



Oral History of the
Belmont Report and the
National Commission for the Protection of Human Subjects
of Biomedical and Behavioral Research

Interview with
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Belmont Oral History Project

INTERVIEW

Interviewer: Dr. Bernard A Schwetz, D.V.M., Ph.D., Director, Office for Human Research Protections

DR. COOKE: I'm Dr. Robert E. Cooke—now retired, but formerly a chairman of pediatrics, Johns Hopkins, and then subsequently at a number of other positions.

I had been an advisor to the Joseph P. Kennedy Foundation for some 45 years and have had a personal interest in the problems of children, obviously, having been head of a large department of pediatrics; and also a personal interest in children who are intellectually disabled, with two profoundly retarded children of my own.

Fortunately, I have other children who are normal, and actually are pretty good athletes. But my interest in the field comes very naturally from both my relationship to the Kennedy Foundation and also my responsibilities as a pediatrician.

INTERVIEWER: Dr. Cooke, when did you personally become interested in questions of research ethics?

DR. COOKE: Well, I think it almost goes back to the birth of my retarded children, because at that time there were absolutely no services whatsoever. And the care of children like mine was really pretty atrocious in institutions, so they lived with us for some 18 years.

And all along, I'm looking for evidence of interest in the field, with very few people—medical students knew nothing about problems of these children, and most medical schools did absolutely nothing about the issues. And that, I think, generated a good deal of interest, at least in that group.

And then as I went on doing research through the years, before moving to Johns Hopkins, I carried out experiments, which I talked about that, I think, looking back, were anything but meeting modern ethics. And as I matured, maybe, I realized that what we'd been doing was very helpful to the world, but very unfair to the subjects that we worked with. And I think that kindled my interest.

I also had the opportunity to spend a year at the Harvard Divinity School, working with Arthur Dike, who is a very distinguished ethicist at Harvard, and that certainly kindled my interest.

Probably the most significant experience I had was when I was chairman at Hopkins, we had the birth of Downs Syndrome baby, and the parents did not want to have surgery done. This child had duodenal atresia, which is a total blockage of the intestinal tract--easily remedied by surgery. They refused. The surgeon wouldn't go ahead with it. And so the baby died.

Another similar situation came up later, and the opportunity to make people aware of the problem of letting a child die--totally needlessly--and we made a film of that particular case, which I'm told had enormous impact on whole field of ethics. It was really a remarkable experience.

As a kind of anecdotal experience, when I was teaching, I remember picking a jury from my class, and telling about this case, and then had them vote. And they all voted to let the baby die, because that's what the parents wanted and so forth, and why burden them. I then showed the film, and the jury switched its votes completely, and they were all for saving the baby, even though the parents didn't want it.

In a subsequent case, we kept the baby alive; found a foster home, and about two months after that, the parents took the child back, and it's become one of the joys of their life.

That film has had a major impact on the field of bioethics. It was first shown in 1971.

The Hopkins case--the second case, that led to this, was actually only about a year before the symposium where this film was first shown. And the people in that film were the actual nurses and physicians. One of them--a man named Bartholomy--Bill Bartholomy--it affected his career, and he went on to become very distinguished ethicist, particular interest in children.

And I think it really did influence the field enormously.

It's a real-life example of an application of ethics to the problems of children.

INTERVIEWER: You pointed out in your talk that Senator Mondale was the person in the late '60s who was raising these questions and holding hearings. And in the early '70s, it seems as if the mantle passed to Senator Kennedy. How and when did Senator Kennedy first become in questions of research ethics?

DR. COOKE: Well, actually, the first symposium in which that film was shown was the inauguration of the Kennedy Center. Senator Kennedy was the host, in a way, and introduced the program. And, of course, his family, for a considerable period of time, had a foundation which was dedicated to the well-being of children, and particularly the well-being of children and adults with mental retardation. And he was chair of the board of trustees of the foundation after President Kennedy was the initial head of the foundation, and then Senator Kennedy took over after his death. So, it was a pretty natural thing that he would be concerned with these issues.

He also had a staff member--Dr. Larry Horowitz--who was a well trained physician, and he handled much of the early legislation. It was a wonderful spirit of bipartisanship. Jacob Javitz was very interested. Paul Rogers, in the House of Representatives, too. But I think Horowitz probably ought to get the major source of credit for really developing the legislation.

My part was, I think, pretty minor. I was obviously concerned about children, and about the mentally retarded. And so those two sections were an integral part of our studies. And why, I'm not sure, but I insisted that behavioral research ought to be included. It was originally just biomedical, and I'm not sure the psychologists have welcomed that ever since. But it seems to me there are just as many problems.

The one thing that I wanted very much, but was not included, was educational research, because at times I think that can do as much harm--at least psychologically--to young kids as any physically study.

INTERVIEWER: It was a pretty complicated process getting the legislation through in 1974. The fetal research question was a very hot topic late in '73, and there were various topics that people wanted to get into the bill. So I would imagine Dr. Horowitz had fairly complicated negotiations to get everyone on board, to create the Commission.

DR. COOKE: Yes, I don't honestly know how each of those issues was introduced. Prisoners research was certainly a hot item also. The Commission visited Jackson Prison in Michigan, and that was a very interesting experience for the Commission. We

were escorted around by murderers who had committed a crime of passion of some sort, and they were delightful people. At times I couldn't tell them from the Commission.

But fetal research was one of the most contentious. And the other--children, certainly was, and I still disagree with the recommendation--particularly, and I speak about that. And then the mentally infirm was not contentious, except for the one critical recommendation, which I still object to.

The problems with children was, in my mind, that they needed more rather than less protection than adults. That was even more true of the mentally infirm, and those in institutions were very vulnerable. You know, I couldn't help but think of my own children which, by that time, had been in Southbury Training School. And the problem was that you'd have a quandary here: how do you carry out research on individuals who can't consent, and can't understand what the problem is about, can't appreciate the importance. And how do you use them as non-consenting people when the rest of the recommendations of the Commission were that you wouldn't do that sort of thing with non-consenting adults?

And it's a true dilemma that we tried to solve in one way or another with children. I gave a little bit of ground on my objections by requiring that parents participate actively in the research. And if there was anything at that time that seemed out of order, then that could be interrupted.

But even that I didn't feel was satisfactory. Because over the years I'd seen research done on children where the parents agreed with enthusiasm, that was really terribly hazardous to the children. One study that was done was cardiac catheterization of newborns to find out the transition from fetal to normal newborn circulation. And cardiac catheterization is certainly not a minor risk. And then, I think, I'd mentioned the revascularization of the brain in children with Downs Syndrome, where an artery was hitched to a vein coming from the brain and, in theory, blood was going to flow back to the brain and cure the mental retardation. But it ended up in profound heart failure in a hurry.

So that parents frequently can agree to things, either because they don't understand the problem, or because they are so concerned about their children, the problem, that they'd like to do almost anything to correct it. And that's been the history of Downs Syndrome--one intervention after another that may be harmful to the child; very enthusiastically endorsed by the parents.

INTERVIEWER: I think your position is that children and people with intellectual disabilities can be involved in research where the risks to them are minimal, but anything above that you think is improper.

DR. COOKE: Yes. One of the problems is that the so-called minor increase over minimal can be an awful lot--wide variation, and each institution may interpret what "minor" is. It can be, I think, very serious interventions--dialysis, for example, in one of my experiences. It was considered a minor increase over minimal. And there are number of such examples that one could cite that indicate that, to some people, what is "minor" is very minor, and to others it's pretty major.

So I felt that we've got to find a better way to justify research because there's no question there are problems with children. And I mentioned yesterday. the studies that I did a number of years ago, before Belmont, where we studied the effects of heat stress on babies, and the justification was that the death rate from summer diarrhea was very high in the world. And so we showed what happened under the circumstances. But it was really, looking back, totally unethical. We used Black babies from an orphanage, and there was no consent. There were no parents. The whole thing was--we justified it by finding nice adoptive homes for these babies instead of being in an orphanage.

But it still wouldn't fit modern criteria at all. It was uncomfortable for the babies, and we had to do punctures, get blood samples and so forth.

So before the Commission, I don't think even legitimate, honest, researchers appreciated what they were doing, other than "helping." And I use the hackneyed expression that the end justifies the means. And that was, I think, the major ethical principle that we were operating under.

INTERVIEWER: In 1966, Henry Beecher published an article, "Ethics and Clinical Research" in the New England Journal of Medicine. And I wonder if you can recall when that article came out, and whether that helped to raise consciousness about these questions.

DR. COOKE: Well, I couldn't cite time. When you get to my age, why, two months may be two years.

But I remember that there was an awakening of interest at that time. There was beginning talk of--a lot of interest in--what was death, and so there was a good deal of

discussion about the criteria for that, and brain death emerged as a concept. And Beecher had something to do with that, along with Bill Curran at Harvard.

But I honestly can't remember the Beecher paper. That was a long time ago.

INTERVIEWER: Coming back to 1974, now, how did you find out that you had been invited to join the National Commission for the Protection of Human Subjects?

DR. COOKE: Well, it sounds kind of egotistical, but I didn't think there was anybody better equipped. I had spent time at Harvard, and thinking about these kinds of problems. I had a pretty well-known department of pediatrics at Hopkins. And I had known the major author of the legislation pretty well. And one of the people making decisions was Duane Alexander, who was then on the staff of the Commission-to-be. He was at NICHD--the child health institute--and he was one of my former residents. So I think the thing was all loaded, and I don't remember exactly how I found out. I think somebody sent me a letter asking if I'd serve on the Commission.

But I understood pretty well what the Commission was going to be trying to do, because of my involvement with some of the drafting.

INTERVIEWER: As you look back on the three Belmont principles, do you consider that those are the most important three? And if you were trying to restate the ethical principles that should underlie research with human beings today, are there others that you would add, or substitute?

DR. COOKE: Well, I thought that those principles were enormously important, not just for research, but I've used them in my thinking about practice and the care of children.

I guess there must be some other principles that would apply, but these are general enough principles, it seems to me, that they've done a terrific job of improving the research climate.

One of the areas that I think have been hardest to follow is justice. And the reason is that it's the organization of medical care that makes justice hard to fulfill. Most research is done in major medical centers, and major medical centers are frequently located in the center of cities. And most of the people that live in the center of cities are poor, and minority. And, as a consequence, many of the patients that may be subjects in research, come out of that population.

I call that administrative convenience, but it's very hard to avoid that in the way we're organized. It's rare to have a hospital sitting out in the most affluent part of the city. And so this even distribution of risk and benefits is in theory more than it is in practice--even though you'd like to be able to have that equal distribution of risk and benefits in the population.

And the most egregious studies that led to the development of the Commission really came from this maldistribution of problems. Looking back, I think the Congress was probably more upset by the Tuskegee study than anything else--and, there, were Black men with syphilis who were treated--looking back--unconscionably. They weren't given treatment. They were to be studied to see what the natural history of syphilis was, which is disgraceful. And then, another study was the one in which Mexican-American women were given placebos--dummy pills--as a control for use of contraceptives. And out of the group of, I think, some 40 subjects--10 became pregnant. And nobody provided care for them or anything else. Equally disgraceful.

And then Willowbrook, in New York, where hepatitis virus was really given to produce hepatitis--had a lot of questionable things that might have been handled quite differently. And that produced a great deal of interest in Congress, in terms of care of people with mental retardation.

INTERVIEWER: Is there any one of the principles that you think is more important than the other two?

DR. COOKE: Well, as a researcher, you'd like to think that beneficence would be the most important; because why do you do research unless you're trying to help somebody out?

But from my standpoint the greatest protection comes from respect for persons. It really means that you value someone as a human being, and not just as a subject of research.

And looking back--and again, in my own career, I think that was probably the one that I least respected. I thought, as I have mentioned, that these children from an orphanage were great subjects. But I didn't think of them, really, as persons as much as I should. And I think that was true of an awful lot of researchers at that time. You know--even the term "subject" of research means that this is not--in the minds of the researcher--a

person. And you might just as well have a dog as a subject of research. And that, I think--the introduction of that concept was probably the most important.

I think fairness--which is really a little bit of what justice might be called--I think we were somewhat conscious of that; that maybe in the negative, in that we weren't going to take private patients as much as ward patients. But at least there was some concern there.

But consent was pretty minor. The only aspect of respect for persons was whether or not you get sued if you didn't have some permission. And that, at that time, was the usual practice that you had somebody sign a form to consent to an operation. But that was pure protection, and not truly a process in which you were considering this as an individual like yourself.

And I think that in medicine, for a long time, the physician was the superior person; what the patient thought wasn't terribly important. And they were much more authoritarian. And I think the Belmont tended to make that--begin to introduce the notion of the patient as a person, even though that came out of the Kennedy Institute in Georgetown.

Paul Ramsey, while he was there, came up with this concept, which I think is the same as respect for persons.

INTERVIEWER: Some philosophers have worried that the notion of respect for persons is a kind of a composite; that it deals both with autonomous individuals who can make decisions for themselves, and it also deals with those who are not competent. Does that double meaning of the phrase "respect for persons" bother you?

DR. COOKE: Well, being interested in children, and in people with mental retardation, autonomy was never a big deal with me. I thought that being a human being is what you are respecting, regardless of what their autonomy amounted to. So I've never--I haven't thought of it as autonomy, really.

The notion of intrinsic or--of human beings has always, to me, been much more important than the issue of autonomy, and respect for that is what I've tried to operate under.

INTERVIEWER: If you had to single out a moment when you think the Commission was at its finest, or made its most important contribution, what one moment would you choose?

DR. COOKE: Well, I had relatively little to introduce into Belmont, but I think Belmont was the most important thing the Commission did, because it established general principles that has guided research from that time on.

Now, because I dissented from some of the other recommendation, I can't say they were the high point of the Commission. I think they were cavalier about children, and the institutionalized and mentally infirm. And that troubled me a great deal, because society in general has been pretty cavalier about that. Children don't have autonomy, and the retarded don't have autonomy. And so--they don't vote and all of the rest of the things in our society. So they, I think, have been abused over the years, totally inappropriately.

INTERVIEWER: I was also going to ask you what do you think you're most important contribution to the Commission's work was, or what moment stands out in terms of your own role? And I guess it would be in connection with these two reports and your dissents.

DR. COOKE: Yes. I think obstinacy was the characteristic that made me the most valuable to the Commission. [Laughs.] It was hard to get something without proving to me that this was correct. I have the bad characteristic, maybe, of obstinacy, and a number of things obviously were terrific. And you jump on the bandwagon. But people had to justify, I think, to get my assent, and they didn't do it with children, and they didn't do it with the mentally infirm.

And so my dissent was pretty intense. And what was so disturbing is that the Commission that followed this one had exactly the same ground rules. They were now talking about persons with limited capacity for decision-making. Well, to my mind that was a child, and it was a person with mental retardation. And to say that you can do research beyond minimal--and I'm not even sure that "minor" was thrown in there--was, to me, didn't show that an awful lot of consideration to my dissent a number of years before. So I resented that.

INTERVIEWER: The fact that 25 years after the Commission's work ended, you still hold to the same position suggests that nothing you've read or experienced in between has changed your mind. And I actually think that your dissenting view is taken seriously by people discussing pediatric research, or research with intellectually disabled people today.

DR. COOKE: Well, I think we actually have made a little bit of a dent in this regard, because when the President's Commission came out with basically the same statement, as I just pointed out, it was not noticed by almost any of the groups that share that concern. And so I took it on myself to get in touch with them and mounted a pretty good group of people who dissented from what had been written. And it was clear that when people think about the problem--at this conference a number of people came up to me after the conference and said, "You're absolutely right about the issue of children."

Now, I think the problem is even sharper now than it used to be. Science has moved to the point where tissue culture can give you a lot of the biochemical hints that you might learn from a whole patient, without bothering the patient; and animal research--which, for a long time I've tried to promote, very heavily, as a substitute for human research. And I think there's been enough progress there to say that you don't have to put children at risk as much as you had to before to get answers to problems.

So, I think it's made the situation even more intense, that children should not be put at risk--significant risk--nor people with mental retardation.

INTERVIEWER: If the Belmont principles were really applied to research as it's done today, how would you think the way research is done would change? I mean, you mentioned justice, for example. And spreading the risks or the opportunities across different groups. Where do you think--apart from research with children--where do you think research today is most out of sync with the Belmont principles?

DR. COOKE: Well, the children and the retarded, that still, I think, is a problem.

But I think there's much greater consideration of the distribution of risk and benefits than previously--despite the problems of where people are that go to hospitals and go to university clinics and so forth. I think there's been an awful lot of effort done to improve consent, but I have to say that an awful lot of consent is very perfunctory, and somebody signs something without reading it, or if they read it you can't understand it. I think my IQ is pretty good, and I read some of these consent forms, and they're absolutely unintelligible. You give somebody a form that talks about a pharmaceutical agent that's being tried in cancer treatment, and they don't have the foggiest notion of what the dickens this chemical is about, and how toxic it may be, etcetera, etcetera.

So I think we've got a long ways to go in explaining. And one of things that I've tried to get people to realize is it's much more important than informed consent, which suggests that you're informing people. What I'd like to get is "understanding consent," where you really find out whether these people know--emotionally as well as intellectually--what's in store for them.

And it's certainly true in medical practice, as well as in research that we've got a long ways to go in some of those areas.

INTERVIEWER: Do you think that the IRB system for reviewing research is working pretty well, in general? Or do you see ways that that could be improved?

DR. COOKE: I understand that much of it is pro forma activity. Somebody looks at the consent forms and it says a lot, and nobody really asks the question: is the patient, with maybe limited abilities intellectually, or language, or something--do they really understand what this stuff is about that's on this consent form?

I think my experience has been that they're a little cavalier in assessing "minor," and the explanations of benefits are probably most exaggerated.

So I think--but I don't know a better--I don't know a substitute for a group. How effective it is depends so much on the sensitivity of the membership. When I was at Wisconsin, there was a man named Norm Fost, who is a distinguished pediatric ethicist. He ran the IRB. And it couldn't have been better. And then I've been in other places where there's been, I think, really almost a dereliction of duty.

And so the system depends so much on individuals. But I don't know what else you could depend on but individuals.

Certainly, the individual investigator, without any kind of review would be a disaster. It's just so important that people want to accomplish something, that for a variety of reasons, as I spoke about, they may have great financial benefit from something working, or they become a professor in a hurry; and, at times, maybe benefit to humanity isn't the primary consideration. So I think it obviously needs some review.

INTERVIEWER: Some people have suggested that there ought to be more of an investment by the Federal government in the staffing of IRB's; that somehow the incentive system ought to be

changed at universities so that it's an honor to serve on an IRB, and perhaps you get a reduced teaching load, or some other compensation within the institution for this very important service.

DR. COOKE: Well, I don't buy that at all. I think that commercializes the whole situation. You know, I sit on an IRB because I can get an extra thousand dollars a year, or I don't have to teach. I think that's totally wrong.

What makes a good IRB is enthusiasm for the issues: "I want to help as much as possible making this optimally--from an ethical standpoint." So I wouldn't buy the commercialization of--I understand that there are some firms that provide IRB review. Now, my guess is they touch all the bases, but where's the emotion?

INTERVIEWER: Some institutions tend to appoint junior faculty members to IRBs because the senior faculty members don't like to take the time that's involved in reviewing protocols. And what you're saying is that this ought to be viewed by all faculty members as a very important activity of the institution.

Well, I happen to believe that senior faculty members probably are trying to get away with as much as possible, because they think they have so many responsibilities. And I look back on my own career as a chairman, I think I put in as much time and effort as the most junior member of my faculty. And I think you have that responsibility--or you shouldn't be a senior member of the faculty.

And one of the most important responsibilities is to make sure what your faculty is doing is ethical and responsible. Why be a chairman otherwise?

INTERVIEWER: As you look back on your whole career, would you say that your work with the National Commission for those four years was your most satisfying form of public service?

DR. COOKE: As far as the most satisfying--well, my recent experiences, despite the fact that I'm awfully old, was working with the Social Security Administration in having benefits for children with disabilities. And over the last three years we've been able to restore about \$2 billion worth of benefits. That, I think, has been pretty exciting for an old man.

But, yes, I think intellectually, no question in my mind that the Commission--and I think a high point in that was the Belmont--was the high point of my career.

It hit all the things you like to have in experiences in life. It was intellectually exciting. It was socially great. And you felt as though you were doing something that was important for the world. And that's about the maximum you can get out of an experience.

INTERVIEWER: Are there any topics that we didn't touch on that you'd like to talk about?

DR. COOKE: No, I think I exhausted the audience.

INTERVIEWER: I think you took your responsibilities very seriously, and prepared two very eloquent statements about the issues.

DR. COOKE: Well, you know, I have a big emotional commitment, for obvious reasons. I think that makes a big difference.

INTERVIEWER: Yes. So for you, this was more than just an academic enterprise. You cared a great deal.

DR. COOKE: Very much. Yes. And the same way in my career. I mean, children have been terribly important in my life. And so anything that might improve the situation for children came very naturally.

INTERVIEWER: Do you see a change in the climate in the country, or the culture, since the Americans with Disabilities Act--I mean, do you think that that signals a change in the way we view people?

DR. COOKE: I wish it did more. I still think there's a lot of public apathy about people particularly with disability. And there have been some major efforts to try to instill more interest. And one I've been involved with, the Special Olympics, I think has done a good job along those lines. But there's still tremendous apathy for people with shortcomings.

And I wonder about the worth of children; whether they're really thought of as a great deal more important than they used to be? They certainly were, from a legal standpoint, they were pretty second-rate citizens, back a number of years. But these stories about children who've been neglected, or children who've been actually killed and so forth, maybe we know about more about them now from the news than we used

to, but it's still very disturbing. And the condition of children in other parts of the world is really terribly depressing, it seems to me.

I think the whole issue of inherent worth of people is terribly important, because it covers children, it covers these cases--the one in Florida interests me a lot; this woman whose husband wants to let her die. For me, that's very disturbing because although she has nothing to contribute, and I'm sure, after all these year's she's not going to "recover," nevertheless, I feel she still has inherent worth, and terminating her life--one of my children's still on tube-feeding for the last 20 years. And so I can't agree with the courts at all in their decisions.

INTERVIEWER: Would you say that your religious beliefs and your training as a child in a particular religious tradition has colored the way you come at questions of ethics, and questions of research?

DR. COOKE: I wish I could say that. I don't think religion has played any part in my life. I'm clearly an agnostic. And I regret that a little bit. But I can't change my way of thinking at all.

INTERVIEWER: So you worked out of a humanistic ethic.

DR. COOKE: Yeah--very much. I think my feeling is that our society would totally fall apart if we didn't have these kinds of concepts. They're almost utilitarian in a way--if you didn't have a respect for others, you'd have a terrible society. In fact, it's one of our big problems right now. We've got groups that have no respect for each other. And, unfortunately, they're religious groups.

So, I think, looking back, I don't know where this came from, other than my own personal experiences with my own children.

INTERVIEWER: I'm interested that you mentioned your satisfaction at having benefits restored to people with disabilities under the Social Security program. With our conference and the emphasis on the Belmont Report, it's easy to lose sight of the whole health care system. And I'm wondering whether you think that something like a National Commission, looking at the health care system, and working really hard to get a better distribution of health care to those who need it might be a good step at the present time.

DR. COOKE: I will not get into what I think about health care. It's so radical that to put it into this would be.... Well, I think it's a relatively simple problem of what ought to be done. Everyone talks about lowering the cost of health care, and no one says how.

What they talk about--politicians talk about--I must say, Senator Kennedy, as well as these others--talk about lowering the cost of health care, which is really moving the payer from the person--the citizen--to the government.

So, I have a radical way of looking at it, because the largest single piece of overhead is insurance. The insurance--the cost of carrying out insurance programs, when you consider what the physician has to do in his office to satisfy the insurers, what hospitals have to do, what the agencies that are the insurers have to do, *et cetera*, it comes to somewhere around 20 to 25 percent of the total cost of health care. That comes to \$300 billion a year.

So, what I have proposed--and nobody will accept a little book I've written--is to call the regional health care public utility. And it gets rid of Medicare, it gets rid of Medicaid, it gets rid of all insurance. And what you do is everyone pays the same amount, just as they do for their water bill or their gas bill or something else, to a utility. And it literally will save some \$300 billion a year.

But it's pretty radical. Physicians all work for the utility. Hospitals are all run by the utility. You get rid of all the duplication, *et cetera, et cetera*.

And I know that we can provide good care to everybody, regardless of income, with the savings out of getting rid of that insurance. My whole point is you don't insure for your rent, you don't insure for your food, you don't insure for anything except catastrophic stuff. But now regular medical costs are so high they're catastrophic, even--you know, having a tooth out.

So, I think we have to totally reorganize the concept. And my believe is you pay the same amount each month. Billing becomes very simple. You pay the same amount for your whole life, because the risk and benefits are distributed across the life span.

But, of course, getting rid of the lobbies--you know, I know this won't happen, because the insurance lobby is so strong, and union lobbies are strong, *et cetera*. But it's the only way truly to save money.

It sounds somewhat similar to... on the Belmont principle of justice to our current situation would be to apply that notion to the distribution of health care, or access to health care, and maybe that's the next step.

DR. COOKE: Yes, everyone would have the same--basically the same opportunities. If you were poor, you could have vouchers to replace--it would be essentially part of welfare, so that could pay your monthly charge for your health services.

But with the large--I'm not big on the single payer system. I just don't feel that the Federal government does things in a very efficient manner. And then they most of them contract with insurers to carry out the unnecessary paperwork. And so it's interesting. I think the for-profit motive is still a good one, so the public utility would be an investor-owned, for-profit system--but regulated. And the big problem now is that this is totally unregulated. HMOs can run the damn costs up, and you can't do anything about it. And they can cut out services, and you can't do anything about it and so forth. And the public utility concept is one that appeals to me.

And I have this little caveat, that the public utility would be dividends, and so it would be tax exempt, as would be capital gains after 10 years. So you get rich people financing the health care system.

So, the whole thing, I think, would be a great solution, but it will never occur. Too many interests that will block it.

But I don't know how else you can get the cost of care down, but getting rid of the overhead.

INTERVIEWER: Well, thank you for all you've done for the Commission, and for the field of biomedical ethics over the years.

DR. COOKE: Well, thank you very much. It's been fun.

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