’ weddings and they come out and go to the Napa Valley. So those linkages, I think everyone, all of us who went through—.

I had mentioned to you that in the early sixties when I was stationed in Hawaii with the Fourth Marines, that again that cluster of people that we’ve kind of kept up with each other. They went on and did tremendous things. But I think there was a sense of duty in a way. I don’t think we articulated it that much. We were too busy waving flags and doing things at the time, but there was a tremendous sense of dedication and need to achieve and need to kind of
overcome in a way. So in that sense then, Tuskegee was perfect for me because it was built on the whole idea of service. This was the ethic that was articulated first by the founder, Booker T. Washington, and that wove its way through the entirety of the institution.

LaBerge: That group that you were with in Wisconsin, what kinds of things would you do? For instance you said you weren’t going to go sit-in at a counter, a drugstore counter, but what activities did you do?

Hopper: Well, we did some marching. No. No. We did some marching.

LaBerge: In Madison or elsewhere, marching around Chicago?

Hopper: In Madison. I joined at the community meetings that were going on in Wisconsin, in Milwaukee, where my wife—

LaBerge: Was from?

Hopper: Went, but most of our work I think was done at the power centers. You don’t sit-in the chancellor’s office. You go and speak to the power structure and say here is what you really ought to be doing. Here’s what you really must do if you’re going to be rational about it. I think that was in many cases more effective because I think the reaction to people sitting in your office is a temporary one. You get mad, and you find ways of dealing with that, but the more kind of insistent, well thought out arguments in terms of the basis for change. Why it’s important that the University of Wisconsin School of Medicine admit more minority students, for example, which is what I had a chance to talk to the entire faculty about while I was on the admissions committee. What importance that had within the overall philosophy of a university that held itself up as one of the really outstanding universities in the country and maybe in the world, that it’s outrageous that you are just now graduating your first African American medical student.

Arkansas did better than Wisconsin along those lines. Henry Foster who headed our OB/GYN department at Tuskegee and who ultimately went on to be nominated to be Surgeon General, but didn’t because some other things interfered with that. But Henry had gone to Arkansas, to the University of Arkansas and had graduated prior to the time when these people at Wisconsin were still kind of sitting on their hands. So in that sense then that kind of activism, number one it was much more suited to my own temper. But I think in retrospect, and I don’t think I’m kidding myself, I think that in some respects it was more effective than—but all this worked. Really you needed both. You needed people raising hell in the streets. Then you needed people—

LaBerge: To get attention.

Hopper: Then you needed people cleaning up afterwards in a sense for the long haul.
LaBerge: How did establishing the black studies department did the others in the group help you do that?

Hopper: Yes, there was a committee. Oh boy, this is very interesting. I chaired it. The other key person involved was Charles Anderson, Dr. Charles Anderson, and Chuck was a meteorologist. He was in the department of whatever department meteorology was at the time. There were only about five of us on the committee, and Chuck was the one that I remember because he was the one that I thought brought the seniority. He was older. I think was kind of a calming influence on the whole thing, but we actually came up with a plan, a rationale, identified a number of potential faculty members even there within the University of Wisconsin who would be good candidates for joint appointments. We thought even then it would be a mistake for them to give up their departmental affiliations, but we thought they would be able to contribute to this. It ultimately happened. It all came together after I left, but it ultimately happened. Of course, there are many black studies or African American studies departments and programs around the country. This was not the first by any means. But it was certainly the first at that university.

LaBerge: So probably 1970, ‘71. It was right before you left?

Hopper: This would’ve been just before that I think, yes. This would’ve been ‘69 or ‘70 when the activity happened, and it seemed to me that we were at this planning thing for maybe six months or so.

LaBerge: Well, let’s go on to Tuskegee then, unless you have something else that comes out.

Hopper: I’m sure there will be things that come back about Wisconsin.

LaBerge: One other thing, your sons. Tell me when your sons were born and their names.

Hopper: Yes. Okay, my oldest boy is Michael who is born in 1966. Brian was born in ‘68, and my daughter was born in Tuskegee in ‘71.

LaBerge: What’s your daughter’s name?

Hopper: Adriane. So it was Michael, Brian, and Adriane.

LaBerge: How involved were you in the parenting?

Hopper: Well, in Madison actually quite a bit. Some of the greatest pictures I have now are with one of the other young faculty members, a veterinary graduate student at that time, Donovan Gordon. Don and I have our two sons, Kendrick and Michael are wrapped around our necks, and we’re walking at the Sun Prairie Corn Festival eating these gigantic ears of corn, and the kids are
hanging on for dear life. I guess for the Madison years, I was really much more present and involved than I was in Tuskegee. Tuskegee was a twenty-four hour a day proposition. The kids even now, when they think about Tuskegee, they think about me on the floor writing proposals at one o’clock in the morning sort of thing. Surely my wife took over the major portion of the parenting during the Tuskegee years.

LaBerge: I know you were busy as a neurologist.

Hopper: As a neurologist. I’m thinking back that I dropped something one day by Michael’s crib, and he wasn’t startled. The light bulb went off, oh my God. There’s something wrong with this kid’s hearing. It turned out that he really did have a hearing problem. So they ended up having to put little tubes in his ear, and it corrected it after a while.

LaBerge: But some other father might not have noticed that.

Hopper: Well, right. Right. Well, not until more damage had occurred. I often wonder, I said, well how—because he would’ve been about probably about ten months old at that time. I’ve often said maybe if I were more astute, I would’ve even picked it up earlier on, but who knows. He turned out okay. So yes, we have nice movies of the backyard in Madison. The kids personalities already were formed at that point in time in terms of Brian being the second kid, the even-tempered one, but when he got mad he raised Holy Hell with everybody, and Michael being the kind of quasi-father, the old one, who was always very protective.

LaBerge: Isn’t that something how they are really established right then?

Hopper: Yes. Yes.

LaBerge: You think you’re going to have so much influence.

Hopper: It’s just amazing. It really is. Yes there is a lot more—I guess, the only other thing that I think might be worthwhile mentioning is that the residents, my fellow resident trainees in the Department of Neurology, I developed a number of lifelong friends there too. I mentioned Keith Bogart, who went on to LaCrosse. Phil Hansotia, who ended up with the Marshfield clinic. It’s in mid Wisconsin. A couple of the guys went on to work at the Mayo Clinic and periodically during the years, particularly when I was still going to the neurology meetings, I would see them. Those were great years, and I often thought that it was kind of interesting. It must have been a challenge to them to have me appointed as a chief resident and responsible for scheduling them and really kind of providing the kind of oversight that you’re supposed to provide as a chief resident. With only a couple of exceptions, they were very cooperative and very nice. The guy who was uncooperative it was very temporary. He got angry about being assigned to on-call duty during a time
when he thought he should’ve been doing something else, but Bill and Jane Wannamaker, again we became very good friends.

LaBerge: Well, on that subject, you’re talking about that they were very cooperative because they could’ve discriminated?

Hopper: No. No. I’m just saying, I’m sure it was a challenge they hadn’t had before. I’m sure it’s something that the chair of the department, Frank Forster—I never knew how he came to that decision as a matter of fact. In fact I was saying, ‘who needs this?’ but then I was astute enough to know that it’s not a bad thing to have on your resume to have been a chief resident. So that worked out, and that actually, that led me to be able to get a fellowship, a National Institutes of Neurological Disease and Blindness, NINDB fellowship, that kind of really made the transition into a faculty position a lot easier.

LaBerge: Going back to the military, did you feel any discrimination when you were in the military?

Hopper: Although in the military, again the military mind or the military way of functioning, is when you walk in with those bars on your shoulder even though you haven’t earned them for God’s sakes, I mean you’re an officer. I think when you’re dealing with enlisted men or their wives and dependents for the most part, I mean, you don’t, whatever you might feel along those lines if you feel anything, you probably don’t want to show it. So no, that was not a conscious or a visible issue, which was kind of interesting, given some of the experiences that I had in medical school. I mentioned before about patients from northern Kentucky not really wanting—

LaBerge: —do their sutures.

Hopper: No, they didn't mind so much the sutures. It was because see, it’s interesting. The difference, when you’re in the emergency room and you have on your paraphernalia and people are bleeding.

LaBerge: They don’t care.

Hopper: They assume that the uniform represents a badge of whatever. But when I was on the OB service, I clearly was a student. I think the objections, but again there was enough of the racial overtones here and there during my career at Cincinnati that really wasn’t the case when I did my internship in Milwaukee. I told you before that it was such a totally different set up, just a beautiful setting. So when I went into the military, number one, I wasn’t looking for it, and number two, I just wasn’t aware.

LaBerge: I’m going to put that in the notes.
Hopper: Not visibly, but what are you going to do? I mean, what are you going to do? Send me out? I might be happy to have my two-year tour shortened!

LaBerge: But it’s even too bad we’re talking about, that this is even an issue. You know, what I, for sure. But you know better than I do.

Hopper: But that’s the reality of American life though. That’s changed. I again, I still I get frustrated at times, but then I think about it and say well, why should it be otherwise. My kids really had no idea what life was like back at that time. My daughter who is a tremendously sensitive, talented, spiritual person. Like when she looks at things like *Eyes on the Prize* on television, it’s like WHAT?! It’s like could this have really have happened because they grew up, well, a good portion of their childhood was spent in Alabama, but it was in a town that had a black mayor. Most of the city council was black. They grew up on a campus where it was an African American campus where the power elite were all African American. So there was not really this sense of being in the South in the sense that it would’ve been years before, or that it would’ve been even then had they had lived in a different kind of setting.

LaBerge: Then from Alabama, Oakland. Right?

Hopper: Then from Alabama, Oakland in ’79. But Tuskegee is an interview all to its own. Or maybe two.

LaBerge: Do you want to start on it?

Hopper: I think we could sketch it out in a way, but where do I start. I’ve already started in terms of why I made the transition.

LaBerge: Tell me what was your first position? Were you medical director?

Hopper: My first position was medical director of the John A. Andrew Memorial Hospital on the Tuskegee Institute campus. This was a, at that time, 150-bed hospital. The name John A. Andrew came from—

LaBerge: John A. or Johnnie?

Hopper: John A. Andrew. John A. Andrew Memorial, and the memorial came from the fact this John A. Andrew was the Civil War governor of Massachusetts, and his, either one of his children or grandchildren, I’m not even sure which, gave Tuskegee the money to start a hospital. They started the hospital way back in the 1890s.

LaBerge: Before Tuskegee was even established?

Hopper: No, Tuskegee Institute was established in 1882.
LaBerge: 1882. Maybe you want to tell me something about Tuskegee in itself, the history of it.

Hopper: Okay. Okay. Well, following the Civil War of course, a number of educational institutions were established for recently freed slaves around the country. One of these was Hampton Institute in Virginia. Again, I don’t know enough about that history in terms of who, I think there was a General Armstrong who was responsible for the establishment of Hampton. I wouldn’t want to be held to that. But in any event one of the students who went there in the 1860s or 1870s was Booker T. Washington.

LaBerge: He went to Hampton.

Hopper: He went to Hampton. His book *Up From Slavery*, he talks about the Hampton years. Of course, the instructors and the principal as they called them at that time, and the instructors were all white. But he worked, and it was very strict place in terms of what you were expected to do and the kind of work you were expected to do and so forth. But he developed a tremendous work ethic and a belief in the power of a good honest labor and hard work. That whole philosophy played its way out when he later on, and again another part of the story here is in following the Civil War of course blacks were enfranchised for a period of time in the South. Political allegiances developed, particularly where some white politicians really wanted the black vote. Blacks very early found out how do you trade off to get something for this.

LaBerge: You can fill it in when you see the transcript.

Hopper: But in Tuskegee, one of the people in that community, Lewis Adams, in exchange for, in a sense, backing this one politician, got a commitment from the state to establish an institution, an educational institution in the town of Tuskegee. Booker T. Washington was recruited from Hampton to come down and start this.

LaBerge: Was he on the faculty at Hampton by this time or—?

Hopper: I think he may have been, but not on the faculty, he had some staff position. I don’t know that they would have called him a faculty member yet at that time. But in any event, he was recruited, and he started the school in a little church there, started to have classes, and this was in 1881.

LaBerge: This was with state money? With state money?

Hopper: This is partially state money. It’s a very interesting tap dance that he perfected, whereas he got state money. The state was always able to then put a certain number of people on his board of trustees, but his other funding came from the northern power establishment, I mean the, I mentioned New England and—
The board of trustees was made up largely of philanthropists, business people, industrialists from the Northeast. He played that game tremendously well. I mean, he got backing from them, but also at the same time, was able to get some modest amount of money, and the institution still gets a modest amount of money from the state in exchange for having—. But it’s quasi-public. But it functions in every respect like a private institution.

Do they still get money from the Northeast, from the same?

Yes, but not nearly as much. Not nearly as much. The board changed about the time that I came out here. But in any event, going back to—and as I said, Booker T. Washington’s, he’s been reviled by many in the African American community as “Uncle Tom.” But his whole notion if I can encapsulate it, and I couldn’t do it nearly as well as his books do, is that the freed slaves number one, needed education. But it needed to be both a practical education, as well as a theoretical education. So whatever the course of study that the students had, they had to learn how to do something very practical. So they built the school. They did the bricks. I mean, they molded the bricks, dug the clay, built the buildings. The girls had to learn how to sew.

It’s interesting that even when we went to Tuskegee in the early seventies, there were still people around at that point in time who had gone to Tuskegee many years before and who were still extremely good at some of the very practical things. Many of them had earned their living doing that sort of thing. But he became—oh the other thing that he did is found ways of reaching out to the very poor, rural community, black community and recognized that their agricultural procedures, there were things that they simply didn’t know how to do. So he organized an extension. I mean, one of the first extension stations in the country was organized by him.

George Washington Carver was one of the people that he ultimately then recruited to develop the agricultural research, in terms of what kind of techniques would be best to go and tell the people. So he had wagons that would actually go, the Jessup wagon that would actually go out and hold classes and hold demonstrations.

Of course, this appealed to the northern philanthropists and industrialists, and it also appealed to the southern whites who liked the notion that blacks were learning very practical things. They weren’t terribly happy that there might have been a philosophy course mixed in here and there. But he took that posture and built the institution, was able to maximize on the fact that his students with their own hands had actually built the buildings—many of them are still there—and built this into a tremendous power base nationally. There are books now that go back and actually look at the extent to which he did wield a tremendous amount of power in the country. But more importantly I
think that there was a very genuine and continuous notion that service was at the heart of the institution. When you left there, you left to serve. Beautiful stuff.

LaBerge: Do you want me to turn this off?
Hopper: What?
LaBerge: Do you want me to turn this off?
Hopper: Yes.

[End of Interview]
The small white community hospital closed, and they closed in part because of the same reasons we were having trouble, that is, it’s a poor area of the country, and keeping a hospital open was difficult, particularly if you only had two doctors. We invited them to come into the John A. Andrew Hospital and about that same time, created a community board. I said, you can’t have it both ways. If it’s viewed as the Tuskegee Institute Hospital, pure and simple, with nobody having any say-so about it, except the institute board officials, you’re not going to be able to really pull together something like a community hospital. So we in fact did create the equivalent of a hospital authority and had a board, and had a number of community members on the board: the mayor, some of the county supervisors. That was a very interesting dynamic, because there were people at the institute who were really unhappy about that. This was their hospital, for god’s sake, for a hundred years or whatever. [laughter]

And you had just come down from the north—

Yes. But there was a recognition, because this was really late in my time, late in the 70s—there was the recognition that the closure of the other hospital, and the opportunity to bring the medical staff together into one unit, was a real opportunity. So the physicians, they came over and practiced for a while, they were never really comfortable. They didn’t like the fact that if you look at the organization of the medical staff at the John A. Andrew Hospital, it was under black control. There’s a lot of correspondence, there’s a lot of interesting stuff in my files on that. And when I tried to pull this together, to try and have it make sense in terms of the things that were moving in parallel tracks, I have the sense of being overwhelmed by how in the name of god did we do all that stuff?

What you’ve described to date is amazing.

It’s just—I don’t know. Well, you’ll see when I bring some of the stuff.

Yes.

Because I think some of the excitement of the young people and the sense that we were doing something very important at a very important time in the history not only of the institution, but of the state and of the nation, that kind of permeated the whole period that we—

What kind of connection did you have with other people on campus? Or were you kind of off on your own?

No, not really. I had an advisory committee. When I first got there, I had—I think we called it a Health Sciences, or an Allied Health Advisory Committee.
I had the dean of the school of veterinary medicine, I had Dr. Johnny Prothrow who was head of whatever unit it was that dietetics resided in, nutrition resided in, there was a unit on campus, a bigger academic unit and this was only one of the programs in it. The Human Resources Development Center, HRDC, which was something the institute had had in place for years, but actually had a huge outreach in the southeast in terms of jobs development, and the person who was the director of that, Ted Pinnock I had him on the committee. So, I had on-going relationships with a lot of people on campus. The director of the Carver Research Foundation, Dr. Henderson, James Henderson, who has a Berkeley connection too, by the way. But you run into the kind of ambivalence on the part of a number of people there, it’s like, god, we’ve been here laboring in the field all this time, and here comes this guy down from Wisconsin, he’s not going to let us sleep at all. He knows a lot of the buttons to push to bring money into the institution. We like that, but we don’t want him to move too far, too fast. [laughter] I got quite a bit of that from the Carver Research Foundation, from Dr. Henderson at first. But then he became a good friend later on.

LaBerge: Now, did you have any dealings with the Alabama legislature?

Hopper: Not directly. Indirectly, because one of the—there were two black legislators who were the first ever in the Alabama legislature, Thomas Reed and Fred Gray. Tom was a businessman, Fred was a lawyer. One of their tasks every year was in fact to keep the Alabama appropriation, they called it, it was a certain small amount of money that the Alabama legislature provided Tuskegee Institute. When I would venture into something that was going to be touchy, legislatively.

We can’t really begin to do anything more than just, I think, touch on it very lightly here. But in any event, in the 20s, it was in the 20s, I think, that they did learn—now I’ll have to go back and check this date too—but they did learn that the government then built a black veteran’s administration hospital, the Tuskegee VA Hospital, but insisted that it be staffed by whites, which was—and the Ku Klux Klan marched through the campus, and marched into the city of Tuskegee because they didn’t like the notion that there were going to be any black physicians that practiced there.

LaBerge: What, at John A. Andrews?

Hopper: No, John A. Andrews, that was on campus, that was owned by the institute. Oh yes, that was almost exclusively black, but the new Veteran’s Administration hospital, which again, had been built on land deeded to the federal government by Tuskegee—they built the VA Hospital, but the whites wanted then to control it. I think the initial superintendent was white, and again, there’s a long, long story about that as well, but the combination of the large veteran’s hospital, plus the John A. Andrew hospital on the Tuskegee campus made this a little oasis in terms of health care and even some real
innovative things that happened. When George Washington Carver, who was of course not a physician, he was a biologist and a botanist, when he was recruited to Tuskegee and Booker T. Washington did all these marvelous things with the peanuts— You may not remember, but Franklin Roosevelt was treated by George Washington Carver with some of the—

LaBerge: For his polio?

Hopper: Yes. For his polio. And had the infantile paralysis association, whatever they called it, the national infantile paralysis group, funded a major rehab center on the Tuskegee campus, right adjacent to the John A. Andrew Hospital to really—I think in part because of the name George Washington Carver, because the guy was a genius in many respects. There’s a long history, and I have a lot of this written out. I can find it. The synopsis of the history of Tuskegee from a health standpoint. In any event, there was the John A. Andrew Hospital, and the institute had funded this and had taken care of black patients from all over Alabama. In fact, when I got there in 1971, pregnant women all the way from northern Alabama were having to be driven across roads in the middle of the night, and passing by other hospitals that wouldn’t accept them, just to get to the John A. Andrew Hospital. Of course, that’s one of the things that I changed, because I told—after I’d been there a couple of years, I told the state director, the state health director, I put down in a notice that the very next time a woman died passing one of these hospitals that was a Hill-Burton-funded hospitals, remember Hill-Burton was federal money—

LaBerge: Yes.

Hopper: —that there would be a major lawsuit. I assured them that they’d lose it, and they’d lose their license. So, bit by bit, patients—by the time I got there, in fact, patients had already started to be accepted—for some reason, not as many OB patients, I’m not sure why—but other patients had been accepted at some of the other hospitals in Montgomery and then Auburn. So, in the late 60s, and I guess this would have been about ’65 or ’66, the institute had a very difficult decision to make, because the hospital by this time was very old and crumbling, it needed to be—they had to make a decision to either stay in the hospital business or get out of it. Staying in it meant investing in a new hospital. Again, this was back when I still was in Wisconsin, in residency.

And they made a bad decision, quite frankly, because by this time, again, in the mid to late 60s, and early 70s, other facilities had opened up, and patients had choices at this point in time. So we were left with a lot of very poor patients. I think about 70 percent of our patients were Medicaid patients. Medicaid was a relatively new program at that time, but it wasn’t paying any better then than it is now [laughter], which is really bad. So the hospital was in constant—there was a constant financial drain on the institute. And poor me, I was brought down there to rescue all that.
LaBerge: To rescue it. Well, even before this, what was the impetus to have a hospital on campus, if there wasn’t a medical school?

Hopper: Just to take care of people.

LaBerge: To take care of people.

Hopper: Service. People didn’t have anywhere else to go.

LaBerge: So it wasn’t just for students?

Hopper: No. Well, it was for students in the sense that one of the first schools of nursing in the state was founded there at Tuskegee Institute, and the hospital served as a training site for the nurses. But again, it was that whole notion that had carried through for the better part of the century—the place was about service, and if there are needs that are not being met, that somehow the institute ought to meet them.

LaBerge: It was for the whole of Alabama?

Hopper: Yes, to a large extent. Although most of the patients would have come from a six-county area surrounding Tuskegee. We got patients—and certainly in the years before I got there, back in the 40s and 50s, patients came from—they would say, go to the hospital down in Tuskegee, where the government will pay. Of course, the government wasn’t paying for it, this was coming out of a fund-raising of the various presidents at this time. The number of issues that I faced when I got there were pretty unfathomable. Nice, beautiful facility, 150 beds, but with a very small medical staff, and with a medical staff that quite frankly—these were African American physicians—were very much a controlling physician. They liked the notion that the hospital was pretty dependent on them, and they pretty much controlled the hospital. And of course, here comes this guy, still wet behind the ears from Wisconsin, who basically says, look, we’re going to have to have lots more physicians and we’re going to open the staff—we were going to do all these things that they really didn’t want.

LaBerge: Open the staff to?

Hopper: Open the staff to new physicians. Bring in new physicians, and have them become active participants. There have been physicians in some of the other areas nearby that had, what was it called, the Southeast and Alabama Self-Help, SEA-Self-Help, they had a medical facility and periodically, they had physicians that would come and work with them. Of course, those physicians were really not given very much of a welcome at the John A. Andrew Hospital. I was welcomed by the community, but not tremendously welcomed—not uniformly welcomed by the medical staff.
LaBerge: Who were you replacing, and what—

Hopper: I was replacing one of the medical directors, I just thought of his name, Dr. Eugene Dibble—had been a medical director there for, oh god, thirty years? Twenty-five or thirty years. He had a home nearby the hospital, raised his family there, and was kind of an institution himself. Well, he had died in the late 60s, maybe ’66 or ’67, and they hadn’t had a medical director after that. This is the person I was coming in to replace. But in any event, I had a lot of energy and a lot of interesting contacts from around the country at that point in time, that I had developed when I was at Wisconsin. So, consequently, I was aware that there was legislation in Washington to create a thing called Area Health Education Centers, AHECs, and was able to talk the president of Tuskegee—even before I came down formally—into traveling with me to Washington to talk about the likelihood of forming an AHEC, an area health education center, using a combination of the Veteran’s Administration and the Alabama Regional Medical Program, all these things you’ve probably never heard of.

LaBerge: No, I haven’t, so we want to hear everything!

Hopper: The Regional Medical Program, which was a national program, but there was one in Alabama, the Alabama Regional Medical Program, the Veteran’s Administration hospital was nearby, and I had wanted to model funding from the two of these to create a rural-based AHEC. Now, most of the AHECs that were being developed at that point in time were based in medical schools. The classical AHEC was one that was formed by a medical school and then branched out into satellite communities. We reversed this and formed an area health education center that was rural-based, using the Veteran’s Administration dollars and the Veteran’s Administration location, and Regional Medical Program dollars, but then we controlled it, in terms of—we invited in the medical schools.

We got the University of Alabama at Birmingham, we had the Meharry Medical College. Auburn University didn’t have a medical school, but we had a number of universities that then became part of that organization. It’s still there, by the way, the AHEC is still there doing marvelous things. So there was the AHEC, and then in terms of getting physicians and dentists in the community, we created the first National Health Service corps field station in the southeast. This was when the NHS, the National Health Service Corps was brand new.

LaBerge: Is it something like—explain what it is.

Hopper: Yes. The National Health Service Corps, the concept was to have physicians, after they had finished their training, provide a period of two years of service in under-served areas. Initially, this attracted physicians who really did have service in mind, who said, I’d like to go and spend some time doing this.
LaBerge: Something like a Peace Corps idea?

Hopper: It’s very similar to the Peace Corps. One of the differences was that initially—and the physicians I got, by the way, had just finished internships, and had not done their residency training. So it was clear, in fact, I wrote a letter to Washington after the first year that we had the National Health Service, and I said, if part of the principle behind the Corps is to attract young physicians right after they finish their training, with the notion of perhaps having them stay in these communities, then you’re going to have to change your focus to physicians who have finished their training and then provide the two years of service. Then there’s at least a reasonable chance that the communities might keep them.

My first three physicians, you know, went back to residency training and so forth. I was constantly having to replace them. What this did was give me a new source of manpower, physician manpower. These were bright—these were white folks too, which did not endear me to some of the physicians, you know. But when I think back on it, there was a kind of grudging cooperation that said, yes, Hopper’s bringing all these people with the federal money and changing things. But after a while, they kind of liked the idea that here was somebody who could take calls in the emergency room, and cover occasional things that came up. And these young physicians, they came in with their eyes wide open. They knew what kind of community they were coming into and the kind of pressures they were going to be up against, and they provided superb service. One of—Allan Silverman, I think Allen was from New York, Ken Ducker, in fact, Ken came to the Bay Area after he ultimately got his residency training in pediatrics.

LaBerge: Is he in Oakland?

Hopper: Yes.

LaBerge: I think he lives up on our hills.

Hopper: His wife is named Dahlia.

LaBerge: Yes. Because—[tape interruption].

Hopper: —Physicians—and very, very special person, cared a lot about children, he was interested in pediatrics of course, and took marvelous care of kids. Allan Silverman was heading towards being an internist, and that was his whole focus. I saw Dahlia, by the way, just as an aside. I saw Dahlia when I went—they had me present the Hopper Breast Cancer Award—I give those out every year.

LaBerge: Is this at UCSF?
Hopper: No, this is—well, you may remember, we haven’t gotten to this yet, I organized four research programs that I ran out of my office. One of these was the California Breast Cancer Research Program. So when I retired, they established awards in my name. I was invited back to present the awards this last time, and somebody walked up and said, “Con Hopper!” And I said, “Dalia Ducker!” I hadn’t seen her in many, many years.

LaBerge: Is it presented to a doctor, or a nurse, or who gets it?

Hopper: These are presented to researchers, to people who do outstanding—who have given outstanding papers or outstanding posters at the meeting, or who have written outstanding papers. In any event, that Health Service Corps, Ken and Allen Silverman were my first two physicians. I subsequently had an additional, I guess five or so, over the period of time that I was there. I also brought in a dentist, which was unusual.

LaBerge: This was under the same program?

Hopper: Under the same program, which was kind of unusual at the time. So we used that cadre of people as the core staffing for a Tuskegee Primary Care Network, which again, evolved over a period of probably five to six years, it was gradual. This was funded by the Robert Wood Johnson Foundation. I had lucked into the Robert Wood Johnson foundation just as they migrated from kind of this little sleepy little foundation in New Jersey with not much money and very little focus, to becoming one of the richest foundations in the world.

LaBerge: How did you know about that and get involved?

Hopper: Because I had been—by this time, I was involved in the machinery of the Alabama Regional Medical Program and knew a lot of the people in the state health department. One of the people in the Alabama Regional Medical Program that—he and I got to be pretty good friends, he was a bit younger—David Cusic—David moved into the state health department. David was aware of some of the things that we were doing with the Maternal and Infant Care Project. David was recruited to come and work for the Robert Wood Johnson Foundation just after they got all this money. So David knew about some of my own dreams and persuaded them that they ought to have a look at this program down in Tuskegee.

Sure enough, the foundation was a staunch supporter throughout the entire time. The Primary Care Network, again, the concept was to have a base, a center, there in Tuskegee that was run by family practice physicians, based at the institute, but then having roving teams, mobile teams, with—each one of the units had a family nurse practitioner, and I sent those out to UC Davis to be trained. One of the first nurse practitioner training programs in the country, by the way. These were Tuskegee nursing graduates, carefully selected—
LaBerge: By you?

Hopper: Yes. And so onboard each of the mobile units there was a nurse practitioner. The driver was trained to do some very, very fundamental laboratory stuff as well. And there was a nutritionist. We purposely used a nutritionist because that’s one of the programs that Tuskegee had, a dietetics program. Plus, nutrition counseling, in terms of what kinds of foods and how to prepare them and so forth, was critically important as they helped delivery for modality for the communities in which the moved. I have pictures of the mobile units here. I recruited—these things aren’t happening in quite the sequence that I’m giving them to you. But I recruited a number of young, brilliant, African American health service administrators who wanted to come and be associated with all this. Henry Snelling and Warren Henderson from the University of Pittsburgh. Henry had gone to the University of Pittsburgh, and then had gone to the Sloane School at MIT, and he was kind of the chief of that team.

LaBerge: You’ve mentioned him before in some other capacity, I can’t remember.

Hopper: Well, he came out—I mentioned that Henry, when I left and came to California, the year before that, he left to enter the school of law at Stanford.

LaBerge: That’s right.

Hopper: We had a tremendous team.

LaBerge: How did you even have this concept to do all these various things?

Hopper: Well, I’m not sure. Well, first of all, I bought fully into the notion that part of the mission, and vision for the Institute was, in fact, providing service. I had a database that said that those Black Belt counties, and Black Belt, by the way, though it describes a population, it was the description of the soil.

LaBerge: That was what the area was called.

Hopper: Yes, the Black Belt. As I said, it was descriptive of the population, because it had large proportions of black people as well. But I had a database, I knew about the housing, about the birth rates, the death rates, infant mortality and all of this stuff. So the question was, how do you take an institution that has a hub, a hospital that has a tradition that’s well-known, and bring into that environment, bright young people, physicians, administrators, organizers, nurses, and get them enthusiastic about developing a model of health care that would allow you to utilize this resource, the Tuskegee resource, to reach out into communities? You couldn’t—we’re talking about small communities, we’re talking about cross-roads communities. It would have made no sense, economically, to try to establish fixed clinics in most of those places, Hertzboro for god’s sake? So our notion was to take the clinic to them and to do this on a scheduled basis. The other person, critical person on the team—
Hopper: The other critical person on this team, or group of people, were what we called community health workers. What we did is we actually recruited, hired, and trained a number—and these were very often middle aged women, most of them were, who had roots in the community, who were well-known in the community, and who were based in the community. They were able to then provide the continuity between the visits, and could also refer patients who needed hospitalization on into the hospital. Now, the other kind of unique thing about the system was that it was one of the first examples of telemedicine in the country, in that our primary care physicians, our family physicians back at the base center in Tuskegee were able to write a prescription and have it appear simultaneously fifty miles away, so that a nurse didn’t get into trouble. That was my way of getting around the Alabama Medical Association, who—the whole notion of nurse practitioners, they didn’t like at all. Remember, this was a relatively new concept at the time.

LaBerge: It really—because there aren’t even many these days.

Hopper: Right. Well, now, nurse practitioners are pretty well accepted.

LaBerge: They’re certainly accepted.

Hopper: There were huge debates going on nationally in terms of what they were going to be allowed to do. [sneezes]

LaBerge: God bless you!

Hopper: What they were going to be allowed to do. That’s why I had to—once I had recruited the initial nurses—I had to send them all the way to California to be trained. The mobile units—we designed and fabricated, and I sent them out to Lockheed to be built. So while they were being built at Lockheed, I would have the nurses who were being trained at Davis, come down and provide insight into where certain things ought to go, or debate, because in many cases, they didn’t know either. Debate in terms of where this particular piece of equipment ought to be and so forth.

LaBerge: Was this the first kind of mobile unit in the country?

Hopper: There had been mobile—to my knowledge, this is the first one, and I have to say, to my knowledge, this was the first one where—there had been mobile teams, they went out for providing TB skin testing and that sort of thing. But to be part of an on-going, coordinated system, where these patients and these rural areas were tied into a system—once they were registered, they were in the system, so they were actually being cared for by the teams that would come, if the problem was such that the mobile team could take care of it. Or,
they were tied into a system where we knew them and they could come into the hospital for the kind of cure that they needed. That was a pioneered model.

And certainly, the tele-medicine concept of being able to write prescriptions—as a way of bi-passing, [laughter] frankly, of bi-passing the law. Because the nurse practitioner would know, they’d been trained, and they had a whole—there was a whole scope of practice thing that we had developed, and a formulary of the kinds of medicines that they were able to then make recommendations for. And the physician, back at the main office, then made the decision as to whether or not, based on what the nurse had been able to tell him—because we had two-way communications as well—whether or not this was something he wanted to write the prescription for, or not.

I think that it’s interesting. I’d gotten by this time, we’re talking probably around ’75, ’76. We did the AHEC very early on, the National Health Service Corps we introduced, I think, in ’72. But the Primary Care Network, the mobile system was really not fully in place until the mid 70s. By this time, the folks in Alabama pretty well knew me.

LaBerge: By that, do you mean all the administrators and the citizens?

Hopper: Well, the university people because they extended me a clinical faculty position at UAB in neurology. I was on the Alabama Regional Medical Program board. And the Regional Medical Program was very much interested in the kinds of things that we were doing, because it was very consistent with what some of their own objectives were. So I knew a lot of the movers and shakers in the state. Joe Volker, who was the president of the University of Alabama at Birmingham, and who played the legislature like a piano—when I would get into real trouble, Luther Foster, who was the president of Tuskegee, would say, well, Con, have you talked to Joe? I would say, well, why don’t you call him? [laughter]

I’m saying all that to say that I think that even though there was tremendous resistance to the notion of bringing the kind of federal dollars and what they saw as federal health manpower—now remember, this is the South, it wasn’t exclusively a racial thing, though there were overtones of that, but it was like the notion that there’s somebody over there who’s going to use federal dollars to supplant an existing health care system, however inadequately it might have been functioning. By the mid 70s, they kind of knew what I was doing. It was like, let’s kind of wink at it and hope he doesn’t go too far. That sort of thing. They never knew, quite frankly, when there would be a huge splash of bad publicity out of the Alabama medical establishment not wanting poor folks to be cared for. Anyway, these were very exciting years, extremely exciting years. Again, I’ve been back—one of the projects I still want to do, and I hope that I can—is to go back and trace the legislation that created area health education centers, for example—The AHEC, primarily because of the VA—the VA doesn’t go away, so that was a good stationary, continuing point. That
AHEC is still there, is still providing lectures, is still doing community services. The other thing is that the primary care network that we put in place, even though the mobile units are not there any longer, that migrated into, or was transformed into a federally-funded community health center, and that is still there.

LaBerge: In Tuskegee?

Hopper: In Tuskegee, but making use of—although, I suspect that the people that are functioning there now probably know none of this history—but making use of the network that we had created, and of the patient records—so when the hospital closed, and it ultimately did, by the way.

LaBerge: The one on campus?

Hopper: Yes. It was almost a forgone conclusion, although I left it in the black, I must say that.

LaBerge: So it closed after you left.

Hopper: Yes, it closed after I left. But I was facing some of the brutal arithmetic there that I subsequently faced here in California, you know, in Irvine and am now facing, to some extent, at Summit [Oakland]. That is that if a large portion of your clientele are indigent or if they’re government insured but their services are being reimbursed at fifty cents on the dollar, you’re going to continue to stay in financial hot water. Well, the University of California can fall back on the state, and we did. I’m getting way ahead of the game there. But we were able to talk the state into—we said, we chose these former county hospitals at your insistence, and so you’re going to have to come and bail us out. If we can show that we were providing good health care and doing it as cost-efficiently as possible, than you have to decide if these things stay open or not. Of course, the state did, and kept them open. But there was no comparable back-up in Alabama. Finally, the drain on the Tuskegee institute was such that the hospital did have to close.

LaBerge: Then where were the nurses trained, after that?

Hopper: We set up a network of training sites, sort of all over the country. There was some training at the VA, they went to Baltimore. That wasn’t all bad, in a way, the fact that they got some exposure to that sort of urban environment. Lillian Harvy, who was the dean of the school of nursing when I got there, was just a gem. She was already using Baltimore and some of these places. She was just not sure that the John A. Andrew Hospital was going to be solvent enough, and provide the patient material for the training. The other thing that we did, we started a School of Allied Health there as well.

LaBerge: On the campus?
Hopper: On the campus.

LaBerge: Tell me what that was about.

Hopper: That was physical therapy and occupational therapy. We made use of the Veteran’s Administration, again, being nearby and having a great interest in manpower, in that kind of manpower. So you can imagine a patient population of veterans, they needed that kind of thing. There was already in place a long-standing dietetics program on campus. So that when you put all that together—which is one of the things I did before deciding to really come—I said, well, if you look at what they have right now, both in terms of the hospital, both in terms of the John A. Andrews Clinical Society, the traditions, the linkages they have with Meharry Medical College—there was really an opportunity to develop a unique health education center, health education/services center that could build on all that tradition.

Again, I don’t want to over-state my role, because there were people that had been laboring in the vineyard long before I came. It was the combination of the Comprehensive Health Manpower Training Act of 1971, that provided money for, and the concept for AHECs, there was the National Health Service Corps, there was a whole variety of things in OEO, the residuals of OEO, and it was like, hey, I can play that game [laughter].

LaBerge: Just to go back, how did you know about that? And who did you go see in Washington when you originally went up there?

Hopper: There’s another name I will mention, Jack Geiger. Jack Geiger was a Tufts professor—this was back in the 60s—when I was in Wisconsin. He and Count Gibson, they were both at Tufts, and they pioneered the notion of the OEO, comprehensive health center. One of the places they did this was in Mound Bayou, Mississippi. Jack heard about me and some of the things I was doing, trying to get a black studies department going and so forth in Wisconsin, and we got to know each other. He invited me down to spend some time in Mound Bayou, at his health center in Mound Bayou. So I got to know a number of the OEO people there, although when Nixon came into office, one of the first things that he did was to try and dismantle a number of those.

LaBerge: Because these were all from Johnson’s administration.

Hopper: Yes, exactly. Oh, I can’t think of the guy’s name now, but I got this call from the president, President Foster, who was at Tuskegee, saying, they want you to go over—this is after I’m at Tuskegee, by the way—they want you to go over and look at Mound Bayou, with the possibility of taking it over. I mean, come on. So, Chief Alfred Anderson, who was the guy who trained me how to fly, but he also trained the black pilots, the Tuskegee Airmen. Chief and I, and a guy by the name of Ted Pinnock flew over to Mount Bayou, and what became very clear was that—oh, I wish I could think of the guy’s name. One of
Nixon’s henchmen really wanted to close the place down, and so in essence was dangling a carrot to Tuskegee, saying, take it over. What they really meant was, close it down. It took me all of about six hours to understand that, after I got there, just what was happening. I called President Foster back, and I said, number one, I don’t know what the carrot is that they’re dangling for you, but let me tell you, it’s not worth it. [laughter] It really is not worth it. Once I explained what was going on, he just—absolutely not. So a lot of the OEO—

LaBerge: What, it stayed open?

Hopper: It stayed open for a while. It stayed open for a while, and I think it stayed open mainly because even though Meharry Medical College in Nashville had not particularly liked the notion of Jack Geiger and Tufts being in Mount Bayou, Mississippi because this had been one of the places they’d been sending their students, you know. But, after a while, again, they thought, this is a pretty good thing, because the approach was that of a community health approach. You have to think about jobs, you have to think about nutrition, you think about all of these things. The quality of the water. It’s not just sitting at the clinic someplace and giving people pills. The community health program at Meharry gradually moved in, I think became the prime mover, and not OEO center. I don’t know at what time the OEO funding dropped out. I think when the OEO funding left, I think the comprehensive health center money 314(e) replaced OEO sponsorship—it’s amazing how some of that stuff comes back.

In any event, going back to me and Tuskegee and the transition. These were very heavy days. There was a sense in the nation—of course, Medicare and Medicaid had been in place by that time for about six years, and the expectations that had been built up in terms of people getting healthcare services, there was really not manpower to satisfy this. So there was a tremendous interest in innovative ways of maximizing the use of health care personnel. Remember, here in California in the mid-60s was when UC created the three brand-new medical schools, around the same whole notion that here we are building up these expectations but we don’t really have the medical manpower to provide the services. So, again, I’m giving you bits and pieces, a lot of these things are going on kind of in parallel.

I did spend some time in West Africa in the 70s, this would have been probably around ‘76 or so, as part of a team that went to Nigeria because there was interest on the part of US AID in seeing whether the model that we had put in place in rural Alabama might have some applicability, certainly in a less technologically-advanced way. But how do you, in terms of West Africa, how to do you take the—they didn’t call them community health workers, but they were the equivalent of a physician’s assistant, I forget what they called them. They were stationed out in the rural villages, many, many miles away, very often. How do you connect them in? What kind of, number one,
communication system do you use to connect them back to when they need back-up in terms of consultation and so forth.

More importantly, how do you get both these community health physicians and physician’s assistants or health workers, how do you get them to have their patients and themselves feel like they’re part of a system, a system that is going to support them, a system that they can actually get their patients into? So elements of what we were developing using Robert Wood Johnson Foundation money in Alabama, we were able to go and talk about that in Nigeria, and to a lesser extent, Liberia. One of the real saddest that I feel now is that a lot of the beautiful people that I met in West Africa back in the 70s, were subsequently slaughtered. They were wiped out by—well, by the upheavals that have occurred. In Liberia, in particular, in Liberia, which had a long-standing connection with this country, historically, there was just an exciting group of young physicians, administrators, public health people, sanitation people, environmentalists. They pulled together just a tremendous team of people in the Ministry of Health. My understanding is that virtually every one of them was killed.

So I worked very hard. My kids now, when they think of Alabama now, it’s me at three o’clock in the morning, lying on the floor writing grants. Had a lot of fun. Probably went places and did things that were uniquely part of coming out of a Tuskegee base. I did okay in Wisconsin too, in terms of being, I think, reasonably creative, but there is no base in this country quite like Tuskegee, at that time. You have the aftermaths of the whole racial revolution, the Vietnam War, the sense of ferment and possibility. That excitement is what brought a lot of these truly brilliant, creative young people who decided to come work with me. They were excited.

LaBerge: It wasn’t a kind of thing where you get a certain amount of money for medical school and then you have to go and put in two years, you have to give back?

Hopper: No.

LaBerge: This was really their—they decided to do this.

Hopper: As a matter of fact, I’ll come back to that, because the National Health Service Corps ultimately evolved, and I’m talking about, because it’s out there even now—it ultimately evolved into a scholarship program where students were able to get scholarships both while in medical school or in their residency training with the notion that there would be a certain pay-back in terms of numbers of years and months for each year of scholarship. Back at the time that Ken Ducker and Al Silverman joined me, this was purely something they did out of altruism. I mean, they were National Health Service Corps doctors, and therefore got a salary.

LaBerge: But they could have stayed in New York or where ever they came from.
Hopper: They could have gone on and pursued their lives like they ultimately did anyway. [laughter]

LaBerge: What’s interesting—last night on the news hour, the Jim Lehrer news hour, they had a segment on rural health care in the South now, now still it’s hard to get doctors. So now there are more foreign doctors, and the problems of that. So it’s still an issue.

Hopper: It’s fascinating. And New York made an absolute industry with using Medicare money to bring foreign medical graduates into their residency programs. Again, the amount of money that they got per resident from Medicare underwrote collectively—the money underwrote the losses they were generating in the hospitals. As I said, it was an industry. Quite frankly, many of the physicians, foreign medical graduates who have come to this country, and I’m thinking of New York because I have a particular vendetta with New York—they had absolutely no intention of going home because there were plenty of places, these small communities here that needed them, where they could go to. How can you say somebody, quite apart from the perhaps sometimes marginal undergraduate medical education that they may have had, who was able to successfully get through an internal medicine residency program at Mount Sinai, how can you—you can’t very well say that this is an unqualified physician, when this person moves into upper division or whatever it is that we’re calling it. [laughter]

There were, on the Tuskegee campus—I’ve been talking about the medical foreigners, but we had a school of veterinary medicine too.

LaBerge: That’s right, and did you have any responsibility for that?

Hopper: No I didn’t. Not directly. I used a number of their professors to, for example in radiology, to teach principles of radiology to some of the students. Because I did develop an affiliation back with Wisconsin, I brought students from Wisconsin down for a number of years. One of my good friends back there by the name of Dr. Judith Ladinsky, who was in community health, was excited to be able to send her students down to spend time with me. And the slow virus work that I was doing—research work that I was doing, a thing called transmissible mink encephalopathy back in Wisconsin, I actually brought some portions of that research along with me, and then I used veterinary medicine, the fact that there was a school of veterinary medicine and some really bright graduate students to help me with that—

Again, when I go back through the notes, I say, gosh how did I do all that stuff?

LaBerge: How did you do so much?
Hopper: Now, from this vantage point of having a poor memory and being old. Some of the stuff that I wrote—because I kept a collection of my letters—some of the stuff that I wrote I’m really proud of, at this point in time. An awful lot of my communication—it was not in writing papers, but in writing proposals and letters and stuff like that.

LaBerge: Those are the kinds of things that somebody might like to see.

Hopper: I’ll bring some of them in then. I’ll bring more stuff in than you possibly could be interested in, and we’ll see what fits once we get through this.

LaBerge: Now when we’re looking at those years, your title changed to vice president for health affairs, were you still doing the same thing?

Hopper: I started off as medical—no, basically I was. I was medical director at John A. Andrew Hospital at first, and in ’74, I think, they added the title of vice president for health affairs. I think he did that mainly to keep me there. [laughter] I was being recruited. I was having a tremendously difficult time with the local politics, not so much the state politics. Well, let me back up to help you get the setting. Tuskegee, again, in spite of Booker T. Washington and Tuskegee Institute—that had been a very, very heavily segregated city, downtown, for many, many years. When I got there, the white physicians in town, Dr. Robert Story and I forget the other gentleman’s name—they had their own little hospital.

LaBerge: Okay, that’s what I want—so there was a hospital where they practiced and where the white folks went?

Hopper: Well, where the white folks went, and some black folks, to their offices. But this was the private hospital, and this was part of a local medical association that wanted nothing to do with the fact that I was bringing in all these doctors. Particularly, these white doctors. [laughter] So there was a constant fight. The county medical society became in a sense the marshaling point for the folks who didn’t like what I was doing. They were periodically sending out edicts, and they would in turn—

[Tape 7, Side A]

Hopper: —Somewhat problematic from the standpoint of the legislature, I certainly was frequently a correspondent. There was not always a terribly good relationship between Tuskegee Institute and its president and these legislators, so I was walking a bit of a tightrope. Some of the other things that I did there—the family did—I was part owner of a radio station.

LaBerge: Oh, tell me about that!
Hopper: A very good friend, George Clay, who in—oh god, this must have been ‘73 or ‘74, George asked myself and Dr. Ellis Hall, who was a radiologist in the school of veterinary medicine, to become backers in a radio station, because there were very few black radio stations in the South at that time. So we did. He was a 55 percent owner, and Ellis and I split what was left in terms of the ownership. George was a good businessman. I did the initial conceptual picture of it—I’ll bring it in and show you. We were covering like twelve counties in the Black Belt. I saw that as a huge, huge, powerful tool, for good, but also just a powerful tool.

LaBerge: What kind of a radio station was it?

Hopper: This was an AM station, but later on—

LaBerge: Music? Talk?

Hopper: All of the above. We had young deejays from town. On Sundays, it was the typical religious stuff, the churches, and constantly selling ads, that’s how radio stations stay—and George was a good businessman, a very good businessman. To fast-forward on that, George and I then—Barbara, my wife, started her own real estate business, opened one of the first black-owned, female-owned, one of the first black, female-owned real estate companies in Alabama—New Horizons Realty. She used all of her profits, such as they were from that real estate company, to found a school, a private school, called the Tuskegee Laboratory and Learning Center. Because she and a number of others were really unhappy with the quality of the public schools, and she said, well, if we’re going to stay here, we’re going to have to do something. So sure enough, they started a private school.

LaBerge: Was it on campus?

Hopper: No, it wasn’t on campus. It was independent of the campus but had campus support. The campus was not at all unhappy that we were doing this because we were helping to keep the number of young families who probably would have left if they had been stuck just with the existing schools.

LaBerge: Were the schools in town segregated or not?

Hopper: To some extent, yes. Back at that time, there was the Macon County Academy—in other words, when segregation was declared, in the schools, outlawed, what the whites did was start their own high school, the Macon County Academy, and left the blacks with the public schools. And that remained that way for many, many years, and largely even now, although the academy ultimately folded.

LaBerge: But those were the schools your kids were going to, were the public schools?
Hopper: Yes. There was a small Catholic school—when we first got there, it was not such a big thing, because on campus, there was a—what do they call it, Chandler’s Children’s House. There was a kindergarten and a preschool. Montessori had a program, and that’s when they tried to tell us that—my second son, the lawyer—they didn’t use the term “retarded” but something like that.

LaBerge: Developmentally disabled?

Hopper: Because he was left-handed, and of course, he couldn’t do—and of course, they’re very much into motor stuff. I got furious, and I called Wisconsin, and took him back and had him tested, and he tested like 170 or something. I brought him back and slapped it down, like, get off my back! [laughter] But once they got beyond that stage, then it was clear that the schools that were going to be available just were not something—and then Barbara got together with some other people and went on and started the Tuskegee Laboratory and Learning Center.

LaBerge: Where did they find the teachers?

Hopper: They recruited them.

LaBerge: From all over?

Hopper: From all over. A number of the wives—the wife of the family practice doctor that I recruited, he wasn’t National Health Service Corps, he came in through the Johnson Foundation grant, Dr. James Carter and his wife Linda. Linda was the first principal, and she had an education background, so the teachers that they had were all trained teachers. But it was one of these things that we had to pay tuition, and you kept—Barbara, I hate to think of all the money that Barbara put into the school [laughter] but it kept her happy. That lasted after we left too.

LaBerge: Is it still in existence now?

Hopper: No.

LaBerge: But it did last.

Hopper: But it lasted for a number of years after we left. Our kids still maintain contact with a number of the students that they had that relationship with out there. Then, Barbara started a community called Heritage Hills built on the whole Tuskegee model of all of the black pioneers that had passed through the place. Then she developed a large, some called it public housing, subsidized housing thing. There were about nine buildings with about, I think, ten apartments in each building. We called that the Capricorn Apartments, because the wives of—my wife is a Capricorn, Dr. Hall’s wife is a Capricorn, and George Clay,
our partner, his wife is a Capricorn, so we called those the Capricorn Apartments. Then we built the first substantial office building for the—ultimately, it was called the Department of Human Resources, but back at that time it was called Pensions and Securities—it’s where poor people go. It’s where they do all the—

LaBerge: Social security, food stamps.

Hopper: Yes, exactly. We built a building and leased it to the state to house that, because they were running that thing out of a little trailer. So we built a beautiful building, 12,000 square foot building. I have to give Barbara credit for a lot of that. I didn’t have time to do all that, I kept her on the straight and narrow in terms of the book-keeping [laughter]. But again, to fast-forward, my business partner, George Clay, we sold the radio station ultimately, but then got them involved in the Capricorn Apartments, but we have a whole different set of partners for the Heritage Hills housing development, which was beautiful. This was on about twenty acres of land, and each one of the home sites was an acre, if you can believe that. It’s still there.

George Clay ultimately went into the legislature, the Alabama House of Representatives, had three terms there, and then moved into the state senate, which represented a multi-county district that was about half white and half black. He was just defeated a few weeks ago, after all those years in the legislature, by some of that same political group that are so powerful in this state, the lawyers, who didn’t like the notion of arbitration awards because arbitration takes away some of the money that the lawyers make. George had opposed some of the incredible settlements that people were getting in that area because people who would have lawsuits all the way up in northern Alabama would come to Macon County because they thought they would be able to get these larger awards.

He fought that, so the lawyers put—for that kind of race, like $200,000 is a lot of money, and that’s what the lawyers put into it. So he called me and said, I’m kind of embarrassed, but you know, I’m really relieved. I said, yes, I guess you are. So I said, what are you going to do now? Because he runs an insurance business. He said, I think—since I’m going to be in the legislature until next November—I think I’ll start a new business. I think I’ll become a lobbyist. [laughter]

But I’m still just trying to say we have had and have a tremendous friendship. So in some respects, Tuskegee is still kind like a home base in that sense, even after all these years.

LaBerge: Yes, and you were there for what, like eight years?

Hopper: From ‘71 to ‘79. Barbara was there for an additional two years.
LaBerge: Right, because she had her business.

Hopper: She had all of those, she had the business, she had just started the subdivision. We had not finished the—Pensions and Securities Building is what it used to be called.

LaBerge: Oh, Pension and Security.

Hopper: Building. Now it’s the Department of Human Resources. We had not finished the Pension and Securities Building, even though we had arranged the lease. So the decision to come out here, came at a very—in some respects a very difficult time. But I’m sure that Delta Airlines loved it.

LaBerge: So she was there and the kids were there for two years?

Hopper: Yes.

LaBerge: So they stayed at this Tuskegee school.

Hopper: Well, the institute, the Tuskegee Laboratory and Learning Center was still there. In fact, the institute had provided me housing, provided a home for me while I was there, and it was only a year after I left that they then—Barbara then built a home out in the subdivision, in Heritage Hills. Of course, she couldn’t stay with any good conscience in the old house, longer. [laughter] That’s still there too. We ultimately sold it. A lot of the things that—a lot of the investments, so to speak, that we made in that decade have borne fruit. Some, as is typical, don’t last. But enough of them lasted. Well, I frankly think, most of the time, when I go back to Tuskegee, they say, “Con, now where is Barbara?” [laughter] Because she always kept so much stuff going. They said she’s like the assistant mayor. New Horizons Realty had its own kind of reputation. And she loved—she would go out and spend time with these little old ladies who lived out in the rural area. They would have these little small houses, they were worth almost nothing. She got more fun—I used to tease her, I said, you get more fun out of getting these people relocated and new housing, settling them, than you do taking a college professor, who can afford a decent house. She said, well, yes, my background’s in social work, what do you expect? Again, there’s a lot of stuff that—I don’t know how long you want to deal with me, but there’s lots of things that when we look at some of the written material from those years, then maybe we can pick up some of the themes and track them if they seem of interest.

LaBerge: Yes.

Hopper: From those years.

LaBerge: Should we do that at another time?
Hopper: Yes.

LaBerge: Maybe end here and do that another time?

Hopper: Yes. What I’ll plan to do is bring in—I’ll bring in stacks of stuff and I’ll have a Wisconsin stack and I’ll have a Tuskegee stack, and then if it’s useful, I’ll have a very carefully selected California stack. Because that’s a much bigger stack, actually.

LaBerge: Yes. So we can look at those, and we can maybe go on to the California and come back to some of these things.

Hopper: Yes. I think it would be perhaps worthwhile to track some of this stuff.

LaBerge: Oh, I think so too. First of all, I don’t think it’s been recorded by anybody. I mean, this is going to be really valuable for people.

Hopper: Well, I hope so. It’s valuable to me, to go back and see. What I’ve done is go through my agendas and I’ve highlighted a lot of the names, that for god sakes, I’ve forgotten, and though, oh yes, like Dave Cusic is one I mentioned. Dave is the guy who really got me tied into the Robert Wood Johnson Foundation. I hadn’t thought of Dave in years and years, you know. That popped up as I was highlighting people in that stuff. Okay.

LaBerge: Okay.

[End of Interview]
Testing. Last time, we had sort of finished Tuskegee, but I’m not sure we really have covered it all, and you have had other reflections since we last talked. You’re talking about the little white hospital in the town.

Yes. Well, one of the things that I’ve done since we last talked was that I realized that I was giving you bits and pieces of things that were important, but not necessarily in sequence, and I will try to do that today. I realized that, for example, I talked about the fact that it was a residue of the segregated hospital system in the South, which only really began to break up in the 60s, in the late 60s, actually, when President Lyndon Johnson, god rest his soul, created a special task force in his government that went out to all of these hospitals, not only the ones that had gotten Hill-Burton funds for construction, but more importantly, the ones that had become very dependent on Medicaid and Medicare at that point in time. He basically said, you are going to desegregate your hospitals.

They fought bitterly, a lot of them did. One of the notable exceptions to this was the University of Alabama at Birmingham, that hospital—again, Birmingham with all of the emotional, historical things associated with civil rights, that UAB, University of Alabama at Birmingham Hospital Medical Center would kind of lead the way in terms of saying, yes, we’re going to desegregate, because that’s the thing to do. They did away with the white and colored signs and the segregated facilities and they didn’t go through the game plan that a lot of the rural southern hospitals, southern hospitals did, where they would hear that the inspectors were coming, and then they would very quickly put black patients temporarily with white patients, but as soon as they would leave, they would take them out and put them back in the segregated—

So it was very tough. This little hospital, the Macon County Hospital—it’s a misnomer, because it wasn’t really a county hospital—they may have gotten a very small amount of money from the county, that part I don’t remember. But I do remember that when I made the transition from Wisconsin into Tuskegee, I came head-on into one of the battles that was being fought by local government that was saying, you’re running essentially a segregated hospital in the sense that you’re not allowing minority physicians, black physicians to come on that staff, and you’re only having a token number of black patients as well, and you’re becoming a drain on the community, so why not close ranks with the John A. Andrew hospital? Of course, they wanted no part of that. I mentioned that last time, that later on, when that hospital actually closed for a short period of time, the physicians did have staff members at the John A. Andrew Hospital.

Again, as I thought back through the sequence of things, again the Area Health Education Centers, the National Health Service Corps, the battles in
getting some of the local physicians to accept some of the things that we were trying to introduce—all those things came back into perspective as I looked—after our last interview, I went back and I looked again at the big folders of stuff that I have on Tuskegee—and it brought a lot of that back to mind. Again, I think that as all this gets transcribed, if there are errors in terms of sequencing, of things that I talked about last time, we can perhaps correct those.

LaBerge: Yes, we can move things around.

Hopper: But as I mentioned as we walked in, going back and revisiting some of that proved to be almost as emotional as when I first started to talk about it before.

LaBerge: Yes. Because it was a special time, those years.

Hopper: Oh, they were.

LaBerge: Also, the amount that you did. I mean, when you left Tuskegee—why don’t you just talk about that—what legacy did you leave there, and who did you hand it on to?

Hopper: I handed the administration part of it, that is, the running of the program—there was a team I put in place, for example, the director of the Tuskegee Area Health Education Center, Walter Oldham, had been in place for a while, and he had recruited staff. At that point in time, I was mainly trying to keep the board, which was a multi-institutional board, kind of keep them watered and fed, so to speak. The primary care network, the Robert Wood Johnson Foundation funded a primary care network operation—was under the administration of the young administrators that I brought in from the University of Pittsburgh, from MIT and so forth. Even though I lost the key person, who came out to Stanford, Henry Snelling, two outstanding people were left there, Thomas Simmons and Warren Henderson.

So that was in place. There was a medical and nursing and dental team still functioning there. The John A. Andrew board, there was a new board by that time, and I served as the founding secretary of the board. The board was in place and functioning. So I felt that I’d left not just the building blocks, but I think, as things have transpired, some kind of permanent pieces in place, both from the standpoint of the educational program—the Allied Health Programs that we instituted on the campus are still there: physical therapy, occupational therapy, and the association with both nursing—and to some extent, to a lesser extent, veterinary medicine, from the stand-point of the curriculum, to the extent possible, being integrated, to maximize those kinds of resources. When I left the hospital it was in the black. It didn’t remain that way very long, and we only got it that way through really Herculean efforts, as I mentioned last time.
One of these documents here, when I made the presentation to the Tuskegee board of trustees, back in the early 70s, when they were really very concerned about the losses in the hospital, and the kind of financial burden that those losses were placing on the institute—at that time, I kind of summarized for them at least my feeling about the position that the health services program, but equally importantly, the educational things that those services and that hospital supported, how important that was to the institute itself. And they held on, they held on quite a long time.

In any event, I think—it’s hard to try and draw a period behind the Tuskegee sentence, and I will bring in lots and lots of material we can look through and see what might be useful for this kind of exercise. Yes, it was, in terms of the amount of work and the creativity, frankly, that was demanded of me as a leader, and I think was also being demanded of the institution at that point of time, because of its history and its traditions. Given the period in our history that the 70s really represented, this was after a lot of the civil rights legislation of the 60s, it was when there were still residuals in the South. I had pointed out that when I got to Alabama, we were still delivering a substantial number of the black babies that were delivered in hospitals in the state of Alabama. Incredible.

How the fact that those patients came to us reflected not just that this was the hospital that traditionally, they’d been able to turn to get services, but it also reflected the fact that in spite of hospital desegregation they were being subtly or otherwise turned away from hospitals as they drove the sometimes hundred and fifty and almost two hundred miles on these rural roads to get to the John A. Andrew Hospital. The role of that hospital, and the role that it played in health care for that population was very much part of the thinking of the Tuskegee board of trustees in trying to decide—well, it had been part of their thinking in deciding to even go ahead and build the hospital. Because remember, we talked about the fact that they had an opportunity in the late 60s to say, well, the handwriting is on the wall. There is going to be desegregation ultimately, and both patients and physicians are going to have other hospitals open up to them, so why don’t we call it a day and recognize that we’re an educational institution, a little poor place in the South, and not build this hospital? [laughter] I think it was—and I know, I looked back at those minutes from the board meetings—that sense of a service obligation was so deeply embedded in their thinking, in that board’s thinking. And that continued. Even through the years when we were losing money, and when that was having a negative impact on the institution’s programs broadly, that sense—that obligation was still very much part of the credo of the institution and also the—the way it operates, it was a given. So anyway, that’s Tuskegee, we’ll find our way back to it or forward to it, as we go through this from time to time.

LaBerge: As you’re talking about this, what about the other historically black colleges, is there that same vision of service, or is Tuskegee unique?
Hopper: Tuskegee’s unique in the sense that—in one of the papers that I think I brought talks about, on this personal note, it talks about or alludes to the fact that Booker T. Washington, when he founded the place, he did so around a couple of themes, one being service: you’ve got to provide service to your people. The second theme was one that you’ve got to provide a practical education along with whatever other augmentations you provide. Because he was such a powerful and influential individual—if you look at the politics of the South, and for that matter, of the North, from the mid-1880s on up till his death in, I think, 1915, he exercised an incredible amount of power, in part because the white South saw him as somebody who was able to accommodate their interest in retaining social separateness. He played that piano like that, like he had invented the scale. Very few key appointments of blacks in the country occurred without the phone ringing in Tuskegee, without his giving the blessing.

In that sense, he was unique, but the institution that he built around him was unique. After all, if you can recruit a George Washington Carver and Thomas Campbell, Sr., and a Calloway, and just mention all these people and the kinds of things that they did in terms of pioneering the whole extension services and the outreach—

To get back to your question, it is an absolutely unique place, however, the predominantly black institutions, colleges, in the country had the same kind of responsibility. The college that came closest to Tuskegee, and in fact pre-dated it, was Hampton Institute in Virginia. That’s where Booker T. in fact got his training. They too have had a very strong emphasis on the technologies, on engineering, on what one might think of as the “hands-on” stuff of the economy. There was a sense of mission. Atlanta University, Morehouse—I wouldn’t begin to try to name them all, but whether they were public or private, there was a sense that they were going to have to assume a substantial responsibility for “the uplift of the race”, and that they were going to have to deal with the kinds of educational raw material, with the students that came to them, that meant that the level of interest and the assumption of responsibility for education would go beyond what you might find in the mainstream schools. In that sense then, there was that kind of common theme, that kind of commonality in black institutions.

LaBerge: And still today.

Hopper: And still today. I think I mentioned that I’m on the board of Meharry Medical College, and that school trains more African American Biomedical Scientists than any school in the country, even now, it turns out more. Of course, regrettably, for many years, the majority of physicians and dentists, particularly, came out of Howard and Meharry Universities, and I think I have mentioned, perhaps not in this series of interviews, but maybe in the earlier ones, that one of the things that I was particularly proud about with the University of California was that they had, in terms of mainstream
institutions, these schools placed within the top ten of universities in terms of their production of under-represented minority students.

LaBerge: Was that one of the things that affected your decision to come here too?

Hopper: No. I had kind of paid those dues already. It was always going to be an interest, and I think that’s reflected in some of the papers that I gave in my earlier years here. But it was neither a responsibility nor an expectation that there would be a big focus. So this was kind of like an avocation on my part [laughter]. But there were plenty of opportunities to interact with people who were thinking this way, and who were taking responsibility in our schools of medicine, and particularly in our schools of public health. We have an outstanding track record in terms of training minority public health professionals. Less so in optometry, interestingly enough, and less so in nursing, much less so in veterinary medicine. But each of those professions and their histories here at the University of California responded to some extent to that interest.

LaBerge: Well before we leave Alabama, you were talking about how the University of Alabama just voluntarily desegregated. What about the other—what experience did you have with the other either hospitals in Alabama or other places in the South, what did you see? Even what you just told me about how they would change the signs when the inspector—I’ve never—that’s probably not written down places, things like that. Was Alabama unusual compared to Mississippi—?

Hopper: I suspect that Alabama, Mississippi, South Carolina, the “Deep South” states were a lot more resistant, but interestingly enough, Germaine, the desegregation of hospitals in the South—for that matter, some of them in the North—was a bloodless revolution, by comparison to the counters, you know, where kids were sitting at the counters and having stuff dumped on their heads.

LaBerge: Or busses.

Hopper: Transportation, the busses and so forth. One of the reasons being money. It came down to the fact that these hospitals had become so dependent on Medicare and to some extent, Medicaid, until the fact that that tall, profane man from Texas, who I learned to really appreciate [laughter], basically said, “Do it or the money will stop,” and that was a very powerful lever. You didn’t read very much about this back at the time, because as I said, it was kind of a bloodless revolution, in a way. But again, given the make-up of particularly the rural South, and rural Alabama—some of those smaller hospitals really drug their feet to the end. If you look at the socio-economic make-up of those communities, it was not likely that many of the black patients would come and bang on the door and say, will you let me in here, because they were dependent on the economic power structure in the community. So a lot of the
actual leveraging came from a unit that was formed in the federal government—I forget what it was called, now. It had a name that basically had to do with desegregation of hospitals. It wasn’t around very long, because it accomplished what it was supposed to.

But I think again, happily on the one hand, as hospitals started to open their doors to patients, in order to keep the money flowing, then it took longer for these hospitals to open their doors to black physicians. And remember, again, that the awful catch-22 that black physicians faced in this country was that first of all, the number of places where they could get post-graduate training to become specialists, was minimal, very minimal. Secondly, you couldn’t get on the hospital staff of most of these hospitals unless you belonged to a county medical society, right?

LaBerge: Yes.

Hopper: And the county medical society would not allow blacks in, so it was an incredible, I call it a catch-22. The residuals of that held on longer than opening the hospitals for patients. But ultimately, black physicians were able to get on to staffs, courtesy staffs, and sometimes, full staffs of the hospitals. Predictably, a number of the patients who used to come from Montgomery, or from Selma, or wherever, to the John A. Andrew Hospital, quite appropriately, began to use the hospitals in their own communities. They started to go to Baptist Hospital in Montgomery, and so much the better. But it meant that we were left increasingly with the truly indigent patients.

Given the fact that the Alabama Medicaid program paid a pittance, then the handwriting was on the wall long before I was willing to either see it, or once I saw it, to get others to see it. We either were going to have to break tradition and limit the number of indigent patients that we admitted, in favor of the patients who could pay, or find federal funding, a different line of federal funding, to cover this, other than just simply Medicaid. Or, as the natural thing happened, the hospital would have to close. That calculus, the compliments of that calculus had been there for a long time. As I think I mentioned last time, had I been wiser back in Wisconsin, I probably would have seen that, the world wasn’t going to remain segregated, and that was going to influence institutions like black hospitals, in ways that would be financially stressful, but paradoxically, would be very good for the black community.

LaBerge: Isn’t that interesting how often things come down to economics?

Hopper: Yes.

LaBerge: When you come right down to it.

Hopper: What’s the word they use—“follow the money.”
LaBerge: What about the county medical societies? How did they open up?

Hopper: By the time I got there—now remember, Tuskegee was like 80 percent black. There were only a couple of practicing white physicians in town, those who were on the staff of the little segregated hospital. So blacks controlled the county medical society.

LaBerge: That one, but what about the others?

Hopper: Oh, very few.

LaBerge: Then how did it come about?

Hopper: The control?

LaBerge: How did it come about that the societies then opened to blacks?

Hopper: I think—you know, I think it was a matter of evolution rather than revolution. And remember, there were not that many black physicians in Alabama. We had a big cluster of them in Tuskegee. There were several, I would say, four or five, now this was back in the early 70s, there were four or five in Montgomery, there were a handful in Birmingham, and a few in Mobile, and that was about it. So that the critical mass of physicians applying for county medical society membership was not there.

But I will always truly resent the American Medical Association because this was the body that was supposed to be speaking for American medicine. Had they said very early on that, we’re going to require our constituent societies, which were the county medical associations, to open up—but they didn’t. It was a long time before they did anything but pay lip service to this. I guess again, as these national organizations are so often do, they were hostages of their membership. If people started voting by not staying members of the American Medical Association, then I guess that was too much of a risk for them.

Standing on principle as I said, the University of Alabama in Birmingham—Joe Volker was the president there when I came, and I think I had mentioned him last time as somebody who was both trusted and I think very influential in terms of the Tuskegee Institute. The president, Luther Foster, Tuskegee, and Joe Volker got along very well. Joel always tried to find avenues for the institute to become involved in state-wide programs. So when I came, I almost immediately was invited to become part of the Alabama Regional Medical Program and to sit on some of their advisory committees. So UAB opened up a lot of avenues.

LaBerge: Did you encounter any of this in Wisconsin, like when you wanted to become part of the medical society?
Hopper: No.

LaBerge: It was mainly in the South.

Hopper: No, it was in the South at that time. Of course, again, in Wisconsin, you talk about a handful of physicians. I think there were only, at the time, in Madison, there was, aside from myself, and I was on the faculty, and another resident physician, there was only one black physician in town, Calloway. Now, there were several in Milwaukee, I think they called themselves the Cream City Medical Society, that was their group, which was a National Medical Association affiliate.

LaBerge: Cream City?

Hopper: Cream City Medical—you usually think of Milwaukee as being beer.

LaBerge: Yes.

Hopper: That was the name of the medical society.

[Tape 8, Side B]

Hopper: Yes, and the leadership, the leadership in Milwaukee were very vocal and very vigorous in terms of being sure that organized medicine, or for that matter, organized hospitals, were responsive to the community. People like Dr. Finlayson—what was his name? Bill Finlayson, who was an OB/Gyn. Again, I would guess there must have been—in the early or mid-60s, there were probably maybe ten active black physicians in Milwaukee.

LaBerge: Then I’d asked you earlier, but was off-tape, if you could comment on the disparity in health care for blacks and whites. Staring back there and continuing on.

Hopper: Oh yes. Well, it’s a tough subject, how many hours do you have?

LaBerge: Yes, right.

Hopper: Again, there are paradoxes involved here. Following the Civil War, and between the end of the Civil War and when Reconstruction—the Reconstruction thing started, I think it was in the 1890s, there was a period of time where although hospitals were segregated, they were segregated more on the basis of class and economics than they were on race. Not many people realize that, but blacks did have access to hospitals back in that—in that brief window of time. There were—oh god, I’ll have to research this later on, but I think there were like seven black medical schools in the country that were formed. It was only after the Flexner Report in the early 1900s that there was this revolution in terms of medical education that said you have to have a
scientific basis for it. So lots of marginal medical schools were closed. All but two of the black schools closed as well.

LaBerge: Which were Meharry and?

Hopper: Meharry and Howard University. But because of the exclusions of black physicians from hospital staff membership, and in many cases because—this is after Reconstruction—because of segregated and very marginal medical care, a number of black hospitals opened in the country. The John A. Andrew Hospital, I had mentioned before, even though it didn’t officially open until 1912, there had been a hospital on the institute grounds since the 1890s. Homer G. Phillips Hospital in St. Louis, a hospital in Chicago, Philadelphia—I can’t think of the names of all these. But these hospitals then became places where physicians could admit their patients and take care of them, but if you look at the burden of illness and disease in the country, there was still a tremendous disparity.

Now, following civil rights, and following the expansion of the opening of more medical school places for black students and increasing the number of black physicians in the country, one would have thought that—and with the hospitals now being desegregated—one would have thought that medical care for blacks and whites would start to approach parity. But the Institute of Medicine Report though, that’s been just released within the last year and a half, I don’t know exactly the date, points out something that some of us have known for a long time, and that is that the biases against black—and maybe this is true of other minority patients, but it certainly has been true against black patients—the biases in terms of both the medical care offered and the quality of that care, has just been incredible.

I’ll just give you a few examples. I’ve given some papers nationally on this, by the way, I’ve got slides and everything. It’s been shown that even if you correct for education, for income, for any of those factors that you can correct for, then black patients were receiving poorer care. They would have cardiac symptoms, they were not being given the high-tech kinds of diagnostic evaluations, and in fewer instances than in whites, were they being offered the same kind of coronary artery surgery, for example. Black patients in nursing homes would receive—who were in chronic pain—would receive medication only a third as often as whites. That’s been documented in paper after paper after paper.

I think the kind of sad element of this is one of the studies involved a very large, prestigious medical center in the East. When the physicians who were making those decisions were actually confronted with the data, they were astounded. This was going on at a sub-conscious level. It reflected, and these are my words now, it reflected a difference in the value that they had learned to place on the lives and health of white people versus black people. The fact that those values came through in spite of the fact that they might be dealing
with college graduates that had fantastic degrees and incomes and so forth, it made no difference. Those values were inculcated.

So we’ve got a long ways to go in this country, I think. One of the positive things of course is, in part as a result of the Institute of Medicine Report, which, as I said, re-emphasized something that had been seen piecemeal from the literature over time, in which a number of people, a number of us already knew—there has been a heightening of awareness, cultural sensitivity. The curricula in our schools of medicine now talk about cultural appropriateness. It sensitizes medical students to cultural differences, and I think in some instances, to the way that they react to patients in certain instances. In a sense, very early on in medical school, you can’t get away with it. I don’t mean that in the worst sense—you are not allowed to of kid yourself about this. That’s very helpful.

Part of the disparity is in health status. Let’s make a distinction here. Health status, for example, representing the incidence of things like tuberculosis or certain kinds of illnesses. That’s different in a sense, although things are connected, that’s different than access to care and the quality of care provided by the healthcare delivery system. Both are important. Right here in Berkeley, you still have blacks having low birth weight babies. The incidence of infant mortality, and there are many measures of health, are disproportionately negative in the African American community.

But that’s a distinction, that’s a different matter from whether or not a patient who goes to Alta Bates Hospital—well, back up, it’s a different matter than whether or not a physician in the community applies for membership of the medical staff at Alta Bates Hospital is admitted or not, and what kinds of criteria are applied there. And then if you go as a patient, what kind of care did you receive?

LaBerge: For instance, for a woman, if the doctor orders a mammogram or not? Or orders a bone density test or not?

Hopper: Yes, exactly. The attitude that a physician has—and again, I think the value system that a physician has about the practice of medicine, and how this plays itself out in his or her interactions with patients is the fundamental—that’s the guts of the issue. The individual physician can’t necessarily change how healthcare is organized, the physician can’t do anything about managed care at this point in time. But what we can do in our schools of medicine, what we can do as individual practitioners is try to adopt a value system in terms of the way that we practice our profession. Again, the promising thing is that the notion of cultural appropriateness is now being taught in medicine. I never heard of the term when I was going through medical school. [laughter]

In some of the papers I’ve written, I talk about some of the experiences I had as a medical students back at Cincinnati in terms of the kind of ways that
professors and staff would treat and refer to, and by body language, by body and actual verbal language, calling 70-something year-old people by their first names, for example. In one booth, and just then drawing the curtain—this is a big county hospital back at that time so you had these wards where the only separation between the beds were curtains. So here would be this 70-plus year-old black woman in this one cubical, who was referred to by her first name, and in very disparaging terms. You go to the next cubical, and here is white woman, about the same age, who’s referred to as Mrs. Whatever, and that speaks volumes. And it speaks volumes to the students who are standing around, being trained by these physicians. How much of that you kind of subconsciously absorb over time is a real question.

LaBerge: Now in your capacity as vice president here, did you communicate some of that to the schools? I mean, how involved would you get in those kinds of details?

Hopper: Not in a very detailed level except the kind of interactions I had with the associate deans who were in admissions, for example. I was able to keep abreast of what the outreach efforts were for all of our schools of medicine in terms of their trying to expand the pool of qualified applicants for medicine. I had an opportunity to both listen to and invite people like Doctor Nolan Penn, who’s a psychiatrist down in, he was on the faculty at the University of California San Diego, to invite Nolan to speak before groups in terms of his—he again had a very good grasp of this, and how these things were playing their way out in healthcare settings.

So again, my position was on the airplane at 50,000 feet [laughs] if I can put it that way. And surveying the scene, I was mainly interested in moving the mountains, or making sure the mountains didn’t fall over and crush us. Again, there were opportunities. As I’ve said, it’s been an avocation, going all the way back to the University of Wisconsin, where I was on the admissions committee. It’s been an underlying interest and set of concerns of mine that somehow, that organized medical education or health sciences education would find ways of being more equitable, open, and sensitive to these issues.

I didn’t bring my parting speech. As I said, I didn’t bring anything from the University of California.

LaBerge: Well, we’ll get that. My thought was too that some things that we talked about in the interview that you already have, we don’t need to repeat, we can just add to it. Should we go on to California, or do you have some more thoughts about Tuskegee?

Hopper: Yes. I think what I’d like to do in anticipation of our next interview is go back and look at some of the Wisconsin papers. I’ve talked about Wisconsin, what I’ve done there and so forth. But I do want to pick out a few of the letters, the position papers and so forth from back in that time. Because remember, this
was really back in the revolution, this was in the 60s when Martin Luther King got killed and buildings were being bombed on campus and stuff like that. I want to be sure that I pick up some sense of how the Wisconsin experience, in a sense, helped shape my future, both professionally and I think personally. That might be worthwhile in terms of this kind of history.

LaBerge: Oh, I think that surely it is.

Hopper: But I think then we can jump into the University of California. We can talk a bit about it today. One of the things that I had provided today was kind of my departing letter to the president of Tuskegee, and departing letter to the then administrator of the hospital. I think one of the things I mentioned in the letter to the administrator of the hospital—I just reread this this morning—I said, the California physician-involved system-wide policy and budgetary coordination, the five major university health science centers, and then I list them, and their teaching hospital. And then I said, a number of these are afflicted on a grander scale with many of the same problems that we’ve been facing here. I said, but it represents a level of exposure and opportunity for administrative experience that comes along perhaps once in a lifetime, and it was one that I simply could not refuse.

And I had that sense in my first few years in the university, given the fact that three of our hospitals had been formed around, at least in terms of their teaching institutions, large county hospitals. Those counties were not reimbursing us. In some cases, the contracts between the county and the university, which had been a condition of the university agreeing to take over the hospitals to begin with, the counties were dragging their feet and not paying. At a place like UC Irvine Medical Center, back when I came, we had the highest percentage of indigent patients of any major teaching facility in the United States at the time. So this turned out to be a very true statement.

LaBerge: Maybe more true than you even knew.

Hopper: Than I even knew at the time, right. But I think kind of getting my arms around both the system and the job both was—it took a year and a half or so to really do that. I inherited an absolute dynamo—Ruth Haynor was her name. Ruth had been the assistant of the person who had held my position earlier.

LaBerge: Who had held it?

Hopper: Clint—

LaBerge: Powell?

Hopper: Clint Powell, yes. When he retired, and Ruth had been with him for a number of years, and she knew the system, and knew a lot of the personalities, knew a number of the issues, which was very helpful. So having her available and
there to kind of introduce me to some of the key people as I made my rounds across the institution was a very important thing. Very loyal person, too. She stayed with me right up until the late 80s before she retired.

LaBerge: We won’t go into that decision of how you came, because I think we covered that pretty well in your other interview. So I’m going to refer researchers to it, we’re going to attach that interview to this, of how you were interviewed, and you thought they weren’t quite serious about this, and you weren’t going to come out and it was Shirley—

Hopper: Yes, it was Shirley Chater, then the Dean of Nursing at UCSF, who was a major friend through the years. She went on to become the president of Texas Women’s University, and then she was a Social Security Administrator, what do they call it? Anyway, she was the head of the Social Security Administration in Washington, and then came back as some kind of senior eminence in the school [laughter] at UCSF, I forget what they called it at the time.

LaBerge: Well, when you came, what did you think you were facing? What was the mission you were going to have when you came?

Hopper: I think I understood that it was the senior staff member position in the health sciences for the university, and that what this meant was involvement in the health sciences strategic planning, which had to do with enrollments, which had to do with the budget. I had to help formulate and defend in Sacramento the budget for the health sciences. I had to represent the health sciences, both in Sacramento, and to a lesser extent, in Washington. Because again, there were a whole spectrum of issues that arose over and over again. We can talk about some of those next time, because some of them have been recurrent over time. So I understood also that I had a health sciences committee to work with, which was a fabulous body. It had been formed back in the mid-70s when the university was going through one of its periodical budgetary crises. This committee had been formed under the chairmanship of Lester Breslow, who was the dean of public health, with the notion of, which medical school are we going to close?

LaBerge: Dean of public health at Berkeley?

Hopper: No, at UCLA. Lester Breslow.

LaBerge: Okay, and so that was the question, which one are we going to close?

Hopper: Yes. And that was long before I came. In fact, it was called, it wasn’t called the Health Sciences Committee then, it was called the Strategic—and I’ll get the exact title later on—the Strategic Planning Team for the Health Sciences, or something like that, was what it had been called. It had some real
luminaries. Lester himself, Jere Goyan, who was the dean of pharmacy at San Francisco, Shirley Chater herself, was on it, Larry Hershman was on it.

LaBerge: He was at UCSF then, wasn’t he, even?

Hopper: No, he was already part of the system-wide administration, but he had been at UCSF prior to that. But that committee, which I convened and basically directed, in terms of the—it did two things, it had the responsibility for serving what I would call the sort of cavalry unity role, and that is to constantly be exploring the periphery of the environment, in terms of what the issues are that are likely to affect the health sciences, and which ones of those ought to be responded to and in what kind of way? It also tackled very touchy issues inside the institution, like the organization of faculty, how do you characterize and find a place for in the university, people who are outstanding teachers and clinicians, but who don’t do research, but who have incredible value—where do you place them? And then how do you propose to fight the battles inside the institution that would result in the academic senate accepting some of these titles?

LaBerge: I think that’s an issue for other departments too, about these wonderful teachers who aren’t—in English, and—

Hopper: Oh, definitely. But with medicine—some of the things we said before, money is always an issue. The practice plans, how are they organized, how do they follow up, how is faculty paid? So again, between Ruth and I, we ultimately wrote a history of the health sciences committee.

LaBerge: Do you have a copy of that still, do you think?

Hopper: Oh sure.

LaBerge: Oh good.

Hopper: That kind of recounts a number of the very critical issues that we worked with that committee in trying to resolve. So that was one of the bodies that I worked with, and I knew, very early on—I’d been interviewed by some of the people on that committee. So I knew that was one functioning body. There was a hospital director’s council that I utilized. We would meet periodically, and issues that they were grappling with would surface there. My responsibility had to do with helping people reach some kind of reasonable consensus, reasonable both from their standpoint, but more importantly, reasonable from the standpoint of the university.

LaBerge: I’m going to just change this tape.
LaBerge: —Council and your job was to have them reach consensus.

Hopper: Yes, well, not only the hospital director’s council, but I’m saying that the notion of helping the constituencies within the health sciences reach a consensus on troubling issues—consensus that to the extent possible dealt with their concerns, but very importantly, a consensus that was in the best interest of the overall university. That was true both with the health sciences deans, with the health sciences committee, with the hospital director’s council. The other big job that I inherited—I don’t know why I’m putting it so far down the list—is I had to report to the Regents, every time the Regents met.

LaBerge: So you went to each Regents meeting?

Hopper: I went to each Regents meeting, and I think I mentioned in the earlier interview that back at that time, the committee I reported to was a subcommittee of the committee on finance. The subcommittee was on accounts receivable in the hospital—that was all outlined in my earlier interview, which was unfortunate. But it also reinforced the fact that the finances of the hospitals were very much on the minds of the Regents and the president and the university at that time. The Regents were focusing down to the nitty gritty—that is, how are you guys handling these receivables? Are you going out there and getting the money that is supposedly coming to us? [laughter] We can talk later about how the various issues that we used the Regents to work through, for example, having that committee evolve into a committee on hospital governance, which is much more relevant and important a body, and how that came about, mainly through a crisis at UC Davis Medical Center, and I think I mentioned that in the other interview.

LaBerge: You did, but probably not quite enough.

Hopper: Yes.

LaBerge: How’s your time, should we stop here?

Hopper: Yes, I think this is a good time—another time.

LaBerge: Maybe pick up the Wisconsin piece and then come back and maybe address each of those?

Hopper: We can briefly do some of the Wisconsin stuff, and I’ll bring some of that material along, and then I think we can pick up with the University of California. One of the things that I would like to do is again, kind of sketch out—you ask an important question, how did I envision my job back at the time? And I think secondly, how has that evolved over the last twenty years? How did that job evolve? I think I can talk a bit more about the kinds of
entities within the institution that I worked through in order to achieve policy consensus, and then move policy forward. And I think I mentioned in the earlier interview that one of the advantages that both Jim Kendrick and I had at the time is that people didn’t know very much about either agriculture or the health sciences, and as long as we were keeping things relatively quiet, folks didn’t mess with us too much. [laughter]

A lot of fabulous memories though at the University of California. Going and representing the president at a number of different venues, problem-solving, knocking heads, which is never very pleasant, changing budgets, which I had no real technical authorization to do but I did it anyway. One of the comments in the—there was a nice three-ring binder when I retired, where they invited people to say nice things—one of the things that was said repeatedly and which reinforced my way of thinking about the job is that, number one, I kept the value of the university always at the forefront, and number two, there was always a sense of fairness, even though when I was ladling out, in terms of policy decisions very often, or having the president ladle out on my behalf, it was not particularly pleasant, but I think that sense of fairness and that sense of a value system that is a constant in that job, on a system-wide level, it was something that I—hopefully I did that because of who I am, but more importantly, I thought about it more. I thought about it a great deal.

LaBerge: Okay.

[End of Interview]
Interview 6: July 23, 2002
[Tape 10, Side A]

LaBerge: July 23, 2002, and this is interview number six with Cornelius Hopper. Well last time we had started with you coming back to the university, and again, we’re not going to repeat what we did in our other interview, so we’ll have more time for other things. We had two big questions, and one was how you envisioned the job when you came. You made reference to the fact that it was like what you faced at Tuskegee, but that it was on a grander scale.

Hopper: Yes.

LaBerge: With the same problems.

Hopper: Yes, with the same sorts of problems.

LaBerge: And how that evolved over twenty years.

Hopper: Yes. It’s interesting, and I can reaffirm that the kinds of things that we were doing in miniature in Alabama—for example, a small, in that case, a small campus sponsoring health professionals education program, veterinary medicine, nursing, allied health, and then trying to provide good clinical outlets for the students, and using our hospital and campus where I was started off as the medical director, but ultimately having to farm out a number of our students across the country. I recall that our school of nursing students, for example, went as far away as Baltimore, for some of their training. But again, the parallels were particularly clear with Irvine, San Diego and Davis in that these were the three hospitals, and I think I mentioned that in the other set of interviews, these were the three hospitals that were former county hospitals, and when these new medical schools started in the university, which was back in the mid-60s, the state required the university to use these county hospitals as their teaching institutions.

When I got here in the late 70s and early 80s, again, you were faced with hospitals that had very large proportions of poor patients. By that time, Medicaid had already started to fail, relatively speaking, in terms of really providing reimbursement—true reimbursement for the services provided, and the counties where we had those hospitals had started to kind of wash their hands of that responsibility of taking care of poor people. It’s like, oh boy, here’s the big university, and they will take this off of our hands. They didn’t want to pay us and they felt that the services, with some justification, by the way, that the services that we were providing were a far more sophisticated set of services than they would have provided had they been responsible for the county hospitals.

This created a crisis to the point that—and I can’t give you the exact year, but at one point in time, not too long after I got there, the Regents basically said to
the supervisors of Orange County, either pay us or we are going to close the place. So those kind of battles went on. Irvine was more of a focus than the other two places, but there were battles in San Diego and to a lesser extent in Sacramento as well. So in that sense, those are the parallels, large proportions of poor patients, trying to provide high quality care in a teaching setting, but being constantly behind the eight ball.

The other issues that were very similar were how do you sponsor innovation in both health services and in health sciences education? What can you do to be innovative to respond to the needs of a population? In our case, in Alabama, it was a very poor, underserved, mainly rural, and mainly black population. This is why we did the primary care network, and I’ve talked with you about that before, where in fact we used the hospital as a base health center but then farmed out nodes of care with mobile units throughout a three-county area. We also created an area health education center, which was to try to bring the educational institutions in that area, including the University of Alabama at Birmingham, Auburn University, Tuskegee and others into some kind of public health preventive educational interface with that population. Then you come to California and you have a state-wide AHEC, Area Health Education Center, which was trying to do the same thing.

LaBerge: Was that based in Sacramento?

Hopper: No, that was university-sponsored. The sponsoring campus was UCSF, but the AHEC was based down in Fresno, and continued to be based in Fresno. But it was a state-wide AHEC in that all the campuses were involved. And primary care, that was one of the big focuses that we had in Alabama. In fact, it was with the impetus for developing a primary care system that we got the funding from the Robert Wood Johnson Foundation, who sponsored us here, and the evolution of family medicine—a lot of that stuff comes back now—family medicine was not looked upon, or family practice was not looked upon by “mainstream medicine” as anything that anybody should want to do. And so consequently, building divisions and departments of family medicine in mainstream medical schools was extremely difficult. At the University of Alabama in Birmingham, for example, they farmed family medicine out into Huntsville and Tuscaloosa, but in those places, Bill Willard and I—I’m blanking on the other guy’s name—they started the family medicine training revolution in Alabama.

When I came to—even before coming to California, Dr. Hughes Andrus, who was the chair of family medicine at UC Davis, and who was the real rabble-rouser [laughter] he was a real change agent—where he had a very aggressive department of family medicine, and where they started training nurse practitioners at UC Davis. That’s where I sent my nursing students from Alabama, out here to UC Davis to get their training as nurse practitioners. In fact, I used the Lockheed Missile and Space Company which was down the peninsula—I used them to fabricate my mobile units. Our nursing students
who were in the nurse practitioner program were able to come down, were able to go down to Sunnyvale and actually walk through the units and tell them where they thought things were, and to work these things out.

So again, when I came to California, there was resistance on the part of medical schools to family medicine.

LaBerge: Because it was considered not sophisticated?

Hopper: Right. It was considered not—medicine started with general medicine, years ago, where the family practitioner was expected to take care of everything.

LaBerge: Yes, exactly.

Hopper: And the training was along those lines. Then as the knowledge base started to grow, and more and more specializations started to occur, then it was the specialist that was looked on as the high priest or priestess—not too often a priestess back in those days [laughter]—as the high priest of medicine. Academic medicine, of course, this was their image. We train specialists, we train neurosurgeons. The notion that you would insist, for example, at UC Davis, with the help of the legislature, by the way, like I said, Dr. Andrus and his colleagues were very active and aggressive on the legislative front as well. The fact that the public and the family medicine fraternity so to speak, would be able to come and insist that family medicine be established within the academic medical centers was like heresy. All those battles were going on in Alabama, though the needs down in Alabama were such that we didn’t face it to the same degree. The state didn’t like the fact of what I was doing, using nurse practitioners and arranging for them to write prescriptions out in the field. But the burden of need was such that they were delighted when I started to recruit family doctors into Tuskegee.

Again, there was a parallel, the Area Health Education Center, which in this case was state-wide, but was still seen as sort of an embryonic model of how you get hospitals, educational institutions—now I’m talking about community colleges, and local government—all involved in the health theme, trying to build not just health services but public health education. That was the hypothetical model. Let’s bring that whole constellation of community resources, educational services and so forth, and let’s have them focus in a new and different way, providing services, needed services.

Again, that’s why I said the parallel. Here again, it’s just that there were about ten additional zeros behind the budget out here. [laughter] The other nice thing about it was I didn’t have to go and raise all the money. We had deans and professors who were writing grant proposals, whereas in Alabama, raising the money was my job, day and night. So conceptually, it wasn’t a difficult transition from that standpoint. I felt pretty secure in my knowledge about what the issues were, both in academic health sciences and also certainly in
health services. But it was a matter of my—within a very short period of time, within a year and a half, becoming so deeply immersed in both the organization of the University of California and in the way that issues got resolved, dealt with and resolved from a policy standpoint. That part was—that was really a monumental task—getting to know the people, getting to know the history, getting to know the issues, because virtually every issue that you encounter had a very long history both within the university, very often in Sacramento, and sometimes in Washington as well. So I was tiptoeing through a mine-field for a period of time.

LaBerge: You mentioned Ruth Haynor who was very helpful. How else did you learn all of that? What kind of orientation?

Hopper: I went out—let me back up for a minute. The agencies that I utilized to get my work done—there were several. There was the university-wide Health Sciences Committee, which was—on that were represented deans, hospital directors, faculty members, leaders in the academic health sciences and in health services. That was the unit that both identified policy issues but also worked through them. That was one of my major work groups. Ruth was important because Ruth was the coordinator, or did the staff coordination for the Health Sciences Committee. She knew the people, she knew the issues and made that very easy for me.

The other group was the Hospital Directors Council. That’s exactly what it says, it was a council made up of the five hospital directors and their key staff people and the issues that they dealt with were the health services issues. Very often, the reimbursement issues, with the constant barrage of complaints as to why the university wasn’t using all of its muscle to get them better reimbursement from both Washington and from Sacramento. That was an important group. It met I think at least six times a year, and sometimes on an ad hoc basis, more often.

LaBerge: The directors were not necessarily physicians?

Hopper: No. Quite the contrary. Although in a couple of instances, they happened to be. Dr. Raymond Shultz and Dr. Balwin Lamson, that may be a name you remember.

LaBerge: It is.

Hopper: Both Ray and Baldy from UCLA happened to be physicians who got involved in hospital administration. But most of them were trained hospital administrators. So that was a group. The other was the Medical School Council of Chancellors, which is one of the bodies that I inherited. This, obviously, was convened by the president. The way this usually worked was that at the end of a regular council of chancellors session, there would be two, or if necessary, three hours where we dealt with that subset of chancellors who
had medical schools and hospitals. Of course that group became a real problem for me in the sense that there were other campuses that would say, wait a minute, we’ve got—here on the Berkeley campus, we have a school of optometry and a school of public health—why the heck aren’t we sitting at the Medical School Council of Chancellors? There was a real resistance to my translating that into a health sciences council of chancellors.

LaBerge: You never did translate?

Hopper: Not successfully, no. There was resistance again on the part of— And again, the same thing later on when I convened a group of health sciences deans, I had to work really hard to be sure that the deans of the non-medical schools were involved—a lot of sensitivity and paranoia there. For one thing, around the issue of state funding. Here, I’m not just talking about—I’m talking about the funding ratios that were established back in the ‘70s. Larry Hershman had a lot to do with that, by the way. In the early ‘70s, the state in a kind of a compact with the university said, okay, we will work with you in establishing student-faculty ratios for funding, for the various disciplines. These were extremely attractive—for a medical school, it was for every 3.5 medical students, there was a faculty FTE and support.

These things worked out quite well except that by the time I came in 1979, a lot of the federal funding that had been in place, for example, for public health, back when these ratios were established in the state, had dropped out, and public health wanted more money. They were saying, why can’t you go back to the state, and say let’s reconsider this? Virtually every president that I faced with this says, you know, we’re not going to take a chance on killing the goose that laid the golden egg. Once you open that box, we’re going to lose. So I became a lightning rod for a lot of frustration on the part of public health, to a lesser extent, nursing, and to a much lesser extent, veterinary medicine, because they were relatively well funded.

LaBerge: Is Davis the only veterinary?

Hopper: Yes, it’s the only school of veterinary medicine in the system, and was, and I think still is, the top school of veterinary medicine in the country. This certainly was true at the time that I left, although there were a number of issues in terms of facilities and infrastructure that had lead the accrediting agency—you know how that works, when you really want something very badly, you go and get your accrediting agency to come and say, boy, the university’s a pigsty. But in this case, a lot of the complaints were legitimate, and we worked very hard—one of the last major tasks that I had in my last couple of years was in fact to have a veterinary medicine study group that tried to prioritize the capital needs of the school so that our budget office could then try to get this translated into money, capital funds.
So a lot of the issues that I dealt with, both early on and through the years, had to do with the budget, budget-related things.

LaBerge: And you had done that in Tuskegee too.

Hopper: Oh yes. Although there, as I said, because of the small size of the place, I and two or three other people on the campus were basically responsible for doing the whole development piece. At one time, I remember, Dr. Walter Bowie who was the dean of veterinary medicine, myself, and Larry Davenport, who was the development officer, and then Theodore Pinnock—crazy Jamaican, beautiful person, who headed the Human Resources Development Center, HRDC, we were known across campus as the “Four Horsemen”, like these are the folks that you’re going to have to go to for the ideas to get money out of Washington. [laughter]

But here it wasn’t a matter of—even at the University of California—it wasn’t a matter so much of raising the money, although there were developmental aspects of this in that we had to do the groundwork, conceptual and political groundwork to get news state funding, new initiatives. I can give you a number if you like.

LaBerge: Yes, do.

Hopper: The whole breast cancer program—see when I left, I had responsibility for three major research programs, AIDS, which dates back to the early 80s, and I mentioned that in my earlier set of interviews.

LaBerge: And Willie Brown—that was the thing with Willie Brown, so we’ve covered that.

Hopper: Yes. There was AIDS and then there was the Tobacco-Related Disease Research Program that we started in the late 80s. Then there was the Breast Cancer Research Program, BCRP. So these were programs that in some instances, the initiative started as a groundswell of concern on the part, for example, of the breast cancer survivors. If you really want to see—I think I’ve said this before—but if you really want to see a functional mafia, you get about a hundred breast cancer survivors to go and start lobbying. So typically, there would be that legislative initiative, that lobbying effort, and some collection of legislators would say, well we want to do something about this, we want the university to do something about this.

These came to me. These came to me, and they came to me for a number of reasons—because I had successfully weathered the storm with the AIDS research program. I had translated what at one time was a University of California AIDS research program into a state-wide program where we were in fact funding researchers from all over the state. It had been very successful, it was seen as a national model. When along came the Tobacco-Related
Disease Research Program, it was kind of like “Let Con do it.” Same thing with breast cancer. But the other reason, in addition to the fact that again, my office had some success in administering these was that the political interface between these programs and the state was such that the Office of the President really wanted to keep that under control, because once you get that disseminated out broadly—there was no way of determining how much—the extent to which the relationships between the university and the state would end up being poisoned by something untoward happening.

LaBerge: That you would have no control over.

Hopper: Yes, that we would have no control over. At the state-wide level, I could at least speak for the university. The other thing these programs did was I was able to then bring together advisory committees from outside the university in many instances—the Breast Cancer Research Program, the state mandated that x number of these people—I can’t remember the exact number right now—have to be breast cancer survivors, they had to represent the general public.

So there was this constant kind of tug of war in terms of whether this was their program, as opposed to the university program, and required, quite frankly, an awful lot of patience and diplomacy to bring them around to the point that they felt very strongly about the value of the program. At that point in the program, they were ready to go and do battle with anybody, so that their program wouldn’t be tampered with or harmed in any way. Same thing with the Academic Geriatric Resource Program, AGRP, much smaller than the others but again, a system-wide program that established on all five medical school campuses and here at Berkeley, academic geriatric resource centers with the notion of having a nucleus of people who were interested in geriatrics, both in terms of teaching and research and who could provide kind of a stimulus for being sure that those issues got built into the curriculum of not just public health or optometry but in a number of other departments.

Again, there was a state-wide committee that I could convene that provided some policy guidance for those programs. Then there was the occupational health centers. Bob Spear, I think I’ve probably mentioned this before, I don’t know—but in the late 70s I guess, certainly two or three years before I came, there had been a major catastrophe—the Stringfellow Pits, or something, where all these toxins had accumulated in one place.

LaBerge: This was an actual place, the Stringfellow Pits?

Hopper: I’ll have to give you the correct name later on, but that’s the name that comes to mind right now. There was a place where there had been an accumulation of toxic materials and a number of workmen got very ill. As a result of this, the Department of Industrial Relations was asked then to start a number of occupational health centers. The governing group for that was to in fact
represent both industry and labor. There was a state-wide occupational health center “advisory committee.” Initially, the Department of Industrial Relations contracted with the university to administer this program. They didn’t trust—again, this whole business of not trusting the university—so it was like, we’ll contract with you to develop these centers—So as I came on board, and not because of me, because of groundwork that had been laid, there was the decision to then actually transfer this over into the University of California.

LaBerge: Okay, let me just change this.

[Tape 10, Side B]

LaBerge: Is it a little bit like the government contracting with the university for the labs?

Hopper: On a much smaller scale, yes, exactly. The university would administer—well, actually, the funding came to the university. Once the program came into the university, the funding did to. This was anachronistic in the sense that there were two centers—there was the Northern California Occupational Health Center, which involved Berkeley as the lead campus, and with San Francisco and Davis being the other two campuses that were involved. In the south, somewhat paradoxically, it was Irvine that was the lead campus and UCLA was the other campus. San Diego was not involved. In the case of Irvine, the reason for their having Irvine for the lead campus was the one really outstanding expert in the field by the name of Dwight Culver—it’s amazing how these names come back as you talk—was there.

The paradox here was that as the price for accepting the responsibility for doing these programs, the health sciences campuses said the money has got to come to us, not go to a system-wide pot, the money has got to come to us. So what my office ended up doing was serving as a point of convening for the state-wide advisory committee. As kind of a place where the directors of the northern and the southern centers could sort of hold their heads and cry at times because even though they had the responsibility, just in case Bob Spear, who was a nationally, internationally-known specialist here on this campus, by the way—

Bob was the director of the Northern California Occupational Health Center and Berkeley was the lead campus, but he had no direct control over the money that had been budgeted out directly to the campuses involved. So his only power was the power of persuasion, but he did it magnificently. I have to say that he did a great job of this. But again, here is an example, somewhat different from the others, where in the other programs I’ve mentioned the money came to my office and was then allocated, in the case of the research programs, based on the NIH model, where I had groups that actually evaluated the quality of the research that was being proposed.
I tried to keep out of it except to be sure that procedurally and policy-wise, and public relations-wise, that things were going well. Because I’d learned my lesson with AIDS—years ago [laughter]. Again, one of the functions, although it’s not in a job description per se—but one of the functions of the Office of Health Affairs, as it evolved during my tenure was a place where you can administer system-wide programs that to put on a given campus would create more problems, quite frankly, than the university really needed. These accrued over time. This was again, not something that I inherited when I walked into the job.

I think that—again, if you think back over the personalities, the changes in chancellors, the change in issues, the common themes throughout, as I said almost too many times—the common theme was to maintain not only a sense of integrity of the health sciences, but an equilibrium between the ambitions and the visions and the mission of the university, and the very real ambitions and interests of the public that funds the university. So there is maintaining that dynamic interface, that equilibrium between those was kind of an underlying, dominant theme of this job—and I think to some extent, the Office of the President—not just my office.

I think that’s what a number of the units in the Office of the President actually do. That’s fun, in a way, in that you’re, as I think I might have mentioned before, unlike Tuskegee, where the reaction times in terms of reports, or punishment, so to speak, in terms of when you make a good decision, you know pretty quickly, and when you make a bad decision you know pretty quickly. Here it’s more like, as I’ve described, moving a very giant amoeba [laughter] in a certain direction, and being patient enough to continue that effort because the amoeba does eventually move, and particularly if you’ve identified the direction as one that people kind of instinctively say, yes, that’s the right way that the university ought to be going. That’s kind of fun, that was fun.

LaBerge: The more that you say that you worked for this committee and that committee—I can’t imagine what your calendar looked like—

Hopper: [laughter]

LaBerge: And how you spread yourself out.

Hopper: Yes, it was rough, particularly in the early years, because there was Ruth and myself, a secretary, there was a small unit that dealt with health policy legislation in my office. It was a very small staff. I think that—I frankly think that David Saxon wanted it that way. I think that, as I may have mentioned in one of my earlier interviews, if you track the history of this office within the Office of the President, going all the way back to the 60s, you go through the evolution where there was a vice president way back then. Then there was a coordinator, then there was a special assistant, which is the title of the guy that
I replaced. Then it evolved pretty quickly back into a vice presidency again. I think it all kind of depended, to some extent, on the level of concern that the campuses had in terms of, “what is it the president’s going to try to do to us now?” As long as the title could be nebulous, like a special assistant or a coordinator, there is not the notion of, there is a vice president up there who’s going to have ways of presiding. [laughter]

So I think the office I inherited was small on purpose. I think that was David Saxon’s—I’ve heard this, by the way, and I’ve heard over time the evidence kind of accrued, that David Saxon really did not want much in the way of power. Again, I’m sure this is true in the health sciences, I don’t know the extent to which it might have been true in some of the other areas of his office—didn’t want too much power and authority residing in the Office of the President. There were—again, I think that the flexibility of this office is built into the fact that most of the rest of the university doesn’t know what you do, just like they didn’t know about agriculture, and as long as you were doing it quietly and successfully, nobody complained too much, despite what your title might be, whether it was special assistant or coordinator, or ultimately vice president.

LaBerge: One of the initiatives you mentioned was the Tobacco-Related Disease Research Program (TRDRP). For instance, did you take the heat when it all blew up about the papers—the papers that UCSF had on tobacco?

Hopper: Oh! Oh god, what’s his name?

LaBerge: I can’t remember.

Hopper: Oh lord. No, Stan Glantz was very helpful, actually. We took the heat from the standpoint of people complaining that he had gone too far in terms of giving the papers from wherever he got them from. But it became very quickly a matter of academic freedom. I didn’t have to worry too much about that. I had organized the state-wide advisory committee in such a way that the key elements that needed to be involved were kind of at the table, and helping to set policy. We had to go report to the state frequently enough on this so that nobody could say they were being misled.

Here again, the program was set up in such a way—I brought out a researcher from the University of Illinois to run it for me. It was established in such a way that we were using the NIH model and no one—even though there were people who didn’t like that, they would much rather have just simply had the money allocated—but no one could really complain when you were using good peer review. Secondly, when you were bringing up people from all over the country as opposed to having UC people reviewing—so that’s worked well. In fact, this is a model—the model that we put into place was ultimately replicated in a number of states once the tobacco tax money started to flow. Remember when the attorneys general were suing the tobacco companies and
large amounts of money would then come into states. Several of the states—my staff would actually go and consult with state governments in terms of how we had set this thing up.

LaBerge: Now can you say something else about what the NIH model is?

Hopper: Yes. The NIH model basically says that a research proposal needs to be reviewed in terms of its scientific merit by peers, by people who know the field, whatever the scientific field may be, and who do this without any conflict of interest, and who subject these proposals to the most stringent kind of scientific scrutiny in terms of the methodology, in terms of how the process is going to work, and what the track record of this researcher has been. Is this somebody who has done credible research in the past?

I have an aside to tell you about that, by the way, in that one of the things that we did within the AIDS program, when we first modeled it is that we purposely had—now I won’t be able to think what we called it—it basically was an opportunity for young scientists who hadn’t had an opportunity to develop much of a track record, to develop ideas. I think it was called IDEAS. To get a chance to get put on the first rung of the ladder. These proposals, even though they were competitive, they were competitive in a different arena than the big proposals.

And in AIDS, quite frankly, the vast majority of the researchers back in the early 80s, when the epidemic first hit, very few of the researchers had a track record in terms of this area. People were—it took a while for established scientists, for example, in immunology or virology, to gravitate towards AIDS as an area that would be worth their building a career on, or investing some portion of their career on.

So in the earliest years, the AIDS task force, which was made up of scientists here, and in this case, started off at the University of California—Dr. Merle Sande was one of the—he might have been the founding chair of the task force—but pretty early on, and I can’t give you the exact year, we expanded it. I had negotiations with the task force around that, but clearly the epidemic was of a magnitude, and the danger of it was such that you needed to get some of the best minds that you could and not all of them reside in the University of California. And there are some of my colleagues that still haven’t forgiven me for that [laughter], the ones who have long memories—but we took basically what was a state-allocated budget to the University of California, and opened it up to the entire state. But a lot of the pioneering work in AIDS was done with this seed money, with this small amount of money that we started with. There have been lots of stories written on that, and I think in fact there might have been some interviews, from Paul—I’m blocking his last name—Paul Volberding.
LaBerge: Yes, we have a whole series on AIDS that’s still on-going. In fact, they’re wonderful. So anyway, you used the NIH model for AIDS.

Hopper: We used the NIH model for all of these. For AIDS, tobacco research, breast cancer—to a lesser extent, for the academic geriatrics program, because here the funds were not diverted. In fact, in Geriatrics only a relatively small amount was diverted to research per se. This was more by way of building a curriculum and providing fellowships for people who would become faculty. Here again, even though this was a small program, I think—I’ll have to recheck this figure, but I think the most that we ever got in geriatrics from the state was like $3 million or something slightly less than $3 million. But that seed money and these academic geriatric centers ended up being models across the entire country where people would come from all over the country to meetings and say, okay, how are you doing it, and how are you getting those folks who don’t want anything to do with geriatrics in your schools of medicine—almost like family medicine—how are you really getting them to do something?

This was a successful program. A lot of the geriatrics faculty—a good number of the geriatrics faculty at UC, but also a number of them around the country now, in schools of medicine, have come out of the program in terms of fellowships and training. But that’s the amoeba syndrome again. You know that geriatrics is important. You look at the facts of life in terms of the number of people that are getting older and the kind of diseases that they have, the kind of social issues that they present to society. You know you need people who are interested in geriatrics and gerontology, but pushing the amoeba in that direction, again, was really—you were kind of moving upstream, if I can mix my metaphors here.

When we did some of the inventories—I say “we”, but this was done by staff on these six campuses really—when you do an inventory of the geriatric content in a whole variety of courses and in divisions, you find out there was really a lot that was being taught. The problem was that nobody had kind of put a label on it and said, “this is geriatrics,” and here is a series of courses that somebody who was interested in following this can take. Part of it is in public health, or it’s in— And that’s what the academic geriatric resource centers on these campuses have managed to do. They’ve served as a kind of core body that provides kind of an on-going organizing principle around the notion of geriatrics. Berkeley has been quite successful about it too.

How long have we been talking? My goodness! It’s amazing.

LaBerge: Oh, do you have more time?

Hopper: Oh yes, I have about fifteen minutes or so if it’s useful, but if it’s useful.
LaBerge: What about student health centers? Did you have anything to do with that also?

Hopper: Yes, that’s right, thank you. [laughter] Let me start back in Tuskegee again. I had responsibility for student health at Tuskegee.

LaBerge: Don’t think—I didn’t pull this out of nowhere, my son is going to start at Cal, and so I had to go look through these forms, it was on my mind.

Hopper: There the issue—the issue at Tuskegee was you had students coming in from all over the South with a whole broad spectrum of experiences in terms of access to health care, immunization, whatever. Some of my bitterest battles, quite frankly, if I can just call a spade a spade, with the president, was saying, look, we have got to absolutely insist that the students that come here have a certain base-line of immunizations, that we have a medical history and so forth. He would always say, no I’ve got to get the enrollment up, and I would say, but one of these days, you are courting disaster, you are going to find somebody who brings in a problem that we should have known about.

So anyway, I had responsibility for student health. We had a student health physician who was part time, who was an internist and an excellent nurse, Velma Bray. I’ll never forget her. Here, at UC, one of the responsibilities of my office was in fact to deal with the Student Health Director’s Council, you’re quite right. Again, to some extent, some of the same issues in Alabama recurred here again, thinking about that continuity again. From the standpoint of what base-line medical information do you insist on having for every student that comes in? If they don’t have it, does somebody draw the line and say, I’m sorry, but you’re going to have to go get it? The Berkeley student health department always has been absolutely outstanding. I think to some extent, because there’s not a medical school on this campus, so they’ve had to develop almost from scratch a comprehensive student health department. Whereas, some of the other campuses have medical schools, it kind of becomes an appendage to the other things that they do.

LaBerge: What’s really happening.

Hopper: Right, exactly. I think the student health programs, the student health directors and their staff—and I may have to edit this later, but I think they had always felt a little bit like second class citizens, from the standpoint of—because they very often reported to a vice chancellor for student affairs. The resources that many of them felt that they needed, they were constantly having to battle with the other units within student affairs for the resources. Here again, they turned to the Office of the President, my office, and said, we really have got to depend on your office to have, number one, the Regents understand what it is that we do, so we organized two I think outstanding presentations to the Regents—with written materials—in terms of what it is that student health has
been, what it is that it does, what kinds of issues it is dealing with, and what its needs are going to be in the future.

That’s been a lot of fun in a way. Here again, Ruth Haynor kind of kept them off my back until I could kind of find my way around. But then I became a real champion for the student health program, because I realized that if you think about it for a moment, the students who come onto a campus, a certain number of them will come from families that are reasonably well-insured; others are coming from families where there is no health insurance. What we ended up insisting on, after a big battle, was that students had to either have insurance when they came, or they had to purchase relatively inexpensive insurance.

LaBerge: Oh, it is very inexpensive.

Hopper: How many illnesses can you deal with in the eighteen to twenty four year-old group? But there was resistance to that.

LaBerge: But you’re the one who instituted that?

Hopper: Together with a lot of other people. The unit in the Office of the President and the vice president of business affairs that handled medical insurance for employees got involved with some of the analyses here. But we had to carry the ball from the standpoint of bringing around a table all the folks who would have to be brought around the table in order to come up with a policy decision that says, this is what we want to do.

LaBerge: It holds through for all the campuses?

Hopper: Yes. Now, having said that, not every student— Yes, the insurance thing that’s on board right now, yes, it does. Unless they have allowed it to erode since I left [laughter]. For some campuses, for example, if you look at Riverside, or at Santa Barbara, or Santa Cruz—smaller campuses—though Santa Barbara soon quickly won’t fit that definition—but smaller campuses that are kind of away from a major medical center. Then the configuration of their student health department would look different, for example, than it would in San Francisco, or for that matter, in Berkeley, although very few look anything like Berkeley in terms of the scope of responsibility that they’ve taken on.

LaBerge: I had some other questions—

Hopper: Legislators—I think we went through a number of those with the other interviews.
LaBerge: Also I was wondering, should we go through each of these groups, or do you think it’s enough that you’ve worked with Health Sciences Committee, Hospital Director’s Committee—

Hopper: I think it would be useful to do next time around. There were a lot of very—

LaBerge: We could think of issues that came up—

Hopper: Yes, there were a lot of very powerful and influential and creative people that used these committees as sort of one venue for working through policies. In the Health Sciences Committee, for example, what we would do is once the Health Sciences Committee as a whole, either spontaneously or at our direction, my office’s direction, would decide here is an issue that really does require more study; then a special subcommittee would be formed that would involve not only members of the Health Sciences Committee, but they would then pull in experts from all over the university to deal with the issues. There were a number of them, and I will bring those in next time to give you an example. Because we do have a history of the Health Sciences Committee that was one of the last things that Ruth did before she left that’s really very good both in terms of the personalities of the people that were involved at the time.

[Tape 11, Side A]

Hopper: So people were involved over time, but also in a kind of an enumeration of the major studies, policy studies, and policies that this group came up with. Again, the nice thing about the Health Sciences Committee is unlike the Hospital Director’s Council, which has a narrow set of issues, or the Medical School Council of Chancellors, or the Occupational Health Advisory Committee, the Health Sciences Committee was made up, on purpose, of a good cross-section of deans, vice-chancellors, faculty members—and so you had all these perspectives and experiences being brought to bear on both planning issues for the university—for example, enrollment planning. But also, key policy issues.

As I said, I’ll bring in a number of those next time, because I think it would be—it might even be useful as part of the— See, I inherited the Health Sciences Committee. It started off as something that was called, back in the ‘70s, the Strategic Planning Team for the Health Sciences. I think its first charge was to figure out which medical school they were going to close. [laughter] And it was chaired by Lester Breslow back then. By the time I came it was the Health Sciences Committee but was, in a sense, the most functional body that my predecessor and I dealt with from the standpoint of being able to bring a whole cross-section of experiences to bear without being prejudiced by, for example, reimbursement for health care, or the other kinds of things that these other groups— These other groups were saying, here’s what we want, and the Health Sciences Committee was saying, here’s what we can be if we’re able to resolve certain kinds of issues. Or here is what the
enrollments in the health sciences in the university ought to look like five years from now. And to the extent that that means more nurses or fewer nurses, here is why. That’s tremendously useful, because these pieces then, these reports, became a kind of neutral looking glass that the health sciences could use to look at themselves.

So I will have to look again at the history and I will bring that in, because you might want to look at some pieces of it. I’m depending on you, Germaine, to use your own experience in terms of what may be useful.

LaBerge: I think this is very useful, because I don’t think—for instance, you know where that history is, but I don’t think somebody else does.

Hopper: Probably—yes, somebody in my office might [laughter], but—

LaBerge: Yes, I think that would be very useful. Also, if you could talk more, I can’t think of the name of it right now, but the thing that’s in Fresno—

Hopper: Oh, the Area Health Education Center (AHEC).

LaBerge: Yes, because I think people don’t know about that.

Hopper: Right.

LaBerge: I mean, that’s not in the news.

Hopper: Yes, I’ll be happy to.

LaBerge: I interviewed, it seems like years ago, maybe it was only ten, Bruce Bronson, do you know him?

Hopper: Bruce Bronson, oh yes.

LaBerge: And after—I interviewed him because of him being a legislator, but at the time he was at Fresno, and I never understood what—because that wasn’t the focus of the interview at all, but I never understood what he was doing in the medical school, why he was in Fresno, I didn’t get that connection. [laughter]

Hopper: Very interesting stuff that goes on. [laughter] The AHEC, I will. And then the Health Sciences.

LaBerge: And focus on all the different groups.

Hopper: Health Sciences Committee, Medical School Council of Chancellors.

LaBerge: And any time there’s an anecdote—there are so many people you dealt with, we probably can’t cover—I mean, you had so many chancellors through all
the years, so many presidents, so many deans—but if you think of particular individuals.

Hopper: Like the North Dakota Ten [laughter] with UCSF chancellor Julie Krevans.

LaBerge: Was it called the North Dakota Ten?

Hopper: It was either the North Dakota Seven or the North Dakota Ten, I forget the exact number.

LaBerge: Were they all from North Dakota?

Hopper: What happened was he went out and made a deal with somebody in North Dakota that they would admit—I think North Dakota had a two-year medical school or something like that, and somebody made a deal with Krevans that he would transfer these students into the University of California.

LaBerge: The medical school?

Hopper: Yes the medical school, at a time when of course there were hundreds or thousands of Californians trying to get into school.

LaBerge: Oh that’d be great.

Hopper: The other thing that I will do is I’ll try to—I need to take Ruth to lunch anyway, I haven’t done that for a while, see Ruth Hayner.

LaBerge: Oh that’s great.

Hopper: Because her memory’s better than mine, even now, in terms of a lot of the personalities. I’m sure she can bring back some of these things that—I’m going to leave these things with you.

LaBerge: And I’m going to copy it and give it back. So do you have your Palm Pilot for a date?

Hopper: Oh yes.

[End of Interviewing]
LaBerge: Okay, we’re on, we’re on track one. Today is September 5, this is interview number seven with Cornelius Hopper. Okay, I’m just going to keep watching this.

Hopper: Is that thing supposed to keep on blinking?

LaBerge: Well, it’s not supposed to keep on blinking but there are little numbers.

Hopper: There are little indicators there that say the time.

LaBerge: Whenever we want to pause, tell me, because I can pause it.

Hopper: Hopefully. [laughter]

LaBerge: Yes. If I look away sometimes, I’m just going to make sure this is going.

Hopper: That’s fine.

LaBerge: It’s quite nice.

Hopper: To be the guinea pig on some new technology that’s as sophisticated looking as that is going to be really thrilling.

LaBerge: Do you want to hear the sound quality?

Hopper: Yes, can we? This is something that sort of transcends two parts of my career, the area health education centers both in Alabama and in California—

LaBerge: We talked about the ones in Alabama, and we only mentioned the one here.

Hopper: And the fact that there was one.

LaBerge: Well, let’s start—we have here a report of the Health Sciences Committee, lots of pages.

Hopper: Yes, lots and lots of pages. This is a history that we did in my office. Primarily Ruth Hayner, whose name I had mentioned before, who was my key assistant throughout the eighties—Ruth had been an assistant to my predecessor, Clint Powell, and therefore her tenure dated back to the formation of the Health Sciences Committee. This was originally called the Strategic Planning Team for the Health Sciences. It was, as I recall, a special ad hoc committee of the Academic Planning and Program Review Committee, APPRB, it’s called, which is one of the system-wide key academic planning bodies.
LaBerge: Under the academic vice president?

Hopper: Yes, APPRB was under the academic vice president, and the Strategic Planning Team for the Health Sciences was commissioned under the vice president for academic affairs back at that time, but was made up of key people from the health disciplines and the convening and coordination of that group was done by my predecessor, Clint Powell, and Ruth Hayner. The reason for this, and this actually ties into something that we’ve talked about before, is that in the early seventies there was a—actually dating back before that, back from the mid ’60s through the mid ‘70s, there was this tremendous sense that we were not turning out enough physicians and other health manpower to take care of the health care needs and health care demands of the population.

As I might have mentioned before, this was part of the impetus for the University of California creating three new medical schools within a very short period of time back in the ’60s. But this was accelerated, the whole sense of urgency and the movement was accelerated in the early ’70s and this led in the state to a directive from the state that the universities should look very seriously at planning to produce more health professional personnel to meet the needs of Californians. That in turn led to a major long-range health sciences plan dating back to the early ’70s where we would markedly increase the number of enrollees in the health sciences, in virtually every health science, as I recall, including veterinary medicine. That was fine, this was when the state first, with the university, created the fixed student-faculty ratios for the various health sciences. I think I’ve used the example before that for every 3.5 medical students, the state funded one faculty FTE plus support, which is tremendously generous.

I have to say again that this state has been just a real leader in terms of its support for the health sciences and its support for the University of California in particular. This point is not made anywhere more graphically than in the fact that they were able to guarantee those health sciences and student-faculty ratios. I may have mentioned before that as I had moved around the country in years after that, my colleagues could not believe it when I would say, “Well, at UC for every seven nursing students there is a faculty member, and for pharmacy—” whatever the ratio was. They looked at me like I had dropped from Mars.

In any event, all of that was to stimulate the university to really get about the matter of increasing its enrollment. As typically has happened, once that movement started, then a budget crisis or something else occurred.

LaBerge: And that is the situation when you came, isn’t it?

Hopper: That was the situation when I came. But actually this had occurred, this budget crisis that I’m talking about occurred even earlier, this was actually in
the early ’70s, not long after this brand new love affair between the university and the state occurred. [laughter] It was in response to the fact that in 1975 the Strategic Planning Team for the Health Sciences, which is, as I said, an ad hoc group under APPRB, the Academic Planning and Program Review Board, was formed. Its original charge was to look seriously at the closing of a couple of these three medical schools that we had just created. [laughter]

That was a very distinguished group, it was chaired by Lester Breslow who was the dean of the School of Public Health at UCLA and a world-wide known figure in public health. Some of the other people were Jim McGaugh who was, I think at that time he was an executive vice chancellor at Irvine, Jere Goyan, who was the UCSF dean of pharmacy, Shirley Chater, who was a senior professor of nursing. It goes on and on; an extremely distinguished group that came together to kind of get a handle on where we should go with the enrollments in health sciences. Clearly they didn’t close any medical schools. That was not their recommendation.

In any event, they did a very nice job of planning. Basically what happened was that the enrollments slowed down, that marked increase in enrollments slowed down because there were not the resources to really support it. When I came in 1979, around that same time, as I recall, again, I may be off here by some months. But again, around that same time, the team had become— actually, prior to my coming the Strategic Planning Team for the Health Sciences had actually evolved into the Health Sciences Committee, which then was, rather than being an ad hoc group, it was a standing committee of APPRB.

This group stayed in place, in fact it’s still in place, and relatively active. But it was an extremely active group throughout my twenty-year tenure. I’ve thought of it and have described it a number of times as the cavalry unit for the health sciences. This was the group that was constantly exploring the periphery in terms of issues that needed to be addressed at a policy level for the university. In some cases, the task or the charge was given by the vice president for academic affairs, and other times by APPRB itself. But more often, the charge grew out of the committee itself. The fact that you had people who represented a cross-section of all the health sciences, plus my office, and we were on top of all the movements. So we were able to then generate the issues that they then would tackle.

They tackled them in a very systematic fashion. Typically, a subcommittee would be formed to look at the issue. The subcommittee would be made up of a number of people of the Health Sciences Committee, but then they would reach outside of the committee, throughout the entire university and bring together a working group to do this. This plan, this history that I have here, remember, this only goes to 1989 rather than through the entire twenty years. To just give you some examples here—
LaBerge: Of the issues that you—

Hopper: Of the issues that were covered in the Health Sciences. The Health Sciences Education in the 21st Century, this was a symposium that was brought together and resulted in a publication that was edited by Shirley Chater and Jim McGaugh, back in 1976. The real critical issue of clinical teaching support, I don’t know if that’s a term you’ve heard before.

LaBerge: No.

Hopper: But basically the notion was that for the health professions that were involved in clinical activities, where a lot of the teaching occurred in clinical settings, in hospitals or other settings, there was the need to then provide additional resources, additional funds to help support teaching in those settings. The state recognized that and would provide the university with one very large fund for clinical teaching support, and it was the university’s responsibility to decide how that was going to be apportioned off between the various health sciences. It was the University Health Sciences Committee that really [laughs] wrestled with that, because if you can imagine, every one of the disciplines wanted the majority of that money.

LaBerge: Yes, and then you’ve got the campuses besides the disciplines, right?

Hopper: Yes, well, the disciplines and then the campuses. And then you would get into campus politics with certain chancellors backing the notion that for example, dental teaching support, which was an additional fund but on the same basis, that dental teaching support should go disproportionately to one campus or to the other. Or that some of the schools that had not participated in the clinical teaching support dollars should have a chance to do it. So the Health Sciences Committee, was very good. My predecessor breathed a sigh of relief because all this started in ’78, the year before I came. He was able to turn to this system-wide body and say, “Okay guys, why don’t you draw up some guidelines in terms of how these funds are going to be spent.” That was one that was done, that was published in 1978, prior to my getting here. Then there were guidelines for academic planning in the health sciences school. This was in May of 1979, just about the time that I came. We did special studies on selected health professions and occupations.

There were issues in graduate medical education, residency programs. There was a subcommittee, and that was an extremely important committee as well, because that began to grapple with the question of whether or not more residency positions in the primary care disciplines—family medicine, internal medicine and so forth—should be created. That was a huge push for this in the legislature, with, quite frankly, a lot of resistance on the part of our medical schools, particularly as it had to do with family practice, because family practice was only a relatively recently established discipline that had not really established itself academically. This is not just true in California, but in
medical schools around the country. These newly established family practice “departments” or “divisions” really played the political game. They knew that legislators were really very interested in this, that there were not enough primary care practitioners, and the communication pipeline between family medicine and the legislature was open all the time.

LaBerge: Who were some of the legislators, do you know?

Hopper: Oh boy, I don’t know if I remember this. I’ll have to go back and research that. Good question.

LaBerge: John Vasconcellos?

Hopper: John Vasconcellos was one—oh boy—I can give you a list later on—

LaBerge: You can add it into the—

Hopper: You can append it, right. A lot of this in the university, in California, a lot of this movement back in the mid ‘70s, prior to my coming here, had actually been around UC Davis, which had one of the earlier departments of family medicine.

LaBerge: That’s right, you used to send your nursing students—

Hopper: Yes. Well, Hughes Andrus, who was the chair of the department, somebody that I met back in the mid ‘70s when I was looking for a place to send my nurses to become nurse practitioners to staff my mobile health units in our primary care network back in Alabama. I found out at least in part in the ‘70s, but in much greater part after I got here, what a kind of a hotbed of legislative, political, and other kinds of pressures were rising out of the UC Davis School of Medicine and the Family Practice Department. One of the mechanisms that was created for this, when the state realized that there was this kind of ingrained resistance within the university to funding family medicine training, the state created—and this is Alfred Song and Willie Brown, created the Song-Brown Commission in the Office of State Health Planning and Development to have a program that would serve as a conduit to direct funds directly into family medicine and residency programs.

My predecessor served on this commission because the university insisted on having a voice at the table, and I inherited that position when I came on board and then I was a commissioner for my twenty years in the university. Again, what this represented was a mechanism that was created by the state to provide an on-going source of funding for the primary care disciplines but particularly for family practice and for physicians assistants and later for nurse practitioners. This was very successful, in fact, and it wasn’t directed just at the University of California, the proposals and the funding went to family medicine residency programs throughout the state.
I’ll tell you another story about it in just a minute—but I was in the very interesting position of sitting on the commission and reviewing proposals at least sixty percent or more of which were being generated by our own family practice residency directors who were in a sense then going off-line in terms of these budgetary resources. But they had no choice, it was the only way that they were going to get any real enrichment out of the programs. As a result of the Health Manpower Policy Commission, which is what it’s called, the number of family practice residency positions in the state grew exponentially but not enough to satisfy some of the legislators and not enough to satisfy the organized Family Practice Association. So that in the early ‘90s they sponsored legislation that would have mandated that the university dedicate twenty percent of all its residency positions to family medicine.

The cries of anguish and horror throughout the university were just amazing. [laughter] My colleagues in the medical schools could not understand this. They were doing this beautiful job of training neurosurgeons, all these specialties, and how dare the legislature come along and say that given our budgeted positions, that is budgeted, residency positions, that twenty percent of them might have to be devoted to family medicine. Well, we finessed this. I have to say I had a real role in finessing this. The finesse was translated into a memorandum of understanding between the university and the Office of State Health Planning and Development. The Office of State Health Planning and Development was the parent body for the Health Manpower Policy Commission.

LaBerge: How did you do this?

Hopper: Hmm?

LaBerge: What did you do and how did you do this?

Hopper: I went to the California Association of Family Practice, I talked to key members of that association who also happened to be family practice directors in our own system and I said that what you are erecting here is a permanent structure of antagonism between our schools of medicine and your discipline. If what you really are looking for is, number one, a mechanism for increasing the number of family practice slots in the state, but if what you really are looking for is a mechanism for gaining a greater level of acceptance of the discipline, then this is not the way to do it. They were ultimately happy with the memorandum of understanding.

And after the thing was finally, the MOU, as it was notoriously called, after I finally saw the final form of this, I said, well, this is going too far. Because this will be, even though it doesn’t say so, this will be interpreted as a contract for the university, as a mandate for the university to do this. I went to, I forget who was president now, I’ll have to go back and look, but I said, “Don’t sign it.” But the political pressure was such at that point in time, he said, “We’ve
got to sign it, you sign it!” I said, “Wait a minute!” [laughter] So I ended up having to sign the document.

LaBerge: So it was between the university and the legislature?

Hopper: Yes, it was a memorandum of understanding between the University of California and the Office of State Health Planning and Development serving as the agent for the state, for the legislature. The quid pro quo being even though you don’t like the MOU and even though the MOU will force you to do certain things, it’s not like what the proposed legislation said, which is that you will either have twenty percent of all of your funded positions in family medicine or we’ll cut the money. They actually had designated the amount of money that they would cut out of our budget, out of the university’s budget every year until we did it. It was Draconian, it really was.

So the MOU stayed in place throughout the ‘90s. This was around 1991, don’t quote me to the exact date, but it was the early ‘90s that this came about. It was in place and we had to give an annual report. This did result, again, in a further expansion in the number of family practice residency positions but it did not result in a major increase in the funding for the positions. There are some things I’m not so sure I should say for the record [laughter]. But what we did, we were required to report annually on the amount of money that the university was spending on these residency positions. What we did was a calculus that said how much it was worth for, for example, the faculty at San Francisco to review the people in Santa Rosa who were coming in to serve as supervising faculty for that residency position. Or what was it worth to have the faculty look at the resident who had applied for those positions in Santa Rosa, which was an affiliated program. When you put all those dollars, all those implied dollars, or imputed dollars, together with what was quite frankly the meager amount of money that we were actually getting, then it didn’t look quite so bad.

Now let me back up for a moment. The other part of this saga is that back in the ‘70s, again, prior to my coming, but continuing to some extent after I came, the family practice residency programs, many of which were being formed in places throughout the Valley in places like San Bernardino and so forth—in many cases these new residency programs desperately wanted university affiliation, right? And so the university would then claim the slots. They would claim, they would say, okay here are twenty family practice resident positions, and so they would send those in and they would get money from the state for those residency positions. Like for every ten of those they would get a faculty FTE and support. But that money wasn’t coming back into the family practice programs, it was going into the great black hole of the university’s medical schools [laughter]. Which further infuriated the family practice establishment. But they had achieved, initially, what it was that they wanted, and that was to have the affiliations, to have the University of
California name and thereby to be able to recruit a brighter and perhaps more able set of residents.

It was this argument, it was this set of facts that, again Isenberg, Phil Isenberg is one of the people that was really behind this. It was this set of facts that led Isenberg, to say, “Hey, you guys have been stone-walling, we’re tired of it, and here’s our legislation, and you’re going to put up or shut up at this point in time.” So I’ll have to say that I really do believe, although I can’t take unilateral credit for it, but I really do believe that without the efforts that came out of my office and to some extent myself, in terms of both the kind of in-reach—that is to our own people—and the out-reach lobbying to the legislature, in both cases in terms of what the damage would really be if that legislation came along. The message internally was, “Hey, if you can’t deal with the MOU—” And by the way, as I said, when I finally saw the final version of it, I was— [laughter]

LaBerge: You didn’t want to sign it.

Hopper: Yes. But the message was, “If you can’t deal with the MOU, understand that these people are very serious, and they are simply just going to cut out the money, that’s the way it’s going to happen.” Well, the irony here is that with those many, many family practice slots that were created, in part with somewhat begrudging backing of the university, but also in substantial degree because of state monies that were funneled through the Health Manpower Policy Commission, we created lots and lots of positions in family practice, and within the last couple of years, they have not been able to fill.

LaBerge: Really?

Hopper: They have not been able to fill. Now, therein lies a whole different story that has to do with the evolution of the health care delivery system. Because the practice of primary care at this point in time, whether it’s family medicine, internal medicine, pediatrics, and some people throw OB in that, but I don’t, has become extremely difficult because of the HMOs and because of the constraints laid on them by insurance, and because of the reduced incomes that primary care physicians have, and the hassle factor of practicing medicine, you know? The family practice or the internist spends an inordinate amount of time trying to figure out whether the formulary for HealthNet or for Pacificare for this month will accommodate the drug that he wants to prescribe for his patient. Adding these things together plus the fact that a number of the other specialties have gone on being relatively lucrative, so that the demand for these positions, that is, the number of residents who are actually applying for them, across the country, this is not just in California, in fact we are still doing relatively better than across the country—the demand for the positions are going down.
Therein lies another paradox, because in the—all these things go in cycles—in the early ‘70s, as I mentioned before, when I went to Tuskegee, there was this huge push for an increase in the number of health professionals to actually deliver health care. Medicare and Medicaid had passed five years earlier, there was now a mechanism for really funding the care of the old and the poor who could now “buy care.” But there weren’t enough people out there to deliver it. So there was this expansion in terms of the number of people that we were producing.

Then in the late ‘70s, as I recall, there was something called the GMENAC Committee, the Graduate Medical Education National Advisory Committee. They came out with a methodology that attempted to project how many physicians in each specialty were going to be needed for the next ten to twenty years, I forget the time frame.

LaBerge: Is this nationally?

Hopper: Yes, nationally. The assumptions that they made were, for example, that an internist would be able to see x number of patients per day, would be dealing with the following cross-sections of illnesses, etc, etc. The fact that it has turned out to be an incredibly flawed methodology is not a complaint about the motives, or the approach at that time. They were trying to rationalize. But the bottom line was they came out with the notion that there was going to be this tremendous over-supply of physicians within the next x number of years, you know. And they were making a big push for the reduction in number of specialty residency physicians, which, by the way, was also part of the UC MOU. That is, we would increase the number of family practice physicians residency positions, that we would decrease the number of specialty positions here. That was harder to take for our medical schools even than—

LaBerge: I’m sure.

Hopper: But the paradox is that right now—I’m on the board now of the Alta Bates Summit Medical Center, and in this community, we are short something like over a hundred primary care physicians.

LaBerge: Really?!

Hopper: Yes. In part because of the high cost of living in this area, in part because this is an incredibly, in terms of managed care environment, this is on one extreme of the bell-shaped curve, you know. And then for the reasons that I mentioned before, practicing medicine—particularly in primary care—has become such a difficult and unrewarding—and I mean that not just in terms of dollars, but in terms of the other kinds of satisfaction you get in practicing medicine—that the physicians are leaving and going into Kaiser. We lose, we have been losing a substantial number of doctors every month.
LaBerge: From Alta Bates Summit?

Hopper: From Alta Bates Summit—remember, these are linked hospitals at this point in time—who are going into Kaiser. And when they are kind enough, or take the time to sit down and write why they are doing this, they say exactly what I’ve said, that they want an environment in which they have time to read, to study medicine, to take care of their patients, to have somebody else do the business of health care. So we are very short of primary care physicians in this community. There are some other selected areas of shortage for physicians as well, and the average age of the physicians on these medical staffs is going up.

So here on the one hand, you have this tremendous output of technology and pharmacology, with new drugs, new technology, every day, which makes the public want to consume more and more of that. They read, they hear. They believe that they are adequately insured, if I have Blue Cross then I ought to be able to get as much of that high technology as I want, or as I want for my grandmother. Well what this has meant is that the projections made by that Graduate Medical Education National Advisory Committee twenty years ago, and other bodies that said the same thing, surplus of positions, have proved to be absolutely erroneous.

And I’ll say something here that the chancellor, who is that, Ray Orbach, Ray will read this and will chuckled. Ray has been trying for years to get the Riverside Biomedical Program upgraded to a full-fledged medical school. Our parting line was “We don’t need another medical school in California.” He kept saying, “Have you seen the population growth lines?” And so forth. He was making his case based on the increase in population without, I think, putting forth what was the even more persuasive argument, and that is that there is an even greater demand for medical care services, because that population is now sophisticated, there is more medical technology available. And yes, we are going to need another medical school in this state. Like I said, that’s heresy, and my colleagues will probably kill me, but what the heck? What can they do to me at this point in time?! [laughter]

But in any event, that all goes back to the notion that the key movements have been in this state, that this committee have been dealing with, and others, that there needs to be some kind of reasonable planning mechanism for the number of enrollments in medicine and the other health care professions that we would have in the University of California. There needed to be a rationale for it, and then we needed to be sure that the resources were there for it, and that this could be justified. So this is one of the very key roles that this committee played over time. That committee, even though their membership has changed, there is enough of a sustained history here so that even now the members can go back and read some of the assumptions that were being made for the university back twenty-five years ago and say, “Wow, we’ve got to approach this is a different fashion at this point in time.” So anyway! So much for the Health Sciences Committee.
LaBerge: Do you want to mention any key players there who were on that committee?

Hopper: Yes, I mentioned a number. Again, originally, Jerry Goyan from pharmacy, Shirley Chater from the University of California San Francisco in nursing. Jim McGaugh I mentioned, who was vice chancellor of—I think vice chancellor at Irvine at the time. Lester Breslow was the original chair. We had Ed Hurley who was at Davis and he had just been made the chairperson when I came in. We always wove in there a number of general campus people in disciplines such as psychology to bring the point of view of the academic senate into all of this. Rosalind Lindheim, for example, who as I recall, was from San Diego. Ray Schultz from UCLA who was an internist, but who also ultimately became the director of the UCLA hospital. The various deans—of the School of Optometry here at Berkeley. Again, some of these names won’t just come to my mind right now.

LaBerge: Is that Marvin Poston or no?

Hopper: No, I’m talking about the dean, Anthony Adams. But virtually every health sciences discipline, at one time or another, has had a dean or a key faculty member serve on the committee.

LaBerge: On that committee.

Hopper: Again, if it’s useful I can go back and kind of resurrect the membership. The debates were excellent. We would get together like on a Thursday evening, have dinner, and then there would be a structured agenda, all day Friday there would be a report of the subcommittees and then the full committee would have a chance to really dissect the subcommittees’ progress reports, up and down, and ask the kinds of questions. So that what would actually come out of these reports were really very often very refined, carefully thought-out things that were quite worthy of national publication, although we didn’t do very much of that, we couldn’t have.

LaBerge: And this was once a month?

Hopper: Well, for a while it was around ten times a year. Then when I left, let’s say in the late ‘90s, it was six to seven times a year.

LaBerge: All right. I’m just thinking of you going to meetings—you were also going to Regents’ meetings one week out of the month.

Hopper: I spent an incredible amount of time in meetings, in system-wide meetings, in special committee meetings. Most of the time, although not all, but most of the times, these were meetings that my office had the responsibility for convening, for developing or at least negotiating the agenda, for crafting not just the minutes but what were the essential outcomes of this, and, very importantly, for following through. In addition to the standing committees—I
mentioned the Hospital Directors’ Council as one of these that was in place for many years—I was vice president. The Health Sciences Committee, there were—and early on in my career there was a Health Sciences Council of Chancellors.

LaBerge: Different from the Medical School Council of Chancellors—you talked a little—

Hopper: I’m sorry, this is—they called it the Medical School Council of Chancellors, unfortunately, we were never able to get it to be a true health sciences council—

LaBerge: You mentioned that being a problem.

Hopper: Yes, and that was a problem. [laughter] That was a problem. Those were always kind of appendages to the regular Council of Chancellors meetings. When the regular agenda was over then we were convene for an additional two hours or so, depending on how serious the issue was. That was important because these guys could look at each other across the table, you know, eyeball to eyeball, and where there were issues, where there were real differences of opinion, then at least there could be dialogue in that setting, as opposed to the bombs being thrown back and forth through letters and this sort of thing. But that kind of went into—I may be wrong in this, but as I recall, fairly early on in David Gardner’s administration, that kind of petered out. It was a key part of the Saxon administration as I remember. It was something that was in place when I came, by the way, and continued for a while, and may have continued for a short time after President Gardner came on board, but it kind of waned after that.

LaBerge: And what about the Health Sciences Deans? Did that continue?

Hopper: Yes, well, that was more of a—there was body called that, but it was really more of an ad hoc structure. It was really, as I’m recalling, it was really more issue-oriented. We would call a meeting in the Health Sciences Deans. Now, in later years we would bring them together to look at public policy issues that were legislative issues, or we would then plan to go en masse to Washington or to Sacramento. In fact, interestingly enough, more often to Washington than to Sacramento because we had a more functioning state legislative representation, the university did. That was Steve Arditti and Lowell Paige prior to him. This ad hoc committee was more issue-oriented—it was a crisis body. We could assemble them to deal with issues that it was clear that they would see as being a high priority and we could get their attention. That was not nearly as constant as the Health Sciences Committee.

Then each of the other major programs in my office had responsibility for their statewide advisory committees as well. The AIDS Task Force, ultimately
the Breast Cancer Research Program, Tobacco Research Program, the Occupational Health Centers, we talked about that.

LaBerge: We talked about that.

Hopper: Right. The Academic Geriatric Resource Program, AGRP. In every instance, these bodies were strong policy advisory bodies. In the case of the research programs, I mean, they were particularly strong because I really depended on them to help structure the peer review process in such a way that our products were always unimpeachable, from the standpoint of how things were conducted. That served us well, and it’s still serving us well. They are—our Tobacco Research Program—the people who are in administrative or directorship positions in that or have been in them are in great demand in other states now because they have this bonanza of new tobacco settlement money. Remember all the big state lawsuits, well, they had this big bonanza, and some of the states, rather than putting it into bridges [laughter] are trying to do tobacco research.

LaBerge: Should we talk about the AHECs?

Hopper: Yes, we can talk about AHECs actually. Again, to revisit the notion that there was the concern—this again still goes back to the early seventies. As I’m remembering, the AHEC was a part of the Comprehensive Health Manpower Training Act of 1971, or a companion piece of legislation. The whole idea behind the AHEC was to bring together a number of organizations and agencies within communities that had some responsibility for health or that should have some of the responsibility for health, and to link these to the medical school, which was the traditional route. That linkage would do a number of the following things: expand the number of students enrolled in health professions. There was very great emphasis on the sponsorship of family practice programs, community health education—So what you have, at least in the form, the form that I created in Tuskegee was different in that it was not generated by the medical school. We generated it and then brought into the whole thing medical schools from the University of Alabama at Birmingham, Meharry Medical College and other local universities, Auburn University. Then you had the county health department, you had the school system, you had, in our case a major player was the Veterans Administration Hospital. All of whom, in one way or another had some interface or responsibility for health.

The concept actually caught on—it was attractive in the abstract, and in some cases was very attractive and functional in reality. I’ll give you a couple of examples. In Arkansas, for example, they have a statewide AHEC that has been used by their school of medicine there to actually put satellite programs throughout the entire state, where the dollars—these are federal dollars—that were funneled to Arkansas has made a big difference in terms of what they have been able to accomplish in healthcare. North Carolina, same thing.
When I came to California the AHEC program nationally was already nine years old. It had gotten started in the early seventies, and there was already a statewide AHEC. The lead campus or the sponsoring campus was San Francisco. The program administratively was based in Fresno, you know, so that you had the administrative focus in Fresno, but then you had AHECs, you had little area health education centers spread throughout the state—San Diego, UCLA as I remember, or in Los Angeles, and a number of other locations. In each of those locations they were expected to bring together the community colleges, the health departments, the hospitals, the local medical society and others, but with the glue being the idea that behind all this there was the academic engine of a school of medicine. Again, I have to say that in the early eighties the statewide AHEC here was very successful—in fact—as kind of like the parent or the sponsoring agency for family medicine. In Fresno, for example, they developed a fabulous family medicine program using in part AHEC dollars and bringing in a number of actors into that whole thing that might not otherwise have been into it. But a statewide AHEC is a tough thing to keep together in a state like this. Again, this was not something that my office, unlike Alabama, where it was my baby.

LaBerge: Yes.

Hopper: In Tuskegee appointed the AHEC board and I could monitor it almost on an on-going basis. Here at UC my office had only a tangential role in that—at the time, and this was UCSF and the other schools of medicine— The flaw, if I could call it that—I want to be careful here because there are still—there are still fledgling offshoots of the AHEC that are still out there and are still functioning. The flaw was that it was so administratively burdensome. Every one of these places had their own board. There must have been about nine AHECs around California. Everybody had their own community board that was involved in decision making for what went on. You had an interminable number of meetings and the amount of money that was spent on administration and on meetings and on trying to keep these people together and talking to each other was much larger than in other kinds of programs like this.

The other flaw was there was always the notion that this would be successful enough in a statewide situation where the state government would pick it up, somebody else would pick it up. Or, take a given AHEC in a given community, the local health department or the local county city administration or county administration, all these folks would happily chip in and pick up the financial burden, and of course that didn’t happen. Without that kind of, again, care and feeding, it did tend to fragment over time.

So for a while the sponsorship shifted from San Francisco, as I recall, to Davis. The reason why Davis was because Davis was so very heavily involved in family medicine and with family medicine being such a prominent part of the AHEC idea, or primary care being such a primary part, the Davis
leadership was—Again, my office, we attended the statewide health advisory council meetings, we strongly resisted—periodically the notion would come up—let’s give this to Hopper and the Office of Health Affairs, and we would resist mightily. [laughter] I don’t know if my successor is going to manage to—whether that’s his point of view, because Mike had responsibility as an associate dean—he ultimately assumed responsibility for the UCSF Fresno programs, where there are a number of—

LaBerge: This is Mike Drake?

Hopper: Yes. But anyway, I know that my senior assistant, Dr. Catherine Nation, who attended all of these statewide meetings and so forth, she really helped resist that notion [laughter] because she knew who would end up having to do the work. So in any event—AHEC—beautiful idea, very functional in many states in the country, not sustained at the original conceptual level here in California because of again the administrative overload and politically the idea that you can have these nodes scattered around the state with each one having its own kind of both governance and administrative mechanism just simply didn’t work. Ok?

LaBerge: Should we go on to some of the things you have on your vitae?

Hopper: Yes. We’ve talked about the research programs in my office. We’ve talked about the Hospital Governance Committee.

LaBerge: Yes.

Hopper: Which started out when I came—it was the Committee on Accounts Receivable, which I’m just amazed by. I think we covered how the reorganization of the board with respect to the medical centers was catalyzed by a crisis at—

LaBerge: At Davis, yes.

Hopper: Yes, where at one point in time it looked like in fact we were going to lose our license. So the board said, “Let’s organize.” I did have a very strong role in helping to frame that, to be sure that the new Committee on Hospital Governance had a charge and a mandate that was concurrent with or at least in parallel with what hospital governance bodies looked like. Regent Frank Clark is perhaps the key figure in all that. Frank I think was recruited to the board because he had been such a strong figure in the UCLA hospital advisory group locally and was a corporate lawyer, trusty, very analytical. As I think back on it, I think his forcefulness and his insistence on detail—he’s a very loyally detailed person who applied all of that to [laughter] to these processes. He and a couple of the other Regents, for example, were responsible when we were having trouble with the counties in both Orange County and in San Diego with the counties keeping their financial commitments to the
university—remembering again that we took over those county hospitals. The counties, after a while, said, “Boy, we got a good deal here, they’re taking over our healthcare burden and let’s not pay them for a while.” So Frank Clark was, as I’m recalling, the key figure in the group of Regents who went down and basically said, “Look, if you don’t pay us, we’re going to close it.” So that committee continued over time, and I had the responsibility up until five years ago for—on a monthly basis or however often the Regents would meet—of reporting on the hospitals to the regents. As Jack Peltason said, subsequently, I can’t remember, one of the meetings—[laughter] he said, “I always appreciated Con because he was the one who would go to the Board of Regents and tell them how hard it was to have this proportion of indigent patients at any major teaching hospital in the country.

But the other thing that we did, and this was in part—well, the other thing that I had a key organizational responsibility for was in reorganizing the Clinical Compensation Plan.

LaBerge: Ok, tell me about that.

Hopper: The notion had always been that the income for a medical school faculty member who was in the clinical series would come in part from the state funded FTE, but that was really not that much money, it was just the core amount of money that went along with this. The second component would be a research piece. The third component would come from the person’s clinical practice, their contributions to the practice plan from their practice. There had always been kind of an on-going—how can I put this? There had been kind of an on-going battle in the schools of medicine between the high producers, for example, the people who were doing the cardio-thoracic surgery, who were generating large amounts of money and who the dean and the chancellor, the department chair, the dean, and the campus would say, “Well, we want a portion of that to come back into the medical school, to the department and then to the school of medicine.” So they created something called the income limitation plan, which then said for that group of faculty that again they would get the base, which was the x, they would get a negotiated y, but then the z would be tied to their earnings and it would be the z that would be “taxed.” With part of the tax going to the department, part to the school, and of course, the amount of that tax was always the issue. Like, “Why are you—” and again, I’m putting it this way and I don’t think I ever heard anyone say it quite this way, “Why are you taxing my surgical department as a way of funding the pediatrics department? Can’t you find some other way of doing that?” The answer is, “We really are all one happy family here.” [laughter]

LaBerge: Or would like to be.

Hopper: In a typical communistic society [laughter] you take from those according to what they can give and you give back according to their needs. There was an on-going tension, and I’m simplifying it—god knows I’m simplifying it to a
great extent. So there had been a uniform compensation plan in place for a number of years. But then in the late eighties there was—for a number of reasons—there were challenges campus by campus and discipline by discipline to whether that was appropriate or not. So we had to go back and revisit the entire thing. By the way, this is still a work in process.

LaBerge: I bet it is.

Hopper: Even though the document that we finally put to bed as I recall in like 1997 or 1998 still is being—pieces of it are being renegotiated. One of the key issues had to do with whether or not people who were on the so-called income limitation plan where their income was very strongly tied to this “2” factor here [gestures], the issue was whether or not they were really independent contractors.

LaBerge: Mm-hmm.

Hopper: And I remember that John Lundberg and the general counsel’s office spent a great amount of time working through the criteria for when a faculty member was kind of like an independent contractor and could therefore be grandfathered into this erstwhile income limitation plan. Large numbers of faculty people were put forward in places like Irvine to say, “Well, you know, we believe that we qualify into this.” In any event, the document that exists out there right now that’s being administered by the Academic Affairs vice president—(thank god I never had to administer it, all I had to do was take the heat for bringing the people together and trying to make sense of it). [laughter] With a close relationship with Academic Affairs, by the way, in doing that. I caught probably more heat for that than anything that I can remember in the past ten years or so, because we know, you were dealing with peoples’ incomes.

LaBerge: Yes.

Hopper: For example, the issue of whether or not, if you served as an expert witness—One of the underlying issues—if you are on the faculty at UCSF, should you really be allowed to testify against a faculty member at UCLA in a malpractice case? Or, if you are going to spend a substantial amount of time doing expert witnessing, should that money go in your pocket, or should that money go into the pot somehow and then be apportioned according to some formula? There were really very angry people in the university who had been doing a good amount of this, and who had started to, I think, depend on this for a significant part of their ancillary income. When we outlined after a lot of negotiation, the things that they could keep, for example, when you are selling textbooks and—

LaBerge: Royalties?
Hopper: Yes, royalties, or the number of days a year that they could consult, all of that is in a formula. But the funds generated by expert witnessing was in fact supposed to come back into a pot that would then be taxed and apportioned according to these previous agreements. The university simply had not functioned that way for a long period of time. You had a lot of—and I don’t mean this pejoratively—but you had a lot of entrepreneurial people out there who were finding all sorts of ways to make income, to make money, some portions of which I’m sure inured to the benefit of the university. If you become a world-class cardiac surgeon, as did a couple of people, for example, at UCLA, then your department chair and your dean and your hospital director will not look kindly on somebody up in Oakland saying that we’re going to find a way of taxing this or putting some kind of a limit on that. It actually at one point in time led to publications in the newspapers of the number of university medical professors that were making in excess of a half million or $600,000 a year, for example. Anyhow, that was—I’ve probably tried to repress as much of that as possible.

One outgrowth of our work under that residency memorandum of understanding—we had the MOU we were relating to, but then we brought together the deans of all the schools of medicine, and we developed together a plan in terms of how we were going to respond over time in terms of enrollments. That resulted in something called Changing Directions in Medical Education. That shifted or modified the mission and the curriculum of the university to accommodate a greater attention to primary care while, at least, in my view, not really eroding or undermining the quality of the university or our ability to go on producing world-class research and specialty training.

I think we talked about the occupational environmental health centers before—

LaBerge: Yes, I think we did.

Hopper: There was—one of the fun things that we did starting back in 1991 under HealthNet’s sponsorship is we created a thing called the HealthNet Wellness Lecture Series where we invited as a kind of a competition, from all the campuses, all the health sciences campuses, papers on aspects of—that dealt with health promotion or public health, again, using the broadest definition. Some of those papers and those publications, again, got sent to medical schools all the way across the country because they showed, for one example, the influence of pesticides on health of people down in the Monterey area. Another example, is it showed how the influence of an older sister becoming pregnant, how that influenced the younger siblings and did so in ways that were—and so on. We could bring a couple of those and just have you leaf through them because there might be some things in there that you might find interesting.
There were an interminable number of committees. We started off as a small office, but there was a—I forget what they call it, but one of the things that was done when we were at University Hall over across the street from the Berkeley campus in the very early eighties—they did an analysis where all of the divisions or departments in the Office of the President had to indicate who they interacted with most often. I forget what they called that study. We were at the center of that stuff. Everybody was saying that they interacted with us or they had a part of our concerns or a part of our issues.

LaBerge: Isn’t that interesting?

Hopper: Yes it is. Well, the Academic Affairs Office, you know, the whole business of the hospitals and then how that influenced the business office.

LaBerge: Budget.

Hopper: Malpractice insurance, the budget office, on and on. The office that dealt with university relations and publications and communications and so forth, constantly. I’ve always showed this to folks when they would say, “Now tell me what it is you do.” I say, “Look at this, and you’ll know.”

LaBerge: You deal with everybody.

Hopper: You deal with everybody. And that was good because—in a way, even though we were getting the benefits of having a lot of issues that brought a lot of other offices within the Office of the President or for that matter, in the university, into an interface with health, the health sciences. But at the same time we were looked at as something sufficiently foreign and unfamiliar so we were able to do our thing. I think I mentioned that our office and agriculture were the two places that had that kind of—of course, there was a much bigger shop in agriculture than in ours, but the same idea.

LaBerge: You needed a certain expertise to be involved in it.

Hopper: Yes, exactly, exactly. And really, as I look at the things that I’m doing now—we can talk about that next time, actually—a lot of it are continuations of the work that I did even starting back in Tuskegee but continued in the university but much more at a policy level, at a macro level. Interestingly enough I find myself now back in with a kind of a hands-on, very proximate relationship to a lot of the same kinds of issues, and that’s a lot of fun. It’s a lot of work, but it’s also a lot of fun.

LaBerge: Well I know because you’re busy, you’re very busy.

Hopper: Yes, but it’s a lot of fun also.

LaBerge: Well, is this a good place to stop then?
Hopper: Yes, I think so.

LaBerge: This has kept going, we’re on track nine.

[End of Interview]
Interview 8: September 17, 2002

LaBerge: Today is September 17, 2002, this is interview number eight with Dr. Cornelius Hopper. Well today we were going to talk about your retirement activities.

Hopper: Yes.

LaBerge: Also how they flow out of what you were doing anyway.

Hopper: Yes, exactly. That’s been one of the delightful things about retirement actually. Immediately following retirement, the president asked me to kind of stay on to take on the responsibility of convening all the state’s medical schools, that is, the UC medical schools and the others.

LaBerge: You mean for the whole state, as opposed to just UC?

Hopper: Yes, for the entire state, to appoint a committee and convene a committee to look at the whole issue of the admissions of minority students to medical school. This was of course in the aftermath of Proposition 209 and it was also a response to some fairly alarming numbers in terms of the drop off of students, underrepresented minority students being admitted to UC in particular. When we looked at this we found out that the trend had actually started prior to the passage of Proposition 209 but it really had become accelerated around the time that Prop 209 was being debated. Remember, affirmative action was being debated for at least a couple of years prior to that time.

That was fun, fun from the standpoint that it gave me a chance to do something I had been doing periodically throughout my time at the university, and that is getting—in certain issues, getting the entire state schools together, you know. One of these had to do with medical resident working hours. I remember that there was a family by the name of Zion, the daughter, Libby Zion, died after going to the emergency room. This was back in New York, years ago. The father thought that this was because the resident who took care of her had been on duty for like forty-eight straight hours or something like that, and had made a bad decision. In any event, that spilled over into the state legislature here and led to initiatives to regulate the number of hours that residents could work. In response to this, I had gotten together representatives from all of the medical schools and so we were able to come up with a suggested set of guidelines of working hours. That was one of the issues. So it was nothing totally unusual about the university serving as a convening agent.

This was an issue, that is, the affirmative action issue I’m talking about now, back to that, was very much of interest to all the medical schools.
LaBerge: I just noticed last week, I cut out this article. It was right after you and I—“Fewer blacks go to med schools.”

Hopper: Yes, exactly. Exactly. This is continuing a trend. That was one of the things I did. This took the better part of a year and resulted in a publication, a report, you know, that had a lot of very good recommendations that in fact are being followed through on now by my successor and others.

LaBerge: Was the report given to more than just the president? For instance, did the legislature see it?

Hopper: It was given to the president, and I think—I don’t recall on this point whether or not he actually even formally shared it with the regents. I know that some of the regents were aware of it. Of course, it went across the entire state because it was a report from all the schools of medicine, it wasn’t just a UC report. The recommendations were very pragmatic recommendations from the standpoint of the kinds of things that we thought might be done to improve the numbers of students who, number one, who elected to consider medicine as a career, and number two, who elected to come to California.

See, part of the problem we discovered was that when the climate in California was perceived as being hostile—that might be a slight over statement of the word, but not totally—when the climate here was perceived as being hostile then large numbers of California minority students just simply bailed out and went elsewhere. They were bright enough and made the kind of scores that they could get into medical school, they were a hot commodity. Then places like Harvard and Yale and the big private schools were able to provide scholarship assistance that we were not able to match. That was one of the influences.

But in any event, that was something that I enjoyed doing. Even though my job never had a formal role with affirmative action, I mean, I had at no point in time—that clearly had been an interest of mine. I had made no secret of that in my communications with the Regents and others. But as I said, it was not part of my portfolio. So this was an opportunity to really do it with a license, so to speak. So that was one of the things.

LaBerge: What were some of the recommendations that are not implemented?

Hopper: Yes, we recommended, for example, that high school and college counselors be brought together from around the state periodically to get good counseling themselves, or get good information themselves on how they could counsel students in terms of what medicine—and I’ll bring you the report by the way.

LaBerge: Okay.
Hopper: It might be worth including in the archives or not. That the enrichment programs being offered by most of the schools of medicine in terms of providing a kind of a sheltered environment for the students for the first couple of years or so—that these be funded and that attention be paid to them. There were similar kinds of recommendations that dealt with what were called the “pipeline”—how do you get more kids involved early enough so that they have a chance for successful admission. And as I said, I’ll bring the report.

The other thing that I did at the request of the president was to review the university’s contractual relationship with the Charles Drew School of Medicine down in Los Angeles. Remember, I don’t know how familiar you are with this, but following the Watts riots many years ago, one of the responses was to, of course, build a large county hospital in Los Angeles, the Martin Luther King Hospital. A short time later, there was a post graduate medical school formed that would use the Martin Luther King Hospital as its teaching facility. Even though it was not exclusively minority or African American, it clearly was intended to try to attract residents in particular from around the country and into residency programs and into that particular hospital and environment.

LaBerge: And there’s a connection with UCLA too?

Hopper: Oh yes, there is a connection with UCLA as an agent of the university and of the Regents, right. Because the state had no way and still does not, of directly funding a program like that. Similar situation to a school I’ve just absorbed, the School of Podiatry in Samuel Merritt College. State had no way of directly funding this, but always used special programs and special contracts, and that was the case with the Charles Drew School so that there were a series of contracts that had to do with improving primary care in central Los Angeles, improving the access of underrepresented minorities to allied health training and so forth. In the late seventies, actually, yes, in the late seventies there was also added an undergraduate medical component so that a certain number of students who would be admitted to UCLA would be admitted as UCLA-Drew students. They would get the first two years of their education at UCLA and the last two years they would take at Charles Drew and particularly with Martin Luther King Hospital so that there were ongoing set of relationships. The president felt, for a number of reasons, some political and some academic, that the university’s relationship with Charles Drew needed to be reexamined and we did. I appointed and convened a committee to look at this. We did suggest a number of ways that the relationships might be strengthened.

But the fact is, because of where Drew was located, and the fact that this was the only kind of institution like that, and given the circumstances under which it was founded in the first place, you know, the whole riots and the race relations and so forth, the community saw this as their school. That’s okay, except they wanted it to not just be a medical school, but they wanted it to
solve all sorts of problems in terms of employment, a magnet high school, Head Start programs. And the school attempted to respond, but in the process spread itself so thin that there were some portions of the program that were not doing as well as they should. And my committee said so.

So these were kind of carry-overs, even though I was retired, I was under contract as the president asked me to do this for a while. Those have been my only really official assignments with the university. But I did join an evaluation team under the auspices of the American International Health Alliances, the AIHA. Again, the history on this—I think I’ve probably talked with you about this before—but the history of this was that with the break up of the Soviet Union back in the early nineties, the State Department was very anxious to identify programs that could build and strengthen the infrastructure of Russia and the former Soviet countries because things were really quite disastrous. One of the things that was done was that USAID had contracted with a newly formed organization called the American International Health Alliance to develop a series of hospital partnerships. It started out as partnerships, where hospitals throughout Russia and the former Soviet Union and eastern Europe—partnerships were developed with counterpart institutions back here in America.

The idea was these were to be true partnerships, they were not just to be handouts where America says, “Boy, you guys don’t know what you’re doing, we’re going to come and show you.” They were true partnerships in the sense that the contracts were negotiated in terms of which partner was going to do which kinds of things over what period of time, what kind of people were going to be involved. It was really a beautiful program because what it did was provide an opportunity for a large number of American physicians, nurses, and other health professionals to go to Russia, to central Asia, to eastern Europe, and to get some firsthand experience on how sometimes people can get along with very little. By contrast, we tend to be real spend-thrifts in terms of the waste and resources that we have here.

It also provided an opportunity for people in Russia and the other former Soviet countries to come and to get a firsthand exposure to modern medicine, to good technology. There were some heartrending stories. Now, remember, I came in evaluating this much later.

LaBerge: Okay, so when did you come in?

Hopper: I’m going back to the very beginning and giving you the background in terms of how this all started. Our evaluation team began work in 1999 in Soviet—

LaBerge: How did you get—who asked you to get involved?

Hopper: Yes, I was asked to be involved by, well, let me back up. In 1997 when I was a member of the board of the Association of Academic Health Centers, which
is, we call it the “vice presidents club.” Basically it’s an organization that has, under one umbrella, medicine, dentistry, nursing, and all the health professions, unlike the Association of American Medical Colleges, which is purely medicine. But I was one of the longest standing members of the group and I was on the board at the time, and—it’s AAHC, Association of Academic Health Centers—was one of the founding organizations that created the American International Health Alliance, the AIHA.

So Roger Bulger, the president of the AAHC asked me back in 1997 if I would come to a conference that was held in Uzbekistan, in Tashkent, a conference that was focused on these partnerships. Remember, by this time, they were well along the way and things had actually moved into academic issues as well as just pure health services issues. So I did and loved central Asia, loved Tashkent and Samarkand. At that point in time the number of us then that were associated with the Association of Academic Health Centers were then identified—it goes back to that—but we really are identified as a group that they, the AIHA then asked to serve as an evaluation group under the chairmanship of Neil Vanselow who was one of the senior people in medicine in the country. That took up, oh god, off and on, about a year and a half. I was going back and forth to lots and lots of different places.

LaBerge: Were you looking at both hospitals and schools?

Hopper: Yes, as I said, by the time the evaluation was organized, the partnership program had been in place for almost ten years, like eight or nine years. So the State Department, USAID was saying, “Well, what are we getting for money?” It’s a reasonable question. It’s a tough set of questions, because it’s hard to directly measure the benefit of the partnership in terms of improved life expectancy or diminished disease frequency and so forth. But it certainly can be measured in terms of the kind of morale and organization and technology and management that had been adopted by hospital directors, by deans, by rectors and so forth. So that was a good experience. We finished our work and our report—it’s been about a year ago now—and we’re just brought back to Washington last month to meet with—this is the annual meeting of the entire group that come from all over the world to get a sense of how they were responding to the recommendations that we had made.

That was fun. I anticipate that there may be some follow-up on that later on. I learned a lot. I learned a lot about—in a sense it reminded me of my work in West Africa back in the seventies in the sense of how you can take systems that we have in place here, systems of care, technology and so forth, and simplify it and have it be useful in other places that don’t have the scientific infrastructure or the resource infrastructure to really get it done. Made a lot of friends, and still communicate by email. One of the great things that this program did was that it put in place in each one of the partnerships, each one of the central Asian, the Russian, eastern Europe partnerships a learning center, a Leaning Resource Center, LRC. The Learning Resource Center
would have a fairly modern computer, you know, and somebody who knew how to operate the computer. So [laughter] I’ll never forget that in Tashkent and also in Almaty, which is in Kazakhstan—the story is that the physicians were getting to a hospital like at four o’clock in the morning so that they could get on the computer [laughter] to talk to their partner colleagues in Tucson, Arizona. That was really great because it kept them—even after the specific partnerships were over with, that is, individual partnerships were over with, the individuals still maintained contact with their counterparts back here in this country. It was one of the things that we strongly recommended that the funds be found to allow that to continue. And they have continued. That was kind of interesting, too.

LaBerge: What other recommendations or evaluations did you make?

Hopper: Oh, on that. Well, we recommended that there be a whole reorganization of the interactions between—and let me—to make this meaningful—you have AIHA in Washington, which is like the central office, and then you have four different regional AIHA offices scattered throughout Russia, central and eastern Europe and central Asia. Then at USAID, which is the parent organization, which is the one that gives the money, USAID Washington, but then there were all of these USAID stations out in the field. AIHA Washington and USAID Washington got along extremely well, you know, they agreed on what it was they were trying to accomplish and so forth. But there had been some years ago a decentralization within USAID so that an awful lot of the power and decision making actually was devolved out to the USAID offices in these countries.

They did not like—a lot of them just really did not like the AIHA program. Number one, because AIHA was on the ground before they even moved into Russia and there was that kind of resentment. They felt that the cooperative agreement, which is the structure of the funding, it’s cooperative rather than a contract. They’re used to working with contracts, where they bring in a contractor and say, “We want to try to establish three primary care programs in this area within this period of time,” and they go in and do that, and then fine, they run a report and then they leave. Whereas the cooperative agreement gives both AIHA in our case and also the regional offices a great deal of flexibility and allows them to kind of react to and adjust to situations as they occur. That was just not the way the government worked. So we made some recommendations in terms of how the relationship, how the communications could be improved. We actually got together in a big room and had the equivalent of a shouting match with everybody in Washington [laughter]. Once we had drafted our report, then it was so hard-hitting along these lines that USAID then asked us to come back and they brought in all the regional USAID offices to give them a chance to tell us directly what they thought of what it was that we said [laughter]. But we didn’t flinch. Of course we all went back our own jobs and we didn’t have to worry too much about it.
The other major recommendation that we made was that the AIHA American International Health Alliance central office build into both the regional offices and into the individual partnerships the capacity to do better evaluation. So much had been done, so much needed to be done in terms of just embryonic systems of care until people were not too terribly concerned about saying, “How do we decide whether we are accomplishing anything?” It’s like, “What do you mean, ‘accomplishing anything’? I saw twenty patients today, I was able to give them medicines.” You know? [laughter] But that recommendation is being taken seriously so that now within the AIHA office in Washington there is a senior person who is in fact in charge of evaluation—of putting in place an evaluation program. I think that’s going to make USAID feel a little bit better as well because they will be able to, I think, have some input into what the parameters of the evaluations will be, and perhaps even the methodology, although I think it will be more the questions that will be asked.

The other things were—as I said, we mentioned the critical importance of the funding of the Learning Resource Centers because those were kind of like the on-going eyes and ears on the world for people would otherwise be isolated. We had recommendations about renewing the management—well, let me back up for a moment. There were the partnership programs and then there were things called “cross-cutting initiatives” like emergency medical training, like neonatal resuscitation. There were about nine of those. These were both great programs but they also were a cause of great consternation on the part of AID because we would be bringing together people from five different or six different areas. For example, in nursing, we’d create a whole—AIHA would create a whole nursing association that covered a whole country and would spend money on it. The various AID offices were saying, “Wait a minute! We don’t have anything to do with Riga or with Moscow. We’re down here in Sumeria.”

So they really resisted that and from their standpoint you can see it because each of them had their own budget. It’s like, you’re spending money that is supposed to be spent on my little area, you’re spending it on stuff that is going to influence a lot of different areas. But we felt extremely strongly about that because—for example, one of the nursing associations in central Asia that was created under AIHA had served almost as a—like the California Nursing Association, it was actually changing the way that the ministry of health was responding to working conditions for nurses. In one instance where a nurse had been fired the association actually went to the powers that be and got the nurse rehired. This is unheard of! This is unheard of not only in Russia, but this was in Kazakhstan, which was under a dictator at this point in time, one of the dictators that was carried over after the break up of the Soviet Union.

Again, these kind of cross-cutting initiatives that allowed nurses, emergency medical people, neonatologists from across the entirety of the former Soviet Union to meet, to talk to each other, to compare experiences, these are one of the greatest things that this program did. We made a number of
recommendations along those lines. Again, I’ll be happy to bring in—I don’t think this is embargoed—I’ll be happy to bring it in and you can look at it and see if it’s worthwhile adding. That was a really exciting, and still is because I’m still getting feedback, and whether or not we will be asked to do a repeat evaluation at some point in time, or to refine certain pieces of that I don’t know. But if they ask us, god knows I’ll be happy to do it.

Some of the other things—there are about fourteen other things I’m doing. I’ll just mention—

LaBerge: Do you want some water?

Hopper: Um, yes, that sounds good.

LaBerge: There’s a water fountain right—

Hopper: Outside here? Good.

LaBerge: In fact, I’m going to— A lot of times— [tape break]

Hopper: I guess another generalization I could make about all of this is that it’s a wonderful continuation of in some cases, and a building on, the experience I’ve managed to accumulate, you know, over a working lifetime. And that’s been really rewarding because I do know of people who have retired and there really isn’t that kind of continuity. They have had all these experiences but there really isn’t any good outlet for it. I’ve been very fortunate along those lines. Some of the things that I’ll start mentioning now I actually had started doing prior to retirement. I continued up until just a few months ago serving as a Health Manpower Policy Commissioner for the State of California. I was nominated by the president right after taking on my job. My predecessor had been a commissioner, and then I became a commissioner although—

LaBerge: This is back in 1979?

Hopper: Yes. Well, I was nominated in ’79, and Governor Brown, our present Oakland mayor, with all of his alacrity, it took him a year to really appoint me [laughter]. But in any event, when I did retire finally, I did stay on. I stayed on at the request of the director of the Office of State Health Planning and Development with the concurrence of the president, because it’s really a University of California position. But I was, for the first year and a half or so I was still closely enough associated with—I mentioned my work with the other medical schools—I was closely enough associated with what was going on so that I think there was the feeling that I still had something to offer. And I felt comfortable doing it. By coincidence I’m going to—I’ve been invited to a meeting tomorrow, they’re going to be giving me some big plaque or something.
LaBerge: For your years of service?

Hopper: For my years of service, yes, which is kind of nice. That was a continuation. I joined the board of the East Bay Community Foundation about a year before I retired, and I’m still serving on that board as well.

LaBerge: And this isn’t really in your capacity as a physician, but as a community member?

Hopper: Yes, as someone in the community, that was recommended. I’ve been on the board of Samuel Merritt College now for—’98, I think—and I’ve been chair of the board of regents for Samuel Merritt College now for at least two and a half years.

LaBerge: So tell me more about that, is it just nursing?

Hopper: No, no, no. It’s fabulous. It grew from a small school of nursing about twelve years ago to now an enrollment above 800 and involves nursing at multiple levels, physical therapy, occupational therapy, nurse anesthetist, anesthesiology. And now we have a doctorate in physical therapy as well as masters programs and we just recently absorbed the only school of podiatry west of the Mississippi. It used to be the California College of Podiatric Medicine that was based in San Francisco. It’s now the School of Podiatry at Samuel Merritt College so that this has extended our reach and hopefully our alumni fundraising to the western United States. That leadership role has been something that’s a continuation—in a sense, a continuation of what I was doing in the university. In some respects the interest in nursing and the other allied health professions is something that goes all the way back to Tuskegee, because I started a school of allied health, or some allied health programs back there and have always been interested in the ancillary health professions in terms of their roles and their capacity to do more to the extent that we allow them to in terms of their licensing and their range of activities. So this has been fun, the Samuel Merritt College assignment has been a lot of fun.

LaBerge: Is it located at the old—

Hopper: It’s located—people always confuse it with the junior college, with Merritt College.

LaBerge: Merritt Community College, right.

Hopper: No this is located on the Summit campus, on the campus—

LaBerge: The Summit campus which used to be Merritt Hospital.

Hopper: Yes, exactly. It dates all the way back to the last century, back in the early 1900s. It carries the name of that absolutely marvelous character, Samuel
Merritt. You talk about a renaissance man, I hope you’ve got something in your library, something on this guy.

LaBerge: I don’t know if we do.

Hopper: Oh, he’s— Just having nothing to do with my interviews, but I’ll bring you a little synopsis of his—

LaBerge: Of his life.

Hopper: Oh, he was— [laughter] we won’t start talking about him, I’ll be talking the rest of the day. But in any event, so that responsibility, I’ve been doing board development in terms of helping to recruit additional people to the board with a number of needed skills and helping out to start a development program because when I first came on the board for Samuel Merritt College, the Summit Medical Center and Alta Bates were separate institutions. Alta Bates had already been taken over by the Sutter system but Summit was still separate. Of course now Summit and Alta Bates are part—they are one unit and they function under this Sutter system. I’m on the board of the Alta Bates Summit Medical Center as well, I chair the finance committee of that board as well. That’s been interesting because it’s been an opportunity to observe the pains and travails of a merger. You’re merging two institutions, and here’s I’m referring to Summit—which, by the way, was a merger in its own, if you remember Providence—

LaBerge: Providence—

Hopper: And what was the other?

LaBerge: Peralta.

Hopper: Peralta.

LaBerge: And Merritt I think.

Hopper: And Merritt came together and then years later you have that entity being merged with Alta Bates which has its own private, you know, and very special history and pride and so forth. Two different organizational cultures. But in a sense being brought together under the pressures of the health care environment, needing and having the parent, this other parent, in a sense, who can provide access to a capital marketplace that otherwise we would not be able to do. So that’s been fascinating, that’s been very interesting.

LaBerge: And the fact that you are chair of the finance committee—

Hopper: Yes.
LaBerge: That’s different for you, or does it come out of your working with budgets anyway?

Hopper: Well, not totally. That’s—remember, for the first—up until the mid ‘90s I had responsibility for reporting to the Regents on hospital operations totally including the finances, so a hospital balance sheet is not at all a foreign [laughter]—

LaBerge: To you.

Hopper: But never the less, it still, I thought—they brought me on the finance committee before I even joined the board. I was already on the Samuel Merritt College board, and the other people on the Samuel Merritt College board included a number of people who were on the big board, the Alta Bates Summit board. So they asked me to join the finance committee as an outsider. They occasionally would bring people in who were not part of the committees, and I did so. Then I got appointed to the board and the next thing I knew, when Claude Hutchinson—you know Claude?

LaBerge: I don’t know him but I know the name.

Hopper: Well, Claude Hutchinson was chair of the finance committee, and he’s a former regent by the way. So Claude got called away to Washington to do something with the VA and so after one of my college board meetings, one of the people who serves on my college board is also the chair of the board of Alta Bates Summit, you know. So Larry Fox said, “Well, Con I want to talk with you.” I said, “What about?” [laughter] And he said, “You know, Claude is leaving and we really would like to have you chair the committee.” I said, “Come on, I’ve only been on the board officially now for like a year.” He said, “Well, yeah, but we really want you to do it.” So I made him—I said, “But you have to promise me that in the meantime you’ll be looking for a more appropriate chairperson for this. I’ll do it—” Because I guess he liked the way that I had run the meetings with the Samuel Merritt board. But I’ve kind of enjoyed it really, it’s at the heart of the action. We lost over $50 million last year, and this year had a budget that lost $15 million. I had a very difficult time getting a second to the motion that we approve a budget of losing $15 million [laughter].

LaBerge: But that’s a lot better! [laughter]

Hopper: But there wasn’t too much of a choice, you know. So that takes up a good bit of my time. I mentioned that I’m on the Kaiser Arbitration Oversight Board, which is very interesting work because I knew nothing about arbitration. But Dr. David Werdegaar who is a long-time friend and who was formerly the head of the Office of State Health Planning and Development and who is an emeritus professor at UCSF—David Lawrence from Kaiser asked David Werdegaar to get this group started, so he asked me if I’d serve on it. After a
few meetings he said, “I want you to vice-chair it.” But that’s very interesting work. Arbitration is very controversial and there is a tremendous push on the part of the lawyers association—they don’t like arbitration of course, for obvious reasons. So the board, the oversight board—it provides oversight to an office of an independent administrator, OIA whose offices are down in Los Angeles. They actually run the system, they recruit the neutral arbitrators, and they do the mechanics. But this board has on it representatives from—well, I mentioned Cruz Reynoso is on it.

LaBerge: Mm-hmm.

Hopper: And there are a number of people, some of whom kind of represent the constituencies who normally might be suing Kaiser, if I could put it that way. So it’s a good cross-section of people. It’s been very educational—as I said, I’ve learned more about— And that’s new.

LaBerge: That’s a new field.

Hopper: That’s a new field. I’ve got three three-ring binders full of this stuff, but it is fascinating. The other thing is, as part of Alta Bates Summit, originally Summit, but now Alta Bates Summit, there is a thing called the Ethnic Health Institute, EHI that is part of Summit’s attempt to reach out to this diverse community where we live. So they created the Ethnic Health Institute with Dr. Frank Staggers being the leading voice there. Frank being a recent past president of the California Medical Association, and he’s a former president of the National Medical Association, which is an African—

LaBerge: The AMA? Oh, and African American—

Hopper: African American group. But the CMA of course, is not African American. So the EHI has programs that involve a number of particular issues like asthma, hypertension, diabetes, prostate cancer. There are initiatives associated with each of these with subcommittees that really do programming. They go out, for example, and screen in churches, that provide training activities, counseling and so forth. This has turned into a really very very prominent set of activities at this point in time. In fact, this other system really raves about the fact that over time we have raised well over a million dollars in grants from major foundations to carry on some of these programs at this point in time. I settled on the advisory committee for that.

LaBerge: That sounds a little similar to your Allied Health activities—

Hopper: Yes—

LaBerge: It’s all in the community—
Hopper: Most of the Allied Health stuff—well, going back, it’s very similar to what I was doing going all the way back to Alabama in terms of reaching out and creating programs around some specific diseases. It’s very much in tune with the special research program I mentioned that I ran out of my office with breast cancer and tobacco-related disease research. So in that sense it’s kind of a continuity. The other linkage is that they utilize the African American and, for that matter, other ethnic churches as kind of an operational base, as an organizing base. That has—I’ve liked that because a number of the people that I go to church with have been very active in doing this, so it was kind of natural. The other thing is, I’m on the board of the Meharry Medical College down in Nashville, Tennessee, I’m a trustee.

LaBerge: Is that new, since you’ve retired?

Hopper: Yes, that’s within the last two and a half years.

LaBerge: Okay.

Hopper: It came about toward the end or very shortly after I retired. [tape interruption] So I’m on the Academic Affairs Committee and I’ve chaired the search committee for a new dean, a new dean vice president successfully. That person is in place and I feel very positively about that because the school needed a number of—well, they needed a lot, quite frankly. I serve on the advisory committee for the California Health Inventory Survey. This is a health interview survey CHIS. This is run out of the School of Public Health down at UCLA. Again, I started doing this just before I retired. I offered to give it up, they said, “No, we’d like to have you stay on.” This is fascinating because there is nothing in the country quite like it. They do surveys of a sample number of families from across the state and the numbers are significant enough so that it really has meaning. In terms of their health insurance status, do they see physicians or other health professionals, and how often? What kind of health problems there are in the family—it’s a huge kind of thing. Matter of fact, you might even want to look at their website.

LaBerge: Is it through their UCLA?

Hopper: Yes. CHIS—I’ll get it for you. I think it’s CHIS—anyway, I have it someplace, I’ll get it for you. Now we’re far enough along in this so that you can actually query the database if you know how to fiddle around with those numbers, and ask a number of questions. Like, how many Asians in the East Bay, in your sample, have health insurance, for example. It’s been a real helpful planning tool for public health departments around the state. So that’s been interesting as well.

I’ve continued my work with the Association of Academic Health Centers even though I’m no longer the university’s representative. I do serve on an advisory committee for their interdisciplinary learning program, and that takes
me to Washington a couple of times a year. I’ve had a chance to—this has provided an opportunity for me to again go back and draw on some of the experience that I had at Tuskegee and some of the things that were done in the university in terms of interdisciplinary training, where nurses and physicians trained together. For example the team concept has always been attractive in theory, but in actuality, there aren’t many places where it has really worked out. It requires a lot of care and feeding to make it happen. But there are programs, initiatives, models of this going on around the country that are going on under the sponsorship of the association, and again, I serve on the advisory committee for that.

LaBerge: What other examples besides nurses and doctors being trained together, what’s another example?

Hopper: For example, in my own school, at Samuel Merritt College, we now will have podiatrists being trained side by side with physical therapists. What this does is it allows us to save money in terms of faculty, but it also kind of enriches the experience of both. How do you utilize social workers both in your education, but also in practice? How do you integrate the clinical pharmacy program, the clinical pharmacist, who in California—San Francisco really pioneered in this, where pharmacy students make rounds with the physicians and are able to provide the kind of expertise and knowledge about drugs, drug interaction, that most physicians don’t think about that much. Having them there at the beside and having them there as part of the team, both in terms of the training but also later on in terms of how they practice—I mean, when they go out in the pharmacies or whatever, they think of themselves as part of a team. It’s like, “Hey I’m not just handing out pills, I do have some responsibility for whether drug a and b are going to interact badly.” Both letting the patient know this but also letting the physician know this. That’s been a beautiful revolution in, I think in health professions education but also in practice.

I’m sure I’m leaving something out here, but there is a tremendous amount of disparity, and I think, I don’t know if I’ve mentioned this before, but one of the really obvious things in the last several years has been the disparities not only in terms of disease burden between minorities and the majority population, but in the way that minorities get treated.

LaBerge: We spent—we did talk about that, but say a little more about this.

Hopper: It’s—how can I encapsulate this—

LaBerge: You start, for instance, I know that you mentioned the physician might come out and say “Mrs. So and So, come on in,” but maybe if it’s—

Hopper: Right—but even more importantly than that, there are studies that show that independent of your insurance status, for example, that your chances of
getting the appropriate care for a given set of systems are worse if you happen to be a minority, and particularly if you happen to be an African American in this society.

LaBerge: For instance, a certain test might not be—

Hopper: For example, yes—in terms of cardiac symptoms, for example, the likelihood of your getting the coronary artery studies or the likelihood of your getting the by-pass, and again, there are those who would say, “Well, this is really a socio-economic thing,” that these are patients that fall at the lower end of the socio-economic scale and therefore might not have the resources to have the care. But that turns out not to be true, if you correct for education, for income, for insurance, and everything else, it’s blatant. So I am now serving on the board of something that was started at Summit, really is going to spin off, and it’s called the African American Wellness Project [AAWP].

The theme there is to number one have minority patients be aware of how the system should be treating them, and to empower them to ask questions. We want to empower them to learn how to use the healthcare system appropriately, as opposed to just simply screaming and saying, “Boy, isn’t it terrible, the way that things are happening right now.” The focus of this is going to be more on the communities, community education, using radio, using television, using churches in terms of how the medical care system is organized, what your rights are, what kind of care you should expect, who it is you should see, what a patient advocate really is within the hospital, how do you access that.

As well as having the institutions, the physicians and others being made aware of the kind of thing that goes on very often at a subconscious level. I think I mentioned to you before that in one major teaching hospital out east, when they actually showed the physicians the data in terms of the decisions, they were astounded. I mean, they had absolutely no idea that they were making those kinds of judgements. So that’s going to be interesting if we get it totally off the ground. The AAWP was started under the Ethnic Health Institute, but since it is focused, in this case, very exclusively on African Americans, then we thought that we’d better have something separate so that politically it’s not quite consistent with what our goals are with the Ethnic Health Institute. I think that’s most of the stuff I’m doing now.

LaBerge: Now does any of this—because you’ve mentioned how the churches are involved in this—connected with your church work?

Hopper: Oh yes.

LaBerge: Do you want to even say a few words about that?
Hopper: Yes, well I’m a member of the Church by the Side of the Road here in Berkeley.

LaBerge: Where in Berkeley is it?

Hopper: This is on the corner of—well, the best way to tell you is, do you know where Shattuck is?

LaBerge: Yes.

Hopper: And Ashby—it’s a block away from Ashby right off of Shattuck.

LaBerge: Okay.

Hopper: Lorina is the street.

LaBerge: And how did you get involved in that?

Hopper: In that particular church?

LaBerge: Yes.

Hopper: Well one of the people that had previously lived in Berkeley had gone to Tuskegee Institute years ago and had moved back to Tuskegee and retired. We met and he talked about the church. He had a tremendous voice, he sang in our choir down in Tuskegee, and he told us all about the Church by the Side of the Road. So when I came out, I immediately looked it up. That and I met a number of people that had gone, who have been friends ever since, like Dr. James Watson, who is a very prominent physician in town. I mentioned Frank Staggars, who likewise has been a friend, and at that time it was an interdenominational church and had a fantastic choir, had a dynamic minister. It was kind of the place where when my kids, when my wife and kids came out, they gravitated immediately to the church and the kids kind of grew up there. But the thing about it is that the physicians—a lot of physicians in the church—and their kids have gone on and become really sensitive, community-oriented activist people. That’s the other thing that I like about it in my own kids, although I don’t have any physicians in the family. I think that a lot of the foundation that they have gotten in terms of their sensitivity to societal issues, a lot of it came from Tuskegee, of course. My daughter’s a Tuskegee baby. But certainly the augmentation and the reinforcement that they’ve gotten through the years in the church has just been important. There are a number of second generation physicians in the congregation, some of them, like Dr. Watson’s son, Dr. Jeffrey Watson has a radio show on health. Some of them have gotten very much involved in the HMO movement. So in any event, this is just one church, there are a number of churches that have dynamic membership. Down’s Memorial is another church that has a very dynamic membership. Down’s became the hub for a ministerial alliance built
around health, so that the physicians and ministers have an organization at this point in time that meets several times a year. A real leader in that, by the way, is Ben Major—I don’t know if that’s a name that you know.

LaBerge: No, it isn’t.

Hopper: But Dr. Major was an OB/Gyn pioneer in the African American community here who went on to the School of Public Health and got his MPh and then did a lot of work in Africa, a lot of very good work in Africa, and was a real leader, and was one of the founders of this organization of ministers and physicians. He just died within the last year or so. So that’s it. I’ll probably think of something else.

LaBerge: Well, you are on a search committee or something right now. Aren’t you on a search committee for the new minister or something?

Hopper: I’m chairing the search committee. [laughter] As a matter of fact, I have a meeting at 6:30 tonight. I’m chairing the search committee for a new minister for our church. Churches go through cycles like all the other organizations in society. I was surprised to—when I started looking into it—to find that—I was teasing somebody not long ago and I said, “You know, the shortest tenure of professionals in the country are deans of schools of medicine and ministers of the African American church.” [laughter] It’s only an average of four years.

LaBerge: Really?

Hopper: So we have gone through—during my time in the church—this will be like our fifth minister, I think. Which is not so bad because that’s twenty-plus years. But still it’s kind of a hairy responsibility because it means having to get a congregation to kind of rearticulate a vision of—it’s not just who we are and who we’ve been historically, but kind of a vision in terms of where we want the church to go, and get enough of a buy-in so that that becomes kind of the license in a sense for looking for a new minister. Because you’re matching profiles of people and their experience and education and so forth with who we are now and who it is that we say we want to be. That’s going to take up a lot of time. [laughter] And will probably take the better part of a year to really do that.

Other than that, I’m playing golf with my son, we’re having fun every Saturday morning going out to Alameda. He keeps score—see all I care about is going out and hitting the ball—but he keeps score very carefully.

LaBerge: For you too? He keeps score for you too?

Hopper: Well he did up until I said, “Brian, I want to keep my own score!” [laughter] But as I’ve said, I think retirement has been—and I still have an office in the Office of the President.
LaBerge: Oh you do?

Hopper: They made an office available for me. I don’t go there that often, I make it a point to not be that visible.

LaBerge: Like looking over peoples’ shoulders?

Hopper: Yes. I mean, when you are done, you’re done. But this does provide a ready access to the university computer system and a number of other resources there that emeriti get. So I get over perhaps three times a week or so. I try to go mainly in the evenings so that I’m not too much in evidence. I still see some of the old staff. I just recently attended the going-away party for the person who had run my tobacco research program for a number of years. She is going over to UCSF now and so this gave me a chance to see the special research staff and I hadn’t seen them for a long time. So it’s good. It’s been a nice transition. I’m staying busy. I like to believe that I’m being productive from the standpoint of utilizing—

LaBerge: Oh, I think you are!

Hopper: From the standpoint of utilizing the experience, the information gained over a lifetime and finding venues in which I believe it can be useful, and apparently a few other people do as well, and that’s gratifying, it really is.

LaBerge: So should we call it a day?

Hopper: Yes.

LaBerge: And we’ll make another—

Hopper: Yes. And again, what I’m going to do is kind of go back and pick up on some of the various threads

[End of Interview]
Interview 9: October 14, 2002
[Tape 14, Side A]

LaBerge: For sure. Today is October 14, 2002. We’re going to pick up different things we haven’t talked about. One of the first ones is the epilepsy commission.

Hopper: Right.

LaBerge: You want to talk about that?

Hopper: With my background as a neurologist, when I left the University of Wisconsin and went to Tuskegee, I continued to have a referral practice, although as time went on, the amount of time devoted to the practice was decreasing and the amount of time devoted to administration and program development was increasing. But in any event, back in the mid ‘70s, I think because of my background as a neurologist but also I think because they liked the notion of having a predominantly black college involved, I was invited to serve on an epilepsy commission. It was called the Commission for the Control of Epilepsy and its Consequences. What we came up with was a nation-wide action plan for epilepsy, and I don’t remember all the details of it. What I do remember, of course, is that epilepsy, like multiple sclerosis, which was again another of my long-term interests, all of these diseases had their constituencies, where people were constantly lobbying for additional funds from the National Institute of Health for research or better patient care or increasing the number of anti-epileptic drugs and so forth.

The commission functioned, as I recall now, for about two and a half years. We went to a number of centers as part of our data-gathering. We both invited people to come and testify before the commission but we also went to a number of locations, medical centers and so forth. I think the chapter here that I remember best were the highlights of the commission’s findings and a lot have to do—and I’ll just mention a few—the patients and families with epilepsy wanted to be involved more in their own care, they wanted to be independent. The fact that the costs of diagnosis and treatment of epilepsy was really, really, extremely expensive, and if you have—it’s interesting the kind of connection between back then and now. Once you get the diagnosis of epilepsy, getting any kind of insurance, health or accident insurance, was extremely difficult.

LaBerge: Because it’s not something that goes away, it’s not ever curable.

Hopper: Well, no. Unless you have seizures that are related to a specific brain lesion, like a small tumor or an area, a residual area from encephalitis. That kind of thing can be cured because they can go in and surgically remove the offending area of the brain. But basic epilepsy, the kind you inherit, the kind of generic epilepsy is not curable. It, in many instances, is controllable, and it’s a whole broad spectrum. When you say “epilepsy”, you are talking about a whole
broad spectrum of what we call “seizures”. To give you an example, Francis Forster, Frank Forster, who was my chair of neurology back at the University of Wisconsin, this was one of his specialties, epilepsy was his specialty. He was one of the world’s experts on something called musicogenic epilepsy, I don’t know if I’ve mentioned this earlier on.

LaBerge: No.

Hopper: I’ll never forget when I was chief resident in neurology and I would be wandering by his laboratory, I would hear these various versions of “Stardust.” I was saying, “What is all that?” It turns out that he had a patient whose seizures were triggered by “Stardust”, but only the Hoagie Carmichel one. And it wasn’t psychological, because they were actually monitoring the EEG. You could—[laughter] they were using this to try to deaden the effect, but you could actually watch the EEG go along, and then when “Stardust” would come on you could see the thing going like this [gestures] and if you didn’t stop it, it would go on to a full-blown seizure. In any event, the focus of the commission was on trying to develop a better understanding of what, first of all, what kinds of problems patients and their families were having in terms of getting control of their epilepsy and their seizures, getting insurance, problems with transportation, problems with misinformation on the part of the public who looked at epilepsy as being some kind of evil thing, going back to the Bible, you know.

LaBerge: Being possessed.

Hopper: Being taken over, being possessed by an evil spirit. It’s amazing how much of that kind of things carries on. So that was very interesting work, and it came along at an important time for me because even though I was very much deeply immersed in program development and doing other things at Tuskegee at the time, this kind of carried me back to my both academic and professional roots in a way. I really welcomed the opportunity to serve on that.

LaBerge: For instance, how often would you meet and where would you meet?

Hopper: As I recall, we met four times a year, and I think this varied. As I remember, and I can go back and research this later. As I remember, the first year we met fairly often. Then the second year when we were trying to pull together what the report was going to look like and so forth, we met less frequently. So all together, I would say we probably met eight times.

LaBerge: In two years.

Hopper: We first met in April of ’76 and it was in August of ’77 that this report came out [shows report]. But we continued—Dick Masland was the executive director, we continued to meet after. That’s how I used to look. [produces photo.]
LaBerge: Oh my gosh! [laughter] We have to start getting photos, we have to get one of these!

Hopper: If I can find it.

LaBerge: This is great.

Hopper: It’s kind of coming apart at this point in time. We can make another of that.

LaBerge: Was Frank Forster on this?

Hopper: No, he wasn’t. Frank was my chair of neurology back in—oh, this report is coming apart, isn’t it—back at the University of Wisconsin. Dick Maslan, who was a well-known neurologist, he was chairman of the Department of Neurology at Columbia, he was the chair of the epilepsy commission. We had Dave Daly—it’s very interesting looking at these too—who had been chair of the Department of Neurology back at the University of Texas. Ellen Grass, whose family actually created the Grass EEG, you know, so she was not only tremendously wealthy but also had a long-standing technical and professional interest in epilepsy because the EEG was certainly the tool, the diagnostic tool at the time.

So it was a very interesting commission. I’m going to go back and find out what happened to some of these people as a matter of fact, but that’s what I looked like at the time. I’ll try to see if we can find those.

LaBerge: I’ll mention that he had a beard and—

Hopper: Oh yes! I was doing the ‘70s thing all the way! [laughter] I think I have some of those pictures. Skipping down to something else that I was doing nationally at the time—I served—I’m going to have trouble remembering the exact years. I served on the National Professional Standards Review Council. What this was was an organization that was brought together at the federal level by the Department of Health Education and Welfare to see if you could get some standardization in medical care. The way of doing this was to create things called Professional Standards Review Organizations, and those organizations were, in fact, supposed to sponsor the development of what we have since come to call “protocols”. You see, it’s protocols. If you have diabetes or if you have hypertension or if you have some other fairly common illnesses it was an effort to try to create benchmarks or standardization for how your diabetes was to be approached and managed. The other kind of sub-set or kind of a corollary objective of the council and these Professional Standards Review Organizations was to try to reduce cost. Because you had such a wide range of practices, and physicians would admit patients to the hospital and some physicians would keep them there for two weeks for a condition that, you know, when you looked at it very carefully, they probably would have
had to only be there for a week. Now, of course, it’s two days if you’re lucky. [laughter] So that was very interesting work.

LaBerge: Like, for instance, how many conditions do the protocols—

Hopper: Well, we actually didn’t do the protocols. What we did was establish the policies and the guidelines for these Professional Standards Review Organizations around the country that would actually then develop the protocols and develop policies to encourage these practices in the medical profession and in hospitals and so forth. I’m still trying to find our final report. I sure as heck hope I haven’t lost it. If I can, I’ll go back through there and see if there is anything in particular that stands out. One of the people who served with me on that council is Dr. Ruth Covell. Ruth was then and is now the senior associate dean at the School of Medicine at UC San Diego. So that was her base at that time, at UC San Diego. We chatted recently because I learned that she had developed breast cancer. I don’t think it’s a great secret, Ruth’s not like that. But I called and we talked, you know, and during the time we served on the council together, she was pregnant for part of the time. She was telling me that this kid now has graduated from Harvard Medical School and is getting ready to enter his residency, which really puts the time frame on that.

It was a good group and a number of them I have had a chance to kind of interact with periodically during the years. The Professional Standards Review Organizations themselves, after a period of about five or six years started to not be that effective, but they were replaced by in the federal government, in Medicare, the fact that Medicare will allow only a certain number of days for a given diagnosis. So a lot of other approaches to cost controls, cost containment, essentially replaced what was set up as Professional Standards Review Organizations, although these did have legislative backing, they were mentioned in a piece of legislation, and I’ll never remember the public law. That was interesting work that I was involved in during the Tuskegee years, as you well know, those were just tremendously important developmental years.

LaBerge: Would the AMA have had any relationship with this? Or would they feel that they were being stepped on?

Hopper: The AMA didn’t like it.

LaBerge: That’s what I wondered.

Hopper: The AMA, organized medicine did not like it because it was seen as an attempt to standardize and prescribe how physicians practice medicine. Of course anything that proposes to do that is an anathema, and this was even more so back in the mid ‘70s, than it is now. Where physicians now, part of their everyday existence is that somebody is trying to control both the practice of medicine, but very importantly, the cost associated with the practice of
medicine, with HMOs, with health plans. The federal government has had a big role in this with the Medicare program. With the health maintenance organizations, right now I think this is even greater because they have pushed the notion of capitation, which is saying that they will allow a certain number of dollars for the care of this patient over a year, you know. But then they had shifted the burden, to the extent possible, for that capitation to the practicing physician and the hospital so that the health plan itself is sort of held harmless. Sort of, “Hey, we’ll give you this amount of money for caring for those 10,000 people in your big practice. And as you run out of money, tough.” That’s another subject. [laughter]

But I did want to talk a little bit more about the Tuskegee syphilis study.

LaBerge: In fact, I don’t think that we ever covered it. The book *Bad Blood*, is that what it comes from?

Hopper: Yes, it’s linked to it.

LaBerge: Okay, we haven’t talked to it.

Hopper: It’s linked to it. The Tuskegee study began back in the ‘30s. It was sponsored by the Public Health Service. What it proposed to do—again, to put this in context—at the time, the study was started back in the ‘30s, there was no effective treatment for syphilis. This was prior to the advent of penicillin, and frankly some of the things they were treating syphilis with, like arsenic, were worse than the disease.

The idea that the Public Health Service had was that syphilis, that the life history of syphilis might play out differently in black patients rather than white patients, or differently in the two patient groups. So they came to Tuskegee and asked for the participation of the Veteran’s Administration Hospital, from the county health department, and to some extent, Tuskegee Institute, in a longitudinal study where there was a control group of black men who had syphilis and they were to be followed to see how the disease progressed, or did not progress, as the case may be, to develop, in a sense, a history of the life cycle of syphilis in this population. To make matters even more interesting, we’ve got to go back even further.

Following the first World War, of course medical care as everything else was deeply segregated in the South. There was a Veterans Administration Hospital created on the then-grounds of Tuskegee Institute which then sold some land to the federal government to create a Veterans Administration Hospital, VA hospital, which opened in 1923. That’s a story in itself because the Ku Klux Klan marched because they didn’t like the idea of there being black physicians and nurses who in fact were going to be making all this money, but that’s a different story. What you had was, you had this Veterans Administration Hospital in the southeast which then became the magnet for hundreds of black
syphilis patients from the first World War that were in an unnatural fashion congregated in this one location because of segregation. And they were not hospitalized all the time, they were ambulatory. So by the early 30s, when they began doing surveys, Macon County Alabama had one of the highest concentrations of syphilis in the entire country. Just imagine, this was a by-product, in a sense a direct by-product of segregation in the South.

LaBerge: Because it was the only hospital.

Hopper: Because this was the only hospital that these veterans could go to. So they accumulated there and then proceeded to infect half the countryside so that finally when they started to do these surveys, like, “Whoa, there are all of these syphilis patients in Macon County.” Nobody bothered to go back and find out why. But nevertheless the federal government came and they proposed to do this study that I just described. The president of Tuskegee back at that time, Dr. Moton, wrote a letter, and I still have a copy in my file someplace, he wrote a letter to my predecessor, Eugene Dibble, who was the director of the John A. Andrew Hospital back in those years, in the ‘30s and ‘40s. He said, “Why do they want to do this study here in Macon County utilizing Tuskegee? Aren’t there plenty of syphilis patients in Birmingham? Some white patients as well?”

But Dr. Dibble, again, thinking about the prestige, not thinking about all of the tremendously negative stuff that came much later, and we’ll talk about that. Dr. Dibble, thinking about the prestige of having the VA hospital and the John A. Andrew Hospital involved in this federally-approved public health study said, “Please, we really ought to do this. This is going to be very good for the Institute.” So this thing started plodding along. I can’t give you the exact time in the ‘30s when this started, but it started plodding along and just continued. They had this group of patients they were monitoring, they would bring them in once a year for a total physical examination and so forth. They were getting what they thought was better health care than would have been available otherwise to them. Nobody bothered, when penicillin became available, nobody bothered to say, “Wait a minute, now we have penicillin available, shouldn’t we look within this group of patients and identify those that still might benefit from getting penicillin?” By the end of the Second World War, the study just kept going right on along. Scientific papers were being written in very credible scientific journals about the Tuskegee study.

In any event, I had been in Tuskegee about a year and I was sitting at the breakfast table and we were watching television at the time. On came this story from the Detroit Free Press or whatever news—

LaBerge: It is the Free Press, because I’m from Detroit.

Hopper: About the Tuskegee syphilis study, and then they started to talk about this— I knew absolutely nothing about this, had never heard of the darn thing. They
were giving this gruesome story about how all these black men had been followed all these years under the auspices of the Public Health Service and had been monitored by physicians both from the Veterans Administration and from the community who practiced at the John A. Andrew Hospital. My wife still quotes me, she said that I said, “I’ll bet my left arm that that never happened.” Well, by the time that I got to my office, I was getting phone calls from as far away as Japan about this study, about the story. I started calling everywhere. Magically, my entire medical staff disappeared. [laughter] I couldn’t find, I think, a single staff physician that day. They were really running for cover. It’s not as though—again, they were consciously aware that they were involved in something that could be viewed almost as genocidal. It was like, they were continuing to be involved in a peripheral way, by providing physical exams, for a study that was still under the auspices of the Public Health Service and that was being run out of the Macon County Health Department. The invective that I received—and I understand it in retrospect, and I understood it at that time—was that, “how could you,” meaning me, “allow that to be done to your own people?” I’d been there a year, I knew nothing about it.

LaBerge: Were the physicians and nurses who were involved black?

Hopper: Yes. Well, no, not all of them. There were still Public Health physicians, white Public Health physicians coming down from Atlanta, coming down from Atlanta and who were ostensibly in control of the study. There was a nurse, Eunice Rivers I think is her name, and they’ve done big TV shows on her, who was really responsible under the auspices of the Macon County Health Department, for monitoring these patients over time. They call them “Ms. River’s Boys.” She was African American. It was extremely difficult for me, because even then I anticipated that the negative association of the name Tuskegee with a study like this was going to undermine and minimize the tremendous history—and I’ve talked about this before, that going back to the late 1800s had been providing care for patients, who had been one of the few areas of the country where once the VA was formed, where residents could come and take specialty residences. Now when the word Tuskegee is mentioned, the thing that comes to everybody’s mind is the Tuskegee syphilis study.

LaBerge: Right, rather than the Tuskegee Airmen, or—

Hopper: And rather than that incredible history, which I still one of these days am going to write. I’m determined to write the history of the institution’s involvement in health dating back to a time, and how that was really a part of Booker T. Washington’s dream and his whole ethos of service. But again, my worst fears back at that time, and I had to sit as the institution’s representative to face the national commission that came down to find out what the heck was going on, and had to choreograph the whole thing. I remember feeling that this was incredibly unfortunate, it was personally damaging, that my name
would be associated. Although people really knew, they said, “Well, this guy has been here for a year, he didn’t—”

LaBerge: He didn’t start the study in the ‘30s.

Hopper: He didn’t start it and it’s clear he didn’t know anything about it. I had to go to the Institute’s archives to even find out anything. Even the letter I mentioned that Moton had written to the medical director, there was something over in the Institute’s archives, there was nothing in the hospital records about it. In any event, that has become, when the idea of involving African Americans in clinical studies, whether it’s with a drug or it’s with a clinical procedure, they think—I don’t mean all of them, but everybody’s kind of mindset is, “Boy, does this have anything to do with the mistreatment that happened with the Tuskegee study?”

LaBerge: Even if it would be beneficial because it’s something that affects them.

Hopper: Yes, it’s like, “this is a clinical trial, this is a clinical study, you remember what you guys did to us back in Tuskegee?” Again, with some real legitimacy. I wrote a physician paper, you know, that the president of the Institute used, and I pointed out very clearly that the initiation of this, the continuation of it, the use of the data, all stemmed from the US Public Health Service. But you couldn’t avoid the fact that a number of physician and others based in Tuskegee had been peripherally involved in this, from the standpoint of providing the periodic medical examinations. They were not making decisions about the research itself. As I said, by the time—remember, this was the early ‘70s when this thing came to light, this thing had been going on since the late ‘30s by that time. Anyway, that’s an unfortunate association with Tuskegee, and it doesn’t undermine by any means at all the tremendously positive experiences that I had there and the tragedy is that again the name is linked in the minds of so many people, both in this country and internationally, with a study that was terrible, that could be seen as genocidal in a way.

[Tape 14, Side B]

LaBerge: People came down to ask you what was going on. What did you do to put an end to it, to change it, to treat those—

Hopper: No, all I did was cooperate on behalf of the Institute with the national—there was a special committee, a national ad hoc committee that was headed by a guy by the name of Broddus Butler at the time, that was assigned to come and find out. What we did is cooperate from the standpoint of providing as much information as we had, which was not an awful lot. I remember at one of the sessions—this took place in the board room of Dorothy Hall, which was like the guesthouse on campus but also where they had the board room at the time. I remember saying, “You know, if you are commissioned by the federal government at this time, then you should have no trouble finding the data
because it’s with the Public Health Service.” But they were not hard on me. Everybody was in a very uncomfortable situation.

LaBerge: They were trying to get information.

Hopper: It’s like, they knew, and they really didn’t want Tuskegee Institute to be hurt, because they knew the history. They knew that the Institute had kind of been drug along in something that turned out to be invidious without really consciously being aware of it. Now, to bring you much closer to the present, the physician who, when I was there, when I came to Tuskegee, who was head of my OB/Gyn department, Dr. Henry Foster, ultimately lost out on the opportunity to be surgeon general because of the Tuskegee study.

LaBerge: Because he was involved?

Hopper: No, because Henry was president of the Macon County Medical Society for a period of time when one of the white physicians who I think was really out to get him and ultimately did, said that the Tuskegee study came before the Macon County Medical Society in a way that should have triggered a question as to whether it should continue. Apparently the medical society did not object, or did not put a stop to it, and that came back to haunt Henry. Ultimately his nomination had to be withdrawn, and I felt very badly about that. Henry left Tuskegee and went on to be head of OB/Gyn at Meharry Medical College and did an outstanding job at it. He is very highly respected nationally in terms of his work with teenage mothers for example. That’s one of the other victims of the Tuskegee study.

LaBerge: What happened with the people in the study who were still alive? Did they then get penicillin?

Hopper: Well, again, they were treated, but syphilis is a very interesting disease. There is a stage in syphilis where the administration of penicillin can be more dangerous than at other stages. So I don’t know, I really have no information about how many of these patients actually got penicillin. But I do know that in all likelihood it was withheld in some cases, on perfectly legitimate medical grounds. Ultimately, the federal government went through a formal apology and an attorney in Tuskegee by the name of Fred Gray, who had also been Martin Luther King’s attorney back during the Rosa Parks thing in Montgomery, with the Montgomery Improvement Association. Fred took this on as a class action suit and got a huge, huge settlement from the federal government, hopefully for the victims. I don’t remember the details of that. That has always kind of festered in the back of my mind as, again, an unmerited and unwarranted negative on the history of the institution and the memory of some of the people who had spent all those years providing health services to Alabama’s black population. Because even, I think I mentioned, even when I got there in the early ‘70s, they were still bringing pregnant women across 150 miles to deliver at this “free” black hospital. That this
legacy of service, of genuine, heartfelt service had to be besmirched in this way has always been sort of a tragedy. Anyway, so much for the Tuskegee study.

Also while in Tuskegee, and this is after we had done the multi-county primary care network we have talked about that was funded by the Robert Wood Johnson Foundation I was part of a team on the International Health Division of the American Public Health Association that went to west Africa. We were—actually I had two trips there—but we were in Nigeria, Cameroon, Ghana, Liberia. The idea was to get a handle on how the ministries of health in those various countries were dealing with issues of healthcare organization. In other words, this was not simply to go in and say, “We’re going to have a small pox eradication or a measles eradication.” It was directed more at how health care was being organized within the ministries of health. Again, in Nigeria in particular, but to some extent also in Liberia there was a great deal of interest in replicating the system that we had developed in Alabama, with the idea that there would be a core base health center that would then support a whole set of nodes out on spokes, in terms of places in the rural area that were connected both by mobile teams but also connected by telecommunications.

Now again, we were doing this in a very sophisticated fashion back in the ‘70s. I think I mentioned before, the family physician at Tuskegee could sit down and write a prescription and have it appear simultaneously seven miles away on board a mobile unit, so that a nurse could in fact hold that prescription that had been written by a doctor, which was important given the laws of Alabama at the time. The basic idea was that you would provide both patients and the community health workers, who were out there kind of all the time in each of these places, with a sense of connectedness with a core support system. The way that this was proposed to be used in Nigeria and some of the other places was by using the simple telephone. Because see they had village health officers. Sometimes physicians but very often not, you know, but the notion of being able to link them by two-way radio, even if there was no telephone, by two-way radio, so that they in fact could get whatever support was available in terms of advice from the health department in whatever the state was; we focused on the Benue Plateau State at the time.

I really would have loved to see over time how that would have worked out, but again, things politically became extremely difficult in west Africa in the late’70ss. A number of those outstanding, beautiful young men and women that I had met who were working in hospitals, who were working in health departments were basically murdered by new dictators. This was especially true in Liberia. In some respects I remember Liberia better because Liberia was settled, as you may know, by returning slaves who had been freed and sent back to Liberia. So there was more of an American/African-American environment.
LaBerge: Doesn’t their flag even have part of our stripes and stars?

Hopper: I don’t remember that. But I do know that the physician who was like their chief person, you know, had graduated from Meharry Medical College in Nashville. He was one of the few people who was spared in the massacre. I don’t know if he got an early warning, was able to leave or not. But things have deteriorated to a tremendous extent since that time. I don’t know if there is, at an embryonic level, whether that system that we were recommending at that time, or that model that we were recommending, has been utilized. There’s nothing profound about it, you know, it’s like just trying to be sure that both people and the people who are taking care of them have access to the best kind of advice that they can get, and hopefully sometimes at least some kinds of medicines.

The parallels in some respect with what I encountered in eastern Russia and parts of central Asia more recently, there were still parallels there. Of course they had very, very little to work with. Like reusing syringes. So you have the paradox, I’m talking about Russia and central Asia and eastern Europe.

LaBerge: Just in the ‘90s, just lately.

Hopper: This is within the past three years. You had the paradox of having these extremely well-trained people—I mean Russia had a highly educated professional class, but the economy was such that these clinics would be so under supplied. Just basic medications, things that we take absolutely for granted they did not have. So in a sense the continuum of my experience with at that time, third world, in Africa, but with a country that in some respects now could be considered a third world country, with the exception that it does have a sizeable well-trained, professional, managerial class. But the frustration of that class is because it does not have the resources to really do what it knows how to do. I’m kind of skipping all over the place. In any event, that was the American Public Health Association International Health experience.

Again, I think that the reason I accord Tuskegee such a tremendous influence in my life is because it’s highly unlikely that I would have done any of these things without that base. So whatever I brought to the institution from the standpoint of my own framing and interest and energy, what the institute gave me in return was a place that was historically known, a place that a lot of people were still very much interested in having it succeed. I think my last act when I left was to basically bring a check or a letter announcing a check to the president to establish an international health unit there. That continued for a number of years after I left under the guidance of Dr. Eugene Adams who was in veterinary medicine at the time.

LaBerge: Where did the check come from?
Hopper: It was a USAID-funded project. Because the work that we had done even with the American Public Health Association had been with funding and sort of under the umbrella of USAID.

Well maybe we can shift ahead. We talked about the National Health Service Corps and the concept behind that, and how that’s been one of the things that’s continued from the early ‘70s up until the present time both in Alabama but also nationally. It’s modified now in the sense that back at that time the young professionals that I was getting in my newly established National Health Service Corps field station in Tuskegee had done just the equivalent of internships, so it was clear that they were not going to then stay on. We were going to have a turnover. Whereas in more recent years, the people that go to the National Health Service Corps field stations are—this is after their residency program, so there is at least the hypothetical possibility that some of them will chose to remain in those underserved areas. There are a number of National Health Service Corps field stations here in California at the present time. That was an excellent idea. It was a voluntary kind of thing with the carrot being that ultimately that the people that sign up for the NHSC during their medical school years and get money from that, you know, and then repay that by a certain number of years of service in the National Health Service Corps. But we have toyed in this country off and on with the idea of having a kind of mandatory national service of one kind or another, not so much having to do with health, but just service. In fact, I think it was just in the—well in the Kennedy administration of course they had, what was it called?

LaBerge: The Peace Corps?

Hopper: The Peace Corps. I think Clinton or maybe his predecessor had resurfaced the idea of a domestic Peace Corps.

LaBerge: I think so too.

Hopper: I don’t know how far it got, or what the incentives scholarship-wise or otherwise might have been. So in any event, maybe we can—

LaBerge: Do you want to go on to—

Hopper: We can talk about SP1 and 2.

LaBerge: One of the things—I realized we hadn’t talked about that, but I was reading too your remarks to the Regents when you left, and that this is one of your big disappointments.

Hopper: Yes.
LaBerge: But I don’t think we’ve talked about any statements you made, who you brought into talk to the Regents, how involved you got in the campaign against it.

Hopper: Yes, well, I think again for context, and I may be repeating myself from some earlier sessions. But for context, once affirmative action became established, or became a notion in the university, then the schools of medicine and the schools of public health, among our health professional schools, adopted this very vigorously. When I came in the late ‘70s the Bakke case, I don’t know if this is something you’re familiar with.

LaBerge: Yes it is.

Hopper: The Bakke case—

LaBerge: 1979 I think.

Hopper: Yes. I came in ’79, and Bakke of course was a white applicant who challenged the fact that there were a certain number of positions set aside for minority students at UC Davis Medical School. That challenge was sustained, he ultimately was admitted to the school. In the Supreme Court ruling on this, the ruling said that it was legitimate to consider race as one of a number of other factors in making admissions decisions. Throughout most of my time in the university, although again, affirmative action and that sort of thing was not part of my portfolio, and I had, I was interested, obviously, but I had no direct responsibility for implementing those policies. It was not really a big issue because paradoxically, our schools of medicine had one of the best track records nationally, outside of the predominantly black medical schools, Meharry and Howard, it had one of the best track records nationally of anyone. This was even schools like UCSF and UCLA that were legitimately regarded as the ivory towers of medical schools, truly research medical schools. They had an aggressive outreach program, enrichment program, which resulted in the constant flow of underrepresented minority students into those classes.

When Mr. Ward Connerly began his discussions with the Regents and his work outside of the university back in the mid ‘90s, he utilized medical schools as his entrée into this for a number of reasons. I don’t necessarily think that he would agree with this, but I think it was because a medical school slot, a position in a first year class at a medical school is a very highly coveted, tremendously competitive thing. When you realize that the University of California medical schools were then and are now one of the best financial bargains anywhere in the country or in the world because the students were paying not very much more than the undergraduate students at the university, well somewhat more in terms of fees and that.
When this family called the Cooks down in San Diego challenged whether or not the medical school admissions process was appropriate and fair and why didn’t this one student get in when the idea was that they were admitting lesser qualified minority students. Well, Mr. Connerly picked up on this and used the Cooks and their experience, even to the point of inviting them to make a presentation to the regents at one point in time, and started his campaign, the campaign that ultimately ended up with SP1 and SP2. But in the course of that debate I was asked to develop a presentation where I brought the associate dean for admissions for UC Irvine and then Dr. Michael Drake who is now my successor, but who was then the associate dean for student affairs and for admissions at San Francisco, and then a—I’m blocking on his name now, a representative from the general counsel’s office as well. We made a comprehensive presentation in terms of what the medical school admissions process was, and very importantly, what had happened to those students, the underrepresented minority students who were admitted. It was an outstanding letter, but—and we had a debate. I probably said at that time some things that were not in terribly good taste. One of the things I remember that I said was, I invited Mr. Connerly go back not too many years in the University of California history and to recognize that neither one of us would be sitting at this table, neither he nor I would be sitting there. That was part of the context within which affirmative action had arisen and it was a response, an investment response in a way by the society, by California society to respond to long-term discrimination and injustices.

Well, he was having none of that. His whole notion is, as I said in my final statement to the Regents, was “It’s not fair.” It’s not fair. That was one thing, it’s not fair. His other theme he is still playing now, and that is that race doesn’t matter, that if you start tracking back—he never said it this way—but if you start tracking back the ancestry for each of us, you don’t have to go back too many generations before you had a genetic pooling that goes on there that makes race not very meaningful. That is technically and scientifically true. The only problem that he overlooked then and continues to overlook in his most recent initiative is that the world doesn’t work that way. People still respond to other people on the basis of their race. Most recently this has played out very clearly in terms of the differences between races both in terms of disease burden, and by this I mean you might have more African Americans with prostate disease and certain other diseases, certainly genetically-linked things like—I can’t think of the anemia now.

LaBerge: Sickle cell?

Hopper: Sickle cell anemia, which clearly is genetically-linked. But also it plays itself out in terms of how people are treated in the health care delivery system. The studies have shown, and I think we might have talked about this.

LaBerge: We did.
Within this context I think it’s worthwhile raising again. Studies have shown, and one place comes to mind, large eastern hospital teaching institution where if you correct for income, for education, for any measure, then patients were treated differently if they were minorities. They were not being provided the same access to technically sophisticated studies, and when they did happen, the studies suggested that a surgical intervention would be helpful, they were not getting that surgical intervention. I think I mentioned again that when these physicians were confronted with the decisions that they had made they were astounded. So this is not overt, simplistic racism. What it is is a set of values that had been imbibed over time that really helped determine one’s behavior when one comes in contact with somebody from a different race. That’s really, really detrimental if the relationship is between a physician with all the power in that relationship and a patient, or a hospital and a patient. The notion that race does not matter is one of Mr. Connerly’s efforts to bring Nirvana into our present situation. His current initiative essentially says that since race does not matter, let’s stop collecting information on race. What this means of course is that the kind of data that would allow us to continue to show the disparities in terms of educational resources, educational outcomes, I won’t even get into health, that those disparities will no longer be able to be identified, and consequently, policy matters won’t have that information.

Okay, you were commenting on your own personal take on that.

Yes, I said I personally consider it an extremely negative, which is even too—

Too soft a word, too soft a word. With consequences again, I think, that I’m not sure Mr. Connerly has thought through. I have on occasion tried to give him the benefit of the doubt because there is something very seductive about the notion of fairness. Why should my youngster be treated any differently than any other youngster when it comes to access to something as precious as a position in a medical school? I mean, that resonates with all of us, that’s really great. But when you carry that to the point of saying that—and I think that implicitly this is what the anti-affirmative action say, when you carry it to the point of implicitly saying that it’s no longer important that society find ways of addressing historical social injustices, and as imperfect as affirmative action was, that is essentially what it was. It was the broader society through the agency of state government, local government, and in this case the universities saying that we want to make the kind of investment that will address, that will partially, at least, redress some of those long-term social injustices.

We are doing this not out of a great sense of benevolence. We are doing this because it is important to society that these minority groups in fact do have an
opportunity to climb up the ladder and then to fulfill their capacities. So that’s an investment that we collectively as a country and as a society were making. It worked tremendously well. If you look at the benefits of affirmative action, there is a book called The Shape of the River that was written by the president of Harvard and Princeton I think—I can’t give you the exact reference but I’ll bring it in next time—that shows the benefits of the time of affirmative action as it played out in higher education. I’ve aggressively fought—I fought SP1 and SP2, I fought it with my national fraternity, I got resolutions passed there. I didn’t get enough people awakened to the fact that this was only, that California was just the beginning.

LaBerge: It was certainly was the beginning.

Hopper: That it was going to really spread. At this point in time, I’m actively involved, I’m happy to say, in a number of organizations that are aggressively fighting this most recent initiative.

LaBerge: Oh that’s good. What kind of interchange did you personally have with Ward Connerly?

Hopper: Well, we had the debate at the Regents—

LaBerge: At the Regents meeting?

Hopper: Yes. We were not friends. [laughter] As small as it may seem, on a couple of occasions when I was invited at a Regents dinner to share a table with him, I said, “Absolutely not.” If it meant leaving the dinner I would have. I’m saying that’s unfortunate to give one individual that much power.

LaBerge: He’s wielded a lot of power.

Hopper: Yes. I’m saying the problem is not Ward Connerly, the problem is the change in attitudes in America and California that he has tapped into for whatever reason, let’s give him the benefit of the doubt and say that his vision is that if we keep on collecting data on race and if we keep on acknowledging that race is here and matters, that it’s going to be to the ultimate detriment of the country and to minorities as well. That’s his mantra. I’m far more concerned about whether or not the patience of America, Californians and Americans may have worn thin over time and that they may not have been able to really see that the benefits of “affirmative action” and the other efforts to reach out to minorities, that these benefits are both tangible, they are statistical, they are impressive. I think that if the vote for Proposition 209 is any indication, again, it was couched in ways that—

LaBerge: Oh, it was poorly written—as far as I’m concerned and you’re concerned—but clever.
Hopper: But it was clever, see, because it was couched in ways that would make it easy for people who vote to do this on the basis of the fairness imperative, without dealing with the other aspects of it. I think that it’s going to be a tougher sell to have the new initiative serve on that same basis, because there will be a lot more people hurt if this passes than was the case with Prop 209. I think going to SP1 and SP2, which is what the Regents ultimately adopted, in fact it was adopted before 209. I think that if I could put it this way, I think that over time—we don’t chose future physicians based on entrance scores or any other quantitative measure. Consequently, if a medical school, if an admissions committee chooses to continually diversify the student body, as our admissions committee has, they can do this, because professional school or at least medical school, unlike the prescriptions that were written, I guess, into SP2, one of these had the prescription that said a certain percentage of the students who are coming in as undergraduates have to be on pure numerical scores, whether or not they were at the time. There is no such formula for—and based on Mr. Connerly’s announcements, he may be a little unhappy about the fact that our professional schools had started to rediversify at this point in time, certainly not nearly to the extent that they were. And there were other forces at work.

One of the other things that we found in the “Special Report on Medical Student Diversity,” again I think I mentioned that I chaired, at President Atkinson’s invitation, a committee made up of representatives from all of our medical schools and the other four medical schools in the state, together with some other people, to go back and look at this. What we find is that in some instances, the trend towards reduced applications, from underrepresented minorities, had actually started prior to—they were accelerated by the SP1 and SP2 debate and ultimately by Prop 209. The result was that with the climate in California being perceived as negative being one factor, but quite frankly I think an equally compelling factor is that our outstanding underrepresented minority students in this state were being given fabulous scholarships to go to places like Harvard, Yale, Cornell and so forth. The recommendations that we made in this document in terms of, as for example increasing the training of counselors at the college level so that they know more about the medical school admissions process, for example, and beginning to look at sources of funds that would allow a university to provide competing scholarships, a lot of this is actually taking place now. I’m delighted that this was not something that simply sat on a shelf and is gathering dust. There is an ongoing good follow-up to this. I’m hoping that somewhere in the library archives this report can—

LaBerge: Oh, it would be great. Any of that that you would like to give is wonderful. Particularly if you have more than one of those things.

Hopper: Oh yes, I have more than one of these. I think this document is important as well.
LaBerge: AIDS research.

Hopper: The AIDS research program overview dating all the way back to 1983, which is almost at the beginning of the epidemic in terms of—and then tracking what we had done, what we did up through 1989. I think there would be a companion document. There are annual reports, and I think there may be a companion document that has tracked things from like 1990 through the late nineties in terms of development, and I will look for that. These are two things that I think will be useful. Finally, my office had to take the leadership in responding to a legislative initiative to increase our training in primary care both at the medical school level, but also at the resident level, both in terms of curriculum, but also in terms of the number of positions that we offer in family medicine, internal medicine and so forth. This is the seventh report, and I think there is a final report that I really—I’ll bring that in—that I really would like to have added to that because that—

LaBerge: That was what, July—

Hopper: July 2002, but it’s the seventh report, by the way, so this goes back a number of years. Then there was a final report that—well the final report actually fulfills our commitment with the memorandum of understanding that we have with the state that said what it was that we were going to do, over what period of time we were going to do it. I like to think of this as being part of my legacy from the standpoint that I’ve always believed that primary care was important, and that medical schools really ought to pay more attention to family medicine and other primary care disciplines. I like to see this as also part of my legacy in terms of the fine line that we had to tread between getting the university, our schools of medicine, to respond to that external legislative pressure and need.

I think in this case, the legislature was probably accurately reflecting their constituencies in terms of wanting the universities to do more along those lines. While avoiding actually having this turn into a bill that would have resulted in loss of huge amounts of money to the university and a far more onerous prescription, legislative prescription being introduced in the university, and modeling that over time and keeping the deans, the department heads, and particularly the research faculty in our schools of medicine who were outraged by this. It was like, “What are you talking about?!” So I would like to have that again, as I said, not so much as the objective things that we accomplished with it all, while I’m perfectly happy to associate myself with them, but what you can’t read in between the lines is how difficult it was to do this.

LaBerge: Well we talked about it a little bit in one of the other interviews, and it sounded like you—I think we have it, but I’m not sure—that you were kind of getting people to compromise and that’s the only reason it happened.
Hopper: Yes, well, you’re right. I was the one, I think I mentioned, that the president at that time, I think it was Jack Peltason, when this whole idea for a memorandum of understanding—see, there was a piece of legislation that had been introduced that would have in fact mandated that twenty percent of the—and so forth. We managed to get that blunted, but the price that we paid for this was to enter into a memorandum of understanding with the Office of Health Planning and Development that would require us to meet some of the same kinds of objectives—well, I don’t want to say “require,” but we committed to meet a number of the same objectives that would have been included in the original legislation. When I saw the memorandum of understanding I said, “This thing is going to be seen as a contract.” I was suggesting at that point that we not sign it, that we just go into the trenches and see if we could fight it through, but there wasn’t the will to do that. Then the crowning blow was, “Well, Con, you sign it.” [laughter]

So I ended up being the signatory of this memorandum of understanding between the university and the state as represented by the Office of Health, Planning and Development. And it has been wielded as a contract by the Academy of Family Medicine in the state, by the Office of Health Planning and Development who have always held it up as being, “This is the commitment that you made.” Quite apart from the fact that the circumstances under which this whole thing came into being in terms of the number of family practice positions available, their funding and so forth.

Circumstances have totally changed. We can’t fill the family practice residency positions in the state right now. If you look at where the shortage is—and I can say this from direct experience, being on the board of the Alta Bates Medical Center and having to—and as chair of the finance committee—having to sign off on loans that we’re giving to specialists to come into the area. The world has changed since this. But this was the academy’s one big hammer that it had, that it really wielded, for the better part of a decade. All this stuff got started back in, what was it, ’93?

LaBerge: ’93?

Hopper: Yes, ’93. The debate was in the earlier ‘90s, but we submitted our plan in June of 1993. Nine years later, we are coming up with the final report. Then again, the university did not lose in the process because it did respond to a legitimate interest on the part, not only of the legislature, but of society, that we start turning out more people who can take care of people. [laughter]

LaBerge: That’s a good place to end today?

Hopper: Yes.

[End of Interview]
LaBerge: We are on now. [laughter]

Hopper: You’re sure about that now?

LaBerge: I’m sure about it, I can see it going. It’s October 22, 2002.

Hopper: I think, again, for context, and I’ll probably be repeating myself to some degree—

LaBerge: I think it’s better to do that though.

Hopper: Again, my office at the time that I retired had responsibility for administering three major research programs in addition to two other system-wide programs that were not major from the standpoint of the amount of dollars involved but were unique. The research programs were AIDS, which started back in the early ’80s, and we have talked about some of the interesting dynamics around the starting of that program. Then in the late ‘80s, we inherited the responsibility for starting a tobacco-related disease research program. Again, these were dollars—

LaBerge: Who did you inherit it from?

Hopper: Because the state decided they wanted to do it and we had done I think a job that the university and the state agreed had been good with AIDS, and they thought. “Well, this is a good place for it.” You can follow the same kind of model, from the standpoint of using the NIH peer review system, and I have always brought my reviewers in from out of state, so that there wasn’t that kind of conflict of interest issue. But my first director of that program was Dr. Paul Torrens who came with me and did a—he’s a professor of public health, a very distinguished gentleman from UCLA who took a year’s leave of absence or during a sabbatical, actually, and came and worked with me to start the tobacco-related disease research program. Same model, we had a multi-disciplinary, multi-institutional advisory committee using NIH peer review model, competitive grants. And with institutions throughout California—now California-specific, but not University of California-specific.

LaBerge: The state.

Hopper: Yes, state of California researchers were able to apply. So that program has continued. Now in the early ‘90s breast cancer research came along. Again, the irony of that was that this happened not long after my wife had had breast cancer.

LaBerge: Oh really?
Yes, right. So in that, I was very much interested, from obviously scientific but also personal reasons. This would have been about, I think, 1993. I’ll have to go back and look at the dates again. But in any event, funded with tobacco tax money, again, but with the state actually, in this case, being very very prescriptive in terms of who it sat on the advisory committee. We may have talked about this.

I don’t remember this, tell me more about that.

Yes, the state wanted to—the organizations that were made up of breast cancer survivors that actually were the major force behind the legislation that resulted in the research program, and the legislation prescribed who would serve on the advisory committee. Not by name, but by organization and by classification. That was very interesting, because there was almost no trust in the University of California initially. It was like, “You guys are going to take this money and do this esoteric research and we’re not going to be able to have a say and boy we are going to be darn sure that doesn’t happen.” So it really took about two years for them to develop a level of trust, both, I think, in our organization, but also in the University of California. But once they did they were tremendous supporters. Any time anybody was going to threaten the breast cancer research money they would descend en masse in Sacramento. [laughter] If you’re talking about radical lobbyists, you know, the AIDS groups can’t hold a candle to these breast cancer folks when they really get started.

Are there some people who were leaders that you can—

There were a number. Oh boy, my memory is serving me badly here. I can go back and piece in some of this.

We can leave it blank for now.

Because the initial chair was a survivor, it was not a scientist. I think a lot of the key roles, initially, were held by people from organizations that were—now we had some scientists on the task force. Gradually, and again, I’m kind of jumping all over the place but I attended a number of funerals of people who served on those task forces early on, on the breast cancer advisory council earlier on who subsequently they passed.

At the time I retired there were a number of special lectureships and awards that were given in my name, and in breast cancer there is such an award. So I’ve kept in contact with the key staff and not long ago, Dr. Mehl Cavanaugh Lynch who has been the director now for I think about maybe six years or so, five or six years.

And where is he, at UCSF?
Hopper: She.

LaBerge: Or she.

Hopper: No, she worked in my office, right over there on—

LaBerge: On Franklin?

Hopper: All these folks—well, actually, we left them in the Kaiser Building. So all the people in the special research programs were part of my staff in a way. So she’s still there. A few weeks ago, she called and said that she wanted to talk with me, I said, “Okay.” And Mehl’s kind of shy and she said, “Oh, I know you’re busy, but we are starting a new kind of state-wide community support operation with an executive committee, and I’d like to ask both you and Barbara if you would be willing to serve.” I guess I hemmed and hawed and said, you know, “Nobody knows the trouble I’ve seen.” [laughter] But then she said, “Well, Sherry Lansing herself has strongly suggested that they would like to have you—Regent Sherry Lansing, who was one of the really successful female executives in this country, you know, runs Paramount. I said, “Well, okay.” Once Barbara heard that, that we were going to get a nice tour of Paramount in addition to the meetings and that kind of—we’ll be going down next month for this.

But it was nice to be able to—as I think I’ve mentioned to you before in terms of my retirement—right now I’ve been able to maintain not just the contacts but I actually have been able to continue to be involve in the continued evolution of some of the programs that I was involved in before, things having to do with the state, the State Health Manpower Policy Commission. I think I mentioned that to you. They gave me a very nice plaque. The road to hell is paved with plaques. [laughter] But that work, the work with Kaiser, the work with Alta Bates Summit, the work, god knows with the Samuel Merritt College has represented a continuation, a chance to really put both the experience and the interest to use. I think I’ve said that to you before.

LaBerge: But that must be so satisfying.

Hopper: Oh it is! It’s incredibly satisfying. I never really thought that I’d sit back and only play golf or anything anyway, but I don’t think I ever really imagined being as busy as I am. I’m starting to be a little jealous of the time that I’m taking away from my reading. I minored in English, and that was my other fantasy is of—between getting Harpers, the New Yorker, the Atlantic, the New York Review of Literature, Granta, all these nice things that I get—do I have time to sit and read and cogitate about them? No, they are stacking up. My kids laugh because they all get the Atlantic and Harpers and they are all constantly complaining about they are stacking up and not having time. My son Brian says. “Are you really reading this stuff, Dad?” [laughter] That’s been fun.
LaBerge: I also—going back to your family since you’re mentioning them. I noticed on the poem that you wrote for the celebration of their graduations, something about bridge. Did you as a family play bridge?

Hopper: We played bridge, but it wasn’t so much bridge, it was whist, bid whist. Like you know, when you say, “I bit three spades.”

LaBerge: I see. So that’s—I’ve never played that, I didn’t know you bid.

Hopper: And poker. Those were really great times around the table. The real shark is my daughter. [laughter]

LaBerge: We do that too. Different sides of personalities come up and it’s fun.

Hopper: But it is kind of interesting, her room is still there and she comes back periodically and so her room is essentially like she left it, with the little bears and all the stuff around and pictures of her running track and the awards and the medals and so forth are there. Of course she lived there longer. My son Brian was there for a brief period. Then Michael, after his divorce he came back for about five months and then waved goodbye and said, “I’m sure you have had enough of me at this point in time.” [laughter] I said, “Well, you haven’t seen the contract yet. We were getting ready to write up a contract.”

But the other two programs, again, I mentioned AIDS, tobacco and breast cancer. But Geriatrics—we had the Academic Geriatrics Resource Program, AGRP. Again, not much money, but it was a unique program in that we were able to establish, at all five medical schools, and here at Berkeley, an academic geriatric resource center that served as sort of a nucleus where faculty from a lot of different disciplines, but with the common interest in aging and problems of aging came together. They would look at curricula in the various disciplines to try to be sure that an appropriate amount of geriatrics was built into them. We gave out some grants as well, provided some basic support. Even though it wasn’t much money, this program became known nation-wide. Geriatrics has always been kind of a step-child of medicine and the health sciences. It’s always been a big fight to get peoples’ attention. I think it’s going to be less so as time goes on and as more of us achieve seniority as the case may be. So that was very satisfying. Over the course of the years in AGRP the people who were fellows that we funded, as fellows, have gone on to be really prominent faculty within the university and some of them moved on elsewhere.

LaBerge: In that field?

Hopper: In the field, in geriatrics, right. The last one that I mentioned, the Occupational Health Centers, I inherited this when I came on the job. They now are called the Occupational and Environmental Health Centers, the name has changed. It was an interesting kind of thing because even though my
office had responsibility for, in a sense, the care and feeding of the state-wide committee that was kind of the oversight body for it, I never had the budget in my office. [laughter]

LaBerge: The budget was in Sacramento?

Hopper: No, the budget was actually—part of the deal, to back up a little bit—This whole movement came about because at some point in the late ‘70s there had been a disaster down south—the term “Stringfellow Pits” comes to mind. There was this big toxic problem and it got the attention of the Department of Industrial Relations. There was legislation to create occupational health centers too—one in the north and one in the south. They were under, initially this was under a contract from the Department of Industrial Relations without the money coming directly into the university, in other words it was still just a contract rather than a grant, being part of the university’s budget. About the time I came was when they actually moved the budget into the university. But the way they did it, the various deans involved negotiated that the dollars would come directly to the campuses as opposed to being centralized. What this meant was that the people who were the directors of the northern occupational health center, Bob Spear—Professor Spear of the School of Public Health was the initial director of the northern center. The southern center was actually based in Irvine—Dwight Culver was his name.

These people had—all they had was the power of persuasion, because the budget, the money, was already out on the campuses. So that was a very interesting experience and these folks did very good research too, both training and research. The idea was to be sure, again, that people were being trained in occupational medicine, occupational nursing, and the other disciplines, but that also there would be some good research that would be going on. The northern center also ran—I won’t be able to think of the name of it now, but it was a clinical program—Labor and Occupational Health Center, I think, LOHP, Labor and Occupational Health—anyway, LOHP, and I can get the—It was a place where people with industrial accidents, or with toxic exposures, or other occupational problems, not necessarily just toxic, could be evaluated and treated.

So again, even though that was not a—my office had the nominal responsibility for this program at a system-wide level and I had to keep up with the advisory committee and all that sort of thing, I never had the same level of control of that that I did of the other special programs. But these were fun, I don’t think they were ever envisioned as being part of my portfolio as special assistant or even as vice president, with the exception of the initial AIDS thing. But again, I’m very proud of the fact that we did the kind of job, established these in such a way that when these initiatives would occur in Sacramento and they would say, “Well this should be a system-wide or a state-wide program, where should we put it? Oh, there’s that guy Hopper, in the Office of the President. And there’s the AIDS program, so maybe we can
take some of that same model and be sure that it’s built into the legislation.” And we did well. These are still doing very well.

LaBerge: So all of those are still going on?

Hopper: Oh yes, yes. The other interesting thing—I still get the Tuskegee newspaper—I always go back to Alabama.

LaBerge: That’s okay.

Hopper: We get the *Tuskegee News*. I think I mentioned that several years after I left, the hospital that I had run closed because—

LaBerge: The John A. Andrew—

Hopper: The John A. Andrew Memorial Hospital closed. But the comprehensive health center, which turned out to be the federally-funded model of what I had put in place with the three county primary care network. It evolved from a Johnson Foundation-funded kind of model initiative that was then picked up as a comprehensive health center by the federal government later on. I read in the paper that between the Tuskegee Area Health Education Center, that comprehensive health program, these served as kind of like the nucleus for a whole brand new urgent care center in that county. A number of those people who were the leaders in this were people that I had interacted with back at that time, and many of us still friends in fact.

LaBerge: That’s wonderful.

Hopper: So that’s a reality now, they found the money for it. Again, the fact that some of the things that you helped put in place, even though they evolve into different kinds of creatures over time, the basic impetus for them is still there and a number of the same people are still there. So that’s been very gratifying as well.

LaBerge: Well, one of my broader questions was from something, one of the papers you gave me, something you said. It’s sort of your reflections on the university as—the words you use were: “as incubator and sanctuary for principles of social justice.”

Hopper: Yes.

LaBerge: First of all, that’s a wonderful phrase. Could you elaborate on that?

Hopper: Well, it kind of speaks for itself in a way.

LaBerge: Oh yes, it does.
Hopper: In that if you look at where a lot of the movements in this country towards social justice, where they started. I’m remembering, for example, that Berkeley, Madison, Wisconsin, these campuses became—and the students gained the ability on these campuses for students and professors to speak freely in spite of some of the stuff that happened here with Governor Reagan and so forth. These campuses were a place where freedom of speech, where the ideas of social justice were really incubated and then spun off at a later time into other elements of national life. As I’ve said, it’s also—it’s not just that it’s an incubator, but in very difficult times it becomes a kind of a refuge, in a way. These are the places where you want to—even in extremely conservative reactionary times, campuses, universities are places where you still ought to be able to find the nucleus or of the ideas of social justice. That’s what I was trying to capture here, and the thing that had appalled me so much was I thought the university was being manipulated, in this instance.

LaBerge: In the instance of Prop 209?

Hopper: In the instance of Prop 209, that the university was being manipulated and brought into a posture that was inconsistent with the posture that I thought we really represented. It’s not that universities can ever be, certainly public universities can never be totally free of the influence of legislation, of politics. Never has been and never will be. But I think that all of us who are part of universities would like to think again that in the final analysis, these are places where you can expect some creativity, some problem solving, some articulation of ways out of whatever thicket or jungle we find our way in. Here’s where the thinkers are, here’s where the exchange of ideas takes place. And to have the university just grossly manipulated, here, we’re going to drag the university into the middle of not just a political movement, or a political initiative, but do so in a way that would require the university to turn its back on affirmative action. Affirmative action in this case meaning, again, society’s way of investing in the future of a substantial portion of the American population. That’s what affirmative action has meant to me all along. This is a vehicle by which, again, the social capital of the country is refurbished. It’s an investment in the future. It says that using this tool, we will bring an ever-larger number of people into the mainstream of American life. That’s why this was so egregious in my view, because again, I think it made us into something, it tried to shape us into something that I don’t think we really were. I think the reaction, frankly, of the university, ultimately had to this was very reassuring to me.

LaBerge: It seems like people in the university, except for the Regents were on a totally different wavelength.

Hopper: Oh yes, the president, the vice president, the chancellors, all the administration, even the faculty, although there was some division, but even the faculty, at least formally, was saying, “What are you doing? This is not
really what we are about.” [laughter] So in any event, that’s what I have reference to. I probably have said it worse now than before.

LaBerge: No, I think it is eloquent. Tomorrow I’m interviewing Roy Brophy because he wanted to do a little follow-up from his short interview, really on this subject. Because he was one of—he stood up in the regents meeting and said, “I’m speaking as a private citizen.”

Hopper: Oh Roy was—oh yes—that white boy was a staunch backer and thought that Mr. Connerly was, again, using the university for political purposes that were inconsistent with the way the university should operate, and he said so. He said so very clearly. There were a number of Regents, of course. This was a—I’m going to go back and reread the minutes from those meetings sometime, to just recall the—Bagley, who—I don’t want to go too far because, you know— [laughter]

LaBerge: Well since that time, he’s been the one to push—

Hopper: Oh yes, he’s been—

LaBerge: To rescind—

Hopper: Oh yes, to rescind. Bagley took the lead in saying, “Now that Prop 209, now this law, it’s part of the Constitution, the very least that we can do, as the university, is to rescind what we said the university ought to be doing along those lines. We all are going to be governed by the law ultimately, but let’s take this mark off of the university.” And they did. Did I ever—did I show you the speech that I made to the National Medical Fellowship? The acceptance speech?

LaBerge: No.

Hopper: Oh! I’ve got to get that to you.

LaBerge: You gave me your farewell speech to the Regents in which you said a little bit.

Hopper: Yes, but see I was made—I was the first—I was given the first Founder’s Award for the National Medical Fellowships. And my acceptance speech came just a short time after the Regents had rescinded what they did before and I commented rather pointedly on it. [laughter]

LaBerge: Well that would be wonderful, you could include that.

Hopper: And you can do excerpts from it, whatever seems reasonable. We don’t want this to be a fifty ton document, but I will— In fact, I will—I can fax that to you.
LaBerge: Do I have—I will email you the fax number and the website.

Hopper: Yes, all right. Good. So email me the fax number, then I will fax that.

LaBerge: Was part of that 209—did you do any calling people—talking to Regents, or—

Hopper: Oh yes, I talked to Regents. Well, I debated Ward Connelly in one of the meetings. But he had fairness on his side [laughter] the way he was putting it. But no, in my national fraternity I did a resolution—in fact, I will be happy to share that with you as well—that basically asked this national fraternity to go on record about what was happening with Prop 209 and then—at that time there was already the early, some of the early movement toward the thing in Washington as well. So I’m going to get that to you as well.

LaBerge: From what I understand, for instance, this special report on medical student diversity—both medical schools, law schools, the minority population went way down after that, and it wasn’t because of the peoples’ perception? What do you think?

Hopper: Well, it’s not very straight-forward and I think we point this out here that some of the trends in terms of applicants had started prior to the debate about Prop 209. But the Prop 209 debate accelerated this because it created the notion of a very unfavorable or hostile climate. What this meant was that many of our very best students, minority students who had choices elected to go to Harvard, to Yale, and so forth. Then there was the additional thing that we pointed out in this study, that many of those schools had scholarship support that we couldn’t begin to actually compete with. But things are rebounding to some extent at this point in time. As I think I said before, ironically, even though medical school admissions became the battleground, the initial battleground for SP 1 and SP 2, there is more flexibility in medical school admissions than there is in undergraduate admissions because people acknowledge the fact that you don’t choose your doctors based on the fact that they might score very well on a SAT test or an MCAT test. So that admissions committees who have wanted to achieve diversity or to sustain some level of diversity have been able to do that. But I know that here at Berkeley, for example, the law school, it took a real big hit, a really big hit.

LaBerge: They certainly did.

Hopper: Yes, I do plan to do some more serious thinking and perhaps writing about that experience, Prop 209. I think from the vantage point of how, again, a society, thinking very broadly about society, what are the avenues that are available to, both philosophically and politically, to not just redress wrongs in terms of slavery and so forth, but more importantly and positively, what are the avenues and the vehicles available for it to bring into the mainstream of our society and our life, our national life, people who have been marginalized
by that experience. I really want to clarify my own thinking on it. Because it comes up again in this whole thing about reparations.

LaBerge: Exactly. Well, there was even an article today or yesterday, about the—in the Chronicle—it’s like the only survivors who were children of slaves. Maybe it was yesterday’s paper.

Hopper: I haven’t seen that.

LaBerge: I’ll look that up too.

Hopper: I’ll go back and look at the Chronicle again.

LaBerge: I’m pretty sure it was yesterday.

Hopper: But I think the notion of reparations in the sense of all the grandchildren and great-grandchildren of slaves, somehow giving some number of dollars—I mean, that’s nonsense. It’s absolute nonsense. In fact, “reparations” is probably a bad word because it triggers that idea that somehow, somebody ought to be handed something because their great-grandparents were— But I think of, again, not reparations, but a positive reaching out and finding avenues and vehicles for bringing the great-grandchildren of slaves into mainstream American life. What is it that we really can do to improve educational opportunity, to improve healthcare access? Once we identify pathologies that are keeping people marginalized, what can we do as a society to try to do something about that? That’s why, again, the whole idea of a university as a collection of thinkers, I do look at universities as a place where you can incubate ideas that can then be passed into the public or the political sphere to do something. That’s why I’ve been just extremely happy to have been associated with universities all my life. Because I believe, I believe in them.

LaBerge: Well, maybe that’s a good note to end on.

Hopper: Okay.

LaBerge: I’m going to say, on behalf of the university, thank you for doing this.

Hopper: Hey, listen, on behalf of my kids, thank you for doing this! [laughter]

[End of Interview]