

Richard C. Oliver, D.D.S.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

Biographical Sketch

Richard Oliver was born on March 16, 1930 in Minneapolis, MN. He pursued a pre-dental program at Carleton College and earned his degree in dentistry from the University of Minnesota in 1953. He then completed a dental internship at Fitzsimmons Army Hospital in Denver, CO in 1954 and served as a captain in the US Air Force Dental Corps from 1954 to 1957. After completion of his service, Dr. Oliver worked in private practice in Southern California from 1957 to 1959. During this time, he pursued studies of advanced dental education at USC from 1958 to 1960. He then earned a master's degree in periodontology from Loma Linda University (LLU) in 1962 and became a professor in periodontics at LLU, where he worked until 1975. From 1967 to 1968, Dr. Oliver was a Fulbright Research Professor at Royal Dental College in Denmark. Dr. Oliver left LLU in 1975 to become dean and professor of periodontics at the USC School of Dentistry. In 1977, Dr. Oliver assumed the deanship at the University of Minnesota School of Dentistry. He stepped down as dean in 1986, but continued on as a faculty member and became a visiting scientist at the NIH. He retired in 1996.

Interview Abstract

Dr. Oliver begins his interview with a reflection on his childhood, early education, and his pursuit of a career in dentistry. He then discusses his dental education at the University of Minnesota and his military service. Focusing more on his education and work experience, Dr. Oliver reviews the following: his time in private practice in Southern California; his time as a student at Loma Linda; his time as a professor at Loma Linda; his relationship with the periodontics program at USC; and his deanship at USC. Dr. Oliver then shifts to a discussion of his time as dean at the University of Minnesota and discusses the following topics: the beginning of preventive dentistry, faculty practice, changes in the dental clinics; dental education for rural and outstate practice; changes in dental hygiene; the implications of retrenchments; faculty research money; the tenures of the different vice presidents of the Academic Health Center; relationships within the AHC; Health Ecology in the Dental School; increasing emphasis on the patient in dentistry; the Dental School's corporate relationships; and his reasons for stepping down as dean. He concludes his interview with a review of his work as a visiting scientist at the NIH, his decision to stay on as a faculty member at the University, Richard Elzay's tenure as dean, his retirement, and the culture of Minnesota.

Interview with Doctor Richard C. Oliver

Interviewed by Dominique Tobbell

**Interviewed for the Academic Health Center, University of Minnesota
Oral History Project**

Interviewed at the Home of Doctor Oliver

Interviewed on July 9, 2013

Richard Oliver - RO
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Richard Oliver. It is July 9, 2013, and we're in Doctor Oliver's home in Rio Verde, Arizona.

Thanks for meeting with me today and having me in your lovely home.

To get us started, can you tell me a bit about where you were born and raised and your educational background?

RO: I was born in Minneapolis. We moved to Duluth and back to Minneapolis, then, to Austin, then to Mankato and, finally, when I was twelve years old—my dad was a pharmacist and he was managing Walgreen and Ford Hopkins Pharmacies—he finally bought his own drugstore, which was a Walgreen agency in Hastings, Minnesota. So I call Hastings home. We moved there in 1942. I actually left when I graduated from dental school in 1953, so six of those years that I was home in Hastings, I was off to college. [chuckles] But Hastings was a wonderful place. You knew everybody in town. My dad had a drugstore on the main corner of the main street. They had coffee for the businessmen in the morning, and the kids came and read comic books at the soda fountain in the afternoon, and farmers came on Saturday night to buy their cigarettes and their booze and whatever else they needed.

[chuckles]

RO: You could go every place on a bicycle in town. It only had about 5,000 people then. It's about 15,000 today.

I spoke for our sixty-fifth high school class reunion last year. I said, “The only thing I can tell you for sure was that in 1947 when we graduated, none of us expected to be here today.”

[laughter]

RO: It was a great place to grow up.

DT: I can imagine with your father owning a pharmacy there, it must be one of the most important businesses in the town.

RO: Yes. As I say, in a small town, you knew everybody and everybody knew you. It was great.

DT: You went to Carleton College [Northfield, Minnesota]?

RO: I went to Carleton for two years. The first thing I would tell you is how I selected dentistry. That’s because, during the war, I decided I didn’t want to become a physician. I was valedictorian of my high school class, and I won thirteen letters in sports. I was on the debate team and sang in the musicals. Our class only had seventy-five people in it. I could have done anything I wanted to do. But the war had been really difficult for physicians. There were only a few of them in town, and they went eight days a week, so to speak. [chuckles] So I decided I wasn’t going to be a physician.

Dentistry looked good. My dentist had built a nice home overlooking the park and had reasonable hours and could serve the community in other ways. So that’s how I ended up going into dentistry. I knew that when I went to Carleton. I was getting my pre-dent and, then, going on to dental school. I had a couple summer sessions at the U [University of Minnesota] with organic chemistry, and I forget what else.

DT: You didn’t think about doing pharmacy like your father?

RO: No. Again, it was really difficult. He was the only pharmacist. There were three other drugstores in town, pharmacists. But in a small town, you couldn’t afford a second pharmacist, so he and my mom ran the drugstore. He could get away for dinner and occasionally hire somebody to come in for vacation after the war ended. Before the war, we didn’t take vacations. So I had decided against pharmacy.

[chuckles]

RO: That was a seven-day-a-week-twelve-hour-a-day job.

DT: You went to dental school at the University of Minnesota?

RO: Yes.

DT: Can you describe your experience as a dental student? Is there anything that stands out to you?

RO: First, it was a wonderful experience. It really was. We had a number of veterans that were coming back, so our class was a mixture of veterans and those that hadn't been in the service. We all got along well, and we enjoyed dental school. We worked hard. We were in the old clinics there. It was before they built the new school. I was president of the freshman class and did various other things. I went out for basketball. I'd played at Carleton, and one day I got a terse note from the dean of the School of Dentistry saying, "You're here to go to dental school or play basketball, not both."

DT: Wow. [chuckles]

RO: So that ended my basketball career. But I could play golf, and I ended up playing on the golf team at the University. I was captain of the team my junior year of dental school. In fact, we played an early match against Carleton and my roommate at Carleton, we had met on the golf course, and I played him in the match.

DT: I was going to say, did you win? [laughter]

RO: At any rate, I really enjoyed dental school.

[pause] This is not about dental school, but during dental school in the summer of 1950, a Carleton friend said he and his brother were going to Europe for the summer with the National Student Association. Would I like to go? It was actually before I was up in the clinic at the school, so I had the summer off. My mother had wanted to go to Europe. She was a farm girl from up at Moorhead [Minnesota] and ended up not being able to go. So she said, "Of course you should go." To be truthful, the whole summer cost \$700.

DT: Goodness. You couldn't do that now.

RO: That's ship over and back and staying in three primary towns and, then, we hitchhiked all around. It kind of broadened my view of the world to go to Europe.

I had spent the previous summer out in the State of Washington. My uncle was a dentist out there. I was accepted to dental school that summer and at the same time, I received an appointment to West Point [United States Military Academy, West Point, New York], which I hadn't put in. Somebody had put it in for me. I wrote to West Point and asked if they had a dental school...

[laughter]

RO: ...which in hindsight is pretty stupid. Of course, they didn't and I said, "Sorry, I'm going to dental school."

After those experiences, I decided a year of a rotating internship would be a good thing if I could get it. So I applied and was selected for a rotating internship at what was then Fitzsimons Army Hospital [Aurora, Colorado]. I was one of two Air Force interns that trained at the Army Hospitals in those days. That was probably one of the best years of my life in terms of learning, because there were only six interns and we spent three months in restorative dentistry, three months in oral surgery, three months in periodontics, and one month in oral diagnosis, and, then, just doing regular dentistry. We were on call for emergencies. We had a lot of experiences that you just wouldn't get.

Then I owed Uncle Sam some time. I would also spend some time in the Air Force and was sent to March Air Force Base in Southern California, in Riverside. I was really lucky there.

I had been working with very good people at Fitzsimons. There was a colonel at March AFB in charge of prosthodontics, making of dentures and fixed bridges, those kinds of things. He was talking to me early on and quoted from an article. I said, "I remember reading that article. Didn't they go on to say...?" He looked at me kind of like this, as if he didn't know young people coming in who knew "the literature," his words. So he took me under his wing. Before I left the service, I rebuilt the mouth of the commanding general of the Fifteenth Air Force, the whole thing. It worked out well.

We had some wonderful consultants. One was from Riverside. He was a member of the Odontic Seminar, which is a huge and very prestigious study club in Southern California [San Diego]. He asked if I'd like to go into it with him once a month. Colonel Brewer said, "By all means, you go." I got exposed to a lot of really first-rate dentists and what they were doing then.

We had consultants. One was a periodontist, and he had taught me a lot. Periodontics was the thing I knew the least about, so when I got out of the service, I was opening a practice, and it wasn't going to be that busy five days a week, so I said, "I'll take a day a week and go into a program in periodontics at USC [University of Southern California] where this consultant was teaching. After about five months, something like that, six months, he asked me if I'd like to join him in practice. It was at a time when you didn't have to have formal training. They were just putting together the requirements. There were no such things as formal training programs in periodontics, and endodontics, and prosthetic dentistry, and such. The only thing was oral surgery, at that time. So he invited me into his practice.

In the meantime, I had finished a master's degree at Loma Linda University, which is right in the San Bernardino-Riverside area there. I was teaching there and practicing and started a graduate program at Loma Linda. I was active in the dental association.

One day, somebody walked by and said, "Dick, you should be interested in this," and tossed a brochure on the table. It described a Fulbright professorship in periodontics in Denmark. So I applied, and I was selected. By then, my practice was busy enough that I had another periodontist with me, and I could go. I ended up working with Harald Løe

who, later, came to the U.S. The year I became dean at USC, he became dean at [the University of] Michigan. Then, he became the director of the National Institute of Dental Research, part of NIH [National Institutes for Health]. So I had the good fortune of meeting him fairly early in my career and having just a wonderful experience with him. And we ended up serving as deans here together. He died a few years ago. [Harald Løe died August 9, 2008 in Norway].

So I had some wonderful mentors—I think that’s what I’m trying to say—the prosthodontists in the Air Force, the periodontist and, then, Harald. I was fortunate.

Then, just continuing the story, I was asked to become dean at USC and accepted that, because, again, I had brought in periodontists in my practice, and they could take it over. The first one I brought in ultimately became the head of periodontics at the University of Oregon and retired just a few years ago. I went to USC, and I really enjoyed it, and I knew a lot of people, and it was a good fit.

This will sound a little funny, but a private school is different than a public school in that—I want to be careful how I say this—you can be what you can be. We were starting new programs and doing new things and doing well, but the academic vice president controlled the purse strings. Everything I started to do that could help us be more efficient and make some money, he was taking it out of the other pocket.

I didn’t apply for the job at Minnesota, but they asked if they could come out and visit with me. I said, “Sure. If you want to bring the search committee out here, I’ll be happy to talk to you.” I did and what I told them was, “If things don’t change above me, I’ll be happy to look at it.” I’d seen the new school. It had just been finished three or four years, at the time, maybe five. It was a wonderful place. Jackie [Doctor Oliver’s wife, Jacqueline] and I still loved Minnesota, but we’d been Californians for a while.

[chuckles]

RO: So we went back to Minnesota. Our younger daughter started school at Carleton. Our oldest son was finishing at Stanford [University] and our oldest daughter had graduated from the University of Redlands and taken some graduate training at USC. So that’s how I ended up back at the University of Minnesota, and it was everything that I had hoped it would be.

It wasn’t an easy time. We had seven retrenchments in the nine years that I was dean, *but* my predecessor had built the school to train 150 dentists, and 150 hygienists, and 150 dental assistants. It’s shared, as you know, with Medicine and Public Health, and Pharmacy is just next-door there, all part of the same complex. But what had happened was that they had started dental hygiene and dental assisting programs out in the community colleges and other colleges. So we were able to cut the faculty in hygiene from twenty-five full-time equivalents down to five. That helped us meet some of those retrenchments.

DT: The dental assistant program was eliminated, as I understand it.

RO: Yes. But, then, we were actually increasing the dental program a little bit, at the time.

I really enjoyed the health sciences. Lyle French was the guy that basically hired me. Yes, I know [President C.] Peter McGrath signed it. [chuckles] But Lyle French was the one. He said, “We’re going to be”—this was while I was still at USC—“down in Rancho...—I can’t think of it—a golf resort in Southern California, where they had a small home. He said, “Could you come down? I understand you like to play golf. We’ll play some golf and talk about Minnesota.” We got rained out at about the eight or ninth hole.

[chuckles]

RO: So we went back and built a big fire, and we talked. To make a long story short, he liked me, and I liked him. That’s how I ended up coming back to Minnesota.

DT: Going back a little bit, why did you join the Air Force?

RO: No particular reason. They were taking applications for Air Force internships. They were probably taking them for Army internships, but I never saw one. So I filled out an Air Force one.

DT: When you were in practice, what were the most challenging things about being in practice?

RO: [sigh] This really speaks to the things that I tried to do as a dean at USC and at Minnesota, the changes that I brought to both schools. What you have to realize is that once fluoridation was developed and became a part of fluoridated water as well as pills and other things in the early 1960s, dentistry changed an immense amount. When I graduated, I could have hung up my sign anyplace and been busy in a week, just filling cavities. You didn’t have recall systems, and you didn’t teach people to brush their teeth. You didn’t teach prevention. There was no fluoride. By the time I was running a graduate program at Loma Linda and practicing part time, and, then, became dean at USC, we had to teach dentists to do more things than just fill teeth. We had to teach them to work with people.

I brought my associate dean for clinical affairs from USC back with me as well as my business manager. I’m not trying to be critical of my predecessor, Erwin [M.] Schaffer, but they taught people to do *procedures*. You had to have so many fillings and so many inlays and so many dentures and so many partial dentures, and extract so many teeth. We traded patients so that somebody who needed a crown, if I had all my crowns done, he could treat my patient. What we tried to do at USC was to say, “You need to meet them. You need to talk to them, and listen to them, and find out what’s important to them, and begin to think about what you could do for their mouth, and whether they would be

interested. You need to care for people is what we really tried to do at both schools. It was quite a change for the faculty at both schools, because both schools were proud of the fact that they really taught students to do good dentistry, per se—and they did. They were probably two of the five best schools in the country, at that time, at teaching people to do good dentistry. That was going to come, regardless. But neither was paying attention to taking care of people.

DT: That does sound like a profound shift in the culture of dentistry. Did you see that shift happening in other places?

RO: Not so much, because, again, fluoridation was unique to dentistry.

DT: I mean other dental schools, like...

RO: I think gradually, it did. It had to. I grew up in a drugstore. You can imagine what I lived on: ice cream and candy and Coca-Cola.

[laughter]

RO: I couldn't go six months without having two or three cavities. Even today, yet, you can see mostly gold in there. All of sudden, once we had fluoridation, you had people, not immediately, growing up with one or two cavities or three, but you still had people who were losing teeth that had had a lot of cavities early. So there was a gradual shift away from it. I'm not close to dentistry today. I go to a very good dentist here. I had dinner with one of my former department chairmen and a nationally known Minnesota graduate, by the name of Omer [K.] Reed, who is here in Paradise Valley, Phoenix. We had dinner just a few weeks ago, and we were all talking about how dentistry changed. Well, we were all in that process, because they graduated about six or seven years behind me. It was just different.

DT: What was the culture of the Dental School when you arrived at Minnesota in the 1970s? How much emphasis, for example, was there on research versus teaching?

RO: Erwin had hired some researchers, and there were some very good people. Bob [Robert J.] Gorlin was outstanding. There was Dwight [L.] Anderson in biochemistry who was a nationally known researcher, along with Bill [William F.] Liljemark and Burt [Burton L.] Shapiro. Larry [Lawrence H.] Meskin was the chair of the search committee and he was running Health Ecology, at that time. Much of what I would talk about and say in sharing my thoughts hit it with him, because that's exactly what he saw coming in health ecology. We're in a change, and we need to address those changes. So we had some very good people on the faculty.

What troubled me was that I wanted everybody to be involved in research. I don't mean formal published research, but I wanted them to think that way. If I see this, what caused it and what am I doing that will prevent it from happening—thinking in bigger terms about that patient and the disease and that sort of thing. We had a few outstanding

researchers and a lot of people who had no interest in research at all. We tried to change that with some success. We developed quite a bit of research in the area of periodontology, for example. Health ecology stayed strong. Charlie [Charles F.] Schachtele and some of the other people in biochemistry along with Dwight Anderson, as I said, were good people. Bob Gorlin was, even then, one of the preeminent oral pathologists in the world. He'd written textbooks before I got there.

DT: It seems like in the other health science schools, too, there was an increasing focus on research and having the faculty do research, to be involved in research.

RO: Yes. You need to have the faculty ask questions. That's what being a faculty member is about, looking at things and trying to understand them. You often can't understand them if you don't ask questions and figure out answers. If you see this, how many times would it be like this and could you have prevented it? You're thinking broader than just fixing this. As I say, the nature of dentistry, not just at Minnesota or USC at that time, was in repairing dental disease. Period.

DT: Just to draw a connection to medicine... It's really interesting to hear you describe that shift and increasing attention on, in many ways, preventive dental care with fluoridation. It seems in medicine, there was more reluctance to pursue the preventive model. It seems it was always about doing...

RO: Again, we had an incentive.

[laughter]

RO: Fluorides had come in. Dentistry was changing, much more so than medicine. Medicine had so many diseases and, yes, they were making inroads on some of them, but they weren't wiping out diseases as fast. This was a disease that our profession depended on.

DT: So if you didn't change, you'd be in trouble.

RO: I look at it slightly differently. When I was growing up, both my mom and dad had dentures and that was not uncommon. People figured they were going to lose their teeth in their forties or fifties. The life expectancy was about sixty-five, something like that. There weren't many people that still had a lot of teeth in those days. Change was being forced and through it, we learned to treat people better.

DT: It's really powerful to hear you describe that shift.

What about debates regarding specialization when you first got to Minnesota as dean? Was there much debate about the degree of specialization within dentistry?

RO: Oh, I don't think so. About the time I got to Minnesota there were national boards in periodontology, and in endodontics, and in oral surgery, pedodontics, and

prosthodontics, so the specialties were pretty well formed with their own national organizations by the mid 1970s. The thing that I found myself in between was to say that all periodontics shouldn't be done by the periodontist. The preventive side of it is really important and that's got to be done first by the general dentist. It's the same with the other diseases. We had to train students to do these other procedures as well. We didn't want them to do really complex procedures, but we'd have them do the basic procedures.

It's hard to appreciate, I'm sure for you, but there wasn't even such a thing as a recall program that was common in dentistry until, let's say, the late 1960s, mid 1970s, something like that. People just went to the dentist when something hurt or when they were aware of it, and he took care of it. They left and the next time something hurt...

Then, all of a sudden, I, and Omer Reed, and Bob [Robert F.] Barkley who was a practitioner down in [Macomb] Illinois, and a bunch of guys from the East Coast were the first ones to talk about the importance of prevention and how you teach prevention and trying to get general dentists to do a periodontal charting of the mouth of everybody and find out where the periodontal pockets are and where there's inflammation, where there's bleeding. That's why people have their teeth today as opposed to my mom and dad and their generation. Nobody was looking for it and finding it early enough to do something about it.

DT: So that recall program you mentioned, that's getting patients in regularly, six months or up to a year?

RO: Yes. Yes. You wouldn't have found that in the 1960s. People went to the dentist when something hurt. I went to the dentist probably every six months, and I never went without them finding a cavity or two growing up in the drugstore.

[laughter]

DT: You're a good model for good dental care having grown up on candy.

RO: And I have yet to lose a tooth, and I don't think I will now.

DT: In the 1960s and 1970s, there was this general national concern about shortages of dentists. I wonder if you could speak to that and how that influenced your tenures as dean at USC and then at Minnesota.

RO: You have to realize that to build the school at the University of Minnesota didn't start in 1971 or 1972. It started in 1961 or 1962. Fluoride came in sort of in the mid 1960s as I recall. I can't give you the exact date. So they were planning it for the dentistry that they had known through the late 1960s, and fluoridation hadn't really hit yet, so to speak, how effective it was in cutting down [caries] for all the kids in small towns and big cities where there were dentists or weren't dentists. I don't mean they never developed cavities. They did, but not anywhere near what they had. That was a pivotal thing, fluoridation, to the whole practice of dentistry.

DT: It seems like with fluoridation, because of the changes that you've described, you'd need more dentists that were going to do the primary care, the preventative care and, maybe less of the specialists who were doing the reconstruction and restoration.

RO: You still had a lot of people who were needing long... My dad was dead by the time he was sixty or a year after. My mother lived longer, but they were in dentures by the time they were sixty. The practice didn't change instantly. We were preparing new dentists that had to practice for the next forty years. We were trying to look ahead when there wouldn't be nearly as much disease and teach them how to do the other things and, more importantly, to sit down with a patient and try to figure out what kind of problems do you have that you know about and, then finally, say, "How can we help those and how can we prevent other ones from happening?" It was a different way of practicing.

DT: When you arrived at Minnesota, did you have a sense for why Erwin Schaffer had resigned and stepped down?

RO: [sigh] He'd been ill, and he'd been dean a long time. I'm not aware that there was anything more than that to it.

DT: I saw in the Archives that there was some student activism in the 1970s and some discontent over the exam procedures. Was that before you arrived?

RO: It must have been—at least, I don't remember any of that.

DT: What were relations like between the School of Dentistry and University Hospitals in those first years of your deanship?

RO: There wasn't a big relationship. Our oral surgeons worked over there, and they were almost the only ones that did. I had done hospital periodontics first in my practice in San Bernardino. I didn't actually do any when I was dean at USC.

I didn't do any hospital dentistry [at the University of Minnesota Hospital]...well, maybe I did one or two, but that was about it. Even deans were allowed to practice half a day a week or something like that. I didn't practice every week, but I continued to see patients because I thought it was important for me to continue to have an idea of what was going on. So we had a faculty practice that we actually started within the school while I was dean. We had an area that had originally been built for the dental hygiene and dental assisting, and we turned it into a faculty practice area. We had a number of full-time faculty who could see patients there a day a week or half a day a week.

DT: Were there any particular challenges for setting up the faculty practice?

RO: Not that I remember, really.

DT: How were the finances worked out for the faculty practice? Did a certain amount of what the faculty earned go back to the Dental School?

RO: Yes.

DT: Was that a fixed amount or did it depend...?

RO: I can't even remember. I honestly don't know.

DT: I know that in the Medical School in the 1960s, there was quite a lot of contention around the faculty practice issue, but it doesn't sound like there was...

RO: No, I don't think there was any about the faculty practice. You know the nature of medicine and the nature of dentistry are somewhat different. We had a day a week, and it was true of the rest of the University, too, that if somebody was in architecture, they could practice architecture a day a week. It was generally thought throughout the University that being in the real world of it was helpful to your teaching.

DT: It's interesting. It's striking to hear that there was such encouragement for even the dean to be engaged in practice. Maybe Pharmacy is the exception, but my sense of the other faculty that I've interviewed is that within Nursing there was less attention on practice if you were a faculty member.

RO: Erwin Schaffer, my predecessor, had his own practice in downtown Minneapolis. He practiced a day a week, and he was dean for fifteen, eighteen years, something like that. I don't remember exactly how long. In fact, very early on, he invited me to go down there and practice with him, and I did until we set up the faculty practice within the school.

DT: What was the insurance system like with regards to dentistry at that time? Were insurers covering dental care or was it out of pocket for patients?

RO: Insurance had started in dentistry. But I wouldn't tell you that a high proportion of people coming to the Dental School had insurance. That's one reason they came to the Dental School.

[chuckles] This will sound funny, and I hope you take it the way it's intended. The clinic income... It was perceived that a dental student doing something for a patient wasn't worth very much, so the fees were very low and the clinic income was like \$6 million a year. When I left, it was over \$19 [million]. It wasn't that we increased the a lot fees, because they were still much less than they would pay in private practice, but we got them up to where it was at least paying costs. It never left us short of patients.

We were doing, I'll say, better dentistry, too. One of the things that we did is instead of as in my class having a hundred dentists out there just meeting procedure requirements, we wanted them to see patients. So we divided them into groups, and there was a group

director. He met with each of the dental students working in his group, and went over their patients with them, and monitored progress with them. We tried to make it more like the real practice of dentistry. As I say, fluoridation had a big effect, but it was also an opportunity to make them more broadly competent general dentists.

DT: Was there any focus in the school to encourage the students to go into, say, rural practice, to move out into like upstate Minnesota?

RO: Even then, we had our rural practice opportunity. They could go out and work in a rural practice their senior year for...I don't remember whether it was two weeks or something like that. They could go out and stay and practice with usually a faculty member that invited somebody to come in and work with them, not just any place. There was one up north, and I can't remember exactly where it was, and one southwest. They'd go out and spend a week or two there, and we'd have a faculty member out there with them working in the practice. So we tried to get them to feel what a practice was going to be like. That was the chief advantage of that.

DT: Do you feel that a good number of students then went into rural practice?

RO: I can't tell you that. I honestly don't know. We didn't try to talk people into going into rural practice or not. Rural practice wasn't seen as a bad thing. A lot of dental students came from rural areas, and they wanted to go back to practice in those areas.

DT: Did you think there was much concern about shortages in rural areas?

RO: No, not really.

DT: That's a great benefit of Minnesota being a state school, especially when it focuses on instate students where they do come from rural areas.

RO: Yes. Keep in mind that we were the only dental school between Chicago and the West Coast, with the exception of a very small school in Nebraska. There was nothing along the northern tier of states until you got to Seattle and not many practices out in the West and various places.

DT: As I understand it, the school had a reciprocal arrangement with South Dakota and North Dakota?

RO: We did. We got a certain number of students from both of them. It wasn't a large number. I think four or six, something like that, a year. We got a lot of students from Wisconsin, because Marquette [University] was a private school. Most of the students from Eau Claire and on north west felt a closer affinity to Minneapolis than to Madison or Milwaukee.

DT: In those first years as dean, what do you see are the major challenges that you confronted? You mentioned the changing of the culture of the school to support research

but to also teach a more comprehensively prepared student. Were there other challenges that you encountered?

RO: [pause] I think that was the primary one. For me in the school, I wanted to get more people interested in research, more faculty. I wanted to broaden the number of people doing research. I didn't care whether it was funded research, but I wanted them to ask a question, figure out how they could answer the question, do it, and publish it. That's what a faculty member was expected to do. Before I came, there were clinicians and researchers, and they never got together. We tried to get a lot more practice going in the clinical areas.

DT: Was there any reluctance on the part of the faculty?

RO: Oh, sure. Some were going to carry on and do it the way they had done it. Again, dentistry has the advantage as well as the disadvantage of having a lot of part-time faculty who practice four and half days a week and they have a half day at the school. So we had the advantage of trying to make them ask questions about their own patients because they saw something at school.

I'm probably over exaggerating to a degree, but so much of dental education when I went to school was teaching you *how* to do something and not why you did it or how you could prevent it or how the patient felt about it. I think back about the way we exchanged patients. The poor patient showed up, and we weren't very nice to them.

[chuckles]

RO: We had to teach students to listen and find out where this person was and what their interests were, what they wanted, and, hopefully, start to educate them a little bit. If all they wanted was a tooth pulled, yes, we could do that. But, then, what are you going to do with...? Oh, I hadn't thought of that.

DT: With the changing role for the dentists, was there also a change in roles for the dental hygienist, that fluoridation kind of helped bring along?

RO: Uhhh... It didn't make that much difference in dental hygiene. What made the difference there was the advent of dental hygiene programs in community colleges. So the number of hygienists continued to go up significantly. More dentists were using hygienists because hygienists helped them build their practice. They found problems. They got people thinking in terms of prevention, and aesthetics, and some of the other things that dentists could help them with.

DT: Why did other schools in the community establish dental hygiene programs? Initially, it was mostly just the U.

RO: I couldn't tell you that. That really started before I came back to Minnesota. As I say, Erwin had built the place for large hygiene and dental assistant programs. By the

time I got back, there were a number. Normandale [Community College, Bloomington] is one I remember and I think White Bear Lake [Lakewood Community College] was another one. I know Normandale did and there were others.

So, before very long, we saw our role as, among other things, training teachers for these programs. That's why we put some of the same requirements on hygiene faculty as we did on dental faculty: get involved in some research and ask questions and figure out how you can answer them. How can you be more effective in your preventive services you're providing? How do you decide whether somebody should have additional fluoridation or not have additional fluoridation?

DT: When you were at USC, did you notice that hygiene programs were starting at other colleges in California?

RO: Yes. You know, almost everything happens first in California...

DT: [chuckles]

RO: ...for better or for worse. [chuckles] Right now, if you look at the economy of it... It's the grandest state in the nation, in my view, but it also has so many problems. When we lived there, there were only thirteen million people in California. There are now thirty-nine million. We've been gone a long time. We left in 1977. We were there from 1954 to 1977. But it was a totally different area than it is today. We still have a daughter that lives out there, and even I hate to drive out there now.

[laughter]

DT: And real estate is very expensive.

RO: Yes.

DT: You mentioned earlier about the seven retrenchments that you had to deal with during your tenure as dean. Could you elaborate on why those retrenchments happened and what the implications were?

RO: I honestly don't remember. I think, basically, it was that times were more difficult in the state, so the state was reducing money to the University. Each dean had the responsibility of taking his share of the retrenched money and figuring out how he was going to deal with it. I can't remember that conditions in the state were particularly bad, but I do remember a number of retrenchments. [chuckles] Some of them weren't huge retrenchments. In education, you kind of hope there's a little more money each year and that certainly didn't happen. As I say, we were able to deal with it because we, essentially, cut down two of the programs, substantially.

We didn't get a lot of flak over the idea, because they were turning out good hygienists in the community colleges, at that time.

DT: I was going to say was there any resistance to that, particularly from the dental hygiene faculty?

RO: Yes, there was some, but they understood. I'm sure at some point, they saw the cuts as draconian, but nothing else was going down except the money we had. Whether you looked at clinic income or whether you looked at faculty busyness, if you don't have 150 students but have 20 or 25, you expect to do it. So there was a logic to it.

DT: As I understand it, I think the entire University, including the school, began to engage in long-range planning in the late 1970s, to plan ahead for ten years.

RO: Yes.

DT: Can you discuss that? Do you have any thoughts about that?

RO: I don't remember much about it. I had been a planner all my life, so to speak, always looking ahead trying to anticipate. The first thing I did at USC was to develop a new plan for the school, and what we were trying to do, and how we were trying to do it. I had some very good people come in, professional planners, to guide us through those things.

By the same token, we went through doing planning early when I got to Minnesota. But, as I say, if deans worry about faculty, funds, and facilities, I didn't have to worry about facilities, for sure, and I didn't have a lot of worrying to do about faculty. So funds, we could just shift them and do things with them.

As I say, I've always been involved in planning—you wouldn't know this—so much so that when the whole profession of dentistry, the American Dental Association, put together their first strategic plan for the future of dentistry, I was asked to chair that effort in 1981. It was a year-and-a-half effort. We were doing it for dental education, and dental practice, and dental research, and trying to say, "What do we think is going to happen? What needs to happen?" We put out the first strategic plan for dentistry in 1982. So I have been involved in planning in a lot of ways. Plans aren't always perfect, but they often lead you to areas that you originally didn't think about, and they become important.

That's how we ended up dealing with some of the retrenchments, too. They didn't just show up and say, "What are you going to do?" "I guess I'll do this." We had a plan, and the plan said we were going cut down the number of students in these areas, and we could cut down the faculty to a certain degree.

We had said from the beginning that we expected all faculty—I'm not talking about people that came there half a day a week or a day a week—all full-time faculty to be involved in teaching *and* research. We were never fully successful in that, but to a remarkable degree, we were. My own specialty area is still one of the big producers of

good research at the school. I was saying, “These are the goals. What are we going to do about them?”

DT: You mentioned earlier with regards to encouraging the faculty to do research. It wasn’t like you were expecting them to bring in big research grants. There wasn’t that pressure on them, necessarily, to do that, but was there an increase in research grants?

RO: Oh, yes. Yes. Some of the people, I’m thinking of three or four that I hired... Mark [C.] Herzberg was the person who originally developed the information that related coronary artery disease to dental disease, and that there was a correlation between poor periodontal health and heart disease that’s fairly well accepted at this point. Larry [F.] Wolff was a colleague of his. Larry is still there producing good research. Bryan [S.] Michalowicz worked out at NIH for a year. Jim [James E.] Hinrichs did some research. I’m forgetting a few people. Those were some of the people in my specialty area.

I was on the Program Advisory Committee at NIH, and I served, one of the rare actual clinical dentists, on the study section that approved grants there before I came to Minnesota. And, as I told you, my former colleague in Denmark became the director of NIH. At that point, I was asked to serve on committees sorting out what kind of research do we need to be doing in dentistry, and how can we encourage it and get it going? So I’d always had a tie with research.

DT: I imagine it’s always got to be advantageous for a school when the dean is friends with the person who becomes head of the major funding agency.

RO: Well, yes, but he doesn’t have a lot to say, the head, about what grants are approved.

DT: The advisory committee would do that?

RO: Not the advisory committee. The advisory committee says, “These are some of the things that we think provide opportunities for good research. Maybe you can find some people that will tackle projects in these areas.”

The study section that I was on before I came back to Minnesota—maybe it was the first year or two I was at Minnesota; I’m not sure—is the one that evaluates grants. It’s heady stuff for a clinician, I’ll tell you.

[chuckles]

RO: They’re talking the infinite scientific questions. How does this work with this under this condition? I think those things had an effect on what I wanted to do with the Dental School. I wanted to turn out faculty that were sensitive to research, and responded to it, and read it, and understood it.

DT: Another thing I saw that happened in the late 1970s around your arrival time was the elimination of the bachelor degree in dentistry. Was that already eliminated before you arrived?

RO: I think so. I don't remember anything about that.

DT: There was a new constitution that ended up reorganizing the school from twenty-six divisions to thirteen departments. Was that under your tenure?

RO: It probably was, yes.

DT: Do you recall anything about it?

RO: Not very much. Now that you mention it, I think that did happen under... I was determined that all departments have faculty involved in teaching, research, and service, all three.

DT: It looks like the hospital clinics were established in 1983. Can you talk about what led to that? Maybe that's the faculty practice piece.

RO: [pause] I'm guessing somehow we have a little confusion in terms. I think we started groups in our clinical education much earlier than 1983. I think that was on the table no later than 1978 or 1979. So we combined various units rather than having twenty-some departments down to the thirteen. As we would think of a department in much of the rest of the University, these were tiny departments with two or three or four people in them and that was it. I wanted them to work in larger groups both to stimulate one another, and to get them to ask questions, and develop the answers.

DT: What can you say about Lyle French? He was vice president for Health Sciences when you arrived. What was your experience of him?

RO: I thought the world of Lyle. It's that simple. He was a distinguished neurosurgeon of world fame, who just had a quiet, gentle manner about him. He could talk straight and honest to you in every way. He was so highly acclaimed and thought of that he didn't have to impress anybody. He was a better listener than a talker, I think. He was very supportive of everything we did.

[pause] Who succeeded him then? Neal [Vanselow]?

DT: Yes.

RO: Neal wasn't there very long, but he had a rich experience. He had his training in Michigan and he'd been at the University of Arizona, and, then, been briefly at Creighton [University], if I remember correctly—you probably know that—and, then, came to Minnesota.

Neal did a good job with that. I think he had some perceptions of things at the greater University level that... At least I don't see were problems in the health sciences in the same way.

Rarely did we deal with the president. Neal handled that for us. Lyle handled that for us. They deal with the other vice presidents and Central Administration; that's their job. That's a huge job to take care of not only all the Medical School, because there are so many different departments and each of them has their own priorities. This is going to be the department that does the first this in the world, you know. Then, you have another department that's turning out good research and maybe not as well known clinically. So the Medical School in itself is a big thing to preside over. Then, you add the other health science schools, and it's a big job.

DT: What about relationships with other health science deans? Did you have much...?

RO: We had a good group. We really did. I got along very well with Larry [Lawrence Weaver] and who was dean of Medicine at the time?

DT: Neal Gault.

RO: Yes, Neal Gault and Larry Weaver. They had different people in Public Health at different times. Bob Kane was one of them.

DT: Yes. Edith Leyasmayer was acting at various times.

RO: Yes. We had a good group, and I think worked well together. I don't think anybody intimidated anybody else. We worked as a health sciences unit should, I think. Again, whenever you say that about health sciences, you realize that the big one is Medicine.

DT: You mentioned, obviously, that the Medical School was the biggest entity within the health sciences. Did you feel that had a significant impact on the School of Dentistry and the Academic Health Center as a whole, that it had that disproportionate large size?

RO: No, I don't think so. I think it was an advantage. There were a number of our researchers, for example, that found people to work with in Medicine, periodically, or could go over and talk to one of them and get a clarification on some aspect of things. I didn't have any we're-just-the-little-guys feelings at all. I think Lyle had a lot to do with that, particularly. I don't mean Neal didn't. I just mean that Lyle set the stage. He was in charge when the health sciences were formed and he said, "This is how we're going to operate." He was, as I told you earlier, a good listener and asked good questions. He didn't favor Medicine over Dentistry or Pharmacy or anything else that I am aware of. I don't know what you've gotten from other deans, but I didn't hear anything and don't remember anything negative from any of the deans.

DT: I have not heard even a whisper of a bad thing about Lyle French. Everyone is unanimous on how wonderful he was and what a great leader he was.

As I understand it, you introduced a number of new clinical programs as dean: biomaterials, occlusion, craniofacial pain, and health ecology that you mentioned earlier.

RO: Health ecology was there when I came. We had a few researchers. I did bring the first top biomaterials person in. We were fortunate. He was good. He was a Brit that had trained at Michigan. I had known some people, and we got together with some people from 3M, and they immediately bought into what he could do for them. He developed the artificial mouth, which I'm sure you're heard about. Bill [William H.] Douglas is the one that I'm talking about. That whole crew up there... Ralph DeLong is still there.

I moved Maria Pintado from dental assisting, and she went to work up there and she was just wonderful. She and Ralph and Bill were that department for a long time. She was doing her share of things. They were getting most of the credit for it. Maria was and is a special person. So we did start that.

Occlusion...I don't remember exactly what happened with occlusion. I don't remember a department of occlusion, but maybe we did put a special program together in that. There were people that knew and understood occlusion. I often encouraged people that had like interests to get together and see what they could do. We didn't let division or department boundaries keep people from working together that wanted to work together.

DT: I wonder if you could say more about health ecology and its increasing importance. What is the concept behind health ecology?

RO: [chuckles] That was there when I came and Larry [Lawrence H. Meskin] was the chairman. He had some good young people under him. Mike [Michael J.] Loupe died and Dave... I can't think of Dave's last name. [David O. Born; also Leslie V. Martens and Muriel Bebeau] They were dealing with a lot of the bigger issues about dentistry and dental practice, issues like what will fluoridation do to dental practice? Larry was only there I think maybe three years after I was. He left to become dean at [the University of] Colorado. He's dead now [Lawrence Meskin died June 26, 2007] He stayed at Colorado, and I think he was actually vice president for health sciences there for a short time. He was a very talented academician. He dealt with mundane things like, what is it that the dental assistant should do, and the dental hygienist should do, and the dentist should do, and the specialist should do? A lot of questions that don't seem scientific but are very important to understanding the practice, not only the practice of dentistry but serving the public best.

DT: It sounds like every school should have a health ecology department.

RO: Yes. That's why you're confused by the name. What is health ecology?

[chuckles]

DT: I get the sense of what it is. It's useful to have it articulated, because it seems like that should be something that encompasses all of the health sciences.

RO: Yes.

As I say, he was a good researcher. He had his own research grants. He'd served nationally in a variety of ways. He brought together good people and they were a very productive department. [pause] I hated to see him go.

It was interesting. I found out a little bit about that a year ago when I got an Outstanding Achievement Award from the University. It's a pretty high honor. Erwin Schaffer got one. There have only been about twenty-five in a hundred years of classes from the School of Dentistry. I only know of maybe one or two others. When I received the award, they wondered if I wanted a fancy banquet. I said, "No. I'd like to do it up in the conference room on the fifteenth floor and just have a few faculty and a few friends. Cherie Perlmutter came. I was just thrilled. She was just a very special person. It was just nice having that. A number of these people that showed up there, I hadn't seen or talked to for a long time.

DT: It looks like computer-assisted simulation was introduced into the curriculum in the early 1980s. Do you recall that at all?

RO: I recall the name. I couldn't even tell you exactly what it is right now, or was. I guess I don't have much memory about it. I'm sure it was important. Again, a goal of what we were trying to do was to get people to think beyond just how to do. Why are you doing it? How can you prevent it? What does what you're doing now have to do with the next thing that needs to be done or doesn't need to be done? You could do a lot of things with computers-assisted simulation. I'm kind of getting a reflection on it now and I think Dick [Richard T.] Ford had something to do with that, if I remember correctly.

DT: It's interesting, this important point about changing the way that dentistry is practiced and the increasing focus on the patient. This coincides with health care in general in the 1970s and 1980s. The patient is getting much more active in his or her involvement in their health care and demanding more from their healthcare providers. Did you see this patient activism have an impact on dentistry?

RO: I can't tell you that I saw that as a dean, but it's the way I practiced and the way I believed people should practice. So every place I went, it was what I was trying to do, to get them to get the bigger picture. You're not here just to fix teeth. You're here to treat patients and get patients to help themselves, too. Prevention was a big thing coming from my own background in periodontics. I don't want this to come out the way it's going to sound, but there was virtually no prevention, to speak of, in dentistry until around 1969, 1970, 1971, that era. There was a time when I was probably one of five or six or ten,

throughout the whole country speaking on prevention and telling people how they could do it in their practice. I spoke in many places. I think I once counted seventeen or eighteen different countries in the world from China to New Zealand to Finland to Greece. Prevention was a big thing, because nobody had ever thought about preventing disease until we had fluoridation. All of a sudden, a lot of things became possible if we just treated people differently.

DT: Did the school have much interaction with the School of Public Health given that focus on prevention?

RO: Not so much. I think the School of Public Health was kind of doing their own thing most of the time. I don't mean anything negative about that. Yes, I think Larry Meskin worked with some people in the School of Public Health. As I say, Bob Kane is the one that I remember. There was somebody before him that I should remember. I don't think we did a lot of work with them.

DT: Lee [D.] Stauffer was dean until 1979...

RO: Yes. Dean Stauffer and I were good friends. Yes.

DT: You mentioned 3M a little while ago, particularly around biomaterials. I'm wondering as dean what your involvement was with facilitating relations with corporations and getting corporate support for the school.

RO: Well, I wouldn't suggest that I played a major role in that, but in the 3M biomaterials thing, I did know some leaders. We lived in North Oaks and there were a number of 3M top people that lived out there, so I knew them. I brought Bill over and talked with them, and that's how we got started with that relationship. Bill handled it beautifully from there. I knew enough people that I was rubbing shoulders with off and on, and they were saying nice things about what was going on, and they were happy with it. The development of the artificial mouth was a big thing. I'm sure you've had something on that. Did you interview Bill?

DT: Lauren, my research assistant interviewed both Bill and Ralph DeLong.

RO: Okay.

DT: And Maria Pintado, as well.

RO: As I say, I think I facilitated things, but Bill was the key person. He had a vision of what this could be, and what it could do, and what kinds of questions could be asked to test it, and such. I played a role but probably a minor role.

DT: You created a culture that encouraged and supported this kind of engagement, which is important.

RO: Yes, and it helped 3M in their dental division a lot. 3M's been a very interesting corporation from the beginning. They've always been looking for new things. I'm not sure their interest in dental materials and the things they've done in dentistry would have occurred without Bill's connection over there. So it was helpful to them as well as to the school.

DT: During your time as dean, did you often have to go before the State Legislature like when it came to the budget and things?

RO: I only remember being over there once or twice. The vice president for Health Sciences did it most of the time. There was one time I went over that had to do with how could you, cutting out so many hygiene and dental assisting positions, still need the money? My answer was very simply, "Because we're doing so much more and we need more people to do more. We've moved this into other areas and you can see what's happened to our research income budget. You can see what's happened to our clinical income budget. We can't do that with fewer people." That's an oversimplification.

[chuckles]

RO: It's what I tried to tell the Legislature, that we were beginning to do some things that the University should be doing, and we can't cut back all the way.

DT: Do you recall if they were responsive to that?

RO: I think so. Again, I think I was only over there once in the nine years that I was dean.

DT: You stepped down in 1986. What led you to step down as dean?

RO: [chuckles] Originally, I thought that I'd serve as dean for ten years. Including USC, I served for about twelve.

I told you all the other things that I had done at NIH. When I stepped down, I went to NIH as a visiting scientist. We began to deal with some of the numbers, productivity, how we're treating people, how many people we're losing, what teeth. We had a lot of rich epidemiologic data that needed to be correlated to what we were teaching and doing and such. I don't mean I took it on by myself. There were some very good people that I worked with. I brought that sort of practical...what we need to know in dentistry, and how you can help us, and this is the way we could find it out. We were looking at what percentage of hours dentists do different types of treatment and that sort of thing and how many more people they were seeing today for regular care. There was a vast difference in 1985 or 1986 than it was from 1966, 1967, 1968 when I was looking at those questions as a faculty member at Loma Linda.

DT: How long did you work with the NIH?

RO: You know, in one way or another, for probably a dozen to fifteen years. For example, I had had my own research grant at Loma Linda. When I got that, shortly after, they asked me to be the clinician that would sit on the Program Advisory Committee that helped make decisions. So that would have been maybe 1967 or 1968, something like that. I finished my own project and was asked to help plan projects in dentistry. I chaired the Planning Committee for NIDR [National Institute of] Dental Research. NIDR, it was then; now, it's National Institute for Dental and Craniofacial Research. I was doing things, reviewing grants for them, that sort of thing from, probably, 1968 to...and I did some of it after. I spent the year of 1985-1986 there as a visiting scientist and, then, I would be back periodically doing little things for them.

DT: Did you stay on the faculty at the School of Dentistry?

RO: Yes.

DT: How long did you stay on the faculty?

RO: I retired in 1995.

DT: What was the process by which Richard Elzay was appointed as dean? I guess you were gone that year.

RO: He was appointed dean and took over before I left.

DT: Oh.

RO: As I walked back to the faculty, so to speak, he took over as dean. I think that was a July first appointment or something like that. I didn't go to NIH until September or something like that. I don't remember for sure.

DT: I know in 1987, there was the threat to close the Dental School. Were you around for that?

RO: I first heard about it while I was at NIH. I came back and jumped into it, so to speak.

DT: Do you recall why that came about?

RO: No, I honestly don't know.

DT: Did you feel like it was a genuine threat, like something that could actually happen?

RO: [pause] You know, I have no idea. I think that's the only answer that I can give you, because I wasn't around. I didn't hear how it developed. I just heard it as a threat, and I tried to respond to it when I came back.

DT: What did you do in response?

RO: Well, I knew the president. I don't remember whether I set up an appointment and went over and talked to him or sent him a letter and invited his response. I did that several times. I put out what I was thinking about and if you'd like to talk about this, and they'd call and I'd go over, but I don't remember what happened right then. I think by the time I got back, it wasn't as serious an issue. But you're saying 1987. I would have been back by 1986. So I don't know.

DT: They were threatening to close the College of Vet Med, as well, at the same time. Both were such important schools.

RO: I think it was just somebody throwing it out as a possibility. This is how we can save so many million dollars and such. It would have been a bad choice considering how few really first-rate dental schools there are in the service area that we covered, all the way to the West Coast practically and much of Wisconsin. We had, as I say, the best facilities in the country, even at that moment in time. I still don't know of a school that had better facilities than we did.

DT: I meant to ask this before we got to your stepping down as dean. I wonder what do you see as your major achievements as dean?

RO: [pause] [sigh] I'd hate to have this come out the way I'm going to say it, so think of that. I think we improved the faculty. I think we improved the product. I think we worked together with the health sciences better, because we were doing more things collectively than before I became dean. The health sciences were a new entity at that time. They were still doing their own things and reaching out a little bit. I think that we began to work a lot more collectively. That's kind of a general answer. I think I told you how what I tried to do in terms of a curriculum and the product. That's the biggest thing, I think. We did increase research, and we did increase the amount of people that got good dental care at the University.

DT: Those are significant achievements.

I wonder if you might reflect on what Richard Elzay's tenure as dean was like, what his achievements were, and maybe his leadership style.

RO: Once I was no longer dean, I didn't sit around second-guessing or trying to evaluate that. I think Dick was a pretty good leader. He'd had some experience. I can't tell you specifically about numbers in research or anything else. I think he worked well with the people, I say upstairs meaning the research floors above the fifteenth floor, sixteen, seventeen, and eighteen, as a pathologist. I don't have any negative reflections on his tenure as dean. I think he got along well and did a good job.

DT: During those years, did you increase your clinical practice or were you mostly engaged in...?

RO: My practice?

DT: Yes.

RO: After...?

DT: After you stepped down as dean.

RO: Not very much. As I said, I went from being dean to NIH and I came back far more interested in research questions. I tried to connect practice with some of the questions of what we were trying to do and evaluated things that there weren't many other people trying to do. I'm not going to try to pretend that I was a first-rate microbiologist or a first-rate person in some of the cell structure synthesis, things like that. That wasn't my cup of tea. I was a practicing dentist, a practicing periodontist who had had a hell of a lot of breaks early in life.

[chuckles]

RO: I had two or three key mentors very early that...I don't want to say set my sights higher, but I thought about things differently than somebody who just went to practice day after day after day. That's what I think that I brought not only to the school, but to the profession. As I said earlier, if you point at the first five or ten people going around the country talking about preventive dentistry, I would have been one of those. I think that was a major contribution—not that I was so good, but there weren't a lot of other people doing that who had the stage and the background that I'd had working with Harald on the Fulbright.

I didn't emphasize this, but when I went on my Fulbright, there were some really bright young Scandinavian researchers. We were all about the same age, and we all grew up together, and we all contributed, and we all became world figures, so to speak. That was a level of excitement that I never anticipated from dentistry.

[chuckles]

RO: Three or four of them became deans in different places. Many of them practiced and did research their whole life. I'm still in touch with three or four of them. Another four or five have died already. We were all bright young people seeing something different than dentists had seen.

As I say, the advent of fluoridation in the early 1960s was transforming to the whole practice of dentistry. I don't know that fluoridation had it never come along whether dentistry would have developed as broadly as it did. I'm talking about at the school level, meaning education, research, and service, helping people, trying to find out why and how we can do it better, as well as becoming health professionals. It forced us to think more broadly about what dentistry was.

DT: We've covered a lot of ground. I wonder if you have any other reflections that you'd like to share about the School of Dentistry, the Academic Health Center, or your career in general.

RO: I really don't. I think I was very fortunate to be invited back there. I don't think my career would have been a lot different had I stayed in Southern California, but it was fun to come home. It was just interesting to me.

My cousin was Lloyd Johnson and that name may not mean anything to you. But, basically, he's the person who headed Norwest Bank, which is now Wells Fargo. Lloyd and I were born about two months apart in Minneapolis. We lived across the street from each other, and grew up building blocks at his house and running cars on the porch at our house, and went to Nursery School, I think it was called, for a year together and started school together. Then we moved to Duluth and moved back to Minneapolis. Lloyd and I were bicycle age by then, and he'd ride to my house, and I'd ride to his house. In Duluth, I guess I had to be either pushed ahead a half a grade or behind a half grade, and they pushed me ahead, so I graduated from high school when I was a few months into seventeen. Lloyd in Minneapolis dropped back so he was a year behind me when we went to Carleton. When I graduated from dental school, he was my best man and we both ended up in Southern California. He was with Security Pacific [National Bank]. I came back as dean at Minnesota and about two years later, there was a knock on the door and here's Lloyd. He said, "What's it like to come back to Minnesota after twenty-some years?" I said, "It's wonderful. It's like you've never been gone. People will just say, "Where have you been?"

[chuckles]

RO: We canoed together. We backpacked into the Boundary Waters together. We had done everything together. He was the person that turned Norwest around. Having come from California banking, he saw the opportunity and facilitated the Wells Fargo merger for them and such. Unfortunately, he died about a year ago. He had Alzheimer's for almost fifteen years.

DT: Oh, goodness.

RO: He was down here in Phoenix. I was the only one coming to see him at the end. He had no idea who I was or anybody else was. He had a daughter living in a different house but trying to keep track of him. I don't know why I told this story, except that we had all these connections at Carleton, and California, and back to Minnesota, and both doing well in Minnesota.

DT: And both to Arizona, too.

RO: Then coming here. He was a great guy, a great loss to me.

DT: Well, thank you so much.

RO: You're welcome. I hope I haven't bored you.

DT: No, this had been wonderful.

[End of the Interview]

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