

Robert Veninga, Ph.D.

Narrator

Dominique A. Tobbell, Ph.D.

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

Robert Veninga was born in Milwaukee, WI. He received his BA in psychology from the University of Minnesota in 1963; his Bachelor of Divinity from North American Baptist Seminary in Sioux Falls, SD, in 1966; his MA in Speech-Communication from the UMN in 1969; and his Ph.D. in Speech-Communication at the UMN in 1972. In 1969, he joined the faculty of the School of Public Health (SPH) at the UMN. He became Assistant dean of the SPH in 1972, then Associate Dean and Executive Officer of the SPH in 1976. He left the dean's office in 1980. From 1985-87, he was division head of Health Management and Policy. He is now retired.

Abstract

Robert Veninga begins with describing his background, including his education. He discusses some of his experiences as a faculty member in the School of Public Health (SPH), as assistant dean, and as associate dean. He describes his research in speech communication, the SPH in the 1960s, the relationship between the SPH and the Minnesota Health Department, the SPH's collaboration with community agencies, the Summer Institute, the relationship between divisions in the SPH, relations between the SPH and other health sciences divisions and their deans, major challenges for the SPH in the 1970s, funding, the shift from an emphasis on teaching to one on research in the 1970s, Public Health Nursing, the effort in the 1970s to establish a school of allied health, the Center for Long Term Care Administrative Education, the Interdisciplinary Studies Program, the Center for Health Services Research, the Program in Human Sexuality, retrenchments in the 1980s, space, the Hospital and Health Care Administration program's move to the Carlson School of Management, and recruitment of minority students and faculty. He talks about Gaylord Anderson, Lee Stauffer, Lyle French, Bright Dornblaser, Edith Leyasmeyer, and Robert Kane.

Interview with Doctor Robert Veninga

Interviewed by Dominique Tobbell, Oral Historian

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

**Interviewed Doctor Veninga's Home
3296 Samuel Court, Vadnais Heights, Minnesota**

Interviewed on February 3, 2011

Robert Veninga - RV
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Robert Veninga. It is February 3, 2011, and we're at Doctor Veninga's home at 3296 Samuel Court, Vadnais Heights, Minnesota.

Thank you for speaking with me today.

RV: I'm happy to do so.

DT: Good. Good, I'm very glad.

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

RV: Sure. I was born in Milwaukee, Wisconsin. I graduated from high school in Parma, Ohio. I received a B.A. degree from the University of Minnesota in 1963. I received a Bachelor of Divinity degree from the North American Baptist Seminary in Sioux Falls, South Dakota, in 1966. I received an M.A. from the University of Minnesota in 1969 in Speech Communication. And I received a Ph.D. degree from the University of Minnesota in 1972 in Speech Communication.

DT: What led you to pursue Speech Communication?

RV: At the time, my career goal was to work in the church. I felt, after seminary education, that I needed a master's degree. So I came to the University of Minnesota for a master's degree and fell in love with teaching and decided, at that point in time—I was teaching while pursuing a master's degree—that I wanted to stay at the University of Minnesota and complete a Ph.D. So I completed a Ph.D. degree in 1972.

DT: What kind of research did you do within speech communication?

RV: The focus of my research in speech communication for my Ph.D. program was in communication patterns in health care organizations, specifically hospitals. So the focus was: does it matter to have effective communications in hospitals in order to keep productivity high, morale high, turnover low, absenteeism low? My research was really geared to understanding how communication impacts human productivity in health care organization.

DT: It was primarily communication between health care workers rather than, say, physicians and patients or nurses and patients?

RV: The focus was primarily on the communication patterns between hospital administrators and staff, including physicians and nurses.

DT: How did you get interested in the health care field?

RV: I was in speech communication. The employment market was either in business or in health care. So I knew I needed to find a niche in either business communications or in health care communications. Because of my value system, I felt more comfortable focusing on health care organizations.

DT: At any point, did you anticipate going back to work within the church or did you, once you did the Ph.D., realize you wanted to stay in academia?

RV: Yes, actually, I realized fairly quickly in my graduate program [that I wanted to be in the academic community]. I felt I could be more effective as a teacher than I could be as a minister. When I came to that realization, then it began to crystallize for me to pursue a career in academia.

DT: Did your experiences at seminary and your involvement with the church before you started graduate work inform or shape how you approached your academic work?

RV: Very much so, because my divinity degree was a very important part of my pilgrimage. When you're going through seminary, you're dealing with questions of ethics—ethics related to people's lives, and, also, to public policy. That really did help frame me for my graduate work in communication.

DT: Studying these communication patterns, were there specific hospitals that you focused on and were they at a university?

RV: Yes, I focused my research on Hennepin General Hospital. It's a county hospital. I did my Ph.D. dissertation at that hospital.

DT: That's so interesting. So, presumably, you're thesis is available?

RV: It is available, yes.

DT: That's fascinating.

From getting your Ph.D. and focusing on communication within health care, was it a natural transition for you, then, to get an appointment in the School of Public Health?

RV: I had a wonderful academic advisor whose name is Doctor George Shapiro. One day, I was going by his office, and he said, "There is a teaching position open in the School of Public Health. I think you ought to go over and interview." I went over and interviewed, and the people were deeply committed to teaching, so they had the kind of values that resonated with my values. While I was completing graduate school, I taught, in the School of Public Health, interpersonal communications.

DT: Which division within the school was that based in?

RV: It was a program called Health Education. I was a faculty member in Health Education. Initially, my entrance into the School of Public Health, though, was through Hospital and Health Care Administration. But my faculty appointment was in the discipline of Health Education.

DT: When you started on the faculty, was Gaylord Anderson still director of the program?

RV: One of the most remarkable things that happened to me was that I came into the School of Public Health when Gaylord Anderson was still dean, and he needed automobile rides home from work. I happened to live not too far from him. I knew he was looking for ways to get home from work. I said, "Doctor Anderson"... You never called him Gaylord in my status.

DT: [chuckles]

RV: No, you never would do that. "Doctor Anderson, I live in Roseville. I'd be delighted, *delighted* to take you home each night from work." In one sense, that was an important part of my graduate education, because we'd drive home through snowstorms when it was hard to get to his home. He was very open with me about the field of public health. What was so wonderful about those conversations [driving] back home, which usually took about thirty minutes, was I was getting educated in public health. All of a sudden, I started to understand the history of public health, the great epidemics in public health, how public health came into being. It was like a tutorial driving home with him. When I look back upon my education, those drives home from the campus with Gaylord Anderson really helped me understand public health, and probably had a pivotal role when I, eventually, decided to stay in public health.

DT: That's sounds like an incredible opportunity.

RV: It really was.

DT: Had you taken any public health classes before you got your faculty appointment?

RV: Yes, but it was just sporadic. In my minor program, I needed to take some health courses, but it certainly wasn't a major amount of course work.

DT: What was Gaylord Anderson like? You said he was very open about public health. What else can you tell me?

RV: Gaylord Anderson was a gentleman's gentleman. That's the best way I can say it. He was a gentleman's gentleman. He carried himself with grace. There was no doubt that he was the Director of the School of Public Health. He could make tough decisions, but he did it in a graceful, graceful way that even if you did not agree with the decision, you had a sense that it was done thoughtfully and carefully. In one sense, he was my first role model as to what it means to be an academic administrator. I always sensed in him that the decisions that had to be made were made not on the spur of the moment, but they were made carefully and gracefully.

DT: It seems like for the School of Public Health, it was an exciting time during the late 1960s.

RV: It was a very exciting time. It was a much smaller school than what it is now. I find that it's so easy to start romanticizing the past, but the truth of the matter is that there was a lot to romanticize about that era. It was a much smaller era, so that the faculty really did know one another. It was, in many respects, a less stressful era; although, I don't want to minimize the issues that had to be faced. It was an era where faculty socialized with one another. It was an era where you could call up a colleague in another department and get help on projects. There was a strong sense that we were in the field of public health together, and that was true whether you were an epidemiologist or you were in environmental health or you were a public health nutritionist. There was a strong sense in the school there of being in public health first and within one's discipline second.

DT: You feel like that changed, at some point?

RV: That did change. There was in the 1980s, in particular, a much stronger emphasis on research. Because of that, the discoveries that are being made throughout the Academic Health Center are impacting the health of the public in incredible ways. Back in the 1960s, the goal was training students. The word "training" was used often as opposed to education. The way it was used was to train people for specific careers, to be a health officer, to direct a health department. It was hands on teaching.

DT: It seems that training was particularly of significant concern in the 1960s because it seemed there was a feeling both within the state and nationally that there was a general shortage of health care workers, including public health people.

RV: That's right. Rewards from the Federal Government and the rewards from the state, economically were very, very forceful in terms of...we need physicians. We need dentists in rural spots in Minnesota. We need public health people. So the economic rewards were there to train people. It reflected the era in which we were in.

DT: What was the relationship between the School of Public Health and the Minnesota Health Department at that time?

RV: That's one of the remarkable, wonderful stories about the School of Public Health, and you would not find this in all states. The relationship between the School of Public Health and the State Health Department has been *incredibly* productive. The barriers for working between the School of Public Health and the State Health Department have been minimal. If one was to ask, "What has made the School of Public Health so unique in terms of educating students?" it has been the relationship with the Health Department, because the Health Department personnel were welcomed as faculty. It wasn't a begrudging welcome; it was a desire to have faculty from the Health Department who really could speak to the issues that were going on in society. So they felt a sense of warmth. They sensed a welcome in the School of Public Health. That kind of culture of helping one another exists to this day. If you were to say, "What distinguishes this school from other schools of public health, I would say that one of the real distinguishing characteristics has been, historically, up to this very moment, this *wonderful*, productive working relationship with the Health Department.

DT: Where do you think those good relationships came from?

RV: I think they came from the fact that the leadership of the School of Public Health knew that their program of study for students would be greatly expanded and recognized if they had practitioners actually doing part of the teaching. They didn't abdicate the teaching role. The relationships with the Health Department were not based on economics; that is, that you could get faculty at less expense. Those kinds of discussions never took place in my office or in other's offices, I do believe. It was just a sense that if we're going to have an exciting educational program, why don't we bring in some pros who every day are working on water pollution, people who every day are working on air pollution, people who are concerned about kids that are ingesting lead paint. Everyday, they're meeting parents who have kids that are ingesting lead paint. Why don't we have them talk to our students? The wonderful part of that is that the practitioners brought fire into the classroom. They brought their enthusiasm. They saw what public health was about, the excitement of public health, that you are changing people's lives for the better. Program directors, when they saw what practitioners were bringing to the teaching program said, "My goodness, it's a win for everybody." The practitioners loved it, because they were working with students. What's more flattering than to be asked for your opinion on things, you know. So the practitioners loved it and the faculty loved it, because they were bringing in a different perspective on what it means to be a sanitarian, a water safety specialist, a professional in maternal and child health. That was one of the most unique things about the School of Public Health in the 1960s and the 1970s. Fortunately, it's continuing to this very day.

DT: That does sound quite incredible, and it seems a stark contrast to what happened, say, in medical schools and the University Medical School where the local practitioners and the Medical School faculty have not had that same kind of collaborative relationship.

RV: That's a good point. If I was to say what is the distinguishing characteristic of the School of Public Health, and I had to list three, I'd put this one as one of the first. It's not just the State Health Department, although, that's been central to the school, but it's small non-profit agencies where people have been brought in to lecture, like the American Heart Association local office, to talk about heart disease, cardiovascular issues. I think in defining the history of the school, it really is important to highlight this wonderful linkage to the community.

DT: I know you said that what makes the Minnesota School of Public Health distinctive is this particularly good relationship with the Health Department, but do you think the collaboration between practitioners and academics is a feature of public health more generally or is it something that's more distinctive to Minnesota?

RV: Let me just think about that. That's a good question. If you look nationally at schools of public health, I think it's fair to say that the vast majority of them would have collaborative efforts with health departments. I think that's a fair statement. But I think people, even from the outside, would say, "What is the distinguishing thing about the University of Minnesota School of Public Health?" Those that have followed the school, historically, would point to these amazing collaborative relationships that they have with community agencies.

DT: It does sound incredible. I know certainly in the 1960s, not just like state agencies but, also, international agencies, like the World Health Organization, as well...

RV: That's true. That is very true. That has increased as time goes on; whereas, in the 1960s, the relationships were more local. As time has gone on, they've gotten more regional and more national and, as you indicate, very much more international.

DT: I don't know if you would have experience this, but the Summer Institute courses at the School of Public Health operated, I think, beginning in the 1950s and 1960s. Do you have a perspective on those courses?

RV: The Summer Institute was truly innovative, because there were practitioners who did not want to come back for a degree program. But they wanted to learn the latest research in public health. It gave them four weeks of time, and they could make arrangements with their employer to get away. That has been enormously successful for the school.

DT: I think some of the courses, especially I think it was ground water development training, brought in a lot of international students and helped build the school's reputation internationally.

RV: That is very true. The international students who came, once again, they could come, oftentimes, just for four weeks or eight weeks, and that was all. They came and, hopefully, we did things for them, but they did so much for *us*, because they helped us learn what was going on in their country health-wise. So it broadened us as faculty, our perspective of what was going on in the world.

DT: You mentioned a little while ago that in the 1960s, there was a sense that you could pick up the phone and you would be able to talk to one of your colleagues and within the School of Public Health everyone knew each other. Could you speak a little bit more about what relations were like between the different divisions within the School of Public Health?

RV: At that point in time, there were programs, primarily. These were small programs, by and large. What is so interesting is to see the historical development. In health education, there were two faculty members: Professor Norman Craig and myself. In Public Health Nutrition, there was one faculty member: Professor Ruth Steif. In Maternal and Child Health, there was one faculty member and that was Doctor Allyn Bridge. While some of the programs had three or four or more faculty, there were a number of very small programs.

Now, how does that relate to your question, again?

[chuckles]

DT: How relations were between those different programs.

RV: Because they were small programs, faculty wanted to get to know others. They wanted to have colleagues. Well, if there's only two people in your program, you wanted to build bridges to other programs so you wouldn't feel isolated. The communication between programs was very, very effective and very good.

DT: Was there any kind of hierarchy between the divisions, do you feel?

RV: Yes, there was. The larger programs that had multiple faculty members, obviously, had larger resources. They had a larger [number of] students. It's understandable that their voice carried more weight than those in smaller programs. That was hard for those of us who were in smaller programs, but it was, also, understandable.

DT: Which ones were the largest divisions, would you say?

RV: Hospital and Health Care Administration, Environmental Health, Public Health Nursing, and Epidemiology were the larger ones.

DT: It's interesting that one of the things that is so fascinating and remarkable about public health is that it brings together a real mix of professionals. You have MDs. You

have Ph.D.s. You have nurses. You have engineers. Did you sense that there was any kind of hierarchy based on people's professional standing?

RV: No, and that's why I felt comfortable in a School of Public Health. Now, it took a certain kind of faculty member to feel comfortable in the School of Public Health, because there were so many faculty that did not have colleagues in their field. I, for example, was the only one who had a background in communication science. That was one of the disadvantages for many people in working in that kind of milieu because you did not have colleagues in your field that you could go down the hall to talk with. Now, the flip side, the good side, about that was it forced you to make colleagues in different divisions. The people who come to public health as faculty tend to be gregarious. They tend to be outgoing. They tend to be individuals who like to link up with people outside of their discipline. Now, I've seen faculty come and go in the School of Public Health who, when they got there, just did not feel comfortable. They were the *only* political scientist or the *only* sociologist and felt alone. From that point of view, it was not a good fit for certain kinds of individuals.

DT: Did you make connections then with the School of Journalism and Communication? I'm not sure when Communication and when Journalism became separate departments within the University, but were you connected to these other outside...?

RV: Yes. To answer the question, I was connected to my home department, which was Speech Communication and, periodically, I'd do seminars for them, which I valued, but I was so enthralled with Public Health and felt so at home and so comfortable there that I did not feel a need, you know, to go outside the School of Public Health. It was truly my school.

DT: That sounds remarkable.

When you first were on faculty, the School of Public Health was within the College of Medical Sciences, and Dean Bob Howard was dean of the College of Medical Sciences. I'm curious how relations were between Public Health and the other members of the College of Medical Sciences, so Nursing and Medicine.

RV: I can't go back to Dean Howard's time. I can only really speak to that in Doctor Lyle French's time. I was too young, too naïve to know about the political world of academia.

[chuckles]

RV: It took a few years. You can appreciate that.

DT: Yes.

RV: So I was too young. But when Lyle French assumed it, I was, then, in an assistant dean's role. Now, keep in mind that I was very young and I was assistant dean; so I was

very much down the hierarchy, but, nevertheless, because I had a dean title, I was able to go to meetings, and I was able to observe. In those days, I seldom spoke, but I was able to observe.

[chuckles]

RV: What I observed was *incredible* collegiality between the deans and between Doctor French and the deans. You had a sense, back there, that there were not divisions separating the academic community. There were not political divisions between Doctor French and the deans. Now, that doesn't mean they didn't, probably, have their disagreements, but I had a sense as an observer that whether you were the dean of Pharmacy or Nursing or Public Health or the Medical School, we were in this together. So there was a unified front in going to the Legislature for funding. The relationship between Doctor French and the deans was remarkable. I saw him consult with them before decisions had to be made. I saw the way they prepared budgets collaboratively together.

What was so interesting is the friendships between the deans. You could see good-natured ribbing and teasing. You could see they were friends. It was a remarkable era because there was a strong sense that, while we were in Public Health or Pharmacy or Nursing or Medicine, there are bigger issues here and that we were going to be much better off if we pulled together. So it was the Lyle French Era, as I saw it, where we came together in the sense of what is going to be best for our health center. I think that, historically, it was a remarkable development. I think, as one looks back, it is noteworthy how those deans kind of looked out for each other, in addition to looking out for their school.

DT: I realize that you were young and new to the world of academia, but did you get a sense of what the impetus had been for reorganizing the health sciences?

RV: No, because I was not privy to those discussions. What I heard was second hand, so I don't feel real comfortable addressing that. My strong hunch, though, is that a lot of that was driven by economic issues and that there was a realization that economically to go to the Federal Government, to go to the state, we were going to be better off working together than having individuals trying to represent their specific interests.

DT: In addition to the collegiality that you witnessed between the different health sciences, was there any sense that some of the health sciences had some kind of priority or were in some kind of hierarchal position relative to others?

RV: There were very strong feelings about that. The Medical School, obviously, had greater resources. Their budget was significantly greater than Public Health. There was a sense that the Medical School truly kind of represented the center and to a lesser degree Pharmacy and Nursing and Public Health. I can truthfully say, though, that in all the conversations I heard in those years—I can truthfully say this—I never heard a resentment about that. It was a fact. People recognized it. But there was such a strong

sense of respect for Doctor French and, then, David Preston and, then, Cherie Perlmutter...that people were going to be treated fairly economically. Even though the Medical School was huge, there was a strong sense that we were not going to be treated unfairly. That does not mean there weren't complaints.

DT: [chuckles]

RV: It doesn't mean that people wished more resources were flowing to their particular school. But in all the discussions I was in I never heard resentment.

DT: What led you to enter into the administration and become an assistant dean?

RV: It's still kind of a mystery to me. I was so young and so naïve.

[chuckles]

RV: Lee Stauffer became the dean, and he needed an assistant dean to help plan academic programs. For reasons that I do not understand to this very day, he chose me, and we had a wonderful working relationship.

DT: Do you remember any of the sentiment around Lee Stauffer's appointment as dean?

RV: Yes, I do. I do. I think there was a question back then of do you promote somebody from within or do you go outside the university? Now, Lee Stauffer, Dean Stauffer as he became known, was a faculty member. I think there was a sentiment that is shared whenever an internal candidate applies for a position. Should you go outside? I do remember there were discussions over that issue.

DT: Once he was appointed, how did the faculty react?

RV: The faculty reacted as faculty do. [chuckles] They were cautious, you know. Lee Stauffer's background was in environmental health, so that's where his heart was. It's like appointing any kind of dean who has got a background in a certain field, he knows that field, and are the resources are going to flow to that field? So I think there was a wait-and-see attitude. The faculty, at first, were cautious.

DT: I noticed in some of the media coverage that there was some controversy over Lee Stauffer's salary, vis-à-vis the Dean of Nursing Isabel Harris' salary, that Stauffer was getting paid a lot more than Isabel Harris, who had Ph.D.

RV: I have no recollection of that.

DT: What was Stauffer like as dean?

RV: Keep in mind, I'm totally biased. So from the point of view of you doing the historical record, I want to go on record that I'm totally biased.

[chuckles]

RV: I will try, in the context of this interview, to be as objective as I can. The question is: what kind of a dean was he? [pause] I think the adjective I would use for Lee Stauffer is that he tried to be *fair* to everyone. His modus operandi was to be as fair as he could be given economic uncertainties, given some budget issues. He honestly tried to sit back in his chair and deal with people as *fairly* as he could. I can truthfully say I never saw him make a decision based on personality. I saw him make decisions all the time on what was right for the school. Now, that caused issues and it caused problems. His perspective was the school. When program directors argued for their programs, Dean Stauffer said, "What is right for the school?" That was the hallmark of his deanship. I think you would find faculty who may not have agreed with his decisions will tell you that his mode of operating was what is first and best for the school and, second, what is best for the programs. So there would be people I saw who would leave his office who did not get what they wanted and may have harbored some resentment. In watching how he lead the school, whenever anybody came in, his first thought was how does this impact the school rather than individual programs.

DT: What did you perceive to be the major challenges that he and you and the other assistant deans encountered during the 1970s?

RV: [pause] The major issues were curriculum and economic challenges. The major issues curriculum-wise were how can we be a school of public health as opposed to eleven separate programs? From an educational point of view, those were hard discussions. If you have a person who believes in their discipline, that's what they want to push forward, and, indeed, that's what you want. You want faculty who are going to push for their discipline. What Dean Stauffer kept pushing back on was what is the curriculum that's best for the school and there was tension on that, but there was also innovation. For instance, no student could graduate without studying with other students in other fields. There was a deliberate attempt to make sure that a student in Health Education would understand students and the curriculum in Epidemiology or Public Health Nutrition. That was a major commitment.

The second was economics. The School of Public Health throughout its history has had to find money from other sources than the state of Minnesota. So, the issues, back there, where is the next source of revenue going to come from? Those were not easy discussions. What can we count on from the State of Minnesota? When we're hiring faculty, can we really count that there's going to be a revenue stream that's going to stay the same or increase from the state? Often, we did not know that, so, then there were discussions. Can we hire faculty not knowing where the next revenue stream was? Those were hard discussions. Those were hard, hard issues, back there. I know those were issues that kept Dean Stauffer up late at night thinking about them, because there were no easy answers.

DT: Yes. I saw that, at least in the 1960s, and I'm sure it was similar in the 1970s, ninety percent of the school's funding was from non-legislative funds, as you point out. So maybe ten percent, at most, from the state.

RV: That's true.

DT: Of course, as you say tuition... You weren't teaching undergraduates, per se.

RV: Correct.

DT: It was all professional and graduate students.

RV: That's right. And because it was graduate and professional students, the classes were often small, so you did not have vast tuition revenues coming in. That creates its own issues.

DT: Was there funding available through the Public Health Training Act? That was initiated in the 1950s, but, I assume it was renewed?

RV: Yes, and that was very helpful, because it provided scholarship help for students, so students could come to the school.

DT: But that didn't deal with the faculty issue?

RV: No, it didn't deal with the more substantive issue of how do we undergird, economically, the school.

DT: How do you make those tough economic decisions? What was the kind of rationale?

RV: The rationale was economic in nature. That was, as we look ahead for the next biennium, what funding can we expect for the school? What funding can we expect from the other sources? Based upon that, projections were made and, then, decisions were made that, yes, we can hire one new faculty member, or we can't hire any new faculty member, or we will not replace faculty, because we didn't feel confident about the financial projections.

DT: If a division was particularly effective at securing federal grants, they would, then, be more likely to get new faculty appointments?

RV: That's correct.

DT: I think I heard from Henry Blackburn, and I think maybe Lee Staffer reiterated it, that the School of Public Health across the University was securing more federal funding than any other unit within the University and that it was per faculty member.

RV: It's remarkable what faculty...the amount of federal money they bring in. It consistently ranks the highest among schools of public health. It's truly amazing.

DT: Obviously, as you mentioned, if you're dependant on federal funds that aren't necessarily guaranteed recurring funds, then you don't have the ability to hire tenure track or tenured professors. You're limited to hiring temporary.

RV: Well, when you don't have a dedicated revenue stream, you have to be much more cautious in your hiring. But for most of the history of the School of Public Health as I have known it, by and large, those decisions were rationally made, and, by and large, the financial projections that were made permitted the hiring of new faculty, tenure track as well as tenured people. So it was just one of the constraints that made this School of Public Health very unique.

DT: Do you have a sense that other state schools of public health were getting similarly low funding from their home states?

RV: At that point in time, I honestly don't know.

Do you want me to go into more depth or do you want me to go into less depth or just like we're doing?

DT: If you have more, then, great.

RV: I can tighten it up, if you want?

DT: No, it doesn't need to be shorter. The more, the better.

RV: All right.

DT: The economic challengers must have been particularly profound, because President [Richard] Nixon and, then, President [Jimmy] Carter were consistently trying to cut federal funding to the health sciences, the way I understand it.

RV: Yes. It's what makes the Academic Health Center unique to most other parts of the University, and that is it is so contingent and dependent upon external sources of funding that, by and large, we have very little control over. It made financial projections incredibly difficult. I had colleagues in other universities in other schools where ninety-five percent of their money is dedicated money that comes in just routinely from the state or from tuition revenues, and they can make plans. When I tell them about the uncertainty of our finances in an academic health center, they truly, oftentimes, say, "I don't understand how you can operate. How do you operate in that milieu?" Fortunately, the Academic Health Center has been *so* good at being able to operate in an uncertain milieu. I give so much credit to Frank Cerra and the kind of deans that he has hired and the deans have hired department heads, who say, "That's just the way it works." It doesn't do any good to complain about it. It's just the way it is. Our funding

comes from multiple streams. We make the best projections we can, and we have to let the chips fall. I do know that it caused a lot of sleepless nights for people in key positions. It's difficult.

DT: As assistant dean, what were your primary responsibilities?

RV: It was curriculum development and working with program directors in hiring new faculty.

This is important... We were moving in the 1970s, and mainly in the 1980s, from a milieu of teaching to a milieu of research. So we needed faculty with very different skill sets. We needed faculty who knew how to write grants, how to obtain grants. Now, in the 1960s, by and large, and in the early 1970s, the school was insular. This is where we worked. But, then, it became apparent that if we were going to thrive, we needed to move into the world of research. This was an incredibly significant development for the school. It meant hiring faculty who had research skills, who felt comfortable in that kind of world. The good thing that came out of that was that, now, we had to link ourselves to other institutions, and we had to link ourselves to Washington, D.C., in ways that we had never done before. Now, we started looking for faculty who had ties to North Carolina, to Michigan, and who could work collaboratively with public health faculty in other schools. So, we started having discussions with faculty in other schools. While the school was quite insular in the 1960s and 1970s, now that changed dramatically as we moved from the 1970s into the 1980s. It was an *incredibly* important moment, historically, for the school, because, now, we were hiring faculty who did not come out of a Minnesota tradition. They came out of other academic traditions, so they had other ideas as to how to do things. They had other colleagues. They had networks. This was just a marvelous, marvelous development for the school. Instead of just being a state school, we became a regional school. Then, instead of being a regional school, we became a national school. Now, I would say, we're becoming an international school in ways that we've never done before.

DT: This transition, this shift towards an emphasis on research and less so on teaching, do you feel that was the result of the economic situation, that the school's funding stream would come from research funds, and that's why it moved? Or was it something else that was pushing for that shift?

RV: The reason that the school moved from a teaching school to a research-based school had to do with multiple factors. One, it had to do with the faculty that were being recruited, who valued research. Second, it had to do with the leadership of the school. When Professor Robert Kane became dean, he had a strong research perspective, which was needed by the school at that point in its history. It was a research perspective, so research became valued. You ask the question, "How did this all come about?" It came about, I think, first because of the hiring of new faculty and, second, because of the dean that really valued research, and, subsequent deans. Then, the third component, like you mention, was economic: if we were going to have a strong school, we had to have a stronger economic base. We realized that one of the ways to have a stronger economic

base was to be able to successfully apply for research grants. So it was a combination of all those factors.

DT: Did that create tensions between faculty, say the faculty who were more oriented towards being teachers versus those that were interested in research?

RV: Yes, there was tension between—quote—the “teachers” and the “researchers.” The tension was that if you were to move up into the hierarchy in the professorial ranks, you really had to be a researcher. So people whose careers were more oriented to teaching had some rather strong feelings, because they did not have the research skills. They were not educated that way. Research was not, oftentimes, in their value system. So there were bumps and there were bruises with teaching faculty. Now, the good thing, though, was that, at its core, the school has never lost its commitment to teaching. We did have faculty that were promoted, primarily, because they were really good teachers. While there was tension—it’s nice that you pointed that out, because that was a key development—between the researchers and the teachers, I think it was a natural progression for moving from a training school to a modern-day, research-based research university.

DT: It’s very striking to me that this same kind of transition was happening in the School of Nursing, at this time.

RV: That’s right.

DT: I haven’t, yet, fully explored the College of Pharmacy and the School of Dentistry, but I expect that there was a similar transformation, a shift from training to research.

RV: That’s absolutely true, and I think you’re going to find that, historically, all this happened at just about the same time.

DT: I know that within the history of science and medicine, a lot of credit is given to the Federal Government’s massive investment in research after World War II.

RV: That’s right.

DT: What’s interesting to me is that at the height of the Federal Government’s investment in research in the 1950s and 1960s, the School of Public Health was still very much prioritizing training, as you mentioned, and the School of Public Health’s transformation came a little later.

RV: That’s right. It really began with hiring faculty who were being educated in a research tradition. That changed the culture of the school and I think very definitely for the better.

DT: You mentioned a little while ago in relation to this, also, the hiring of faculty from other institutions and this helped create a culture in which the faculty were collaborating with others outside.

RV: Yes.

DT: I wonder if that's, again, something that's particularly distinctive to public health research, because so much of public health research is broad-based...it's population level, so there is a need to collaborate beyond just the local.

RV: That's right. So many public health issues and problems are national problems. You can have a Minnesota perspective on a national problem, but you're so much better off if you have national perspective on a national problem.

DT: I'm most familiar with the work at the Laboratory of Physiological Hygiene and, later Epidemiology and what epidemiologists do is these multi-centered national and international studies that seem to epitomize so much about what public health research is.

RV: Yes.

DT: You were promoted to associate dean and, then, executive officer of the School of Public Health in 1976. Did your responsibilities change with that?

RV: As assistant dean, I was focusing, primarily, on curriculum type issues. As associate dean, I was more an operating officer of the school. My relationship with the program directors was much more frequent. It was moving beyond curriculum to budget, to policy issues for the school. So there was increased responsibility.

DT: You mentioned a while ago that you were able to go to meetings across the health sciences. Did you speak more in those meetings? Did your responsibilities in those meetings change?

RV: Yes, they increased. As time went on, I was asked to chair committees for the Academic Health Center and chair search committees for the Academic Health Center. As time went on, those responsibilities increased.

DT: You mentioned the challenges that the School of Public Health faced. Were there particular challenges that the health sciences at large encountered, say during the 1970s and early 1980s?

RV: Let me just think about that a minute. [pause] I'm trying to make sure that I get this right, historically accurate. What happened in the 1970s is so different than in the 1980s, so I want to make sure it's accurate.

I would say that, from the Academic Health Center's point of view—it's a priority to this day—there was a strong priority of having good communication with legislators. That

was Doctor French's *incredible* strength. He could go over the Legislature, and he could talk to a legislator that was from an urban area in Minneapolis to somebody who might be a farmer in the western part of the state, and he could talk to them in ways that they understood what the Academic Health Center needed. So the priority was economics. That was what was driving a lot of things, to make sure we had good relationships with the Legislature. I think it's fair to say that this emphasis has continued to this day. As I saw the Academic Health Center evolve, one of the ways that it evolved was that we had to keep those relationships really strong with legislators and state government officials.

DT: Was it ever the deans that were the ones communicating with the legislators or was it always through Doctor French?

RV: Generally speaking, Doctor French was the point person. That seemed to work very well. In subsequent years, deans would testify. Doctor French had such *stature* in the Legislature. When he talked, they knew Doctor French, you know. He was so effective that I think it was best that he really was the point person.

DT: I'm glad you brought up the relationships to the Legislature. One of the things I've seen in looking at the history of the institution is that, as the reorganization and expansion of the health sciences was going on in the 1970s, a lot of that was tied in with building expansion, too. Around the mid 1970s, some legislators started getting a little wary of how much money the University was requesting in order to build new health science schools. I know there was particular controversy over Unit F, what became Unit Densford.

RV: Yes.

DT: What was your take on that?

RV: [pause] I wish I could tell you. That issue just escapes me. I can't remember. I do remember, though, what you're talking about, but I can't give you any insight.

DT: That's just fine.

In the archives, I saw that you were involved with the Health Systems Research and Development Advisory Committee. Do you remember that at all?

RV: No.

DT: I thought it might just be some random committee, but it sounded interesting, so I...

RV: No.

[laughter]

RV: Keep in mind, I've been retired for five years and these things you kind of forget.

DT: No, no, that's why I gave said it with a caveat, because I realize that not everyone remembers absolutely every committee that they were on.

Within the School of Public Health, something that I have been particularly curious about was the relationship between Public Health Nursing and the School of Nursing. Can you talk about that relationship at all?

RV: Well, yes. [For many years they co-existed. Public health nursing students would enroll in courses in the School of Nursing and nursing students enrolled in the School of Nursing would come to Public Health for part of their studies. Faculty from both schools would serve on student committees.

But it was always an uneasy relationship. Finally the question was addressed: Where should public health nursing be located in the Academic Health Center? There were two points of view. First, there were many who felt that the administrative home for public health nursing should be in the School of Nursing. The second point of view was the opposite: public health nursing should continue to have its administrative home in the School of Public Health.

The discussions were difficult. Faculty had rather strong opinions about where public health nursing should be located. Practicing public health nurses who were alumni of the School of Public Health also had rather strong opinions—most wanting public health nursing to remain administratively in the School of Public Health. What were the pros and cons of the arguments?

Many made a strong case that public health nursing should have its administrative home in the School of Nursing. Why? The faculty in the School of Nursing were larger in numbers than what was in public health nursing. This would provide additional educational opportunities if public health nursing was located administratively in the School of Nursing. Furthermore, research in nursing practice was progressing rapidly in the School of Nursing and could encompass public health issues. The fact that most public health nursing programs in universities across the nation had their administrative home in schools of nursing lent credence to the belief that the proper place for public health nursing was in the School of Nursing.

On the other side of the coin many felt that public health nurses should be educated in a school of public health where they would have curriculum in broad public health disciplines such as epidemiology and environmental health. Plus public health nurses make up the backbone of public health practice. In some communities the only public health presence are public health nurses. So why shouldn't the bulk of their education be in public health?

I must candidly admit that in my 34 years of being in the School of Public Health, this was one of the most difficult issues for me personally. I knew that if the decision was made for public health nursing faculty to be located in the School of Nursing, some of

our very, very best faculty would be leaving the School of Public Health. These were good challenges. I also worried about the financial implications of losing so many students.

In the end an administrative decision was made to relocate the public health nursing program into the School of Nursing. When faculty moved from the School of Public Health to the School of Nursing it *was* indeed a loss. But it was in my opinion the right decision. Fortunately public health nursing students are still receiving curriculum taught by public health faculty. But the public health nursing students are benefiting from a large research oriented faculty in the School of Nursing—who are focusing on *nursing* issues. It was a painful time. It took time to sort everything out. But in the end, I believe it was a wise decision to relocate public health nursing into the School of Nursing.]

DT: Looking through the archival documents, I think that question about why is Public Health Nursing not in the School of Nursing was a question that was raised by the National League of Nursing [NLN] who was accrediting the school.

RV: That's right. I had forgotten that. I remember NLN raising those issues, [which was an impetus for addressing the future home for public health nursing].

DT: When did you leave the dean's office?

RV: I left the dean's office in 1980.

DT: What led you to that decision?

RV: Fundamentally, I value teaching. I became so involved in administrative issues that I could no longer teach. Teaching, to me, is why I went into academia. I missed it. After eight years or so of being in the dean's office, I felt like I had to get back to my students. I had to get back to the classroom, because that's what I love.

DT: So you went back to Hospital and Health Care Administration?

RV: No, I went back to Health Education. Then, later on, I went into Hospital and Health Care Administration and taught in that program.

DT: I realize, before we move on, I have some more questions, actually, about the 1970s. I think in the early 1970s, as part of the reorganization, there was some effort on the part of various individuals in the health sciences to establish a school of allied health professions?

RV: Yes. I remember that distinctly. Yes. There were very strong advocates of that. There were others who did not feel that the disciplines involved merited their own academic discipline. Those were difficult discussions. I remember very distinctly those issues coming up and very, very strong opinions on that both ways.

DT: Are you comfortable identifying who was for the school of allied health professions and what their arguments were for it?

RV: [Many faculty who were teaching in such disciplines as physical therapy, occupational therapy, laboratory medicine, felt strongly that their disciplines were as important as other disciplines and should have their own administrative structure. Others felt that these disciplines were so basic in medicine that they should continue to be administratively located in medicine. Providing a separate administrative home would, in this perspective, threaten the concept of the health care team working together for the good of the patient.]

DT: I've seen documents from so-called allied health professionals, particularly those that were in the Department of Laboratory Medicine and Pathology, for example, the Department of Physical Medicine and Rehabilitation. Obviously, a lot of these allied health professions were already working in very close concert with physicians. The occupational therapists and the medical technicians were writing to, I guess it would have been, Lyle French saying, "We don't actually want to be in a separate school. We want to stay where we are, because we function here."

RV: Yes. It was so interesting because there were faculty in those disciplines who just said, "Why do we need to have a separate administrative entity with the bureaucracy and new people to report to?" Many of the faculty were very satisfied with their relationships. Others took a much broader view, and they said, "What's good for our discipline?" "What's good for our profession?" "Where are we going to be ten years from now?" They had a very different perspective.

DT: That's interesting because that debate over a school of allied health sciences is ... I believe they are going to be getting a school. I was in a meeting recently where there was discussion that it was finally going to happen.

RV: I have no knowledge of this.

DT: I don't know if that's for certain. I just heard it, and I find it interesting because forty years ago, it wasn't so clear cut what was wanted.

I saw that Bright Dornblaser was particularly vocal in promoting the existence of the school, wanting a school of allied health sciences, but within the School of Public Health.

RV: Bright Dornblaser is an absolutely *amazing* individual. He lived and breathed hospital administration. I can truly say when I think of all my colleagues who really cared about other disciplines, Bright Dornblaser comes to the top of the list. He comes right to the top of the list. He's one of those wonderful, rare individuals who could step aside from his role of being an advocate for his discipline to say, "What's best for the school? What's best for the Academic Health Center? What's best for allied health?" I learned a lot from him. He had this global view that was not provincial.

DT: I've been trying to reach him, but I haven't had much luck yet. [chuckles] I'd very much like to talk to him.

RV: I hope you can, because he had such a broad perspective.

DT: His name appears many a time in the archival record, not just related to public health but, as you say, for the health sciences more generally.

Speaking of doing what's best for others in the health sciences... Going back to the issue of nursing, I know the School of Nursing worked very hard through the 1970s and the early 1980s to get a Ph.D. program established.

RV: Yes.

DT: Were you involved in those discussions at all or do you have some perspective?

RV: Minimally. Do I have a perspective on that? I felt like it was the natural evolution, that they really did need to have a doctoral program. I remember speaking in support of that. But I was not involved in any of the negotiations or curriculum planning.

DT: It seemed like they had a difficult time making the case.

RV: They did, but they were persistent. That I do remember, how persistent they were, and they, finally, got it through.

DT: I've seen evidence that several people in Public Health and faculty in Medicine, too, including the deans, supported the idea.

RV: Yes.

DT: At some point during the early 1970s, the program in Hospital Administration, their master's program...they wanted to change the name from Hospital Administration to Health Administration or Health Care Administration. Did that come up to the dean's office at all, that decision, or was that really just located within...?

RV: That did come to the dean's office, yes.

DT: What were the issues involved there?

RV: Minimal from my perspective.

You've really got a good understanding of the issues. This is a marvelous interview.

DT: Likewise. The key, I always think, to a good interview is to have done good research, have good background information.

RV: Your research...I just can't tell you how much I admire how you approach this.

DT: Well, thank you. [chuckles] I ask these questions and I get wonderful responses.

RV: The reason you're getting wonderful responses, though, is you really are honing in on the crucial things. The things that we've talked about from a historical point of view, you've honed in on. These are the issues.

DT: Well, good. I'm glad to hear that.

RV: These are the issues, historically.

DT: That's what comes out from reading the archival documents. You kind of see where the tensions and the issues were and, then, it's crucial then to get the perspectives of people who lived through it, went through it. Not everyone has the same perspective going through it, because there were tensions, so it's critical for me to try and get a broad representative perspective on things.

RV: Just parenthetically... Do you get widely divergent perspectives on certain issues?

DT: I haven't to a great extent so far, I think probably, in part, based on who I've interviewed so far, and who is around. I have had some divergent opinions, and I think that's, in part, grounded in different personalities with different perspectives.

RV: Sure.

DT: Taking, for example, the issue of Public Health Nursing... I've asked former School of Nursing faculty members about the issue and, obviously, I've asked some public health nurses, members of the School of Public Health, about that issue, and you do get the response from both sides.

RV: Depending on where they were.

DT: Yes. That's a good example where the issues that you identified, they play out, too, in the interviews. More often than not, I'm seeing confirmation across interviews. There are going to be nuances in people's perspectives, certainly, if there's an issue that everyone else has seen the issue, too, and some people have better memory of it or were more involved with it than others.

RV: Let's take another issue, like the issue of moving from training to research. I would presume there, there's kind of unanimity in the sense that... Or not necessarily?

DT: That's what's so fascinating. What's one of the great things about this interview is... People have talked about it around the edges, but no one encapsulated it in the same way that you have to make it such a clear transition. As soon as you say it, it makes sense, based on what I've seen in the archives, but the way you describe it and the

philosophy behind it, I think that's a unique perspective. Yes, if I, then, went and asked the question, "Was there a shift from training to research," everyone would be like, "Oh, yes, there was that shift." [chuckles] People I've spoken with have said when Bob Kane became dean that there was this new focus toward research.

RV: Yes.

DT: That, I definitely heard, but not everyone has put it in such positive ways. [chuckles]

RV: That's where personality comes in because they're talking about how it may have affected them.

DT: Right. Yes. This is one of the benefits of talking to someone who's in the dean's office and had a different perspective on it than someone who was just within the program. It's interesting... Faculty from different programs—they've admitted this—their perspective is limited to what happened within their division.

RV: Yes, that's their world.

DT: There was a sense that the divisions were separate in many ways, because they had different disciplinary backgrounds.

RV: Yes, that's right.

DT: So a lot of people said, "You have to talk to Bob Veninga." They said, "I don't know about the school question or the health sciences question, but talk to Bob Veninga and talk to Lee Stauffer. They are the ones who will tackle that for you." I found that to be the case more so with the School of Public Health than, say, with the people I've interviewed from the School of Nursing. The nurses I've interviewed are far more aware of what was happening big picture.

RV: More global.

DT: Yes. It makes sense because nursing has a unified body of knowledge.

RV: That's right.

DT: On the Medicine side, I've mostly interviewed people from the dean's office, so I haven't, yet, spoken to so many faculty members. I will be curious to see how much of a global picture some faculty members have.

RV: It must be interesting as an historian for you. How do you tease out the natural biases because of where people were located? That must be a tremendous challenge.

DT: What's interesting is I've found that people are very honest about... As you said, "I'm biased about how Lee Stauffer was as a dean."

[laughter]

DT: Well, of course. One would expect that. People have been very honest about expressing their biases. They may not have said, "I'm biased," but "This is just my perspective and my perspective comes from my particular experience." People have been very honest about that. I think for people reading the interviews... I mean, a lot of historians can read those biases and understand them. Again, that's why it's so critical for me to go out and interview as many people who had a different role, so interviewing staff members, not just tenured faculty, not just people in the dean's office.

RV: When you first told me...I can't remember how many interviews you were...

DT: I've done twenty-eight so far and many more to go. [chuckles]

RV: I was a little overwhelmed. I thought to myself, do you really need to talk to that many people? But, now that we're into it, I can understand why you really do have to. This has to be multiple interviews to kind of tease out the biases and all that.

DT: Exactly. The more interviews I do, say, in Public Health, there will be consensus between the interviews about the major things that happened or the issues that took place or some of the tensions. While reading just one interview in and of itself, you might say, "Well, this is just that person's perspective. How do I know how representative this perspective was?" But if you see that repeated over and over, well, then, it probably did happen that way.

RV: Because it's been repeated three or four, ten times in the interviews.

DT: So, as you say, you can discern the biases, the unique perspectives. Also, there's a value in saying, "What are the shared narratives of people?"

RV: The historical time period that you're concentrating on would be?

DT: The 1960s, 1970s, and the 1980s right now, really that transformation period in the health sciences, trying to understand what led to the creation of the Academic Health Center and what the consequences were of that reorganization, how it influenced things within the different schools, within the different programs. Ultimately, the goal will be to bring the history very recent, going into the 1990s and 2000s, but, for my purposes, I think what's most valuable right now is getting that earlier history. Some of the people I've interviewed have been at the University since the 1940s, so getting the perspective on the 1940s and 1950s, too.

RV: That's amazing.

DT: It's incredible.

[laughter]

DT: I have a few more questions if you have the energy for it.

RV: Oh, sure, yes. This is fun.

DT: Oh, good.

RV: This is enjoyable.

DT: For me, too.

Within the program in Hospital Administration, I saw that the Center for Long Term Care Administrative Education was established in 1972.

RV: That's right.

DT: I interviewed Ruth Stryker-Gordon.

RV: Oh, good.

DT: She gave me some good perspective on that.

RV: Yes.

DT: I'm curious, from the perspective of the dean's office, what prompted the establishment of that center?

RV: What prompted it was—so much relates to economics, as you know—that even back then, not to the degree it is now, there was an aging population. So we had nursing homes springing up all over the country. At that point in time, it was nursing homes. That was the era where we were starting to talk about residential centers, people aging in place. So there was just this whole new movement. The administrators of these places—I don't say this pejoratively—tended to be people who just cared about older people and they'd set up their homes, but they weren't trained. They were not educated. Due to Ruth Stryker-Gordon and Ken Gordon, there was really...don't we have an obligation for this part of the health industry to be training individuals who can run and administer these things? That was what precipitated this whole interest and commitment to long term care administration.

DT: My understanding is that they were able to secure a good amount of funding to support the program, at least in the beginning?

RV: That, I don't recall. I don't recall how we got that going.

DT: Another innovation within Hospital Administration in the 1970s was the Interdisciplinary Studies Program [ISP] that Vernon Weckwerth was...

RV: Oh, yes. That was a huge development.

DT: Do you have any perspective on that?

RV: Incredibly positive. There was a strong feeling that we really weren't educating administrators in small rural hospitals. We just weren't educating people who were in charge of community health departments. The way the curriculum was set up is you had to come here for at least eleven months, and, oftentimes, then twenty-two months. If you're an administrator in a small rural community, there is no way that you can just pull up and come to the University of Minnesota for that length of time. Vernon Weckwerth, to his great credit, formed this program. As you know, it's just, literally, served hundreds and hundreds of students so that they could get a credential in administration that they would not ever have had a chance to get.

DT: The program was sort of an extension course? How did it work?

RV: I have to refer you to Professor Weckwerth on this point. It was more continuing education. That's kind of how it started out and, then, gradually moved into credentialing and, then, moved into a degree program.

DT: As I understand it, it attracted not just regional students but international students.

RV: International students. It was a very, very strong program just because it met a specific need that practically no school of public health was meeting.

DT: That's what's so striking. There are just so many innovative things that the School of Public Health was engaged in in all the different divisions.

RV: Yes.

DT: It really does seem that the Minnesota School of Public Health was really up there.

RV: Well, I think it's a fair statement. To use a word out of the business community, that School of Public Health has been populated with entrepreneurs, and there's a sense of entrepreneurship in the school to this day. If you have a good idea and you could figure out ways to get funded, you could start an Interdisciplinary Studies Program, as Bob Schwanke did—you probably have come across that name—or the wonderful program that Vernon Weckwerth started. So there's entrepreneurship. I think, historically, it's fair to say, if you look at the School of Public Health and you say, "What differentiates this school from many other schools of public health?"—that's not to minimize the great things that are going on in North Carolina and Michigan, which I know about—this is a school of entrepreneurs, of people who can get an idea, run with it,

figure out how to get the thing funded. And to the University's credit, minimal roadblocks put in its way.

DT: A while ago in the interview, you credited the support of the vice president of the health sciences office. Do you feel that that's Lyle French having done that? David Preston and Cherie Perlmutter...?

RV: Yes, and I'd say that—we haven't talked about this—one of the really key factors of Lyle French's leadership was that he was able and willing to delegate to Dave Preston and to Cherie Perlmutter things that needed to be done. They may have been associates or assistants, but that was in name only. I saw deans all the time calling up Cherie, "I need some advice on this." When Cherie spoke or Dave spoke, they knew that Lyle was going to back them up. It was a wonderful threesome there, just an incredible threesome, because they spoke as one voice. Both Dave Preston and Cherie Perlmutter had the authority to say, "No," on issues and they had the authority to say, "Yes," on other issues. So decisions could be made. The way the history of the Academic Health Center was is you could make decisions fast and you could move fast on things, because we did not have all these layers of bureaucracy. If you had an idea, and you were—quote—an instructor, weren't even a professor, you could take that to the dean of the School of Public Health. You could go right to the Gaylord Anderson and you could go to Dave Preston and say, "I've got this idea." It didn't have to be reviewed by countless committees. I think that, historically, was one of the hallmarks of why this entrepreneurship attitude and spirit was in not just the School of Public Health but was throughout the *whole* Academic Health Center.

DT: That sounds incredible. Cherie Perlmutter was interim vice president for some time, as I understand, in the 1980s.

RV: That's correct.

DT: Another innovation was the Center for Health Services Research, as well.

RV: That's correct.

DT: Can you speak about what led to the establishment of that center?

RV: Yes. Now, we're moving more and more into the era of research. While public health...the research that was starting to be emphasized was in specific entities, such as cardiovascular disease, cancer, water pollution, air pollution. Now, all of a sudden, there was a feeling that research had to be done on health policy. This was new. This was an important part of the evolution of the Academic Health Center and the School of Public Health. Who had thought we need research into health *policy*? I mean, back in the early 1970s, few thought that way. They, obviously had policy interests, but no one thought we need to research policy, that the policies that are being developed at the state level are really going to impact low-income people. They're going to impact kids in our schools. So the impetus behind that was that the school needed to study public policy. It was a

marvelous development for the school. John Kralewski was incredibly successful at getting a strong group of faculty together. It was a major historical development for the school. Once again, it's the entrepreneurship attitude. John Kralewski was an entrepreneur, essentially. He had an idea. It was an idea that was embraced. I think, historically, that you can trace that in other schools; it's not just Public Health... Amos Deinard, in the Medical School, was concerned about children's oral health. He was a faculty member in the Medical School, but he could bridge right on over to Dentistry. You'd have an idea. You'd go for it. You'd figure out how you could fund the thing. There was this wonderful spirit of go-for-it. Now, we also had some ideas that were out of the norm.

[laughter]

RV: There were times where we just had to say, "No, that does not fit public health. It might fit some other place in the University, but it's not public health. But, by and large, the attitude was just say, "Yes," if it's viable. Historically, I go back to Stauffer's influence. He really did have a just-say-yes attitude... if it seems viable, if it seems fundable, and if you know that it fits into the framework of public health

DT: Kralewski, was he recruited to the University?

RV: Yes.

DT: And, then, he developed the idea for the Center for Health Services Research or did he come with that?

RV: I believe he was recruited specifically to get this off the ground.

DT: I'm going to be speaking with him.

RV: He'll be a great interview.

DT: Yes, I'm looking forward to it. We're just trying to figure out schedules right now.

[break in the interview]

DT: ...of the School of Public Health, but it strikes me as having relevance to public health was the establishment of the program in Human Sexuality in the early 1970s.

RV: Yes, I was not involved in that.

DT: It's been tricky to find out who was involved, so it's a question that I ask pretty much everyone.

RV: It was important to development, though, historically, for the Academic Health Center. That program was known nationally. It really had a very national audience. It

was looked upon as one of the innovative things going on at Minnesota. I remember distinctly going to professional conferences and people saying, “What is that about sexuality that’s going on there?” [laughter] They were just curious. “How does that fit into everything?” It had national implications.

DT: There was some controversy in the mid 1970s, late 1970s, where a couple of the regents were unhappy with the program.

RV: Yes, I remember that. It seemed out of the norm for the University to be involved in those kinds of issues. It just didn’t seem right. Several of them were vocal about it.

DT: But it prevailed.

RV: It prevailed.

I know we talked about economic issues, but I wonder if you had any more to add about the severe retrenchments that took place in the early 1980s.

RV: It was tough. It was tough. Public health as a field was really coming into its own in the 1980s. So we had the establishment at the federal level of public health initiatives, particularly in maternal and child and health. All of sudden, public health is starting to have a big presence nationally, and, yet, we had to retrench. So it was a tough time. It meant rethinking the kind of faculty we had, the kind of programs we had. It meant that the entrepreneurial spirit had to be squelched somewhat. It was hard on faculty. It was hard on the administrators. It was a difficult time.

DT: I have this statistic here that, in 1979, only a third of the school’s faculty were tenured, because of this reliance on committed funds.

RV: Yes, that’s right.

DT: An issue that seems to have come up a lot in the health sciences was that space was a premium.

RV: Ha, ha.

DT: Maybe this was particularly the case with Public Health, because...

RV: Oh!

DT: ...you were located in many locations. So what was the space situation like?

RV: The space situation was that the School of Public Health was located in *so* many different places and buildings. I don’t know how many different locations I was in my career, but here, there, and everywhere. It was very hard, because you didn’t feel like you were together as a faculty, and you didn’t feel like you had a common meeting place.

You didn't have a common cafeteria to go and have lunch with people. You didn't have common places to talk. It was very hard and, to this day, it still is a very perplexing problem. I think to some degree, it's been diminished somewhat.

DT: I interviewed Bob Howard at the very beginning of this project. He made a comment that I found really profound and surprising that his power as a dean rested largely in his ability to assign space.

RV: Well...

[chuckles]

RV: There's the old saw, you know: if you can get a parking space for faculty, you've accomplished a lot.

[laughter]

DT: Do you think that in Lee Stauffer's and any other deans in the dean's office that was seen as something that... I don't want to say in a negative way that you had power over people because you could assign space, but that was really such an important part of the responsibility of the dean's office was to assign space.

RV: No, not in the School of Public Health. I would put it in the realm of being an irritant. We'd hire a new faculty member. Where were they going to sit? They're going to sit down in the second floor of the Mayo Building. But the program is on the eleventh floor. But there's no more offices on the eleventh floor. That's why they have to sit on the second floor. I can't tell you how many discussions I had on that, you know. [laughter] It was an irritant. I never had anybody be visibly angry with me. They'd go and would say, "I just don't understand why we can't get people together in one location?" Well, there was no space, you know. So you'd go to the bottom of the stadium to find your *space*. It was an issue, though, at certain points with hiring faculty. Can I see, please, where my office will be? Well, umm...

[laughter]

RV: We have to kind of look into that matter. Will you be able to look into that before you make an offer? Yes, we will definitely do it. It was an irritant; that's how I would put it.

DT: The fact that the school was so dispersed, physically dispersed, did that hinder interdisciplinary work?

RV: Very much so.

DT: It seems that it would be a factor.

RV: Very much so, yes.

DT: Lyle French stepped down as senior vice president in 1981, 1982, I believe, and Neal Vanselow was appointed senior vice president. What was the effect of that transition, do you think, on the health sciences and on the school?

RV: That's just when I went back into teaching. I was not privy to discussions and really did not know Neal Vanselow very well.

DT: How about closer to home when Lee Stauffer stepped down and Edith Leyasmeyer was appointed acting dean?

RV: Very much involved in the discussions with her.

DT: Do you know what led to her being appointed?

RV: [pause] I can't shed light on that one. I don't know.

DT: How was her leadership style? Did it change anything about the culture of the School of Public Health?

RV: Her leadership style... Did it change the culture of the school? [pause] Her leadership style was decisive. That would be the word I would use. The good part of that was when people came to her office, they got answers and they were very direct answers. The bad part about it is they got answers that they didn't want to get.

[chuckles]

RV: It was a more decisive leadership style. I think it kind of fit with the way the school was moving. It was becoming so much more complex, that you just didn't have time to sit around and have long faculty meetings about things. It was bigger. It was much bigger. The budgets had increased, so you needed, at that point in time, from my perspective, a dean that was decisive and could make decisions efficiently. That was her strength. I think, given the dynamics of what needed to be done, it was the right leadership style for that period of time. Now, whenever you have a decisive leader, you know it creates issues for those who don't get the kind of support and information, and that happened in the school. So I think there were times in the school where people left her office disappointed, but I think it was so much more complex, at that point in time, that that kind of leadership was needed.

DT: Do you know why she was only appointed as acting dean initially?

RV: I do not.

DT: Then, Bob Kane was, subsequently, recruited from outside and appointed.

RV: Yes.

DT: We've talked a little bit about his tenure. Do you have any other perspective to share on what he was like as a dean?

RV: Well, he really moved the school forward from a research point of view. His great legacy to the school is he moved it into a research environment. Because of his leadership style, he, also, was very decisive, and, for him, research was really the critical component that would bring us to a different level as a school. For people who did not have that perspective, it was hard. I think for people who did not share that research perspective, it was more that they felt that they were going to be left out, that they were going to be, maybe, second class citizens. So that was the hard part in his tenure. But, if I was to look back over the past forty years and you would say, "Was there one pivotal figure who changed the School of Public Health?" it would be Bob Kane. I would *definitely* say he changed it for the better. I lament that there were people in the School of Public Health who did not fit into that kind of a research model, but that happens in industry all the time. It's the natural progression of organizations. But he brought that emphasis at the right time, and it was very much needed.

DT: As I understand it, eventually, the division heads, and I guess faculty, too, organized themselves to, basically, challenge his position and expressed their discontent and, basically, called for a new dean.

RV: I don't recall the call for new dean. That may have happened. I was administratively out of the loop, at that point in time. I was tending to my own teaching and my own research, so these more global issues... I think it's fair to say that because of his forceful style, his forceful personality, there were people in the School of Public Health who just had difficulty with it. I think from Dean Kane's point of view, he felt that we could be stuck, that we really could be stuck in a model that was outdated, that the only way that's going to change is if you really dramatically and forcefully move the school forward. By force of his personality, he did it. It was hard on people who did not share that type of philosophy.

DT: I think someone told me that during his tenure, he moved the program in Hospital and Health Care Administration to the Carlson School of Management?

RV: Did that happen under his administration? I don't think so.

DT: Okay.

RV: That happened under Dean Leyasmeyer's Administration.

DT: Oh. I may have the timing wrong.

Do you know why that decision was made?

RV: Yes. The Hospital and Health Care Administration faculty [felt that the School of Public Health was not supportive of their emphasis on education. I'd say one of the biggest reasons for moving to the Carlson School was, in part feeling like they were not a vital part of the School of Public Health like they once were.

But there was also a second reason and that was that the Hospital and Health Care Administration program was moving more to a curriculum that was associated with business schools. There was a strong perception that students needed in depth course work in strategic planning, informational technology, human resource management. These courses were not generally available in the School of Public Health. The Carlson School had the curriculum that future health care administrators needed. This was a big reason for the alumni and the faculty to vote in favor of moving the Hospital and Health Care Administration program to the Carlson School. In looking back at this particular era, it seemed a reasonable approach to take at the time.

DT: It was actually a program initiative rather than a dean's directive?

RV: I believe it eventually became a mutually agreed upon decision to move the program to the Carlson School. There were strong feelings about the merits of doing this on both side of the equation however.

DT: But they were only in Carlson for a short number of years.

RV: That's correct.

DT: Then they came back.

RV. Yes, they came back. They came back for a number of reasons. When they moved to the Carlson School it was an era in which quantitative sciences were being emphasized in the training of health care administrators. Finance was given increased emphasis in the curriculum, for example. But in just a few years—a very few years—the issues changed dramatically. The business model, while important, was being augmented by a more public health model. Courses in the prevention of disease, the epidemiology of illness, health care policy were needed. Increasingly it was felt that health care administration students needed the type of curriculum that was offered in schools of public health. Discussions began in earnest about the hospital administration program returning to the School of Public Health.

I think there were other reasons why the Hospital and Health Care Administration program returned to the School of Public Health. Many alumni had good feelings about their education in the School of Public Health and had some misgivings about the move to the Carlson School. Then too, there were faculty in hospital and health care administration who continued to have good ties to their former colleagues in the School of Public Health. Those bridges were not burned. When the possibility emerged about the program returning to the school there were faculty in other administrative homes with the School of Public Health who felt that this was a positive development. In fact, there were

faculty in the school not associated with the Hospital and Health Care Administration program who really lamented their moving to the Carlson School to being with. So it was a good reunion when the Hospital and Health Care Administration faculty and their students returned.

DT: You mentioned that when you were in the dean's office, you were involved with recruiting faculty and with curriculum. I'm wonder if there was much effort made towards recruiting minority students and minority faculty?

RV: There were efforts. Yes. That's really a good question. Can I digress from that?

DT: Yes.

RV: You're really on a crucial point. The emphasis was on trying to get minority students into the School of Public Health. That was felt to be an easier task than to get Ph.D. minority members as faculty. So there was a major emphasis made to get Native American students in the School of Public Health with very, very mixed and, at times, poor results. We were not very successful. We had a cooperative training grant with the University of California at Berkeley to get Native American students into the School of Public Health. Relatively few completed their degrees. But that was the emphasis mainly because we felt like we had a better chance of diversifying the school at the student body level.

At the faculty level, it was *incredibly* difficult to get Ph.D. minority faculty members. One, there were relatively few, at the time. Two, they were being recruited very hard by our peer institutions. Three, because they were so highly sought for, the salaries and benefits were clearly significant. While, yes, that was an emphasis in recruiting faculty from minority backgrounds, we did not have a lot of success in that.

DT: You mentioned in terms of recruiting and getting minority students through the programs that there were some challenges to that. What were those challenges?

RV: Well, I can talk best about Native American students. We would bring promising young Native American students who had baccalaureate degrees into the School of Public Health. There would, maybe, be two, or three, or four at a time. There wasn't a cohort, so they felt isolated, very isolated. Some of the Native American students were coming to us from colleges where the rigor wasn't there, and they were put into a graduate program where there was extreme rigor, and it was an incredible cultural shock to them. We didn't have the support mechanisms in place. I happen to be responsible for the Native American program and threw my heart and soul into that, because I really believed in it, and we were not successful. I think we were not successful, in hindsight, because we did not know Native American culture, and we did not understand the barriers that these new students were going to come to. We did not understand the tremendous gap between coming from—I don't want to say this pejoratively—a college that generally did not educate its students for graduate school, and, now, they were coming to graduate school. We did not understand the problems they would have to face.

Even though the Twin Cities has a large Native American population, we did not understand how hard it was for Native American students coming from reservations to come to an urban area to study. As I look back upon that, I think it was amazing that we actually tried and we were somewhat successful with a few students.

We just were unprepared to know how to do it. Unfortunately, we didn't build the bridges to the Native American community. You know, in the history of working with minorities, we've had this kind of attitude as white people that we can figure this out. We can work this all out without really understanding what it's like to come from the reservation or come from a small college into an urban area, to a big school, and suddenly hit them with high level statistics, hit them with high level epidemiologic models. We didn't think that thing through. We thought if we had the money to pay a stipend and had tutorial assistants for them, that, by and large, this would all work out, and it did not. When I look back upon the successes of the school and the failures of the school, I'd say that the failure of the school was, at that point in time—I think it's changed a lot—it was our failure to not just recruit minority students but to have the kind of cultural mechanisms in place where we really recognized what they could contribute to the school, not just that we didn't solve the problems for them, but what they could contribute to the school. I look back upon that with considerable lament, because we just did not do a very good job.

I remember reviewing summary documents when search committees were formed... They'd bring to the dean's office... "We have two applicants for this position," and they were white and they were males. I can remember [saying], "Let me see your applicants." "Let me see your pool list." Oftentimes, there were no minorities on it at all. At times in the 1970s, there were relatively few women involved, unless we were doing a search in Public Health Nutrition or Public Health Nursing. That was the history of that time. When the question was asked, "How come there are no minority candidates?" they would say, "There were none." "Really?" "There were none." "Really, there were none?" Then, there were times where we would find that it was a cursory review. There were other times when the head of the search committee said, "We really did look for minorities," and there was no reason to doubt it. There were times we brought in minority applicants for faculty positions, and we could tell very quickly that the kind of offers they were getting from other prestigious schools...we had very little chance.

DT: In order to recruit the students, what did you do to go out and recruit and get them to apply to the school in the first place?

RV: The University of California-Berkeley had a wonderful Native American office out there. They helped us a lot. They knew the inroads into the reservations. They knew the inroads into the Indian community. And, largely, due to their ability to screen, they really were the ones that helped us get the program off the ground.

DT: I can imagine what Native American students would bring to the program given there seem to be a number of reservations in Minnesota. I know that there's the Indian

Health Bureau [Service]. I presume that there was some role for public health workers on reservations and to have that mutual exchange would have been productive.

RV: Yes, and, by and large, back then, that didn't happen. Now, it happened in the 1990s. Out of the dean's office, there's really good relationships with the Indian Health Service. They are part of Advisory Committees, so it has changed dramatically. In terms of the history, one *rich* vein on the history of the School of Public Health would be how did we move from, first, not being interested, by and large, in minority students to making a commitment, particularly for Native Americans to where we are now, where we really do have good relationships. It would be an incredible history lesson as to how and what we learned.

When I look back upon the 1970s and 1980s from this perspective, I realize how misspoken we were and how careless we were in not really understanding and not really caring to understand about what would be the needs of Indian students who came to the school. We just thought we were doing God's work by getting them there, you know. That was where the world was, at that time. It's where the school was.

DT: Do you have a sense of why the school became interested in recruiting Native American students?

RV: Initially or now?

DT: Initially.

RV: Initially, it was because of funding. We knew that we could have a stream of funding that could be dedicated to those students, nice stipends, support for faculty. So we thought that was really viable and we could really have a good program, particularly for Native Americans.

DT: Was it at all a consequence of, say, the Civil Rights Movement and kind of broader activism about increasing diversity and Affirmative Action?

RV: No question. The experiences of the black community influenced our interest in the Native Americans, let alone that we have a large Native American population of any urban setting in the country. The black experience certainly impacted what we were trying to do.

DT: I know when the Academic Health Center was first established in 1970, that one of the first collaborative efforts across the health science units was the establishment of a program for minority students.

RV: Yes, that's right.

DT: Were you plugged into...Was the Native Health...?

RV: No, it was completely separate. I was not a part of that. You're correct; there was definite emphasis made. That was reflective of the Civil Rights Movement. It was reflective of the black experience in the country.

DT: So what the School of Public Health was doing was something separate?

RV: Something different, yes.

DT: You've given me tons of information. I just wonder if you have anything else that you'd like to add about your experiences at the school.

RV: Well, I'll just say, personally, that I can't imagine a better career. I cannot imagine a better career and a better place to have a career. I worked with terrific, terrific colleagues. When I describe my career at the University of Minnesota, I say, "I really worked with people who cared about people." I think that was why it was such an easy transition for me to move in my career from seminary and from what I wanted to do into public health. Public health people—I don't mean just to say public health; it's throughout the Academic Health Center—had the kind of values of caring for others that I just admired. I feel very blessed and fortunate that I had my career there.

DT: It makes me want to be in public health.

[laughter]

DT: Is there anyone else that comes to mind that you think I should interview?

RV: [pause] No.

[End of the Interview]

Transcribed by Beverly Hermes

Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com