

Russell V. Luepker, M.D., M.P.H.
Narrator

Lauren E. Klaffke
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Russell Luepker was born October 1, 1942 in Chicago, IL. He earned his bachelor's in history at Grinnell College in 1964. He graduated from the University of Rochester Medical School in 1969. While at the University of Rochester, he was an NIH research fellow in cardiology at the University of Göteborg, Sweden. He completed his internship at the University of California at San Diego in 1970. To complete his military service, Dr. Luepker worked as assistant chief of cardiology at the U.S. Public Health Service Hospital in Baltimore, Maryland while also pursuing research at Johns Hopkins University and the University of Maryland from 1973 to 1974. He was appointed assistant resident and then director of the Lipid Clinic at Peter Bent Brigham Hospital in Boston while working toward his master's in epidemiology at Harvard University's School of Public Health, which he completed in 1976. In 1976, Dr. Luepker moved to the University of Minnesota as a professor in the Laboratory of Physiological Hygiene, which became the Division of Epidemiology in 1983. He became associate director of the Division in 1986 and served as Division head from 1991 to 2004. He began serving as director of Graduate Studies for the Division in 2004. His research includes cardiovascular epidemiology, clinical trials, community disease prevention, and outcomes research. He continues to serve on the faculty in the School of Public Health.

Interview Abstract

Dr. Russell Luepker begins his interview by reflecting on his early life and education. He then describes his medical education and the travel and training programs in which he participated at the University of Rochester, specifically his time in Nigeria and Sweden. He also discusses his time in the U.S. Public Health Service in Baltimore, MD, his internship in San Diego, CA, and his recruitment to the University of Minnesota. Dr. Luepker reviews his experience applying for and executing the Minnesota Heart Health Program grant; the culture at the University in comparison to other institutions where he'd studied and worked; and Ancel Keys work in the Laboratory of Physiological Hygiene and the merging of the Laboratory with the Division of Epidemiology. He then gives his perspective on retrenchments as a result of his time as chairman of the University Senate Finance and Planning Committee and the impact of the Rajender Consent Decree. Dr. Luepker also describes the following: his research programs; interventional and observational epidemiology in the School; public health as an activist profession; collaborations with the Medical School; the influence of the Academic Health Center on collaboration; his views on leadership in the AHC; the tenures of the deans of the School of Public Health; and his work with the regents. He concludes his interview by discussing the combining of the roles of Medical School dean and vice president of the AHC and collaboration within the AHC.

Interview with Doctor Russell V. Luepker

Interviewed by Lauren Klaffke

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

**Interviewed in Doctor Luepker's Office
in Moos Tower, University of Minnesota Campus**

Interviewed on September 11, 2013

Russell V. Luepker - RL
Lauren Klaffke - LK

LK: This is Lauren Klaffke. I'm interviewing Doctor Russell Luepker. It's September 11, 2013, and we are in his office in Moos Tower.

Thank you for meeting with me today.

To get started, I was wondering if you could tell me a little bit about where you were born and raised and your early education.

RL: I was born on the south side of Chicago, in a place called Roseland, which happens to be the place where Barack Obama was later community organizer. This was a working class neighborhood. I went to the Chicago Public Schools until eighth grade when my parents decided to move to the suburbs. So I graduated from Niles Township High School, which was in Skokie, Illinois. On the south side of Chicago, it wasn't good to be a smart kid. That was not favored. In Skokie, Illinois, which was mainly Jewish immigrants, it was not only merited, it was encouraged. Although, we're not Jewish, it was a much better environment for me. So I went to high school there. I'm the first person in our family to go to college.

LK: Oh, wow.

RL: My father had an eighth grade education. As I said last Saturday night when someone asked me to pour the wine, "I have experience. My grandfather was a bartender all his life, except during a time in prison during Prohibition..."

LK: Ohh!

RL: ...because wasn't connected with the mob. He was just a guy serving whiskey illegally.

[chuckles]

RL: He said to my dad, "Once you learn to read and write and do arithmetic, you don't need to go to school anymore. You need to become an apprentice, learn a trade...plumbing." So my father had an eighth grade education, but, nevertheless, had much ambition but was very unable to do practical things. He didn't make it as a plumber. In fact, he wound up working for Sears Roebuck and became a store manager, but was always ashamed that he had an eighth grade education.

LK: So he very much valued education.

RL: Yes, he valued it. There was no question what was going to happen to me and my brother.

I wound up going to Grinnell College in Iowa, which is a small liberal arts school, but some would say a good liberal arts school. I majored in history, actually Russian history because I was really interested in that. In my junior year, I began to see that the options in history other than teaching were limited. I had a disconnect. I could remember all sorts of facts that made it easy for me to take exams. Who were the combatants in the War of the Roses? I could spit that out. I probably declared history because Arnold [J.] Toynbee, a name that may mean little to you, wrote *The History of the World*. He was regents professor at Oxford, who did a sabbatical and you had to be a history major to take his course.

[chuckles]

RL: So I wound up going to medical school instead. By that time, my family had moved to New Jersey, actually to a suburb outside of New York, because my dad was transferred to the New York City office of Sears in Manhattan. I went to college and finished college there with a history major, but got into medical school at the University of Rochester in New York, partly because it was much closer to where we lived then.

I should say that we've been married forty-six years. My wife [Ellen L.] was a classmate in college, but we survived that. [chuckles] I keep on running into classmates but they're divorced.

LK: Mmmm.

RL: My wife took off for graduate school at Smith College in Northampton in social work and did a rotation in Queens with the Board of Ed[ucation] in New York—much

more exciting than what I was doing—and, then, got an assignment at the University of Rochester Medical Center just before we got married.

So I went to medical school. I was fortunate to have some really good mentors. The first, [J.] Lowell Orbison, who became dean of the medical school at Rochester, was my advisor for the first three years. I got to know George Hoyt Whipple, another name that may mean nothing to you but there is a disease called Whipple's disease, a procedure called the Whipple procedure...

LK: Yes.

RL: ...and he won the Nobel Prize for discovering vitamin B-12 back before that was known.

LK: Right.

[chuckles]

RL: Somebody had to discover it some time. This was in the 1930s. He was an interesting man, quite old when I met him.

Then, I became interested in cardiology. I went to the head of cardiology and asked if he could be my advisor. He was a guy by the name of Paul [N.] Yu, who had been born in China, studied cardiology in London and, then, came to the states. He was also [General] Chiang Kai-shek's doctor when the general was head of Taiwan and ran that country like a personal kingdom, which it was for him. So he was a well-connected guy. He said, "What do you want to do, Russell?" I said, "I like to see patients." The goal of every second-year medical school student is to see patients, because you're just in lectures the first two years. The first thing Doctor Yu said to me is, "Are you married?" I was not at that time, so I could safely respond... I didn't say I was engaged.

LK: [laughter]

RL: Since I said, "No," he said, "Good. If you want to be a good doctor, you can't be married." Now, he happened to be married to a neurologist. It's do as I say, not as I do. [chuckles] On Saturdays and Sundays, he took me to see his patients. It was an extraordinary experience. I learned a lot about cardiology examining patients. I worked a summer in his lab between my junior and senior year.

I had done a public health elective between my freshman and sophomore year in rural Nigeria.

LK: Wow [whispered].

RL: In Nigeria, we did a tuberculosis [TB] study in a village. One of my former college roommates was a Peace Corps worker there. It was just before the civil war with Biafra.

It was an interesting and intense time. It gave me some insight into public health and population medicine in a developing country.

I gave a lecture the other day in class about recruitment of participants. I remember standing in the village square of this village in Western Nigeria, and we were doing TB testing, which involves a little injection under the skin and seeing two days later how big the reaction is. This was a community organization, so the chief stood there. We injected him, and he said, "This is good for my people. Everybody do it." So we didn't have any participation problems.

LK: Yes.

RL: Of course, this was a village where everybody is related to him and one another, a polygamist society.

[chuckles]

RL: I had the desire to travel more. I went to Paul Yu and I said, "Doctor Yu, I hear we have a scholarship program. The scholarship program is doing a year's research, taking a year out of medical school." Everyone before had done it at Rochester. The NIH [National Institutes of Health] sponsored this program. It has been going on for years. They took a year and they worked in a local lab. I said, "I'd like to go somewhere else." So he gave me six names of people in Europe who he knew. Five of them were in the UK [United Kingdom] and one was in Sweden. I wrote this nice letter saying, "I'm a medical student. I have a scholarship." It was \$2800 for the year, but things were cheaper then.

LK: Right!

RL: But, even then, you couldn't live on that, and we were married, so there were two of us. We had to take out loans. Three people from the UK never answered me. The other two said, "Oh, you should come. We can find something for you."

Then, I got a letter from Lars Werkö in Göteborg, Sweden. Lars was with André [F.] Cournand at Columbia University when Cournand won the Nobel Prize for cardiac catheterization. So he was one connected guy, who later became head of AstraZeneca, and later became consultant to the prime minister on science affairs, and only recently died at ninety-two or something like that. So Lars writes me this letter. I didn't call him Lars then. He said, "Oh, please, come. It would be wonderful to work with you. We have lots of things going on," the type of letter that medical students don't get from famous people.

LK: Right.

RL: My wife and I picked up. We got a cheap flight to Brussels and took the train out to Göteborg, Sweden, where Werkö was head of the Department of Medicine. We got a

one-room apartment that was only slightly bigger than this. It had a kitchenette and a bathroom, but we were just married. We were twenty-four, twenty-five. You can do anything.

[chuckles]

RL: It was being sublet from a guy named Gunter Vestberg, who was very left wing. He was a nephrologist. He was really enamored of Chairman Mao [Tse-tung] and he was in China. All over his apartment were little busts of Mao and the *Red Book* translated into Swedish. This was during the Great Leap Forward. He had some fascinating stories. He became less left wing after that experience. So we had this little apartment in the suburbs.

I went to work the first day, and I discovered that Lars Werkö wasn't there. He was on sabbatical in Argentina.

LK: Oh!

RL: But that didn't turn out bad, though it was three months before I actually met him. He had also sent the same letter to a bunch of other people, so I arrived at the same time as four or five other people: a guy by the name of Endo Achya, who was chairman of the Department of Medicine in Indonesia, in Jakarta; Zoltan Nagy, who was a professor of cardiology in Budapest; Johann Orha, who is Romania's greatest cardiologist and a personal friend of President Ceasescu; and Attilio Maseri, who became a professor in Conoon later. They were all doctors. They were really disappointed that Werkö wasn't there. They wanted to do really important things with him. As a medical student, if they had told me, "Your job is to wipe up the floor of the clinic after he's done," I would have said, "Yes, sir, I'll do it." But they didn't ask me to do that.

Instead, I wound up in the catheterization laboratory. It was because of my summer experience running certain types of technical equipment. They had the same brand of technical equipment. I was running it in the animal lab, but it was the same as we use in the human lab. I wound up essentially doing any procedures in catheterization laboratory.

After three weeks went by Ed Varnavskas, who was professor of cardiology, and another well known guy in the field—he's still alive—called me and said, "What do you want to do, Russell? You're very helpful to us. We need one less technician, because you can do all this work." I said, "Well, I want to catheterize humans." I was twenty-four.

LK: Yes.

RL: I had quite an interesting time. I wrote five papers while I was there. I have a paper that's still quoted, because no one else will ever do it again, which is "Left atrial pressure"—the atrial being part of the heart—"during exercise in normal human beings." You might ask how this formed consent was obtained.

LK: [chuckles]

RL: To do a left atrial pressure, you have a needle about three feet long and you put it in the groin, and you puncture the septum of the heart from the right to the left side, and you pray that the needle is in the right place. You're looking on the X-ray in two dimensions. It's not three-dimensional. So you know roughly where the needle is going. We had a x-ray table that broke away, and we put a bicycle on it, and they exercised lying on the table. This was a group of Swedish fighter pilots who had had heart murmurs. You may not know any fighter pilots, but flying is what they do. If you said to them, "Unless you have a brain biopsy, you can't fly anymore," they would say, "Start drilling."

[laughter]

RL: "I don't care what you have to do." So they had heart murmurs and the Swedish Air Force was worried lest they black out or something during a maneuver, and crash the plane, and kill themselves. So they were all really healthy, in-shape guys.

I was able to do that. I met a lot of people and had an incredible experience for a kid.

I went back and finished medical school. Then, I did an internship at the University of California-San Diego, when a fellow named Gene [Eugene] Braunwald was chair of that department. Gene Braunwald was probably one of the handful of the most famous cardiologists in the world. He's still active at age eighty-four. I had a really good experience and worked hard.

As I was telling students this morning, in those days, if you were male and you went to medical school, you were going to be drafted into the military. I had a friend who had had polio and his right arm didn't work very well. He graduated from medical school and they drafted him.

LK: 1-A?

[chuckles]

RL: He wasn't going to have to shoot a gun. He worked in a rehab facility, which he knew a lot about, and that's what he pursued. So he wouldn't have ever passed a physical exam.

I was fortunate here again; I've been fortunate a number of times. One of the alternatives to military service was the Public Health Service, what we called the Yellow Berets. If you were the Yellow Berets, you weren't likely to get assigned to Vietnam, as many of my classmates did. What you could be assigned to—the Public Health Service takes care of the Coast Guard—if your commanding officer didn't like you, he could put you on an icebreaker in the North Atlantic. All winter, the ships go back and forth looking for

icebergs and looking for people to rescue. So it was horrible duty. It was cold. The boat is rocking all the time. If anybody gets sick, it's your problem—and they did.

I got in, but I got assigned to an administrative job in Washington [D.C.]. I went to Braunwald and said, "You know, I think this is good. I'll certainly accept it, but I really want to do research." I thought things like this were immutable. You couldn't argue with the military when they assigned you to somewhere. He picked up the phone. I had my own laboratory in Baltimore on the Johns Hopkins campus.

LK: Oh, wow!

RL: Really, it was very fortunate. If I hadn't walked into his office and complained, I probably would have been an administrator for the government. That's what my brother-in-law did.

So I spent three years. I had a fantastic experience. I diminished the stray dog population of Baltimore in my laboratory.

LK: [laughter]

RL: I did a fair amount of work in Johns Hopkins Hospitals, things that people at my level of training, partly because I'd done all this stuff before, would never be allowed to do today. That was a really good experience.

But I hadn't done the residency yet. What was I going to do? I could have stayed at Hopkins. I was offered a position there. But Braunwald had moved to Harvard by then, and I decided to go to Boston. Either would have been good moves.

I should tell you one aside in San Diego.

LK: Yes.

RL: In those days, that was an every other night internship so you were on duty every other night. The concept today, which you may have heard, that residents can only do a certain number of hours a week [eighty] did not exist. So it was every other night the whole year. I'd go home at eight o'clock and fall asleep and get up at five the next morning and go back. We lived two blocks from the hospital. It wasn't a commute problem. We were making \$250 a month.

LK: Oh, wow.

RL: No, I'm sorry. Twenty-five hundred a year, so \$200 a month, plus change, but we got food free in the hospital cafeteria.

LK: Okay. [laughter]

RL: If you were married and had kids... We had only two women in the group. Those people who had kids, the wife had to work.

So I was part of a strike to increase wages for medical residents. We were plotting with all the University of California hospitals. They were all involved in this, so UC Davis, UC San Francisco, UCLA, UC Irvine, and UC San Diego. We sat there and said, "We don't want to come across badly in the newspapers as abandoning patients." So we decided we would not admit any elective surgeries or elective cases, people coming in for testing or coming in for plastic surgery, things that if you waited a month, so what? It was an inconvenience. Suddenly, the number of beds filled in the hospitals plummeted.

LK: Right.

RL: And they got the message, the hospital administrators, and they raised our salary to \$400 a month.

LK: Oh! that's huge.

RL: That's the biggest pay raise I've ever gotten.

[laughter]

RL: But they didn't change our work hours.

LK: Paying interns so little, has that changed?

TL: Oh, yes. They're making \$40,000, \$50,000 now, but, they have \$200,000 in loans.

LK: Right.

RL: Yes, it's better and people are likely to be married, and it's not at all uncommon to have children. It was very uncommon when I went through.

At the end of this when we were on our way to Baltimore, we went up and visited my father- and mother-in-law who, then, were living in Palo Alto in Northern California. I was complaining about how hard I was working every other night, \$250, and we had a strike. My father-in-law was mortified that we would do anything like that. He was an intern in San Francisco in 1940. He said, "Two fifty. Every other night. You could be married. What a soft life!"

[laughter]

RL: He said, "In 1940, we were on five out of seven nights. We got twenty-five dollars a month and you *had* to live in the hospital. You couldn't afford to live anywhere else. If you were married, you had to keep it a secret. But you could never be home anyway.

You were always in the hospital.” I’m sure his father said to him, “Five out of seven nights. What a soft life you guys had!”

[chuckles]

RL: So we moved to Boston from Baltimore and lived in Wellesley. I was a resident and, then, I was a cardiology fellow, and I got a degree in public health and epidemiology from the Harvard School of Public Health while we were there.

LK: What spurred your interest in public health? I know you had done that...

RL: My experience in Nigeria. Much of my research up to then had been physiology. In the interval there, in my last year of college, my father had a sudden death. He was fifty-one. So I became interested in blood pressure and things like that, because he had high blood pressure. That kind of moved me toward that and to get a degree in epidemiology rather than what my classmates were doing, which was gearing up to become private cardiologists.

LK: How did you end up at the University of Minnesota? Were you recruited?

RL: Yes, I was.

One of the things I had done in Baltimore while in the service was a study of heart disease at Parklawn. Parklawn is the Social Security headquarters. There were 30,000 employees that made sure the checks were printed and correct and they run Medicare, too, out of there. So it’s an enormous data processing operation. The chief of the cardiology clinic I was working in there knew there weren’t enough Coast Guard men to keep his hospital busy. The Coast Guard men, we frequently saw and I saw, were guys who had volunteered for the Coast Guard thinking this was a way to stay out of Vietnam. Well, the military decided the Coast Guard should patrol the rivers in Vietnam.

LK: Ohhh.

RL: So they could get shot at or they could do icebreaker duty. It became dangerous. Suddenly, they decided they were much sicker than they were before and they wanted to get out. Fortunately, I didn’t have to make the decisions about that. They did not have heart disease. They were not complaining of that.

I had made a number of connections during my time at Social Security. As it turned out, the workforce in Social Security was largely young women. It was a clerical workforce and some computer guys to run the computers. The problem was printing checks and making sure records were correct and things like that. We decided to use that population for the Multiple Risk Factor Intervention Trial, MRFIT.

Henry [Blackburn] may have talked to you about that project [MRFIT]. I don’t know if you’ve interviewed Henry...

LK: My advisor has, yes.

RL: Henry is a renaissance man...

LK: Yes.

RL: ...who can be *incredibly* charming when he wants to. I was twenty-nine and impressionable. I got put on a committee that Henry chaired planning for MRFIT, planning the physical exams. He appointed me secretary of the committee, because I was the only junior person there. I learned that being secretary is really important, because you're the only one who actually gets to record and remember what happened. All the people yelling around the table, they don't remember what they said two months later.

LK: Right.

[chuckles]

RL: I'm secretary of some things now. We become the memory of what happened or what you think happened.

So Henry invited me here. The Harvard people offered me a faculty job, too. I tell this story... Henry was charming, and people at Harvard were charming, and I knew them, but they have a different system. They have a really tough pyramid system. They're seven years up or out as assistant professor. Eleven years up or out as associate and most people don't make it. So you find people, even people around here, who've been eleven years at Harvard and they didn't get promoted, so they're done.

LK: Yes.

RL: Of course, some people will stay at Harvard no matter how they abuse you.

Gene Braunwald called me in and said, "Russell, I think you're doing a nice job. I'd like to offer you an assistant professor's job here. We want to have better connections with the Epidemiology Department at the school." It was right down the street from his office. "I'll pay you such and such. But, I want to tell you something. I'm going to hire twenty-five assistant professors this year in the Department of Medicine." It's a big department.

LK: Yes.

RL: He said, "Maybe five of them will get promoted to associate and the other twenty will find good jobs in other places at the end of six, seven years." It's a philosophy. Of course, many of my friends who were a year or two ahead of me had made this choice. You've got people at Harvard, every one of them has always been valedictorian of their class and always succeeded in education and things and they're going to be the ones that are going to make it, they're all convinced. Many are deserving. Some of them cheated.

This was a group that no one helped one another. In fact, if somebody stumbled, they viewed that as a positive. That meant there's one less competitor for one of these highly valued positions. We talked about this at home. We had two children by then. It was not a happy operation at the Harvard Medical School, because of that.

LK: Right.

RL: And Henry was charming.

[laughter]

RL: He spoke several languages, played music.

LK: I know he's a big jazz aficionado.

RL: No, he's more than an aficionado. I've been with him in New Orleans where people at Preservation Hall ask him to sit in and play with them.

LK: Oh, wow.

RL: That's how good he is.

So we came here. Actually, two of us came here. One of my classmates in residency and the fellowship, Rich [Richard F.] Gillum, one of the first black cardiologists, came here. We came together. My office is down the hall there and his office was a little farther down the hall. What I saw here is not only a place that did epidemiology well, but it was very well known for cardiovascular epidemiology and the things I was interested in.

The big thing that Henry wanted done—this was his office for years—was to do a community prevention study. So that's the origins of the Minnesota Heart Health Program.

LK: Right. Were you principal investigator [P.I.] on that?

RL: No, Henry was principal investigator, but I wrote it.

[chuckles]

RL: Henry is an excellent writer, but if you know him now and you didn't know him in his younger years, he was an extremely demanding person. He used to eat up secretaries and staff. They would go crying off, because they weren't perfect and disappointed Henry.

LK: Oh, wow.

RL: So I started writing this grant. There was no page limit on grants then. So it was a hundred pages of text. My main contribution to this, other than writing it, was the purchase of the CPT [computer processed text] machine.

LK: He did explain that.

RL: The CPT was a local company that made the first word processor or one of the first. It was a big machine. You had to put a cover on it, because it made so much noise. It was an IBM [International Business Machines] ball typewriter and a little computer screen. It did one line at a time, but you could change it before you printed it out. Before that, in the first year, it was carbon paper and White-Out to do anything.

LK: Uhh!

RL: We went through twenty-eight editions of this 100-page, plus appendices, grant. Henry was a devastating editor. The secretaries, they're gone.

[laughter]

RL: Or they found other jobs at the University. We sent it in. This was 1978. I came here in 1976. They sent out a big team for the site visit. We were out in Minnetonka at the... What's the family that owned the *Des Moines Register*? The [John] Cowles family. They had what had started out as a house, but they moved and it became a conference center. They sent out fifteen people to exam us. We were doing fairly well, we thought, until we had a consulting guy by the name of Jack [John W.] Farquhar, who was a medical resident with Henry here in Minneapolis many years ago... Jack had a similar program at Stanford. It started two years earlier. Just as Jack is going out the door, the head of the committee said, "How different do you think this program is from what we're sponsoring at Stanford?" Jack said, "Oh, maybe ten percent different."

LK: Mmmm.

RL: This did not help us.

LK: Right.

RL: Why should we pay for the same thing out in Midwest? So we were depressed and cursed the whole thing. I cursed Henry, particularly...

[chuckles]

RL: ...for getting me into this quest.

But I was fortunate in that, in the meantime, I had already NIH funding. We did a small community study in Montevideo, Minnesota, with the Journalism School, the Montevideo Heart Project.

By some strange sequence of events that will never occur again, I received with Andy Johnson, who is out on the West Coast now, a postdoctoral training grant. Assistant professors don't get those today. We were very fortunate. We had some fantastic fellows. The first two fellows in the training program, one of them is associate dean at Ohio State and chair of Health Education, and the other is associate director of the NIH.

LK: Wow.

RL: So our fellows, generally, did quite well and are scattered all over the country.

We went back again and this time, we got the community prevention study. At that point, it was the biggest grant the NIH had given to the University of Minnesota ever. Ultimately, we consumed \$50 million, \$60 million of taxpayer money...

LK: Wow.

RL: ...back in the day when you could hire a graduate student for six dollars an hour.

[laughter]

RL: And they didn't get free tuition with it—but tuition was a lot less then.

LK: Right.

RL: We had 120 employees, not only here but we had field offices in Fargo [North Dakota], a field office at Mankato, a field office in Bloomington [Minnesota]. We were running a large operation.

LK: This was education?

RL: In 1980. It was education. We used a variety of methods. There were, actually, a half a dozen. We did mass media with a fellow by the name of Jerry [Gerald] Kline, who was, then, dean of the Journalism School here, a fantastic guy. He helped us with that. We did community organization to engage community leaders with a guy by the name of Neil [F.] Bracht, who was, then, the dean of the School of Social Work and had studied with Saul Alinsky on how to activate communities. We did that. We did mass screening. We screened 16,000 people, adults in Mankato and 20-some-odd thousand in Bloomington and Fargo. It was quite an operation. We did physician education and had some successes in changing practice there. We did education in the schools with someone who came about that time from Stanford, Cheryl [L.] Perry, who is now dean of Public Health at Austin [University of Texas]. She is probably one of the best kids' health education people anywhere. She left a couple years ago, but she did an extraordinary job. What was the sixth thing? I'll think of it.

LK: Okay.

RL: We started off then and, for thirteen years, we did it from 1980 to 1993.

LK: Is this still going on in some form today? I've seen something with like Partners in Prevention.

RL: That's one of the things I'm doing now.

LK: Okay.

RL: What we gather is a lot of expertise in different methods, how to measure things in the general population. The restaurant program, the food program, we did that. A woman by the name of Becky [Rebecca M.] Mullis, a very creative woman who is now chair of Nutrition in [University of] Georgia, did that. She had a load of fantastic ideas and we got the restaurants to change their recipes, did a lot of things.

LK: Ohhh.

RL: What we developed is expertise in large group randomized studies. In fact, one of my colleagues has written *the* book on that topic [D.M. Murray, *Design and Analysis of Group-Randomized Trials*, 1998]. You don't randomize people; you randomize whether it's schools or factories or towns to different treatments. The classic old study is the study in Texas of fluoridated water where in some towns they fluoridated the water and in other towns, they didn't. They looked at dental caries.

LK: Did you run into much resistance in pursuing these education campaigns? I would think there would be a lot of resistance in getting restaurants to change recipes.

RL: You know, it's very interesting. I learned a lot from Neil Bracht and he's written a book on this, too [*Health Promotion at the Community Level: New Advances*, 1998].

We were really careful at planning these things. I have a picture in my other office. We were in the stadium then. We left the stadium to go down to Mankato to meet with the Chamber of Commerce, an influential body in town. We had talked to some people ahead of time including the mayor [Herb Mocol] who owned a trucking company. We presented this, a bunch of docs from the big city. [chuckles]

LK: Yes.

RL: We were ready to be thrown out of town, but we had done our homework. The mayor stands up and says, "This is the best damn idea I ever heard for Mankato. We ought to do it."

LK: Wow.

RL: That wasn't just a spontaneous comment.

[laughter]

RL: We had spent time with him ahead of time. But he understood that he was an influential guy at all levels. Then, the head of the Ministerial Council of Churches stood up and said, “Yes, I think this is a fantastic idea. We’re supportive of it.”

About two years later, we were attacked in the *Mankato Free Press* because of our anti-smoking program in school kids.

LK: Hmmm.

RL: Some of these kids were coming home after having our anti-smoking education and bugging their parents who smoked, which happens anyway. It would have happened whether we were there or not. So somebody writes a letter and the editor decides to write an editorial on these anti-smoking Nazis from the University

LK: Oh. Did he use the word Nazis?

RL: Right. People who try to get other people to do things they don’t want and try to force them to do it. We were into smoking bans and things like that even before that became so popular here. We started writing a response to this and, then, talked about it and thought about it a bit and, instead, the mayor wrote a response. So this is infinitely more powerful than university people from the big city. I remember doing a TV show with the president of Mankato State [Margaret R. Preska]. She was very supportive of it. Their students worked on our program. We did learn lessons about how to come to the community and engage people to be supportive instead of doing it ourselves. Any good community organizer knows that but they don’t teach that in medical school.

LK: No. [laughter] Is that something that’s been adopted more into the curriculum, the community organizing idea in schools of public health, at all?

RL: Oh, yes. We have a major in that.

LK: But it’s not in a medical school?

RL: There’s so much to teach these kids. There’s an MD/MPH program if they want to do something like, but they’ll discover they don’t get paid enough to pay back their loans.

LK: Oh.

RL: We worked hard on that for years and did all sorts of other things. We continue to do that kind of work. We’ve done a lot of work with kids, a lot of work with measurement methods, looking at disease outcomes in communities.

LK: Did you do much in the Twin Cities or was this more...?

RL: In Bloomington...

LK: Okay.

RL: ...a much harder place to do. Mankato and Winona are fairly intact units. They have their own everything, their own school district, and people don't move in and out that often. When you get to the metro area, people are going back and forth all the time. It may not be, frequently, the same people you started with living there, but those are the people you're trying to educate. And the media, you can't break into the Twin Cities metro area media to do one town. Although, Bloomington is a big town, you can't focus at all... There wasn't such cable penetration, but I would argue that, still, people don't watch Bloomington cable. They watch ABC, and CBS, and CNN. You can't afford to break into those to target one relatively small place.

LK: Right.

I had a question... This is backtracking a little bit. You were at a number of different programs in California, a different geographic region in a public school and, then, at Harvard as a private institution, and, then, here in Minnesota in the Midwest as another public institution. Did you find a lot of cultural differences between those different programs? I know Harvard was very competitive. Do you have any other comments on those different areas?

RL: I think Harvard and Hopkins were very competitive places. Having lived in Sweden a year surrounded by busts of Chairman Mao in your apartment will make you a little lean to the left.

One of the things I used to say when I came here... I had patients at the Brigham which is the Harvard Hospital where I worked, and when they had come to the end of their hospitalization and needed to go home, or to a nursing home, or whatever depending on their condition, it was really hard to find a place to place them. You wound up keeping them in the hospital extra days and the insurance companies didn't like that at all. When you came here to Minnesota, agencies were fighting over who was going to provide home care or take them. I think that's probably less true today, but it's still much more than other places. So this is a much more caring community, I think, than many eastern towns. I've lived in Jersey, and I've lived in Baltimore, and it's different...or in Southern California where you don't even know your next door neighbor and they may be gone next week. Why bother to get to know somebody? They're going to move. I think that's one of the important differences.

I think people are more cooperative, in general. That's partly why we were able to do this. Some people accused us..."You can do that in Minnesota, but we could never do that in Pennsylvania." I'm not sure that's true, but I haven't tested things in Pennsylvania. I think within the University, although, we have our own tensions and

problems, people are much more likely to want to help others and be cooperative than in some of the places. That's why I've stayed—one of the reasons I've stayed.

LK: Because of the cooperative environment?

RL: Yes, it really is quite nice.

LK: I know that Henry Blackburn brought the Laboratory of Physiological Hygiene into, was it, the Division of Epidemiology?

RL: Yes.

LK: Do know how that transition...?

RL: I was there. I was part of that.

LK: Okay.

RL: This was Ancel Keys' department and he called it the Laboratory of Physiological Hygiene. Having known Ancel, who died at 100 a few years ago [Doctor Keys died November 20, 2004], I can quickly understand how this happened. I've read his autobiography; the subtitle is "All about me, because he never mentions anyone else.

[laughter]

RL: Then, I did this; then, I did that.

At any rate, Ancel was a brilliant guy. He was at Harvard and got recruited to the Mayo Clinic [Rochester, Minnesota]. He was only there a year or two. This was the late 1930s and he was studying the physiology of humans. He got divorced and remarried down in Rochester and came here to work with Maurice Visscher. Having met both men, both of them got information directly from God without any intermediary.

LK: [chuckles]

RL: Unfortunately, they were speaking to a different god. They were learning different things. They were incredibly strong-willed guys. As the story goes—I wasn't here; this was like 1938—it took about two weeks before they came to blows.

LK: I've heard that.

RL: You've heard this story?

LK: I've heard the nice version, I suppose.

RL: Ancel walked out as he was more than capable of doing and he walked over to whoever was athletic director, maybe [Louis J.] Cooke or someone like that, somebody whose name is on a building, and said, "If you give me offices to stay and do my work, I'll teach physiology to the phys-ed students." And he went to Gaylord Anderson, who was the first dean of the School of Public Health, and said, "I'll do research for you. I won't ask for any money. Give me a department title." He named it the Laboratory of Physiological Hygiene. The athletic director gave him the visitor's locker room so many of us spent many years under the football stadium.

LK: Yes.

RL: You couldn't go there during games, because there had been a collapse once, although, it was the old stadium, old Memorial Stadium with concrete stands, not collapsible stands.

We plugged along quite successfully. This has been, historically, the most funded unit in the University.

LK: The Laboratory?

RL: Yes. Oh, yes. Even now, we bring in external funds...\$600,000 a faculty member.

LK: Wow [whispered].

RL: So we're highest of any school of public health, including Harvard and Hopkins and those places. We don't have much hard money from the state, and we don't know any different but writing grants.

[chuckles]

RL: We grew under Henry. We went from five or six faculty... Ancel retired. Henry became chair. A number of Ancel's colleagues were like age to him and he retired at seventy and they retired. We moved to Moos Tower. They were going to wreck the stadium, but they never wrecked it. So we kept both areas and they replicated the stadium facilities here at Moos. So if you go down the hall, this belongs to the nurses now, but there's the tin room, which was a climate-controlled room that had the biggest treadmill in the world, so Ancel could exercise a dozen people at the same time.

LK: Wow!

RL: They put us in the basement allegedly because it shook so much. They couldn't put it on an upper floor. We were a fairly vigorous operation.

Right next to us in the room over there was Epidemiology, which for reasons best known to Doctor [Leonard M.] Schuman; who was the chair, he never cultivated anyone to take his place. He had a number of part time people who taught for him. So the dean, then,

called in an outside committee and said, “What should we do? These guys in Physiologic Hygiene are doing epidemiology. The Epidemiology guy [Schuman] has got to retire”—he was seventy by then; he didn’t want to retire, but he needed to—“and he has no successor.” The committee recommended that the departments be merged. We decided to call ourselves Epidemiology, because no one knew what physiologic hygiene meant; although, some of the older guys lamented this. And we became Epidemiology. We went from a unit that did entirely research... We would have one doctoral student every five years, because a doctoral degree in physiologic hygiene had no particular currency.

Epidemiology suddenly inherited teaching programs. The School of Public Health had eighteen different programs. Every federal agency who had some money to give, dental public health, whatever, we took it. So they started a department. It may have only had one faculty member but it was a department. So they began merging us...Edith Leyasmayer, in the late 1980s. We took over health education, which we turned into community health education.

LK: Okay. Yes.

RL: Then, when I became chair in 1991, 1990...?

LK: I should have that. Yes, in 1991.

RL: I inherited Nutrition and Maternal and Child Health. So, suddenly, we had four programs, four MPH programs, and a lot of faculty. We grew fairly dramatically from twenty to near fifty faculty. We now have a massive teaching program in addition to our research.

LK: Yes.

When you’re talking about combining programs, I’m reminded of retrenchments that several of the other schools within the Academic Health Center experience. But from what you said earlier, you said the School of Public Health didn’t have a lot of hard money. All you knew was writing grants. Did you all experience any retrenchment when University budgets were cut?

RL: Well, sure, but what the University gives us is such a tiny fraction of our overall budget that, perhaps, we felt more immune to that than other units. As a way of background and disclaimer, I’m now in my fourth year as chairman of the University Senate Finance and Planning Committee.

LK: Ohhh.

RL: I know a lot about the finances of the University...

[chuckles]

RL: ...and the Academic Health Center more than most faculty members. There were retrenchments, and it may have hit some of the other divisions harder than Epidemiology because they had less external money, but most all do now, because they've come to realize the state isn't going to rescue us. I think...I know we've been hit harder because I've looked at the books for the last ten or fifteen years.

[laughter]

RL: We've been shaved and we pay more than twice as much into the cost pools than we get from O & M [State Operations and Management]. So we're in the same boat as the Carlson School. You can listen to [Srilata] Zaheer labor on about that or the Law School. It's just that you guys are doing okay. Liberal Arts needs this money. There are some other decisions that [University of Minnesota President] Eric Kaler needs to make in my opinion about that. He can't keep assuming that historically self-supporting places will need no money at all.

LK: Right.

RL: Are we immune to cutbacks? Nobody is immune, but we've been less affected. We grew for many years without tenured positions. I didn't come here as tenured.

LK: Wow.

RL: I happen to be tenured now, but I wasn't tenured until the Rajender Decree where they gave a lot...

LK: Oh, wow! The year it started?

RL: Well, Rajender... Do you know Rajender?

LK: Yes.

RL: Rajender, they had to give a number of women tenure. Minnesota being what Minnesota is said, "Well, there's some guys in the same position.

[laughter]

RL: Rich Gillum was black. They weren't going to say, "No, you can't have it. We're going to put some white women in there." I just hid behind them and snuck.

[laughter]

LK: Was that in 1980?

RL: I think it was 1980, 1981, yes.

We're not allowed to do that at the same rate we were. I would go to the dean and say, "I need a new person in Nutrition." The dean would say, "You don't need a tenure track position. Can you pay for it? Because I can't." I said, "We'll hire. We'll find the money for this." And that's what we did.

LK: I wanted to ask you more about the different research programs that you were part of. I don't know maybe what you'd prefer to talk about more than others. I didn't know if you wanted to maybe talk a little bit about Rapid Early Actions for Cardiovascular Therapy.

RL: Let me talk about a few things.

LK: Okay, yes.

RL: A number of population-based studies were started. The first one we did, actually about the same time as we did Montevideo, was the Robbinsdale Anti-Smoking Project. The Heart Association gave me money. We did a junior high program that was quite successful in the Robbinsdale schools. That grew to some NIH funds and much larger research that we did in 1980s.

We did a study of cholesterol management in rural clinics [PACE]. We had randomized twenty-four clinics in northwest Minnesota and North Dakota to different treatments.

We did CATCH [Child and Adolescent Trial for Cardiovascular Health]. I was chair of the steering committee of CATCH. That was a study randomizing ninety-six schools around the country, in San Diego, Houston, New Orleans, and us. That was not only an enormous but a successful program.

We did REACT, which was Rapid Early Action for Cardiovascular Therapy. We randomized twenty cities of 100,000 or more around the country, in Massachusetts, Oregon, Washington, Alabama, and Minnesota.

LK: Texas?

RL: Yes, Houston. At any rate, that was an interesting study that didn't meet its goals because the controls did better than we predicted. But it was very successful in getting more people to use the ambulance. We spent a lot of the taxpayers' money and a lot of those materials are still used today.

LK: Are a lot of these studies measuring the effectiveness of media interventions.

RL: Well, media are one of the things that we do. We have experience with that, but we have a lot of experience with direct education of people whether it's in clinics or schools, wherever people gather, churches. We learned a lot from the original Heart Health Program about community-level organization and education. People believe the mass

media. You can get on television and you can convince people. We ran a television studio over in Murphy Hall...

LK: Wow!

RL: ...and created our own full-length features, an enormous expense. [chuckles] If you want to do production quality television, it ain't cheap, even if you can exploit journalism students...

[laughter]

RL: ...which we did. You need people who can act and they don't come cheap and so on.

Now, I have cable. I have 200 odd stations. I can't even surf them in one night, much less know what they're talking about. Newspapers, which we used to use heavily, are a dying breed.

LK: Yes.

RL: So we've gotten more experience with the web and doing things on that. I don't know if you've met [B. R.] Simon Rosser or know Simon?

LK: No.

RL: He does HIV [Human Immunodeficiency Virus] work on the web. He's in the department and that's his expertise, this web-based stuff. You can do more, but we live in such an overwhelmingly diverse and media rich environment, it's hard to be able to focus on any one good thing that's going to work better than another thing. And you can't afford to do all the things.

LK: Yes, yes.

RL: I use the example sometimes in class... Have you ever heard of the purple pill, Nexium?

LK: Yes.

RL: Do you know how much the company spent to market that in the first nine months?

LK: No, I don't.

RL: Nine hundred million dollars.

LK: Wow.

RL: That's why everybody in this country knows about a drug that, in fact, is no better than Prilosec. It's actually the same drug with a little modification. It's an L-isomer instead of a D-isomer, but the FDA [Food and Drug Administration] said, "That's a different drug." It's a highly sold drug. It's like three or five dollars a pill, until the patent runs out.

LK: Yes.

RL: If we had \$900 millions that we could spend in nine months, I bet I could make something happen. You could saturate all the media outlets that way, which is what they did.

LK: It's incredible. It's kind of crazy how problems with the communication have changed in the past century from not being able to communicate to...

RL: To being over loaded.

LK: Yes.

I also wanted to ask you about—I don't know if you have any comments on this—changes in epidemiological studies over time. It seems like a lot of what we've been talking about has been interventional.

RL: Right.

LK: But I've heard a lot about observational epidemiological studies, which I would think the Seven Countries Study would be the big one that comes to my mind. But do you have any comments on whether public health epidemiology is moving more towards interventional or if that's just...?

RL: Well, actually, we may be as much known for that [observational epidemiology] as for our interventions.

I am principal investigator of the Minnesota Heart Survey, which has been going on since 1979. We look at hospitals. We look at death records. We look at randomly selected populations.

Some people actually read our materials, occasionally. I got off the plane last Wednesday night a week ago from Amsterdam. It was the late plane. It gets in like at seven-thirty. My wife and I get home and I said, "Well, I better look at email, because I'm lecturing in class tomorrow. Maybe something is happening." I get a note that says, "Russell, you're presenting at the ICSI [Institute for Clinical Systems Improvement] tomorrow for Tom Frieden," who is head of the CDC [Centers for Disease Control]. I said, "What?"

[chuckles]

RL: I've had email problems in Europe. Maybe somebody told me this and I didn't notice it. There's a paper we'd written in *Circulation* last fall sometime, the end of 2012, and Frieden wanted to learn how we got the results we got. Well, it was an observational study on blood pressure. I said, "I'm glad to hear somebody finally read an article that I wrote." [chuckles]

We're very involved in the technology of surveillance. We have a couple grants under review now using electronic medical records for disease surveillance that I'm doing with junior colleagues. I'm on a committee for the CDC looking into this and a committee for the World Health Organization that is into definitions and classification of disease. It's a big interest of mine and of the department.

My belief when I came here hasn't changed, which is that public health is an activist field. Many people who go into epidemiology, certainly at the epidemiology department at Harvard where I was trained, count things and they're good at counting things. They count weird things and have tests that are very clever. They're all friends of mine.

But public health work is not just to count things. It's to ask this next question: so you find more people dying in this group than group, what are you going to do about it? The answer may be a traditional clinical answer that you do in clinical trials, but the answer as well might be a public health measure, the fluoride case. Those were observations that some towns had naturally fluoridated water because of whatever the rock was that lined the lake. Well, they found that there were a fewer dental cavities in those towns. Or Ancel's work which is for our field incredibly seminal work when he observed the eastern Finns has ten times as much heart disease as the Greeks did. Well, why is that? You have to go to eastern Finland to understand why it was.

I love telling the story, so I'm going to tell it whether you want it or not.

LK: Okay. [chuckles]

RL: You have to remember this is the 1950s. These were farmers and lumberjacks in the pre-automated era. So when they cut down a tree, they did it with two guys on the other side of the saw going back and forth. They burned 10,000 calories a day easily. We should all learn how to do that. They were constantly physically active. How can you take in 10,000 calories a day? You can't do it with fruits and veggies, I can tell you that. You could not eat enough to do that. You've got to eat a lot of fat. In those days, when you saw a Finn butter his bread, the layer of butter was equal to the thickness of the bread.

LK: Oh, wow!

RL: So they were taking in tremendous amounts of fat. Despite the fact they were slim and in incredibly good physical condition, they tended to die in their forties of heart disease. So what do you do about that? The observations that Ancel made were critical

and caused Finland to make some changes in people's diets, and what the restaurants served, and things like that. The rest is history.

LK: Yes.

RL: The rates have gone down. They don't use handsaws anymore to cut down trees.

LK: [laughter]

I also saw that you were chair of the Framingham [Heart] Study.

RL: Right, I still am.

LK: Okay.

RL: The Framingham Study is probably the best-known cohort study in our field at least or maybe in the world. It's been going on since 1949. I've been chair of the Advisory Committee for longer than I should have been, like twelve or thirteen years. I was brought in when they started doing genetics. They had several advisors, famous geneticists from out at Stanford and Harvard and MIT [Massachusetts Technical Institute] that constantly yelled at one another in the committee. I was brought in to broker peace and get them to get stuff done.

[laughter]

RL: So I did that. That's been a very interesting job.

It has been less interesting and less fun than the other one that I was chair of. I was chair of Honolulu Heart Study Committee.

LK: Yes, I did see that. That was next on my list.

RL: I didn't start out as chair. Al [Herman Alfred] Tylroler from Chapel Hill started out but Al retired and I took that over. I remember sitting in one of our meetings and people were looking at their calendars, a bunch of famous guys from around the country, and a woman from Seattle, Eunice Sigurdson. They were saying, "Well, I can't get there in April. Maybe I can free up time in May or June." I said, "Folks, wait a minute. I have no interest in going into Honolulu in May or June. We're going in January or February."

[laughter]

RL: When I became chair... What's the sense of going and visiting in the spring? Now, they put you in the basement of Kuakini Hospital so it could be storming snow outside, but everybody stayed longer than the meetings. The director of the Heart, Lung, and Blood stopped that. Although, the committee was only five members, more and more government officials felt a *need* in January and February to go see how the program was

doing. So there'd be the five of us accompanied by fifteen government officials who needed to check out the program. He finally said, "We're having this in Washington." That's the way it is.

LK: Yes.

RL: I was very disappointed by that. The people living in Honolulu were very unhappy. They're always looking for ways to get off the island. You would think, who wouldn't want to work in Honolulu?

LK: Right.

RL: It's not at all true. Do you want to live in [Las] Vegas? Do you want to live in a tourist town...?

LK: Yes, that's true.

RL: ...where eighty percent of the people walking on the streets are Japanese tourists? They're always trying to plot ways to come here [the mainland] and we're always trying to plot ways to go there.

I did that. They closed that down. [J.] David Curb died just recently [January 8, 2012] of a liver disease and he was the point person for Honolulu at the University of Hawaii.

The study was based on 11,000 Japanese-Americans who were picked up by the draft in 1942. They wanted to know exactly where these guys were and what they were doing. Many of them, including one who just died, the senator from Hawaii, [Daniel] Inouye, served in a highly decorated army division of Japanese-Americans that fought in Italy. He lost his arm in that war. He was a senator forever. He was also in the cohort. That was one of the better advisory committees.

LK: Were there any other programs or grants that you wanted to talk about that I didn't hit on before we move on?

RL: I've been really lucky. I probably have said that a couple times. I made a lot of friends in Sweden and have kept contacts and done research there. They're easy people to work with. They understand what we're doing. We went there by chance. We have no Swedish relatives or anything. We knew no one. It got me involved in a variety of NIH interventional programs.

The first one was the German-American program. A number of my colleagues here went to Germany to look over what they were doing and they came and visited us.

Then, there was one with the Soviets and I was in the Soviet Union in the 1980s a fair number of times.

LK: Oh, wow.

RL: We did a study of blood pressure in seventh graders in Moscow. The study didn't produce much of scientific value, but we had some fantastic trips.

Then, the Japanese-American treaty, which was later, in the 1990s and early 2000s before they decided we were just enjoying ourselves much too much.

I've been to Georgia several times for USAID [United States Agency for International Development]. I've been really lucky that way. The other Georgia.

LK: Yes.

RL: [unclear].

LK: You mentioned wanting to travel earlier. I was making connection to all the traveling that I know Doctor Blackburn has done. It just seems like part of the job in epidemiology, a lot of traveling. I don't know if that's just...

RL: Henry speaks fluent French and German, been trained in Paris. His first wife is—she's still alive—French. Have you heard that story?

LK: I haven't.

RL: Well, that's a fantastic one. His first wife was Nellie Trocmé. Nellie's father [Andre Trocmé] was a Protestant minister in a village [Le Chambon] in France on the Swiss border. When the war came, the Germans occupied the village. Her father was the minister of the Protestant Church. So he and the family are personally credited with rescuing 7,000 Jewish children...

LK: Wow.

RL: ...and getting them across the border into Switzerland, because this village was under the nose of Germans. Nellie's cousins, several of them, were shot by the Germans. A movie was made called *Lest Innocent Blood be Shed*. Nellie is quite a fantastic person in and of herself.

LK: That's a good story.

RL: I see her occasionally.

[chuckles]

RL: I'm sorry. That was a digression.

LK: Oh, no, that's okay. That's fine.

RL: I have thousands of stories.

LK: Digressions are always welcome.

RL: I don't want to see this appear in the *New York Times*.

[chuckles]

LK: I was wondering if you could comment a little bit on your balance—in quotes—of teaching, and research, and clinical work. I know you continued to be a clinician, correct, when you came here?

RL: Right.

LK: Could you speak to that a little?

RL: When I came here, we didn't do any teaching in this division.

LK: Oh, really?

RL: I came to Physiologic Hygiene and we were not a teaching unit until 1983. I was one day a week doing cardiology one month doing acute care at the hospital. I also had a half-day-a-week private practice in Saint Paul.

LK: Oh, wow.

RL: That was to make money.

[chuckles]

RL: I kept doing that until the late 1980s when Chuck [Charles] Gooder, was, then, the administrator of the Department of Medicine. He called me in and said, "Russell, you know you cancelled fifty percent of your clinics last year, and you generated \$27,000 income in clinic, and your malpractice insurance is \$22,000."

LK: Oh, wow!

RL: The insurance company was charging me as if I were working fulltime. I said, "Chuck, I was on the road a lot. I took a quarter leave in Europe. Give me another year." The same thing happened.

[laughter]

RL: It's very hard, because you've trained years to do this, I thought the competent clinician; although, working one day a week is not enough to be in the catheterization lab anymore. So I stopped that.

In 1983, we began inheriting more teaching duties. I had taught for a couple of years the core course we taught on chronic disease, cardiovascular disease epidemiology. But that began growing and I began teaching more. Then, when I became chair, I taught intro epidemiology to eighty to a hundred students. I did that not because I'm an extraordinary teacher, or because I liked that connection at the time, or I had good T.A.s [teaching assistants]. I did that because it gave me the moral high ground to say, "I can teach this class. You're an epidemiologist. You can teach this class, too. Don't tell me it takes too much time. I can be chair and do it." Then, I quit doing that after I got on the high ground.

Then, in 1986, David Brown and I—David Brown was dean of the Medical School—were talking about the sad state of affairs of clinical research in the country and in this University. A number of scandals had come out.

LK: Mmmm...

RL: We wrote an editorial for the *New England Journal*, which they, in their wisdom, never published. But it got us together and the result was the MS [Master's of Science] in clinical research, which began in 1989. Steve [Stephen P.] Glasser, who is now in Alabama, was PI. He's a cardiologist, as well, but he was in this department. He was the D.G.S. [Director of Graduate Studies] and, then, I was the D.G.S. until last year.

LK: Oh, wow.

RL: That's a program that's probably trained, now, 150, 200 people. You have to have a doctoral degree to get into it. It's mainly, maybe, sixty percent post doctoral fellows in the Med School, an occasional dentist, an occasional veterinarian, an occasional PharmD. The other third are faculty. I've had everyone from assistant professors to full professors taking the degree. I teach three courses that are related to that major, still. I have help. I have a lot of help.

Then, when we began doing the CTSI [Clinical Translational Science Institute] or CTSA [Clinical and Translational Science Award] and that longstanding, painful process, I said, "We ought to start doing some things," and I wrote into the grant, which never got accepted... It took us five years to get that. I said, "There's no sense in waiting." So I just taught a course that I started six years ago that's for sophomores and it's connected to UROP, Undergraduate Research Opportunity [Program]...

LK: Right, right.

RL: ...only they get to work on a clinical research thing. We give them one credit course that we teach in the fall. You can't take a college sophomore who is nineteen

years old wearing holey blue jeans and having a Def Leppard t-shirt that has a swastika on it and say, "Go interview these patients."

[laughter]

RL: So we start them off with professionalism and appropriateness. This is a highly competitive program. We take ten students, and we get many, many more times that applying.

Then, I teach a second class called Clinical Research from Bench to Bedside to Community. I've been teaching that six years with Chuck [S. Charles] Schulz. Do you know who Chuck Schulz is?

LK: I don't.

RL: He's the chair of Psychiatry.

LK: Oh.

RL: So if I have emotional problems, I can talk to him and he'll give me pills.

[chuckles]

RL: I was the D.G.S. for eight years and that program has flourished. It got connected to the K12 [CAPS, Career Advancement Program] that I got. Do you know about K12?

LK: No.

RL: It has nothing to do with Kindergarten.

LK: That was my first thought.

RL: Yes, that's what everybody says. That was a big NIH... It got \$13 million over five years to train assistant professors in clinical research. I paid seventy-five percent of their salaries. I actually had no one from Epidemiology. It was very competitive to get into. I had Monica Colvin-Adams. Do you know Monica in Cardiology?

LK: Yes.

RL: She was in that program. I had a lot of people. I had twenty-three assistant professors, an occasional dentist, an occasional nurse. No veterinarians were in that.

Now, I started a new program last year, which is causing me some headaches, which is a certificate program. To get a certificate program in this University is not as hard as getting a new master's program, having been through that one. But it's got to go through everybody and up to the Regents...in clinical research. It's aimed not at physicians and

dentists like the MS is. It's aimed at people interested in working in the field and it's a distance-learning thing, which has taught me a lot about how to do this. We probably have eleven people in it at the moment. There's one in Australia.

LK: Oh, wow.

RL: So that's a new and exciting challenge.

LK: You said you began your work teaching about clinical studies through a conversation and that paper with David Brown. Did you often collaborate with people in the Medical School? It sounds like you did.

RL: Yes, I've been collaborating with people in Cardiology for years. I think one of the things that's happened, to talk about the AHC [Academic Health Center] connections here, is that the Medical School has struggles at the moment, as everybody knows. The president knows. The Legislature knows. The governor [Governor Mark Dayton] seems to know, so I'm not telling you a secret here. In general, people in medical schools have tended to look down on public health people, because they take care of sick people and they save lives every day. What does trying to clean up the water and sewage? It's even an issue at Johns Hopkins, which happens to have probably the number one rated medical school and number one rated school of public health in the country. Even though they're right across the street from one another, sometimes they don't do things together. We, suddenly, are appreciated by the Medical School, a lot.

LK: Oh.

RL: I've particularly benefitted because they understand my degree. Most people in the School of public Health are Ph.D.s and don't know anything about patients and health care. So I think we have more people asking us our advice and involving us than ever before. It's lots of people; I'm not suggesting that I'm the source of this. We are a successful school, and they appreciate it.

Dan Garry [head of the Cardiovascular Division] has given me a modest flexible fund, so I have half a dozen or seven assistant professors in Cardiology who are trying to find their way in clinical research. We go out to dinner every month somewhere. We talk about our struggles and they can talk to me, I think, better, because I'm not part of their administrative hierarchy. I understand what they're going through, the whole mentor thing. A number of them have been promoted and got grants. I think I've profited from fantastic mentors over the years, including Henry Blackburn; although, I didn't appreciate him some of the time.

LK: [chuckles]

RL: You need to try to pass that on.

I'm fond of saying—I'm fond of saying a lot of things; you know all the papers I've written and I've written a fair number, hundreds of papers—"Ten years from now if anybody reads them"—ignoring the head of the CDC; that was a random event—"they'll say, 'Why did anyone believe this? It's clearly been disproven. Why would anybody write this?'" Your legacy is in the people you train and if they do a good job and they're upright citizens and contributors, then you've been a successful person. I've been lucky to have some really bright people work with me over the years and still do.

Likewise, in cardiology, if you're a cardiologist here—or other places; Minnesota is not unique—you've got to earn your keep by seeing patients. If you don't see enough patients, you're going to get called in and, they'll say, "I'm going to have to cut your salary. And, by the way, have you written any papers or written any grants lately?" If you say, "Oh, my god, but I'm seeing patients all the time..." People feel isolated, and alone, and in trouble, and some of them leave, and go to Abbott [Hospital] to go into practice, and make a lot more money, and nobody asks them, "Where are your papers or grants?"

LK: Right.

RL: But they work very hard; no doubt about it. Anything we can do to help these people not feel isolated, that there are not only other people in the same situation but that are willing to work *with* them. Even though they're just down the hall and they're in the same unit, they don't communicate over this, and I think I've been able to make some connections that wouldn't have been made otherwise. I've failed sometimes.

LK: I think that creation of a mentoring program across schools is really interesting.

RL: Yes. A number of the people that are in my mentor group are doing things in Epidemiology and actually get part of their pay out of Epidemiology.

LK: Oh.

RL: So that's the way it should work.

Dan Garry is a basic scientist and he's a great guy. He's the best thing that's happened to Cardiology, in my opinion. I don't need to say that.

[chuckles]

RL: I knew him before when he was in Texas and he was a good guy there, too. He's got lots of clinicians, which keep the system going and they need help, too. The lab guys don't have to see patients. They just have to see mice and rats, a different type of career.

LK: Yes.

I know that the Academic Health Center was formed prior to your arrival at the University, but did you feel any of the effects of that when you came and did you see that relationship changing between the different schools in the Academic Health Center?

RL: I have strong opinions on this and it may not reflect everyone. I think the *theory* of the Academic Health Center is an outstanding one. It's really a good idea. But, in fact, it hasn't worked very well. I think there are several problems that have inhibited its growth. Some are natural, different disciplines. I talked about the Medical School and Public Health. You could talk about the dentists who have a whole culture of their own and the nurses that really have a whole culture of their own. I've done some things with the Nursing School over the years. Those natural things have to do with training and history. Nurses don't want to do what the doctors do and the doctors don't want to do what the nurses do. There's such a thing, for example, I was told once, as "nursing statistics." I said, "Statistics are statistics."

LK: [laughter]

RL: It's the same stuff, but they're taught by nurses. This isolates them.

The second issue with the Academic Health Center and the University is the growth of administration. I've said this publicly. I've said it with the president in the room and you're not a *Wall Street* journal reporter, are you?

LK: I'm not.

RL: I got quoted there in January. The president was not amused. [*Wall Street Journal*, December 28, 2012 - "Dean's List: Hiring Spree Fattens College Bureaucracy—and Tuition" by Douglas Belkin and Scott Thurm.]

LK: Ohhh.

RL: We have a serious leadership problem. We don't have visionary leaders and the AHC is a classic example of that. The first head of the AHC, at least that I remember, was Lyle French.

LK: Yes.

RL: Doctor French was a neurosurgeon who had said, "I have operated on the back of every important person in this state." Lyle could go to the Legislature and recognize the backs of people.

LK: [chuckles]

RL: And they listened to what he said. He got money out of them for the health sciences and was extraordinary in that way. When he retired he was replaced by Neal Vanselow then Robert Anderson. They didn't have the connections of Lyle French.

These were people that operated small offices with about a half a dozen people and they dealt with the Legislature in getting money. They did not provide a vision of how the whole should work.

LK: Right.

RL: Then, Anderson did very little and he was fired.

LK: Right. [William R.] Brody came in next.

RL: I was on the committee that selected Bill. Bill was an extremely bright man who had no discernable social skills; although, they say that he did fine later as president of Johns Hopkins. He came here because he didn't get the dean's job at Johns Hopkins.

LK: Ohhh.

RL: I know about this because my lab partner in med school did get the job.

[laughter]

RL: He had to go away for a while in order to apply for something. He created all sorts of storms here when he said, "We're not structured the right way. We have too many ophthalmologists and not enough dermatologists, and we're going to have to change things, and I'm going to do away with tenure." He did that with my friend, the woman who was chair of the Board of Regents [Maureen Reed]. She was an internist at HealthPartners.

I saw her a couple months ago. Medical director of HealthPartners was her job.

They [Maureen Reed and William Brody] got together and said, "Well, we've got to change things. We've got too many people in the wrong positions and the future of medicine is at stake," the same thing people say now, twenty years later.

So he brought in this guy, who had been his college roommate [James Champy] at MIT—Bill Brody did—who had written a book called *Engineering the Corporation* [by Champy and co-author Michael Hammer]. He [Champy] had done a fantastic job at Taco Bell. We were, suddenly, inundated with recently graduated MBAs [Master's of Business Administration] who moved here and did studies on us on how we should change. It turns out this guy's reputation was not Taco Bell. It was based on that he was top of the non-fiction *New York Times Best Seller List* for month after month until it was discovered by *Business Week* how he did this. He found the bookstores that the *New York Times* monitored and he sent people to buy copies, not just copies but hundreds of copies, of his book. So that scandal blew up.

For once in their lives, the people on the other side of Washington [Avenue] when they heard that tenure might go in the Academic Health Center, decided to defend us even though they hated us. I was one of two Academic Health Center members on the committee of nineteen, which opposed this, I and David [W.] Hamilton, who, later, became dean of the Graduate School.

LK: Yes. I'm hoping to interview him.

RL: David lived with us when he first moved here, because we knew him from Boston.

For the guys on the other side of Washington, tenure is not just a casual issue. It's a life or death issue and they were ready to defend us. The scandal with this business guy helped undermine Brody and, then, he got this other job and left.

LK: Yes. I hadn't realized this aspect of his tenure as senior v.p. I have read about his work in selling the [University] Hospital to Fairview [Health System] and that's a huge change, making these almost immediately thereafter.

RL: It's a bad deal. Most would say now that it was bad deal.

LK: How are we on time?

RL: Niki Oldenburg is coming at four [o'clock], but I'll wait till she knocks at the door.

LK: I can speed up my questions a little bit.

RL: I could shorten my answers, but that's not likely.

LK: [chuckles]

Do you have any comment on Lee [D.] Stauffer's tenure as dean of the school? I know he was dean when you were recruited.

RL: Yes. Lee's a wonderful guy. Lee left us alone.

LK: That's good. [chuckles]

RL: That's what the department loved him for. He was a good spokesperson for Public Health. He was a sincere, honest, hardworking guy. He didn't have any particular plans that I discerned; although, he did bring us from eighteen to four units, which was very painful on many people. You know, you're an independent department. You don't want to be merged. People didn't want to be merged with us. When he gave us Nutrition, which was practically all women both in students and faculty, the head of it went to the [Minnesota] Daily and said, "We don't want to be with that obvious chauvinist, Russell Luepker."

LK: Oh, wow!

RL: I said, "I didn't know I was that obvious.

[laughter]

RL: That didn't work.

[laughter]

RL: I said, "Talk to my wife about this."

I think Lee was a good guy, but his goal was not to make this a great school.

LK: Hmmm. What would you say his goal was then?

RL: It was to make it a good school and train... Lee had a master's degree in environmental health/sanitary engineering. He was an expert in sewers and sewer treatment.

[chuckles]

LK: I'm sure that makes for a lot of good jokes.

RL: He wasn't a scientist academic. He had an MPH in an important field for public health, but not somebody learning how to better treat sewerage, that I know of.

LK: Did he step down in 1982 to retire or just felt that...?

RL: He retired. I just saw him recently. He's still around. His wife got cancer and died. She was mayor of Woodbury [Minnesota].

LK: I know Edith Leyasmayer was...

RL: Acting for a while and, then, Steve [Stephen] Joseph came in. No, it was Bob [Robert L.] Kane. We conveniently forget Bob. Have you interviewed Bob?

LK: Not yet. I'm hoping to.

RL: He'll be interesting. Bob's an *extremely* bright, accomplished guy who was never really dean. He was busy doing his research and out of town all the time.

LK: Ohhh.

RL: Finally, he was given an endowed chair and he was very happy to not have to deal with all these administrative problems. Bob was dean four or five years, I think.

LK: Yes.

Then Stephen Joseph came in. Were you at all involved in his appointment?

RL: I had just become chair when he came.

LK: Oh, right.

RL: He appointed me. He came a year after. Steve had been commissioner of health in New York City, a really big job, a much bigger job than being commissioner of health in Minnesota.

Steve used to tell the story... He was a sailor. I'm a sailor, so I appreciated him. He had his own boat, which he sailed down Lake Superior to get here. He said somebody came to his office at the New York City Health Department and they had to go through some demonstrators to get in the front door. They asked Steve, "Steve, how do you deal with this? These people are calling for your neck. They're down there." He looks out the window and he says, "They are only twenty-five, though. This is an average day. There are no news cameras or anything."

[laughter]

RL: "There are many days like this." It just goes with that job.

LK: Was he commissioner in the 1980s...

RL: In New York, yes.

LK: ...during the AIDS [Acquired Immune Deficiency Syndrome] crisis?

RL: Yes, he was, I know the late 1980s. He left here after just a couple years and became Under Secretary for Health in the Pentagon.

LK: Wow.

RL: I remember visiting him there. This was an extremely powerful job. He stayed there a couple years. No one has stayed there very long, at all. That's been a high-turnover job. Then, he moved to New Mexico and became a consultant. He retired...a very bright man.

Then, Edith was dean for years.

LK: Yes. It seems like she was dean, acting...

RL: Yes, she was interim. She became permanent dean.

LK: Now, it's John Finnegan, correct, whom you have worked with on a number of projects?

RL: He was a student of ours back in the early 1980s. He started out working on the Minnesota Heart Health Program.

LK: Is that strange to have someone you taught now be dean?

RL: It's happening more and more.

[chuckles]

LK: I guess you're becoming accustomed.

RL: No, it's just that I'm becoming old.

John's been a very good dean. I wouldn't say that if I didn't believe it. It's a lousy job.

LK: Administration?

RL: Right. The person who I mentioned who was my chair in Boston, Gene Braunwald, who could have been a dean said, "Dean is one letter away from dead."

LK: Oh!

RL: You only have problems unless somebody has just dropped a billion dollars on you and you can spend it. But that doesn't happen anymore. You have to deal with cutbacks all the time.

LK: Did you do any work with the State Legislature to get money or campaign at all?

RL: I have. I testified just a few months ago about the tobacco tax.

LK: Ohhh.

RL: So I testify. I'm a state employee and I'm not supposed talk to the Legislature as a state employee.

[Niki Oldenburg knocks at the door - extraneous conversation]

RL: I've been very active as a volunteer in the Heart Association. As a representative of the Heart Association, I can go testify on issues even if I'm not specifically called. I've done a moderate amount of that over the years.

I testified before Congress a number of years ago in Washington. That was an interesting experience.

LK: Was that about tobacco?

RL: No, it was about cholesterol.

LK: Have you done any work with the Regents, at all?

RL: Yes, I'm going to the Regents meeting tomorrow. I'm chair of Senate Finance and Planning.

LK: So that's been more of a recent...?

RL: The last four or five years, I've been chair. It turns out the new head of the Regents, Rick [Richard] Beeson, is a good friend of my wife, so I have an in already. She's a more important person than me anyway—my wife, not Regent Beeson.

LK: Do you have any final thoughts on the School of Public Health and the Academic Health Center? I know we're pressed for time.

RL: Again, I've said this publicly, so I'm not sharing confidential material. The review committee that came back for Eric Kaler this summer noted the serious problems in the Medical School. I think starting with the sale of the Hospital and the ascension of Frank Cerra, we have struggled. When he fired Deb [Deborah E.] Powell as dean of the Medical School—one can call it other things, but she was fired; I think these events really have been harmful to us in Public Health and to the other *little* schools.

LK: The v.p. taking on the role of dean?

RL: Yes, because the Medical School was in deep financial trouble and Frank was gathering money from other schools. If you look at the budgets, their budgets have gone down while the Medical School's has gone up, because they have financial troubles. I think it has harmed the over all Academic Health Center and not promoted goodwill and cooperation.

Now, as I said just a moment ago, we're doing things with Cardiology. We do things with OB-GYN [Obstetrics and Gynecology]. We do things with Neurology. They come to us as departments, not as the school and they tend to be individual relationships, because we know somebody and we can get things started. The same with the V.A. [Veterans Administration]. We do stuff with the V.A. Now, both with the clinical research and the epidemiology degrees, many of our graduates are in positions in other schools. So we have those connections that are helpful to us, I think, in creating collaboration.

The Academic Health Center, despite trying by laying out money and things like that, I don't think has been very successful doing that.

LK: What I've heard from other people has been that it's really about the personalities involved and just personal relationships that have been the foundation of a lot of the collaboration between the schools.

RL: Yes, and it's that way everywhere in the world. But it could be easier. I don't think we've had leadership—Frank Cerra was there forever—that either knew how to do this or saw this was useful to do. Clearly, his career depended on saving the Medical School from going under and that doesn't leave much time for the little schools, I thought, or how to make the Academic Health Center better as a whole than it was before.

Again, I've said this publicly, so I'm not telling you something that I wouldn't tell to the *Daily* if they asked me—okay, maybe not the *Daily*. The Academic Health Center as opposed to a funnel for money and distributing resources and things like this ought to be a collaborative group of deans who include, perhaps, CBS [College of Biological Sciences] or CFANS [College of Food, Agricultural, Natural Resource Sciences] or CSOM [Carlson School of Management] that also have an interest in health. The Department of Psychology does all sorts of research in human beings that most would call health related. They would call it health related study, but they're not part of the system. I think it might be nice to have a smaller group that consists of the deans and has a rotating chair and some budget.

Right now, the Academic Health Center core has a budget in the tens of millions and has several hundred employees. When Lyle French was head, he had five people that worked in his office and a lot of politicians to get money out of.

[chuckles]

RL: It's kind of grown into an organism that, by and large, supports the Medical School and consumes... In terms of O&M budget—you can tell I'm into this—the Medical School gets the most. The next is the AHC core, something like \$50 million a year...

LK: Ohhh.

RL: ...of quote/unquote state money. It doesn't teach people. It doesn't get research grants. It gets state money. The School of Public Health got \$7 million last year.

LK: Wow.

RL: Some things happen and I understand the reasons. But it has not helped the broader good. It certainly hasn't helped Public Health.

LK: Right.

RL: But maybe it's good if we don't get money. Then, we realize we have to fend for ourselves.

Did you read the article this morning in the paper about Tony [Sutton]...the guy who is head of the Republican State Committee? [*Minneapolis Star Tribune*, September 9, 2013 – “Former GOP chairman Tony Sutton declares personal bankruptcy” by Baird Helgeson.]

LK: No, I didn't.

RL: He just declared bankruptcy.

LK: Oh, personally?

RL: Yes. He's \$2 million in the hole. They quoted things he said over the last years, “Don't raise my taxes. All those people mortgaging their homes and being irresponsible with the money”—he's got a couple second mortgages on his home—“why should we help them?” I don't want to reveal my politics, at all. [laughter]

LK: Chairman Mao. [laughter]

RL: If you sleep around these busts, anything can happen. They were on little platforms on the bookshelf. I turned them so they faced inward. That didn't help.

LK: Well, thank you so much for meeting with me.

RL: Well, thank you for listening to me. People like nothing more than to talk about themselves. Have you not heard that?

LK: Well, some people are resistant to it.

RL: Really?

LK: Yes.

RL: There's an advantage of being an old professor, being tenured, and having no aspirations for a higher job. I could have been dean a number of places. I didn't move for UCLA or Alabama or a couple of other places, so I can say what I want.

LK: Yes.

RL: Now, that can be bullshit maybe, but I can say it. I'm going to leave you with a feminist joke, if you don't mind.

LK: No, I don't.

RL: I've come to do that more and more. This is a joke *allegedly* told by David Brown at the Nobel Prize ceremony in Stockholm when he and Joe [Joseph L.] Goldstein won the award. He was given time. Generally, people don't tell jokes. They say, "Thank you to my technicians, and my students, and my colleagues, and my mentors," and so on. But he told this story.

There's this guy, a Nobel Prize winner up in Berkeley, and he's driving his sports car, with his wife, around the wine country. He notices he's running out of gas. So he pulls into a gas station in a small town. It's not like the gas stations now. The guy comes out of the garage and he's wiping his hands on a rag. He fills the tank, and takes the guy's money, and he walks back into the shop to get him change. He comes back out, though, and he goes to the wife's side of the car, and he opens the door handle, takes her hand, and takes her out of the car, and kisses her passionately, let's go of her, puts her back in the car, closes the door. The guy goes zooming off. About a half mile down the road, he stops the car and he turns to his wife and he says, "What is going on? You, my wife, are kissing this strange man in a small town? What is going on here? You didn't resist him at all. This is crazy. How can you do that? I'm your husband. I'm a Nobel Prize winner." She says, "Well, you know, that was my childhood sweetheart. I've not seen him for twenty-five years. The passion of the moment just overcame me." The guy, who is still furious, says, "But I'm your husband! And I'm a Nobel Prize winner!" She says, "If I'd married him, he would have been the Nobel Prize winner."

[laughter]

RL: See if you can remember that.

[End of the Interview]

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