

Robert Dickler, M.H.A.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

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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 Dickler was born and raised in Chicago, Illinois. He attended Western Reserve University (now Case Western Reserve) for a degree in history of religion and comparative religion. After graduating in 1967, he worked in a state mental hospital in Cincinnati, Ohio, which prompted his interest in healthcare administration. He completed a master's degree and doctoral coursework at the University of Minnesota as well as a residency program at University Hospital in 1972. He served in several administrative positions over the course of his ten years at the Hospital. He then moved to the University of Colorado as Director of University Hospital in 1981. He returned to Minnesota in 1987 as General Director of University Hospital and Clinic and Assistant Vice President of the Academic Health Center. In 1992, Mr. Dickler left the University to serve as Senior Vice President in the Division of Health Care Affairs and then Chief Health Care Officer at the Association of American Medical Colleges. He retired in 2009.

Interview Abstract

Robert Dickler begins his interview with a brief timeline of his education and career. He relates how he decided to attend the University of Minnesota and his experiences as a graduate student during a period of social change. He discusses his interactions with Gaylord Anderson and Lee Stauffer, the influence of the Alumni Foundation, and working with Vernon Weckwerth. He describes completing his residency at University Hospital as a student of John Westerman, the "virgin territory" of hospital administration education, the changes in financial support for hospital administration, and, on a related note, the changes in hospital technology. He discusses the key issues the Hospital confronted in the 1970s, including the information explosion and new levels of bureaucratic accountability. He then discusses the importance of focused governance in a university hospital and the building of the Ambulatory Care Clinic. He reviews the relationships between the hospital and schools within the Academic Health Center, with significant detail on nursing. Mr. Dickler also discusses unionization within the Hospital and the health sciences, the changing patient experience, the effects of abortion legislation on hospital policies, University Hospital's relationship with community hospitals, growing competition within the healthcare industry, University Hospital's mission, and the growth of the clinical care dollar. The interview turns toward the following topics: the 1970s (and continuing) nursing shortage, Mr. Dickler's move to the University of Colorado, the differences in hospital administration at Colorado and Minnesota, the outbreak of AIDS, structural change at Colorado, his return to Minnesota, pay equity, the tax exempt status of nonprofit hospitals, town/gown tensions, and his move to the American Association of Medical Colleges (AAMC). He describes his time at the AAMC with attention to health reform under the Clinton administration, the relationship between the AAMC and the American Medical Association. He concludes with a discussion of the relationship between Minnesota's University Hospital and the Veteran's Administration Hospital and his relationships with Lyle French, David Preston, and Cherie Perlmutter.

Interview with Robert M. Dickler

Interviewed by Dominique Tobbell, Oral Historian

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

**Interviewed at the Home of Robert Dickler
in Williamsburg, Virginia**

Interviewed on June 10, 2012

Robert Dickler - RD

Dominique Tobbell - DT

DT: This Dominique Tobbell and I'm here with Bob [Robert] Dickler. It is June 10, 2012, and we're at Mister Dickler's home in Williamsburg, Virginia.

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

RD: Born and raised in Chicago and I'll clarify...*in* the city of Chicago, not in the suburbs. I went to the Chicago Public Schools and so on. I did my undergraduate at Western Reserve University, and it was not Case Western Reserve when I went. Then, I sort of bummed around trying different graduate schools and, eventually, wound up working in a state mental hospital in Ohio, in Cincinnati, for a couple of years. That piqued my interest in healthcare administration. So I applied to a number of schools and got in. Actually, Minnesota offered me the most money, so I went to Minnesota never having been there in my life.

[chuckles]

RD: I went to Minnesota for my graduate degree and, then, decided to do my doctoral studies and applied for the residency at the University of Minnesota Hospital, because it would work much more easily. So I did my residency at the University Hospital and did my course work. I never finished my degree. I'm what's known fondly as ABD [all but dissertation].

DT: [chuckles]

RD: I was there for ten, eleven years, the first part of my career. I went to the University of Colorado as the CEO [chief executive officer] of the hospital and about six and half, seven years later came back to Minnesota as the CEO of the University of Minnesota Hospital and was there a little less than six years.

DT: What did you study at Western Reserve?

RD: History of and comparative religion.

DT: Hmmm.

RD: Very valuable.

DT: Yes. That's great news to my ears. [chuckles]

How did you end up working at the state mental institution?

RD: It was one of these round about, totally unplanned things. We moved to Cincinnati, because I went to the seminary, Hebrew Union College in Cincinnati, and discovered after about eight months that that was not where I should be.

In the meantime, my wife [Sue Dickler] had gotten a social work job at the state mental hospital in Cincinnati. While I tried to *find* myself, I applied and also got a social work job at the state mental hospital. So the two of us worked together, although, we had separate responsibilities in Longview State Hospital, which dated back to before the Civil War. The main building was built around the time of the Civil War, had its sub-basement with chains and all those good things.

DT: Ohhh.

RD: The alcohol detox [detoxification] unit was down wind from Gilbey Gin, a very thoughtful placement.

DT: [chuckles] Yes.

What about that experience kind of led you then to pursue graduate work in hospital administration?

RD: Ummm... I think I was like a lot like people of my generation. I was very idealistic, and I wanted to do good things, and I wanted to change the world. You know, this was the Vietnam War, social revolution, and assassinations, and so on. It was a pretty tumultuous time. But I also realized at some point that I had to make a living. We became good friends with the fellow who was actually serving his residency in healthcare

administration at the hospital. It was the first I ever heard or learned about the field but, the more I looked into it, it seemed like a nice combination of continuing to try and work in an arena where you could, hopefully, do some good things and help the community and population but still have a reasonable income and career track. So since, I couldn't figure out anything better, I decided I would pursue that.

DT: Can you talk a little bit about your experiences as a student at Minnesota?

RD: It was interesting because, in the world at that time, Minnesota was considered, if not *the* best program, one of the best programs in healthcare administration. There were relatively few, maybe twelve real, established programs. Hamilton Associates had been instrumental in starting the healthcare administration program and James A. Hamilton was the founder of the program and actually had left a couple of years before I came but was still brought back to indoctrinate the students and so on. So Minnesota was viewed as sort of the best place to go or one of the best places. University of Michigan had a very good program and there were some others. As I say, I went for really two reasons: one the traineeship they were able to offer me was as good or better than anything else I could get and I had no money, and two, it was a one-year-plus-one year program—one year academic plus one-year residency. I preferred that to a two-year academic program. I was getting older and I wanted to start earning some money. We were married and so on and so forth. So that's how I wound up at Minnesota and was sort of taken aback with, you know, how highly regarded the program was, and how everybody was in awe of being there and having been selected, and how arrogant everybody was about how good they were. I think it was good, but it had strengths and weaknesses like everything else in the world looking back. It was a very pragmatically oriented academic program and that was useful to me, because I didn't have that strong of a background in administration or business or public health or whatever. I was able to gain that through the academics. Then, staying on at the University was really ideal for me, given the combination of study and work that I could do. I did full time student, full time job. I'm not sure how I did it, but like a lot of things in life, you would never do it again, but you didn't pay any attention while you did it.

DT: [chuckles]

Were there any faculty that were particularly influential or notable during your time?

RD: Ted [Theodor J.] Litman was my advisor, a sociologist, medical sociology, and was probably the most influential. He really sparked my interest in continuing my studies. Vern [Vernon E.] Weckwerth, who is still there, taught statistics and was sort of the Boy Scout camp leader for the program. He would organize trips and all that stuff. Even to this day, there are certain statements that he would make that I recall and use in the course of my activity. He used to refer to standard deviations as ax handles, which I always found to be useful. Probably the one I remember the most was the difference between output and outcome. Output was the bird flapping its wings and outcome was whether he flew and reflected that we do a hell of a lot of wing flapping in the world, but we don't fly very much. I think that's absolutely true and saw it all through my career.

[Bright] Dornblaser was the program director and there were a number of other faculty. It was a small group.

It was a time of change. When we started, we were required to wear ties and jackets, because we were going to be leaders and business leaders. Ostensibly, the program only trained educated people. We were going to be CEOs, the whole orientation. By the time we left, we wearing regular shirts and no jackets and no ties. Those were *traumatic* changes that we were going through in our society.

DT: [chuckles]

RD: It's sort of silly now.

DT: What do you see as stimulating that change within the program?

RD: I think it was just the whole shift we were seeing in society from rigid protocols and you have to do it this way, because you've always done it this way, to saying, "Why?" and people saying, "It just doesn't make sense. It doesn't make sense to sit in a hot classroom in a tie and jacket and go to all the expense of cleaning your jackets and doing your ties." So, at least let us wear turtlenecks or shirts and stuff like that. It wasn't just there. It was sort of everywhere within society that we were seeing these shifts. It was a time of great questioning, a time of great turbulence, and people were sitting on the edge of being drafted to Vietnam. If you left school, you were immediately vulnerable to going to Vietnam. It was the war that nobody wanted and we, shamefully, took it out on our Armed Forces, which is a lesson I think we did learn from that time to today.

When I was an undergraduate, the first year I was there, a woman could not go past the front foyer of the fraternity house without our having a chaperone in the building. My senior year, we took a vote of whether women could be anywhere anytime within the house, which I actually voted against because it was where I lived and if I wanted to walk naked to the bathroom, I wanted to walk naked to the bathroom. But it passed.

So just in four years, we had this incredibly dramatic shift in sort of the standards that people were living by. I think that just kept carrying through.

DT: When you were a student in the program, did you have much involvement with the other areas of the School of Public Health?

RD: We had a core curriculum at that point. There was an overview course in epidemiology. Gaylord Anderson, who was the old titan of the School of Public Health, taught that. He was actually in failing health at the time. There were moments when we weren't sure whether his moment had come; he'd sort of pause and we weren't sure whether he was just pausing or he was having some problem. Then, there were small groups where we got together with nursing students, medical students, and so on. It wasn't very successful. It's still something that's being debated today. How do you teach people to work in a team and cross-fertilize the knowledge base and so on? The

disparity between the age of the students, and what they were going to be doing, their viewpoints on life, and so on was such that I've never been convinced that you can do it in the classroom. I think you can do it in a work environment, but I think it's extraordinarily hard to do it in the classroom—but we had that. We had a three-person class committee and I was the elected chair so you met with other similar committees in the school and so on.

DT: Were there any women in your cohort?

RD: A couple of nuns. I'm not saying that facetiously. That was it. I was Jewish, and I discovered they didn't know I was Jewish. That wasn't part of what was admitted either. There had been very few people who were Jewish. Really, women were nuns and no others. That, again, changed very rapidly to the better in all aspects: minorities, and race ethnicity, religion, gender. I taught in the course for a number of years. The first time I was there, it had changed dramatically and by the time I was there the second time, women were the majority and they were a heck of a lot more capable and brighter than the guys, on average.

DT: [chuckles]

You mentioned Gaylord Anderson. He stepped down as dean and Lee Stauffer replaced him. Did you have much experience with Lee Stauffer?

RD: I knew Lee very well. Actually, we used Lee's house when we were moving, because Lee was on sabbatical. We watched his kids and stayed in his house. It wasn't the easiest thing in the world. [chuckles] We were good friends and spent lots of time together. I thought Lee did a very nice job.

You need to appreciate the program in healthcare administration. It was sort of a world unto itself. It was big. It was well funded. The alumni had this incredible alumni network that supported it. Its graduates were in high demand. While we were part of the School of Public Health that was sort of a home for the program, but we viewed ourselves as apart from them, in some ways better than or the lead program in the school. I think that was unfortunate, because there were a lot of good people in the school, Bob Veninga and some others, and they had a lot to contribute, and we didn't have much cross fertilization or as much as we could have.

DT: That's been my sense of each of the units within the School of Public Health, that Public Health has been disparate units, geographically disparate on campus and, then, intellectually.

RD: Yes. It was a tough deanship. There weren't a lot of funds, it was sort of a poor child within the University. As I say, the program in healthcare administration had its own foundation, so you couldn't touch any of that money, and funded people and so on. I think the other programs were pretty autonomous, as well.

DT: So what explains the strength of the Alumni Foundation? I've heard that from everyone.

RD: I think it's something that Hamilton and his colleagues really emphasized when they first started the program. Hamilton and some others had come out of the eastern tradition where they had seen strong alumni associations in the schools. They knew how important the old boys network and connections were, and they wanted that for placements of their students for residents or projects and so on. They spent a lot of time and money cultivating people who were in the field to connect them to the program and, then, tracking graduates and following their careers and saying, "The program is always there. We'll help you find jobs and give you recommendations and so on and so forth." And, I think Hamilton Associates because they employed a number of people who graduated from the program and they went all over the country. It was a very deliberate initiative by the founders of the program. I think, to this day, it's benefitting from that. It's not as important as it was back then or as powerful. People went to the Alumni Institute and took pride in...

I remember sitting in a meeting at the American Hospital Association, where you were in a room with the president of the American Hospital Association, the president of the American College Hospital Administrators, president of this, and president of that. An individual who had gone through the program and never graduated was the head of Healthcare Financing Administration. You'd sort of have the power structure of healthcare in the room. That's pretty impressive, especially when you're young and don't know what you're doing.

DT: [chuckles]

RD: That made you want to be part of that group—and we made friends. There are lifelong friends that came out of that, not necessarily in your class, but from working with the alumni group.

DT: That's been a remarkable thing that I've gleaned from the interviews I've done so far is just how effective and powerful the Alumni Foundation has been.

RD: Yes.

DT: You mentioned Vernon Weckwerth. I saw from your résumé that you were an instructor in his Independent Studies Program [ISP].

RD: Yes.

DT: Can you talk about that?

RD: Oh, boy, that's a long time ago. I have in mind two things. I took over teaching a course that Litman had taught in the masters program, which is social, political, and economic aspects of healthcare delivery, which was the overview course...broad brush

strokes, workforce, economics, and so on. There was a need for that in the Independent Studies Program, as well. I worked with a couple other people who broke it up into chapters or components of the ISP, out of that and out of some other materials. I would say the ISP, you know, certainly has served the program very well, but it never really was something I felt was a focal point in my life and effort. I was on campus. I was at the University Hospital. I was teaching in the program and you can only bounce around in so many arenas. I did it, because Vern asked me to do it, but it's not something I spent a lot of energy trying to build up my activity level and so on, and, over time, drifted away, and other people took over the course, versus the course I taught, which I did all through my first iteration at Minnesota. It became, in effect, a core course for the School of Public Health and elsewhere. I think my last year, I had 200 plus people in it.

[chuckles]

RD: That got a little silly, because...

[break in the interview]

RD: I taught that core course. Yes, it was great. I enjoyed it. I got to the point where I encouraged students not to complete the course.

DT: [laughter]

RD: You know it's an incredibly short time period to read the paper and read the blue books. We did blue books then.

DT: We still do.

RD: I just couldn't do it. I'd sit up two, three nights all night reading that stuff.

DT: Why didn't they give you a T.A. [teaching assistant]?

RD: Well, I was a freebie, and they figured they could get away with it. I said, "Look, I'm fine with an incomplete, send it to me anytime." Just don't make me read them all in one go.

[laughter]

RD: It was great and, of course, you needed to keep up with the literature and with everything, which tied into my Ph.D. studies, which was also good.

DT: You mentioned earlier that you had the residency at University Hospital. Was that a competitive process to get that residency spot?

RD: You applied and there were a number of applicants, were interviewed by the senior staff, and I was fortunate enough to get it.

DT: What were your responsibilities or what did you do in the residency?

RD: It was pretty free form. You sat outside John Westerman's office with Shirley Sudduth, his secretary, and it was everything from being his gofer, get the car and drive me to this meeting and this and that, to research this, to I'm on a certificate of need committee and I need this somebody to read all the stuff and summarize it for me, so you did that, to I want you to go to every department in the hospital and spend a couple days. I want you to go up on Nursing and spend a week. I want you to do this. So it was quite varied, very diverse. But the way it was handled and structured, I was in more meetings and really had access to meetings that nobody else would have access to, other than the CEO, because John never thought twice about taking you. But since I was a student in the University, nobody ever argued with a student having access; whereas, if I was an assistant administrator, an associate administrator that would be different. So whether it was with Central Administration or other University officials or other hospitals or whatever, John really provided the opportunity for *enormous* exposure to *all* aspects of what running a hospital and functioning within the community, and planning, and so on was all about. It was just a terrific experience. You had to be a self-starter. John didn't tell you what to do. John didn't give you a weekly schedule. You had to keep yourself going. He drops lots of stuff on your desk. You always did all the questionnaires. You also learned a lot from that. John was maybe—this was true all the time I worked for him—the best delegator I've ever encountered in my life. He could say, "Take care of that," and he'd, literally, just walk away from it. If you needed his advice, you went to him and you chatted about it. Otherwise, he sort of waited for it to be done. I was never able to get to that level of proficiency of delegation. I worried a little too much. I wanted to know what was going on.

DT: [chuckles]

RD: So it was a great residency.

Then, fortunately, I was able to stay on the staff and did this nice progression. Again, John had a philosophy that you should be generalist, so you kept changing your areas of responsibility with great rapidity, every year or two. By the time I left as senior associate director, I, basically, had been everywhere and done everything in the Hospital. It was great preparation.

DT: That's quite distinct from what the other general tendencies within healthcare were at that time...to specialize and to just kind of focus on one area.

RD: Certainly on the medical side. But the administrative side, this was virgin territory. You've heard the term cottage industry. It truly was a cottage industry. There's a fellow named Dennis Countryman, who was on the staff. He put together the first set of financial books for the Hospital. We never had a balance sheet. We never had an income statement. But, with Medicare coming in and Medicaid coming in, all of a sudden, you're having to do cost reports and all of this stuff. We began to have to do business-

like things. People didn't think in terms of marketing, finance, support services, operations. That was evolving. Things were very intermingled and crossed over, except for the clinical area. Nursing was clearly nursing and the physicians were clearly physicians. But the administrative realm was just beginning to try and figure out how to function in this new era.

When I came back the second time, one of the things on the bookshelf—I'd never seen it before—was the original ledger of the Hospital. Such and such a patient had such and such...a dollar ten cents. Such and such...twenty-three cents.

DY: [laughter]

RD: There were the legends of Ray Amberg, who was John's predecessor. Ray had a different jacket for each type of meeting in his closet, this type of jacket for the Legislative meeting, and this type of jacket for faculty, and this type... He knew everybody. That's how you got the money and you got the Legislature to give you this and so on and so forth.

It was very public. It was very much, you know, I get money from the public coffer. We were just beginning, when I started, to make the transition to we're going to be self-sustaining and self-generating. Now, that took years, but the fact that we would make money to do what we want rather than wait for the Legislature to *give* us money to do what we needed to was really in its early days of the transition. It had clearly happened already and John had set that direction. Until Medicare and Medicaid and private insurance really took hold in the late 1940s and the early 1950s, you didn't do any of that stuff. Private hospitals were not all that different. Boards of trustees would just write checks at the end of the year. So we were all going through a big transition.

DT: You see that really being due to changes in the healthcare economy, as you say, the third-party payers, Medicare and Medicaid?

RD: Yes, and the fact that we could do more. One of the things that we forget about healthcare is how many advances were made in World War II in terms of medicine, and antibiotics, and doing research and rehabilitation, and technology and applying that technology after the war in sort of this burgeoning of knowledge that was going, and setting up the research infrastructure after the war began and so on, but out of the military and the war effort. During the 1970s, the first CT [Computed Tomography] scanner, the first this, the first that. That stuff just didn't exist and, all of a sudden, you were doing things that nobody ever dreamed of, and that's still going on today.

It costs money. You had to sign contracts. You had to fulfill obligations. Granting agencies wanted accountability. Things were changing.

DT: I'm glad you mentioned the technology piece. I know that particularly the diagnostic imaging technology, like the CT scanner and, then, I guess in the 1980s, the

MRI [Magnetic Resonance Imaging]... My assumption was that with the arrival of those, it's so expensive that must have stimulated some kind of change.

RD: It did. At that time, Minnesota had certificate of need, so the great advantage at the University was that we were the University. If you're going to have one CT scanner in the Twin Cities, you should have it at the place (a) that's going to test and see what it's good for, because like lots of things, it was going to drive your car, and it was going to fly your plane, and it was going to do this and do that, and (b) you'd have to train the next generation to be able to use it and you have to train this generation to be able to use it, and that's the University's responsibility. So in the certificate of need process, we were *presumed* to be the one who would get things first.

There was a fellow named Gene [Eugene] Gedgaudus who was the head of Radiology. He was very proficient at getting GE [General Electric] and others to donate equipment for clinical trials and so on. We'd have to build the infrastructure and so on.

Another question was how soon would others in town begin to do it? It was almost a given that if we were going to start with one of something, whether it was radiation therapy or it was CT scanners or MRIs or nuclear radiology or whatever, the University would be where it started.

So in that sense, I would argue the certificate of need was very beneficial to the University and that part of the problem that the University ran into down the road was when certificate of need went away and anybody could do any of that. You had sort of this competition by technology. I've got two CTs. Now, I've got three. Now, I've got four. I remember the Twin Cities, at one point, had more CT scanners than Canada, because of this total release of any restrictions on who could do it and how you did it.

DT: Can you say a bit more about the certificate of need process and what it was there for and what its function was?

RD: Well, it came into being in the late 1960s. At that time, the United States, actually, was much more enamored with government planning, central planning, and the rational development of new things, whether it was housing and zoning, or healthcare, or water rights, or whatever. A certificate of need was, basically, a hospital mechanism, it didn't apply to physicians, at that point, that said if you want to spend more than X dollars, or you want to build more beds, you need approval from a government agency, so they set up a bureaucracy. Actually Don [Donald] VanHulzen, who started as a senior associate director when I started as administrative resident, had been the head of that planning agency for a long time. You had to work with the staff and you had to appear before the planning agency board, and they had hearings, and you testified and everybody else testified, and there were criteria. Once, they had the audacity of suggesting what should close. That just got everybody in knots on that one. You needed their permission to do this stuff. It was pure government bureaucracy. It was long and arduous and you'd produce these incredible submissions. There were no word processors at that point. This was typewriter stuff.

[chuckles]

RD: As a matter of fact, the first one we ever used the word processor for was the new facility certificate of need and the only one we had was our medical word processor. So we used our entire computer capabilities to do that document...now what you can do on your iPad.

DT: Yes.

RD: This is personal bias and prejudice. Certificate of need was always condemned as government regulation, government interference—free market is better—etcetera. The proof was, well, see, they didn't turn down that many applications. I always thought that was the wrong way to look at it. What you couldn't get your hands around was what never was applied for because people said, "We're not going to get it approved and we don't want to look like fools." So *I* think certificate of need actually had a lot impact on the shape of the healthcare delivery system. I think in terms of what we worry about today, constraining costs, over capacity, etcetera, it was fundamentally good, but it was an inhibiting agent. It wasn't a denial agent and it wasn't a reversal agent. They tried to say some OB [Obstetrics] units were going to close. That, they were never going to get away with. You can't measure the absence of something. So, eventually, it failed, because the free market argument seems to always prevail whether it's a valid argument or not.

DT: The certificate of need was just a Minnesota thing?

RD: Actually, at one point, most states had it. There are still some states that have certificate of need. I know Florida still has it. I'm not sure which other ones have it. Most of them got rid of it, but there are some residuals around.

DT: What would you say were some of the key issues that the Hospital confronted in the 1970s that you, in your positions, dealt with?

RD: Oh... It would be interesting one day to see how closely all the people you talk to match up with this.

DT: [chuckles]

RD: I think, clearly, one was evolving to a new way of doing business and a new structure. I'm not sure it was that evident to us at that point, but it *really* was exciting time, you know. We'd set out and we'd reorganize the departments. You'd put in your first computer. It took the entire bottom floor of the building. All of a sudden, you had all this information. The *explosion* of technology and research that was going on and how we could accommodate it and really bring it in and do it in the most appropriate fashion... The whole process of planning... John really was at the University because of his planning experience in Rochester, NY and doing master planning for the University

of Minnesota health sciences. All of a sudden, there was a master plan. There were buildings A, B, C, D, E, F, G, H, I, J, all with the Boston fortress look to them and so on. But we had a plan. How were we going to fund this, and who was going to do it, and what do you go to the Legislature with were important because we were conceptualizing ourselves as a health sciences center, not just as a hospital or a medical school or nursing school. So we had to find a way to bring consensus in terms of, okay, how are we going to stage this and what needs to go first? While you're doing the master plan, what do you do with all the stuff you have to do anyway and that was the Hospital more than anybody and, to some degree, the Medical School research labs, because we couldn't wait ten years to put in an MRI or a CT scanner or this or that. So there were a lot of balancing acts that we were just sort of figuring out how to do it and putting it into much more sophisticated budget processes where we'd debate what our priorities were.

Now, the economic constraints were nowhere near what they are today, because of Medicare with cost reimbursements and Medicaid with cost reimbursements, but, still, you had to find a way to get the total resources and you didn't want to raise charges fifty percent. That just wasn't acceptable. We did go through public scrutiny, you know. Everything, the regents were publicizing. I think that the ability to make decisions and prioritize as really transformative in that period of time.

I think the decision, which John really spearheaded, to bring some focused governance to the Hospital was a *big* change and benefitted the Hospital enormously and, at times, was a problem, because, at times, the Hospital Board, if not better than, functioned differently than the Board of Regents. We had a fair number of community leaders and business leaders on the Hospital Board and they didn't feel second-class to the Board of Regents. There would be some tension there and so on. That was all interesting. But just putting that focused governance, all of a sudden, who were you accountable to? It used to be John would be accountable to Lyle French, who would be accountable to the president. I can tell you, it wasn't all that transparent. You just started and did what you wanted to do. Now, you had a board. These board members had the audacity for saying, "Who authorized that? When did we decide that? Gee, I haven't heard anything about it." All of a sudden, you had finance committees, and planning committees, and medical staff committees. The faculty begins to go a little crazy. These boards were saying, "You're going to fulfill the Joint Commission on Accreditation requirements" and "You're going to put in your medical records on time," and they called them before the committee. Now, the chairs are saying, "Why aren't you doing your job?" These are sort of demigods, you know. Who am I accountable to?

A lot of things that are still playing out today in terms of more of a business model, more refined decision making, lines of authority, accountability, responsibility, trying to find ways to bridge the Hospital and the Medical School and the other health sciences, admissions, and activities, and to capitalize on the synergy that was possible were all really set in motion at that point in time.

Then, of course, we built the ambulatory care building during my first time at Minnesota. I went through the entire planning process and approval process for the replacement

hospital, which was a good solid three years, which was, you know, the cornerstone to really being able to function and flourish in our future. Without it, we were still a 1911 building, which just couldn't make it. This was really till two months before I left.

DT: The establishment of the Board of Governors really seems to epitomize that kind of tension of being a university hospital operating within a university. Is there some kind of disconnect between what the mission of the university hospital is with the mission of the university?

RD: I don't think there was a disconnect. I don't think we ever said there was a disconnect. I certainly never had any doubt in my mind that the only reason the University of Minnesota had a hospital was because it was an educational and research institution. It didn't start a hospital because it wanted to care for the people of the Twin Cities or Minnesota. That was a good mission. Like Ag [Agriculture] Extension, that was a good mission. But it wasn't what the University existed for. What the University existed for was education and research and to the degree that a system's caring, etcetera in the Vet [Veterinary] School were necessary parts of fulfilling those activities, they were embraced and they were supported. When I first started at the Hospital, it was like a laundry. We were the support unit of the University. So with the establishment of the Board, all of a sudden, well, wait a minute. This isn't like a laundry. This is something very different and a lot bigger. The rationale was not so much that we were not part of the University. It was that we had to have focused governance and the Board of Regents didn't have the time or the inclination to do it. There used to be a health sciences subcommittee. We'd get push back. We can't spend that much time on Hospital matters. Yet, the Joint Commission is saying that you have to approve all appointments to the medical staff, and the leadership positions. You have to have a budget and we have to approve this. We have Medicare saying you have to do this. We have state licensure agencies coming in and saying you have to do this. The ultimate authority in a normative community hospital is the *board*. Well, the board for the Hospital was the Board of Regents. The Board of Regents had four campuses, Ag Extension, football teams...you know, important stuff.

DT: [chuckles]

RD: I'm not trying to be facetious. Most regents didn't become regents so that they could be on the Board of the Hospital. They wanted to be the University Board, so, really, the Board of Governors was the Board of Regents recognizing that to function as a hospital in this new world, you had to have focused governance. So you have a couple choices. You either spin it off into a new corporation, you sell it off or close it down, or you restructure within the University. At that point in time, the decision was let's restructure within the University and set up this delegated board. The brilliant stroke—again, John—was not to specify what the board could do. It was to specify what the board couldn't do, which was a short list. They couldn't change the mission. The regents would still have ultimate appointment of the CEO and ultimate final budget approval. Other than that, go to it. So you really created a board.

We had struggled with advisory boards. After a while, people who are asked to serve on multiple boards to sit on an advisory board say, “It’s nice that I hear reports and I hear what you’re doing, but why do you need me? You’re not asking me for advice. You’re not asking me to get involved. You’re not asking me to do this.” Advisory boards were hard to really keep people’s attention and attract some of the people that you wanted.

So the Board of Governors was key. It *never* would have had, I believe, the new hospital, without the Board of Governors. It also wasn’t just some egotistical self-centered person like myself standing up and saying, “I want my monument to the future. I want to build a new hospital.” It was prudent, thoughtful people who said, “We spent months going over this. We’ve probed. We’ve pushed. We’ve detoured. We’ve looked. We’ve talked to outside experts. We have concluded that that needs to be done for these reasons.” People like myself did the work, which is the way it should be, but that didn’t mean they always agree. I can tell you, they shaped a lot of stuff, as did the planning agencies and others. It was an iterative process. That, for years, was back and forth, back and forth, back and forth with the planning agency.

I still remember there was a reporter for the [*Minneapolis*] *Star Tribune* who got interested in our project when it was near the end. Basically, his question was, “Why aren’t you getting any flak? Why aren’t you getting all this pushback? It’s denial and it’s too big. Dah, te dah, dah.” I kept trying to explain, “Because we’ve been working with them for years and they’d ask these questions and we’d look at it. If it made sense to do it differently, we’d do it differently. If it made sense to do it the way we’d proposed it, they say, ‘Okay, we understand now.’ There have been lots of changes, but it hasn’t been done by their saying, “We deny. We prohibit. We do this.” He couldn’t accept this, so they ran this huge series of articles in, I guess it was the *Trib* at that time.

DT: This is Joe Rigert?

RD: Yes, Rigert. I didn’t get along with him very well after a while. There was an article every Sunday for months. If Sue were here, she’d tell you, at midnight, I’d go out, and I’d get the newspaper, and I’d have my response letter by 6:00 a.m. the next morning. I was just fried. I learned a lot about the press, such as don’t file grievances, because you don’t win. That, then, really created a lot of controversy around... At some point, we had the abortion issue come out and all this stuff.

But, in the end, I think it was a tribute to the Board of Governors, the Board of Regents, and just a ton of people who spent, literally, months and months and months working this through. We had a small group when we were at the Legislature, about six of us. We’d meet at least once a week, if not more frequently, and talk to every legislator. Who can help here? What can we do? How do we explain this? We kept changing stuff. You know, people ask good questions and, sometimes, they see stuff you just don’t see.

I remember back when we built the Ambulatory Care Clinic. One of the outcomes of the controversy in that was that we should develop some more community clinics. It was great until we found out nobody wanted us to set up a clinic where they were. [chuckles]

Everybody said, “Oh, not here. Not here.” But, you know, we had to learn that. We weren’t against it.

For *all* of the stress and the pain that those things have, I think, ultimately, the product was better and it wasn’t a diminished product, because of the process.

DT: It sounds like a very cooperative process.

RD: It was one of the highlights of my career. Lyle French, John Westerman, Dave Preston, Cherie Perlmutter, several other people from Central Administration...I forget...Stan somebody.

DT: Wenberg?

RD: Yes—or was it Wenberg. I don’t know. There were six or eight. It wasn’t, “It’s mine.” It’s, “How do we do what we need to do?” Boy, you don’t get many of those in your lifetime. You really don’t. It was just a *wonderful* career experience to go through that.

I remember the night of the final vote. We celebrated a bit. When I woke up the next morning, I didn’t remember going home and my car wasn’t outside, we had to find it!

[laughter]

RD: It was sort of fun.

DT: It sounds that the accreditation issues of the Joint Commission was calling for better governance of hospitals.

RD: Yes. When the debate first started, it was a nice external, neutral way to say, “We need to do something. Board of Regents, if you want to do this, if you want to add another day to your meetings, that would be great.” But that didn’t make any sense to them or to us. So something else had to be done. It didn’t mean the Board of Regents didn’t pay attention.

On the hospital building project, I still remember we had to report to the Board of Regents. It was nearing the end of the process and there was a question of what kind of bonds might we use. We wanted flexibility. They could be hospital revenue bonds or they could be state bonds or they could be University bonds. I remember one of the regents saying, in effect, “I just want to be sure. Are you saying if we use University bonds and the Hospital can’t pay that we’ll have to use all other sources of University revenue to pay this?” I said, “Yes.” He said, “Okay. I just wanted to be sure.” That was remarkable! That was saying, “Okay, I understand what we’re getting into. That seems a little scary, but okay. That’s the type of thing we need to do.” Well, what more support could you ask for than that? It was thoughtful and it was putting those scary questions on the table. Oh, god, don’t ask me. Then, having a good discussion and dialog.

DT: How were the relations around this issue and others in the 1970s between the Hospital and the schools of Nursing, Pharmacy, Medicine?

RD: Ummm... They were variable. We had very good relationships with the School of Pharmacy. Our Pharmacy Department, we had a lot of interaction with the school. We went up and down with the School of Nursing, especially when we appointed a non-nurse as the head of Nursing.

DT: Was that Donna Niels?

RD: Donna Niels Ahlgren.

The reality was we had twelve heads of Nursing. We had clinical heads, similar to clinical chiefs in the Medical School. Donna was *their* choice to be the administrative coordinator and facilitator and to keep things on an even keel, and do the budget and all that. But the school and the State Board of Nursing went absolutely nuts on us. It was really too bad. But, you know, things like that sort of set off the edge.

Basically, good relationships with the School of Public Health. To some degree, they were all through the Hospital. The third floor of the old Mayo Building was the School of Public Health with program in health administration and hospital units and stuff. They just wanted us to get out so they could have all the space.

[chuckles]

RD: Vet Med, that was fine. In fact, the Agriculture School was very helpful in our communicating with the state through the other campuses and through Ag Extension about the renewal project and the replacement and really having the opportunity to talk with leadership throughout the state in forums throughout the state. So the rest of the University and the Ag campus were very supportive and really opened my eyes to how important the University's role in agriculture was, not only to agriculture but to the University and the perspective on why the University is important throughout the State of Minnesota.

The School of Medicine was, clearly, our partner, more so than anybody else. The chairs of the clinical departments were the chiefs of the clinical service in the Hospital. We had continual meetings with the dean, with the clinical chairs, as chairs, as chiefs. You tried to keep everything together. You couldn't always do that. A not uncommon refrain from leadership in the various clinical departments was, because both offices were on the third floor, "We were told this." "That's nice. Go see him, go see him, go see him." The chairs had a really tough job, because they sat at the nexus of all three missions and everybody held them accountable and demanded of them all three missions. I think, all in all, it was a very collaborative and positive thing, but there were different primary missions. Sometimes, you had to sort of battle it out and find a way to make it work.

DT: I'm interested in going back to your comments about the School of Nursing. It stands as a nice contrast to the Medical School, because, as you say, the department chairs were the clinical chiefs, but in the School of Nursing was...

RD: Totally different education model where the Nursing School wanted faculty sort of superimposed on the nursing units when their students were there; whereas, with the Medical School, the faculty were the care providers. I often thought Nursing made a mistake in not going with that model. They did not think they made a mistake and it was what they did throughout the community. We made it work. A lot of our Nursing leadership were faculty, clinical faculty, and so on in the School of Nursing. Joanne Disch, who was the acting head, was somebody I actually hired way back when. There has been that kind of transference between the School and the Hospital. It wasn't antagonistic at all.

It was complicated because we were still in era when we were moving from physicians are gods to physicians are mortal beings and nurses are not handmaidens. They are critically important care providers. Nursing was advancing their education and moving to all baccalaureates and masters and so on, wanting more autonomy, and to be care providers or at least within the Hospital to have much more self-determination and parity with the physicians. All of that created some tension. While lots of people would embrace it, there are opponents of every organization that resists change. I've been happy for forty years; I'm not going to change. We had some blowouts. Sometimes, they'd be very dramatic like the way nurses would be treated, it was to the point where we had to, literally, remove the privileges of some surgeons, because of that behavior or the role they were playing, to much more subtle... the way they interacted on the units and the way they talked to each other, sort of he-said, she-said, she-said, he-said type dynamics. I honestly will say, early on in my career, you sort of shrugged, but you learned you shouldn't shrug. It was becoming more and more and more pertinent to just be really focused and a lot times sitting down with people and helping people understand and change their perspective. I think that's all to the good. It wasn't always easy.

DT: I interviewed Marie Manthey and she credits John Westerman, again, with kind of being really supportive of what she was doing in the nursing service, particularly around primary nursing.

RD: Yes. We had the first units that were primary nursing, I believe in the country at that point, but it didn't catch hold that much. There was lots of debate about that and it evolved and so on and so forth. It was the medical faculty, in the end, who you really had to convince. In the end, the patients have to get the best care you could provide and if you had sort of this war going on, it wasn't healthy for anybody, especially the patients. The primary nursing model had to evolve and the medical model had to evolve.

DT: Something else that was also in transition from the late 1960s through the 1970s was Pharmacy.

RD: Pharm-D.

DT: Yes, and the clinical pharmacy movement.

RD: Yes. That, I think, we had an easier time with that, at least that's my recollection. I wasn't that directly involved with it. I think we were generally supportive of that and our leadership in Pharmacy. We did collaborate with the School of Pharmacy in picking some of them and so on. I think the Pharm-D, we were a little more skeptical of but, you know, that's sort of our view of the world, which is, well, what does that extra academic layer really get you in the delivery of pharmacy services? I'm not sure I ever heard all that good an answer. There was the conceptual answer, but I'm not sure I heard the pragmatic answer.

The parallel in Nursing is the technical versus professional nursing. I went to lots of meetings and I have to admit that I was still confused after most of those meetings. I still don't understand why you say everybody needs to be a professional nurse. Who is going to clean the bedpan? They'd just sort of look at you and say, "You don't understand." So you'd get into those discussions.

By the way, I actually had that on a continuing basis through Colorado and through my time in Washington when I'd be with the Association of Nursing Educators. I'd sort of ask the same questions and they'd stare at me and wonder about it.

DT: I guess the nursing assistants and the nursing aides and the practical nurses...

RD: But, then, they say, "Well, the license says they shouldn't be able to do anything." Part of it is that there's also a difference between the school and the practice community. It wasn't just we/they; it was, sometimes, we/we/they sort of wanting to shape it out of community hospitals and ignore the academic imperatives and advancement of the profession. So you'd sort of swing there. Sometimes, you'd have some disagreement internally. Sometimes, we'd join together and sort of say, "We oppose what they're trying to do externally."

DT: I've spent a lot of time working, especially recently, on kind of the changes within nursing education practice in this period. There's no unified nursing position, as you say, depending on whether you're on the academic faculty side...

RD: Correct.

DT: ...or out in the practice community.

RD: You have all these different pathways to the ends. You had the hospital-based schools. You had the community colleges. You had the B.A. You had the masters and so on. Everybody had their own perspective on it. From a pragmatic sense, *most* hospital administrators I knew would rather have graduates of hospital-based schools of nursing, because they were educated to do what hospitals wanted them to do. [chuckles] That makes perfect sense. The associates' degrees were very—quote—more malleable—

unquote—and you could make changes more easily. The B.A. graduates were less malleable and tended to view their role as more of a clinician telling other people what to do than providing direct hands-on care. If you're dealing with expense and you're dealing with FTEs and you're dealing with recruitment, you sort of have to say, "Indians-chiefs." Every organization deals with that. You don't want to overload how many people are telling other people what to do, because you flip the organizational structure and you can't afford it.

DT: To continue this issue of nursing, particularly the kind of tension with the efforts of the academic community to put greater professional autonomy on nurses, then within the Hospital nurses were trying to be represented by unions, which kind of conflicts with the professional standard and is much more of a kind of worker...

RD: Of course, they say they're a professional union. The faculty, you know, did that, too, especially up in Duluth. We were not unionized. There was a while they couldn't do it. Then, the law changed.

I, actually, in my youth, was lead administrator on some of the early labor negotiations when the union was formed around the core of Students for a Democratic Society. They'd storm my office every two days and demonstrate. It got kind of tense. There was a period there for about three months that I'd check under the hood of my car every day and unlisted my phone number and we had some shots put through the front window of some of our department heads and stuff, you know, things that were rare. Sometimes, you weren't quite sure whether that was or wasn't union-related. They were tense times.

DT: Was this in the 1960s or the 1970s?

RD: The 1970s. Teamsters were a little different. Teamsters were sort of the teamsters. They have a much longer history and tradition of how they function.

The pharmacists were into a professional group. We had great support from the University. They did the labor negotiations for us and stuff like that. I remember being told that the secret to labor negotiations is your seat...who can sit the longest.

DT: [chuckles]

RD: There was truth to that.

DT: I'm glad you brought up the union more generally. I was looking through the Archives in the Board of Governors minutes. There seems to be a lot of back and forth between whether the teamsters union or the AFSCME [American Federation of State, County & Municipal Employees] would represent the workers in the Hospital.

RD: Yes. What happened was the state had prohibited unionization. Then, they changed the state law for public employers. So you had organizing efforts. Each sub group of employees sort of had advocates for we should be AFSCME, We should be teamsters,

We should be this or we should be that. You'd go through the elections. That was a huge learning curve for us. None of us had ever dealt with labor relations and what you can say and what you can't, when you're going to have an unfair labor practice and, all of a sudden, you're called down to the court on a temporary injunction and this and that and all that stuff. There was a lot of tension in some areas of the employee law, between employees, of where they wanted to go. We had to do our best to keep saying, "You cannot do that during the work day. If you want to go somewhere else after work, whatever you want to do, but you can't stand in the hallway and have these screaming matches." Obviously, we'd bring it to the Board of Governors and let them know what was going on and so on. But they really had very limited discretion. The only thing you could do—I think we could have done it at that time; you know, I get a little confused over twenty or thirty years—...

DT: [chuckles]

RD: ...is unilaterally recognize the union. But we felt that was unfair to the employees. *If* they wanted a union—we didn't think they needed a union—then they should choose the union. That shouldn't be Bob Dickler or anybody else saying, "Well, your union is going to be..." So we didn't go that route, if we could. I think we could, but I'm not certain.

DT: I hadn't appreciated that the labor issue was a new thing in the 1970s. I hadn't realized that the state could prohibit unionization.

RD: Yes, they had permitted representation but not collective bargaining. Then, they permitted collective bargaining.

DT: As I understand it, there was some discussion over whether the health sciences would establish a bargaining unit.

RD: Oh, yes. There was the Medical School would be their own. The Hospital would be their own. The health sciences... And there was no right answer. We'd have people working side by side. You'd have a School of Nursing faculty member and one of our nursing leadership who held a faculty title. Well, one wanted to unionize and one didn't want to unionize, and so on and so forth. Then, you had the Medical School in Duluth and the Medical School on the Twin Cities campus. Should they be in the same bargaining unit? Those are the things you sort out through just a lot of time and a lot of effort.

DT: You brought up a while ago, obviously the patient, that the patient was important. I noticed that the Hospital established a Patient Relations Department in 1969 and, then, there was the Patient's Bill of Rights after 1973. It seemed like the patient occupied an increasingly important visible role in discussions around how the Hospital would operate.

RD: We actually, if my recollection is correct and I think it is, developed a Patient's Bill of Rights and Responsibilities largely on the impetus of the medical students. That was

before there was any law. To some degree, as I recall, the law was shaped around what we had done in promulgating that. Then, we did develop this function of the patient representative, because what we discovered was it was hard for patients to talk to somebody and get a response to their concern. “I don’t want to complain to you if you have caused my problem, but I wasn’t sure who to complain to about you, and if I never heard anything back, then did you ever pay attention to me?”

So we did form a relatively small group of people. Kathy [Kathleen] Countryman, I think, was the first head of that group. They did a simple thing. They tried to visit every person, I think, within forty-eight hours of admission and say, “Hi. Here’s your rights and here’s your responsibilities. I’m here. Here’s my phone number. Are things going okay? Great. If they’re not later on, just give me a call. I’m here to try and help.”

I think that was part of the, again, empowerment people were looking for within society. I want to take more control of my life and do it my way. I want to know what you’re doing with my body...the beginning of the popularization of you’re accountable for your own health and so on. And I think part of it was our recognition that we were a pretty tough place to be a patient at. We were cutting edge, tertiary, quaternary, quinary care, Herr Professor, hordes of students... One of the things, if you walked through the University Hospital or you walked through a community hospital, it always struck me as just how many more people were in our hospital. You can walk into the University Hospital and there’s hordes walking all over the place and confusion. Who’s my doctor? I had three doctors come in. I had it happen to members of my family. So I think *we* recognized that *we* had a problem and that was that the patient was confused, felt they didn’t know how to communicate, and it was variable by unit, it was variable by service, it was variable by month. I could tell from complaints who was the attending that month on certain services. Some would see every patient everyday. They’d listen and they were great. Some...nobody ever saw them. They were there, but nobody every introduced them and so on and so forth. That was one of the attempts: to try and improve the patient experience, patient satisfaction, and outcomes. That story is not over. I mean, hospitals are working on that today, being measured by HHS [Health and Human Services], and others, and so on. It’s still a problem. It’s still a struggle. It’s absolutely true that a thousand things can go right and one thing can go wrong and when you walk out of the hospital and I say to you, “How did it go?” you’ll tell me about the one thing that went wrong.

I remember sitting at a dinner table with twelve people, all business people, except myself. I got to talking to the guy next to me. He had a fairly large business. I told him what I did and he said, “Oh, my god.” And he launched into a story about a friend that had come to University Hospital. It was a horror story. I was cringing as we were visiting. I wanted to crawl under the table. I said, “I can’t excuse anything. I really want to look into this. Could you give me the person’s name and when they were there?” He gave me the name and he said—I think this dinner was like 1975 or 1976—“I think it was in 1952 or 1953.” I just sort of sat there.

DT: [chuckles]

RD: What I realized was it was like it had happened five minutes ago. Twenty plus years later and whenever the University Hospital was mentioned, that's all he could think about. Well, the only way to overcome that is to never let it happen. You see these things and you want to say, "How do we begin to attempt to...?" The patient rights and responsibilities is a really nice start. As I said, we had students involved and that really made it interesting.

DT: You mentioned that you got to the point where you could guess who was the attending on some months. Was there ever any effort to kind of push back against those less patient-sensitive attendings?

RD: Sure. We'd do educational programs. They weren't very successful. People didn't turn out. They didn't pay much attention. But we did a lot of one-on-one talking. I think one of the things that has changed is that people, even the CEO, tended to spend a lot more time talking with people than they do today, part of the byproduct of corporate transformation.

My daughter, every kid in school, is asked at some point what their father does, what their daddy does. I'll never forget my daughter's answer was, "He goes to meetings," because at the dinner table, you know, Sue would say to me, "How was your day?" "Well, you know, I had thirteen meetings and talked to all these people." But that's what you did. I went in very early in the morning to do my paperwork, I stayed late to do my paperwork, and I did my paperwork on the weekend. But the day was people. There would be one-on-one. There would be small groups. There would be regularly scheduled meetings. It would be with the University. It would be with outside community agencies. But, basically, from six, six-thirty in the morning till six o'clock or if you had dinner meetings beyond that, what you did was you meet and, then, tried to bring it all together when you had a chance to do some deskwork. I'm just not sure it's quite the same today. My impression is there's not as much one-on-one. A lot of one-on-one would be sitting down and saying, "Listen, I need to tell you that I hear a lot." You learn to phrase it. It depends on who it is and, as you would suspect, some people said, "Boy, I'm really glad you told me," and some people would just walk out sort of halfway through and not say a word.

[chuckles]

RD: People are people.

DT: You mentioned earlier the controversy around abortion. The abortion services were changed at the University Hospital in the 1970s.

RD: Well, we had the Supreme Court ruling. All the policies had to be changed. I think I was administrative resident. I'm trying to remember exactly what the sequence was. I remember I got all the letters. They were just amazing letters. They ranged from they didn't realize that we were controlled by the Pope to if you keep murdering people, we're

going to have to murder the murderers. You get these letters that just... I think the classic one was that abortions were really something that were attributable to the wine industry, because they wanted people to drink more and more, which led to inappropriate behavior when people were drunk and, therefore, people needed to get abortions. I just thought that was sort of an amazing letter.

[chuckles]

RD: We were a public institution. At that time, we didn't have sort of the tax dollar argument. You had what services are available and so on. We set it up with all kinds of appropriate reviews and so on and so forth. It got much more difficult as the years went by. There was the magic moment when they were debating our building renewal bill where it was hung up by somebody introducing the amendment that would *prohibit* us from doing any abortions within any of the new facilities. After they sort of debated for a while, the chair ruled it out of order and not relevant to the legislation. But, you know, it kept coming up. It was always out there.

DT: I see that the Hospital eliminated second trimester abortions in 1975. I remember reading the arguments that there were plenty other clinics who were doing that, so the University doesn't need to, but the counter arguments were put forth that how are our residents and students going to be trained in doing...?

RD: The answer was the residents were out there. That was one of the hallmarks of the University, basically, that almost all the residencies were under the umbrella of the Medical School and that they were pretty community-wide residencies. You had trained at the University, Hennepin and Ramsey and the V.A. and lots of community hospitals. I think that served, and I think it still serves, the Twin City community quite well today. How many things can you battle over? It's nice not to battle over who has the residents. We formed the Minnesota Association of Public Teaching Hospitals to coordinate the residency programs, and set stipends, and might share contracts with some more and stuff like that. That was very useful, as well.

DT: How do you feel relations were between University Hospital and, then, the other hospitals in the region?

RD: It depends on when you're talking about. They change over time. In the 1970s, I think everybody worked very well together, partly because the University was the University and we were sort of the tertiary, quaternary, quinquenary. This is where the first heart surgery was done and the first this and the first that. The county hospitals were serving the county residents. We had a mandate and a mechanism called county papers to serve as indigent hospital for the rest of the state and the community hospitals were beginning to merge and transform themselves, but really were sort of secondary care hospitals. As years went on, there was more and more interest in putting in the new technology and the more complicated and specialty-oriented programs, open heart surgery, and so on and so forth. Then, you became more and more competitive. I think we always worked pretty well together. One, most of us were graduates of Minnesota's

program, so we knew each other and, two, at least in those years, we still thought we were there to serve the community. That would actually come up in discussions. I'm not sure it does much anymore, but it would come up in discussions. For the University, it was also true that a very large percentage of our patients came from outside the metro area. I think something that people had not appreciated is that, at one point, I think over fifty percent of our patients came from outside the metro, either the rest of Minnesota, North Dakota, South Dakota, and so on. We really didn't view ourselves as competing for the local business, at least in sort of the secondary level or even the more routine tertiary care. And they were all our graduates.

But, as time went on and healthcare became more and more competitive and they became more sophisticated and the market shrank and the outstate hospitals became more capable, and our referrals became less, and Mayo [Clinic] became more competitive, I think tensions rose and the level of cooperation became more difficult.

DT: Did the HMOs [Health Maintenance Organization] or third party payers in general play a role in changing that competitiveness?

RD: Sure. Minnesota, obviously, moved to a fairly significant portion of the population that capitated healthcare earlier on than most parts of the country. Who would get the contract for this population? It was common for us to have negotiations, especially as time progressed. You're too expensive. We're going to constrain who can go to you, or it's going to take a special referral to go to you, and so on and so forth. We'd push back and our competitors would cheer and stuff like that. But, again, I think part of what the University's struggle was—I thoroughly struggled with it—we could see the transformation that was occurring in healthcare and all of its aspects, you know, more sophistication in community...

[break in the interview]

RD: Smaller communities having more specialty capability, regional centers, referral base shrinking, more capitation, cost constraints coming in, public dollars being more limited...I mean, all these things were pretty obvious. What wasn't obvious was how soon and how much impact. So going back home and saying, "We need to move now or we need to do this," was hard. We did have this referral buffer. We had a lot of tentacles out to the rest of the state: physicians going out. We were running clinics, had a great relationship with the Iron Range. We bought the clinic in Red Wing, which was not without controversy, but we bought it. That sort of buffered and cushioned us from the transformation occurring within the Twin Cities. We knew it wouldn't be forever but if I'm still making enough money and the Hospital is still making money, why should we change today? Why should we do it peremptorily or in anticipation? At least in my opinion, we didn't do things as quickly as we should have in a number of instances, especially in terms of changing structure, and looking at mergers, and reorganization, and so on.

DT: Given that you said that in retrospect the Hospital didn't respond in those ways soon enough, were there other things that the Hospital was trying to do to attract patients as the market became more competitive?

RD: I think we were doing a number of things. You start with the facilities. You had to have facilities that were competitive and where you could do the new technology. We did begin to do marketing, advertising, and other things in the marketing realm. I'm still a skeptic on marketing, but we certainly got into marketing. We intensified our networking and outreach effort. We tried, as our compatriots in town were acquiring hospitals and clinics and so on, for the most part to be the alternative. What is it you would like? And we'll try and do it for you. If you want a clinic one day a month, we'll try and get you a clinic. If you want us to help you with certain aspects of management, we'll help you with certain aspects of management. But we're not going to walk in and tell you what we're going to do for you; you have to tell us. Sometimes, that was successful and, sometimes, it wasn't. Sometimes, it left us vulnerable to...we were too nichey and, then, somebody would come in behind us and just start to acquire the whole place.

And we were public. So we tried to streamline our decision making and say, "Yes, we really can make decisions. We really can do it with a handshake, like anybody else and so on, which proved *not* to be the case. That was a fairly big problem in convincing anybody that it was worth the time to try and do a deal with us. I ran into just a *lot* of skepticism whether you could ever consummate a complicated deal with the University, because of the public-ness and so on and so forth. Legitimately, a lot of places don't want their laundry hung out during sensitive business negotiations and so on. We had a hard time managing that and constraining that, but we worked on that. We streamlined it, and we went into executive session more often and stuff like that. I think we probably improved that process.

We said, "Okay, we are willing to acquire practices." Red Wing was really sort of the test case to be the evidence that we could do that. In fact, we consummated it. It didn't go as smoothly as I would have liked and that was a big problem. That was more than just acquire Red Wing; that was, we can play in that arena as well as anybody. We can acquire a hospital. We can acquire practices and so on.

But we were not leading. We were sort of Johnny-come-latelys, and were, at best, on the same track as everybody else. We were the University. Do I want to be a public institution? They're too academic. They don't really know how to run anything, all that stuff. It was all there. You had to work hard to overcome it.

DT: Do you feel that the University had a responsibility different from the non-University hospitals toward the state and what the state needs were?

RD: Absolutely. I said this earlier. You have to start with why does the University have a hospital if it isn't to be the primary laboratory for education and research? Then, they shouldn't be in the game. Now, the run up is, as things kept transforming, we were in

danger of becoming the place where the Medical School and others did what they couldn't do anywhere else. So instead of, we were spearheading everything, we could become the leavings. We can't find a place to teach that, so we'll have to do it at the University. We'll do it there if we can because we need to build them up and we need to make them stronger and so on. That conceptually and practically was a big problem. If our primary strength was we're the cutting edge and if you can't be a cutting edge or it's compromised by money, by others getting into the game, by not getting approvals to do certain things, it's hard to convince the third-party payers and the general patients that they want to come to the University or want to do business with you.

DT: It sounds like there is in a way a bit of inherent tension. If the University has a obligation to do what the state needs it to do, train and prepare healthcare professionals, but, at the same time, as you mentioned earlier, the changes in the healthcare economy was such that the Hospital needed to be self sufficient, so then have that kind of...you might want to focus on preparing enough healthcare professionals, but, then, you still have to balance the books. Did that take away...?

RD: And you have to have the sufficient clinical base to do the education and research. You can't teach if you don't have the patients and you can't do the research protocols if you don't have the patients. This is the dilemma that's faced almost every public institution in the United States. As Medicare grew, as Medicaid grew, as private insurance grew, the responsible organization, legislature, city council, etcetera, said, "We can reduce our level of support, because you can earn that money elsewhere." And that was correct. In fact, without our ever saying it was the policy of the United States to finance the academic infrastructure with the patient-care dollar. If you look at the expansion of Minnesota, there's some grant monies and there were some state...but it was primarily done through the patient-care dollar. That's what paid for a lot of those buildings. It's what brought in new faculty in the Medical School. It's where the startup money came to get research grants and so on. So whether it's Minnesota or wherever, we really said, "Let's move from the public dollar, at least a substantial component of the enterprise, to financing all future expansion off the patient-care dollar for both the Hospital and the Medical School." I used to give lectures when I was with the Association. In the 1960s about three or six percent of the Medical School budget would be on the clinical dollar. Well, it's now over fifty percent. So the Medical School is every bit as affected by the changes in the delivery system as the Hospital is. When you can't get the patients or when reimbursement is gone, they have exactly the same problem. Yet, you have a set of costs that nobody else has. So you're caught in almost an unresolvable dilemma, unless you control and dominate the market. If you look around the country, that's what the most successful academic enterprises are doing.

DT: Who would you say they are?

RD: Oh, Partners in Boston, [Johns] Hopkins in Baltimore... The University of Michigan has done that to a large extent. I don't want to overplay it that they can do anything they want, but they saw a pathway that said, "We have to be at least as big, if not bigger, and more dominant than any other delivery system. Most of them were

private that were able to do that. [University of] North Carolina [in Chapel Hill] has done it. The University of Washington has done a nice job. There are a number of them out there. But, if you did not sort of shape your own system or join a private partner who wanted to build an academic system, then you are at a disadvantage. Then, you're debating, well, how much are you going to spend on academics and should we keep it?

DT: And the public institutions, as you mentioned, like the state's contribution is declining.

RD: Or even if it's held steady as the budget keeps inflating, well, it doesn't matter. It becomes less and less and less and less. This is why there's been a lot of separation of public hospitals and so on and so forth. You have the tail wagging the dog. Well, ultimately, we can still tell you what to do, so we're not making much of a contribution anymore but you're still under [unclear] control. To the credit of the cities and states, they said, "That's nuts, too." So, they changed that.

DT: I guess then, when the changes in Medicare and Medicaid were introduced in 1983, the Diagnosis Related Groups [DRG]... That sounds like that really contributes to this kind of change in economics.

RD: That was a very big change for institutions with an academic mission, because, as we said before, Medicare was cost reversed. Medical education and monitoring research and so on, for the most part, were part of your cost structure and were subject to reversal. With the diversion to prospective payments in the DRG system—there were a couple stages there—what Medicare faced was, well, we now have a system that says we're going to pay everybody who does appendectomies the same thing and we're going to assume everybody has a normal distribution of patients. If you're a forty-bed rural hospital or a 2,000-bed urban hospital, your appendectomies are going to go up the same, and we'll adjust your regular costs and stuff like that. But, basically, it's the same.

People said, "Wait a minute. There are some problems with that. One is that our costs are related to medical education, residents, and so on. It costs the Hospital for..." They said, "Okay," and they created direct graduate medical education reimbursement, which said, "Medicare will pay its program share. We'll add up resident's stipends, faculty costs, and so on, and if thirty percent of your patients are on Medicare, we'll get you thirty percent of those dollars." Not unreasonable. "It doesn't pay for it all, but we'll give you that."

Then, there was a second problem and that was you assume everybody has a normal distribution—but they don't! We don't have an acute measurement system that really differentiates. Everybody said, "You're right. What do we do?" They said, "We know teaching hospitals get sicker patients. So we will provide an adjustment to teaching hospitals and we will do it based on the intensity of their graduate medical education-training program. So the more residents you have, the more of an adjustment you will get. We will call that indirect graduate medical education payments, because we will use graduate medical education as the indirect proxy for severity." Now, it actually is

accurate. I mean, it works. It's higher than it should be from quantitative evidence, but, in fact that intensity, the more you have, has been shown quantitatively. In fact, teaching hospitals do get more severely ill patients, you know. If the community hospital gets a valve replacement, the University Hospital gets the fifth re-do. Those are different types of surgery.

Now, there's two problems with that. One is we called it indirect medical education, which says to everybody, who has no idea of the history I just outlined, that's medical education. So therefore, everybody that's teaching thinks that's their money. The second is that in theory that money should go away, if, in fact, we adjust the payment system to the fields of severity and acuity. However, it became a catchall. It does cover indirect medical education payments. It does cover indigent care. It does cover poison control and this and that. So it *became* the source of funding for what I would call the differential mission of teaching hospitals. And we keep cutting it. We put mechanisms in place that were very beneficial and they're still very beneficial, but they're shrinking as time goes on. Then, we capped the number of residents and all of this stuff in later years. What we have *not* done is said, "If we're not going to provide as much or any of those funds in the future, how are we going to finance those missions?" We're not even having a debate about that. That can't even surface in the reform debates, which is why we still have the mechanism. Nobody knows how to do it. It's a lot of money. There's a huge question mark over that into the future. At the moment, if you're a dominant enough healthcare delivery system, you can manage it. But if you're a marginal player, it's becoming more and more and more difficult for that and for indigent patients and so on and so forth.

DT: Can you say that in those states, say, where there's one, maybe two medical schools...? Say in the University of Minnesota, you're preparing your residents and they're staying in Minnesota. They're going to the competitor hospitals and those competitor hospitals have similarly strong programs, kind of like what you were talking about earlier, that they're providing that kind of complex care that the University Hospital would do.

RD: Right.

DT: That's a disadvantage to the University in that sense, because there is that competition for those complex cases.

RD: Absolutely.

DT: So in those environments where either the Medical School isn't preparing the residents as well or they're leaving the state and going elsewhere so the other hospitals in the area aren't as competitive, so they don't have the dominance. They can dominate the market.

RD: There are some labor theories that surround this. Why would the University of Minnesota train its competitors? So now you're into is that good? Is that supported by

labor economic theory or is that public policy theory? You get into all of these things. One of the things that you have to admire is that people made it work. There is still the University. There is still the University Hospital. Portents of doom have existed almost all of my career, and while things have had to change a lot and sometimes they're not as good as once were—I'm not sure, but from what I've read, Minnesota has had some slippage in some of its national rankings and so on—it's still there.

I'll tell you that if I needed healthcare, I'd go to the Twin Cities without thinking twice. I mean, when I was there, there's no doubt in my mind that this was as sophisticated a medical community as existed *anywhere* in the United States and the quality of care was second to none. That wasn't the University; that was everybody, because the University, and to a lesser degree Mayo, had done such a great job. How many bone marrow transplant programs do you need and how many of this, and how many of that do you need, and how many can we afford, and how much of it is overuse are all questions we have to come to terms with. As we come to terms, as we *constrain* where we're willing to spend money, it is going to affect the more cutting edge stuff and whether the fact it is really worth using it for a whole number of things. We're all familiar with the studies that say, "Bone marrow transplant is not something that affects this kind of cancer, this kind of cancer, this kind of cancer," and people still get it. Why? Because there's a case in 1,000 or a case in 100,000 where, in fact, the person got better. If I'm not paying for it, I'm willing to take that chance or even if I'm paying for it, I'm willing to take that chance.

It's going to be a very challenging and a very interesting time. I think that the University on one hand and Fairview [Health System] on the other have recognized this from some of the stuff people send me. They're talking with each other and trying to reconceptualize the future and how they're going to proceed. Actually, they're talking about some new facilities, again, and so on and so forth. These are not going to be easy times. Given the economic dilemma that the country is facing, it's unclear to me how we're going to finance this stuff.

DT: If we can go back to the late 1970s when there were some concerns...

RD: How about taking a break?

DT: That's fine. Absolutely.

[break in the interview]

DT: In the late 1970s and early 1980s, I think there were concerns about nursing shortages?

RD: Yes.

DT: Can you speak to that issue?

RD: I think there are still concerns about nursing shortages.

[chuckles]

RD: The largest pool of health professionals are nurses. People looked at the stats. It was an aging population and the number of people entering nursing school was diminishing...lots of reasons for that. Part of it was a lot more women were choosing to go into medicine, which was great. I think there was a lot of noise, not as much action. Some schools expanded in size and new schools started a couple new associate degree programs, and stuff like that. The latest data that I've seen says we still face an imminent nursing shortage. Probably the thing that has helped the most is the poor economy, which has led to more dual-employed families and people staying in nursing longer than they might wish either when they're having a family or from an aging standpoint. I think if the economy were to become robust again, you would hear that clarion call go up very rapidly.

DT: I remember seeing at the University Hospital in particular, the Hospital seemed to be having recruitment difficulties. There were some complaints from nurses that the working conditions weren't satisfactory.

RD: Ummm... Part of it was the facilities. I mean, the facilities were crummy. I think part of it was that we were in the more traditional model and that we were still trying to transition out of that. And part of it was sort of the over all noise of shortages and rising union activity in the community. Now, we were one of the few that *weren't* unionized. That always adds to the fire.

DT: It must have come from the nurses, maybe the Minnesota Nursing Association, that the Minnesota Hospital Association had long opposed the mandate that a baccalaureate degree was required for professional nurses to work in the Hospital, because of wages.

RD: Right.

DT: So that was the case?

RD: The University pretty well committed to trying to go to a baccalaureate nursing staff. I'm not sure we were as energetic as we should be at times, but I think we were more on that track than almost anybody else.

DT: So what led you to leave Minnesota and move to Colorado in 1981?

RD: Ummm... Well, a job. [chuckles] It was really that simple. I was ready to try being the CEO someplace. At that time, it didn't seem that John would be leaving very soon. He sort of messed me up a year later. Colorado offered me the opportunity and it seemed like a reasonable prospect. They had gone through a lot of CEOs... A troubled institution. So I thought I could have an impact on it, so I did it.

DT: One can assume it was for the job, but because John Westerman stepped down a year later, I was wondering about why you didn't stay on. It sounds like you didn't know he was planning...

RD: I didn't know at that time. John had talked about it, but nothing was imminent. They did offer me the position at that point. I had made a commitment to Colorado and I just didn't feel I should do it. I appreciated the offer, but said, "No."

DT: You were at Colorado for what, like, six years or so?

RD: Six and a half, something like that.

DT: Were there differences or what were the differences between running the hospital in Colorado versus Minnesota?

RD: There were a lot of differences. The states were different. Minnesota was the penultimate welfare state. I mean we had indigent patients, but there were mechanisms to get them on Medicaid or county papers or whatever. Colorado was a basic Medicaid program and lots of indigent patients and, by law, the University Hospital, which had been Colorado General Hospital, was the state indigent hospital. So it was a hospital that, at times, would turn away private patients to take indigent patients. At Minnesota, the University is constitutionally autonomous and we had a lot of flexibility with our budgets and what we did and so on. In Colorado, the hospital was functionally a state agency. The budget was in the state budget. There were fifty line items and, as I joked, if I added a half FTE [full-time equivalent] above the line, I went to jail and if I saved money, it all went back to the state. The hospital had no reserves. It had no capital flexibility, etcetera. So, really, the task was how to work with the state and work with the hospital to transition it to a new level of flexibility and self-determination while maintaining its historic mission. That's really what we did for those six-plus years in Colorado. We did a lot of things to stabilize the hospital, get budget flexibility, and then position ourselves so we could be spun off from the state, which they did after I left, partly because they wouldn't do it while I was still there. I don't know how much detail you want to go into. Colorado is a very different state. Minnesota comes out of that populist movement, farm co-ops, cooperatives, governance is basically good, serves a useful purpose. Colorado is mountain west, independence, rugged individualism, shoot thy neighbor before they shoot you. So the legislatures are different. They're attitudes are different.

For example, I had been in Colorado about a month and I got called by a legislator who said he had a medically indigent bill. I couldn't figure out what that was. I should come over and read it. What it boiled down to is since the University of Colorado Hospital was really the only mechanism to provide care to the indigent, he was writing a bill in terms of what we should do and what we shouldn't do. This is a true story. I said to him, "I'd like to go back and read it and think about it." He said, "No, read it here. You may have a reaction." So I read it and I said, "Well, the first thing I notice is you didn't cover OB [obstetrics]." He said, "That's right. Poor women don't have a right to get pregnant." I'm not usually at a loss for words. I said, "Okay, but they do. What do you want me to

do?” He said, “Tell them to go out on the lawn and drop their kid.” At that moment, I knew I was in a *very* different place. [chuckles] It was quite a cultural shock for me. Now, he, obviously, was way out there. To even have somebody say that was beyond my comprehension.

DT: That’s incredible.

RD: Yes, it really was. It was a great experience, because they were *so* different. All these things I thought I knew and all these assumptions I would make were just worthless, *absolutely* worthless.

I met with a hospital department once and their revenue was way below budget, their volume was right on budget, and their expense was way above budget. I said, “I don’t understand this.” He said, “Well, I have nothing to do with the budget. Some office does revenue. Some office does expense. Nobody tells me about it.” I said, “Okay. We’ve got to straighten this out. What can we do to increase revenue?” We were talking about things and he said, “We could charge for narcotics.” He kept going. I said, “Wait, wait. Stop. Go back. What do you mean we could charge for narcotics?” He said, “We changed our system a couple years ago and we’ve never put in a mechanism to charge for narcotics, so we haven’t.”

[chuckles]

RD: It was hard not to improve it.

DT: [laughter]

Because it’s so different from Minnesota, that’s stark evidence that the place of the University Hospital in the state and health economy matters and where the legislature stands is important.

[telephone rings – break in interview]

RD: It was. In some ways, it made Colorado more energizing. There was just lots and lots and lots to do to make it much more impressive. It was a good medical school. It was a good state...good people. They just didn’t have the wherewithal to do what they needed to do. That contrasted a lot with Minnesota, which had really been one of the preeminent institutions for a long time—and still was at that time.

DT: During your time at Colorado, the HIV-AIDS [Human Immunodeficiency Virus-Acquired Immune Deficiency Syndrome] epidemic began. I’m wondering what kind of impact HIV-AIDS had on the hospital in Colorado, for example.

RD: There were several types of impacts. One was there was a lot of portent and doom. If you looked at the stats, it was untreatable. We couldn’t cure it. It was spreading into the heterosexual population and so on and so forth. Every bed was going to be filled with

AIDS patients in fifteen years or something like that. There was the here and now. There are people with AIDS. What do we do? You know...dealing with some absolutely superb and saintly physicians who really figured out how to nurture these patients, how to help them, how to bring new drugs online, how to develop outpatient models for caring for them, and so on. Then there was how to help the hospital staff, the physicians, deal with threat of infection and new infection control procedures and so on. I think the portent of doom was something you just sort of had to live with, the developments of the programs to help AIDS patients was both very depressing and very energizing. Helping the staff and working with the staff was ninety-five percent very rewarding and five percent very frustrating... I still had hair then and I pulled it out regularly, because for people with a scientific background, you often couldn't have a conversation. There were people who refused to care for AIDS patients. On one end are the people who refused to take the right precautions and put other people in danger and so on. That absorbed a fair amount of time. Usually, you didn't have to go to extreme measures, but it just took a lot of effort.

DT: Were there any cases of transmission between patients and hospital workers?

RD: [pause] I'm trying to remember. I think we may have had one or may have potentially had on. But that was about it.

DT: I'm reading about the early days of the HIV-AIDS epidemic and the lack of knowledge there was around...

RD: The lack of knowledge, and, then, we still didn't talk about it much. I had lots of friends who had themselves tested. You sort of sat there and said, "Well, thirty years ago, you know, I had this interaction with this person. I could potentially have AIDS," or "Ten years ago, I had a blood transfusion." Everybody, basically, felt at risk. Then, at that time, it was a death sentence. It was a matter of how many months.

DT: That's a good point about the blood transfusions. Did it make patients reluctant to undergo transfusions?

RD: A lot more demand for patient's banking blood. We encouraged it. We said, "Sure. If you think you may need surgery... If you've got a prolapsed valve and you're going to need heart surgery someday and you want to bank blood, bank blood." It's only good for so long. "If you want friends and relatives to bank blood for you, good. Do you really trust your friends and relatives?" I mean, that's part of it. You don't know. I don't know what you've done every moment of your life. People were pretty unclear even about how you could possibly get transmission? Yes. It was pretty clear it was blood-to-blood and fluid-to-fluid and so on. There was always this hypothetical maybe that we didn't know about.

DT: You returned to...

RD: By the way, dentistry was a big issue.

DT: Oh, yes, I guess, because that's so much closer to

RD: People didn't talk about it much, but that was a big issue.

DT: Did you find that among dentists on your staff?

RD: Yes, and then how to handle it in those situations.

DT: What do you do as the CEO when you have your employees refusing to...?

RD: You can't force anybody to do it, just like you can't force anybody to participate in abortions. You try and help them—we had a couple of really good infectious disease people—understand what were the facts and what did people know and really had to take the time to put them together and say, “No, that's not right.” “No, that is not right,” and try to get them to a level of comfort.

DT: By the time you left Colorado, were there better controls in place over the attitude toward treating HIV-AIDS patients?

RD: My recollection is yes. It was an issue, but, I have to admit, it was not the dominant issue. It's not one that if you'd asked me to spontaneously list the most troublesome issues in Colorado, it probably wouldn't have been on my list.

DT: I know you mentioned some of the differences. What would you say were the most troublesome issues?

RD: I think all the structural changes were really what we focused on. When you have a group of people who have lived in a world where you have to spend the last dollar of each year's budget or you're not going to get it back the next year, where you have no flexibility in decision making, where you have, basically, remote bureaucrats making decisions... If we had a compensation problem, it was handled by... My first major victory was wrestling the specification of meat away from the prisons who didn't mind high fat content so much.

[chuckles]

RD: Our compensation levels were set by the State Department of Human Resources and they did sort of a rote survey, a mechanical thing. Did salaries go up or down? Well, at that point in history, we were hiring lots of nurses, so our average salary went down. We were getting rid of lots of social workers, so our average salary went up. So they gave a big increase to social workers and they cut the salary of nurses. [chuckles] I had absolutely nothing to say about it. I mean I was just informed.

Then, I did this thing that got me in a bit of trouble. I went with a group of nurses down to protest at the State Department of Employment. [laughter] All of them looking at me.

“What the hell are you doing here?” I said, “Well, it’s wrong. You can’t do this.” We got it turned around. That was the type of stuff you had to spend a lot of time on there, and, then, building relationships with the state institutions, which we had not done, and then just stopping the indigents from Wyoming with no payments and some other challenges.

DT: Not only were you the indigent hospital for Colorado but also for Wyoming?

RD: Well, they just kept sending patients down. Our big change, which is what I thought would get me fired, because I was still in the Minnesota frame, was why don’t we put a limit on how much indigent care we would provide? You’re in a dilemma. You can’t provide an unlimited amount of care against a limited budget and you can’t earn any additional revenue, because it isn’t in the budget. We said we would send all Denver County patients to Denver General [Hospital], because that was their mission. We would set up a priority list for other Colorado patients and have the medical staff involved and all this stuff. We set up definitions of emergency care and critical care and so on and criteria. It was actually a pretty good system. It went to the Board of Regents and, after two or three meetings, they finally authorized it.

Then, we implemented and, of course, you got headlines about turning away people. So as I expected, I was called down to a meeting of the Legislature. That’s where I thought I would get how dare you and all that stuff. I put on my three-piece suit, the last time in my life I wore a three-piece suit with a regimental striped tie.

DT: [chuckles]

RD: I walked in and these five guys walked in in Stetsons [hats] and string ties. The first one looks at me and said, “Did you do this?” I said, “Yes.” He said, “Well, it’s about time somebody did this.” That’s what all five of them said! I became the darling of right wing Republicans.

DT: [laughter]

RD: I just sat there and said, this is so wrong. I don’t know what I’m doing. It was an interesting experiment.

DT: Then, you returned to Minnesota. That was after Ed Schwartz stepped down?

RD: Yes. Ed stepped down.

We had made a lot of progress at Colorado and we were at the point where we were ready to separate the hospital from the state. Whether you can keep it with the state or separate it is really determined by the constitution of the state and what flexibility you have and so on. In Colorado, you really had to separate from the state. Every process like that carries a lot of baggage. It became increasingly evident to me that it would be very hard, in my opinion—I’m not sure anybody else agrees with this—for it to happen with me there,

because you're sort of the one who's advocated this and pushed it and all of this stuff. So it seemed like a good time to separate. There were a lot of these things going on. The legislature had reversed the budget flexibility and took most of our reserves and stuff like that.

And Minnesota became available. The question there is can you go home again? I debated that a long time. My judgment, obviously, was yes. I really saw my primary responsibility was to try and position the Hospital for the changes that were coming up here. I'd have a greater feel for what those were, a good history at Minnesota, and I'd had a good experience in the process I'd gone through in Colorado. So, my hope for what I might be able to now push was to find a way to put the University in a more stable market position than it was at that point in time. We went back. We moved to Minnesota. We had lots of friends there [in Minnesota].

DT: Can you articulate what you thought the changes were that were coming?

RD: Well, we've alluded to them. We were seeing more and more movement to HMOs and capitation. We were seeing more and more movement to limited networks. I think fairly rapid acquisition of specialists and specialty capabilities by smaller community hospitals, and hospitals with smaller cities. That was beginning to dry up some of that referral network and some of the more sophisticated systems in the Twin Cities had really gotten into that referral business, as well. Mayo was clearly on the move to expand its presence. So the question was you've got all these systems around you and the referral patterns are diminishing, because systems are either going out and diverting, or you've got new systems and capabilities developing out there, and you've got an insurance environment which is constraining where patients can go. How do you position yourself within that?

There's no one answer or clear answer on that. My belief, after spending a fair amount of time trying to sort it through with a lot of people, was that we really had to find a partner. There was Abbott Northwestern, whatever that system is now. There was Fairview. There was Health East. And there were the other publics and each of them had pluses and minuses. Some seemed potentially more feasible than others. We explored all of those. I think we could have moved on one, maybe two of them, into the formal process of consideration of acquisition and merger. But, I was unsuccessful—I don't point a finger at anybody but myself—in really pursuing any others...that we needed to give up our freedom and independence for the future, and that it was better to do it sooner rather than later, because we were still making money and we were still in a relatively strong financial position. I, at least, have always liked to negotiate from the strongest position I can find rather than a weaker position. But I didn't do it.

DT: I'm sure there's a lot of other people that would say, "Well, why do it, because we're in this position of strength."

RD: Yes. We're still making money. You worry too much. Things are going to change. This is just a blip. We've seen this before. People have tried and failed. This [President

Bill] Clinton guy isn't going to do anything and so on and so forth. They can't keep us out of the system, because the patients will demand that we be in the system and so on and so forth. I think a lot of them were sincere. I think a lot of them believed it. I think a lot of them did not really want to hear some of what I tried to convey. I think some of them had a time-limited perspective in terms of how far they are from retirement, how long until I leave, and so on and so forth. So there's a lot of reasons and lots of complications in trying to do that.

In the end, I think we were successful in identifying the options. I think we were successful in making ourselves a little more attractive by Red Wing and solidifying the relationship with Hibbing and continuing to strengthen our flexibility and our decision making and so on and so forth. But, I didn't find a way to bring it to at least a definitive process to try and put it in place.

DT: Who were you having those conversations with? Who were you getting resistance from?

RD: The conversations of what was possible were with everybody. I just don't think it's beneficial to sort of going into which of those...and it's probably not beneficial to go into the specifics on the internal...

[chuckles]

RD: ...but that was with really all the points of decision-making and power within the institution.

DT: So it was within the University rather than...?

RD: The vice president's office, the deans' offices, the governing board, University officials, and appropriate chairs and stuff like that.

DT: Yes, I wasn't sure if it was with the Legislature or...

RD: The Legislature, not so much. That clearly would have had to be dealt with. I think one of the experiences from the building project was if you didn't have some agreement *within* the University, don't go to the Legislature. That's just a big mistake. The legislators, some of them, would like nothing more than to get into the business of telling the University what to do. So you've really got to be careful there. We really did not have any legislative discussions that I recall.

DT: You pointed to, obviously, the change in structural and economic environments. I'm wondering when you returned to Minnesota, were there differences within the institution that kind of stand out to you, that had changed since you left?

RD: Well, the new building was up. I mean, the facilities had changed dramatically. I sort of picked the perfect time.... I got it approved and left, and I came back after it

opened, and I didn't have to screw around at all with the construction. I had done that on the Phillips-Wangensteen [Building], and I didn't need to do that one again. So that was a big difference. A number of chairs had changed. The deans had changed. I knew Neal Vanselow. He, actually, had been v.p. [vice president] right after I went to Colorado. We knew each other, and I knew a number of other people in the power structure and always worked well with them. There was a period of getting to know people I didn't know.

My interpretation, right or wrong, was that people were more anxious about the future. They did sense that change was accelerating, and it was less clear what we were going to do than maybe it had been five years before. I'm imputing into other people and that's always dangerous.

DT: [chuckles]

A bit more of a focused, specific thing I noticed from the Board of Governance minutes is that gender pay equity and debates on the comparative worth of Hospital employees was a subject of contention from like the mid 1980s onwards. I wonder if you can reflect on that at all.

RD: I think that's correct and I do recall some of those discussions, but those are up against the market. I think that we wanted to be market competitive. We never really sought to be market leaders. I think that would have been nice given that we were already one of the more, if not *the* most, costly facilities in the city. That posed some problems. But I think that the Board kept pushing on it and made sure that we didn't get sloppy. Where the opportunity arose, we wanted to avail ourselves of it, but we didn't take the great leap and say, "No matter what, we're going to head that way." I have to tell you that equity is a tough thing, because there's a lot more that goes into paying equitably than gender. It's experience. It's performance. It's the level of responsibility, and so on. I don't want to diminish the very clear stats on gender, but you can't simply say, "Everybody at a certain level is going to make the same amount." It just doesn't work. And you can't even say, "Everybody who has worked the same number of years," because then sort of toss performance *totally* out the window. Now, it's absolutely true that women were often disadvantaged, because they were in positions where they couldn't perform to the same level. They didn't have the opportunities. We kept struggling with that and trying to find ways to deal with it. So we didn't treat it lightly but we didn't find a solution to it, however.

DT: Another issue that came up, I guess, were debates over the tax-exempt status of non-profit hospitals.

RD: That surfaces...that's still being debated. I'm actually, right now potentially, being an expert witness in a case in another state.

[chuckles]

RD: That's simple. You are tax exempt because you are a charitable institution. Do you do enough charitable work to justify that exemption? That's somewhat in the eyes of the beholder. So, I might argue that the discounts given to Medicaid is charitable and you may say, "Nonsense. That's just write-offs." I might say community education is part of our charitable work and you may say, "That's marketing." I might say.... Okay? We don't have any good definitions of charity. In theory, a charitable write-off is one that you make prospectively; whereas, a bad-debt write-off is one you make retrospectively. But the reality is that I usually don't know your insurance policy very well, so I say, "Well, if it doesn't cover it, or if, in fact, you don't have insurance, we'll figure it out and we'll break it off later." Is that charity? So we don't have good definitions and we don't have good agreement on what are the areas of it. Whatever cities are looking for more income, they say, "Where are we going to get money?" Washington, D.C. is famous for it. They keep debating the level of the federal contribution in lieu of taxes. Well, the University always made contributions to fire, and this and that protection, had their own police force, etcetera. So the general topic of hospital tax-exempt came up. Then, we added a layer of yes, and we're also the University and how do you do that? I would say, from my recollection, it was more an abstract possibility debate rather than ever getting to the point of negotiating what taxes we might pay and, then, it sort of dissipated.

DT: So the Hospital retained its tax-exempt status then?

RD: Yes.

DT: There are so many confusing, complicated things about the way the Hospital runs and how it fits within that...

RD: Remember, at that point, it was still part of the University. Technically, you're a public entity; you are not a not-for-profit entity. By IRS [Internal Revenue Service] code, you are a not-for-profit. A lot of people mess up IRS with tax and legal status. You can be a not-for-profit taxable entity by the IRS code even though you're a not-for-profit. They're not one and the same.

DT: Yes.

Can you talk about the situation with John Najarian and the ALG [Antilymphocyte Globulin] situation?

RD: No [whispered]. Most of it happened after I left.

DT: Oh, it did? Okay. I wasn't sure of the timing.

RD: I'm aware of it, but I wouldn't be comfortable talking about it.

DT: That's fine. I wasn't sure. I'm asking everyone who was around in that time period. I've interviewed John Najarian.

How were relations between University Hospital and the physicians who weren't working for the Hospital? I guess I'm trying to get to this: a lot of people talk about the town/gown tensions that were everywhere in Minnesota. I wonder if you have any perspective on that.

RD: One, almost no physicians worked for the Hospital. They were faculty in the schools. We might pay part of their salary or, in some rare cases, all of their compensation if they were in a full time administrator post. So the town/gown was faculty versus people in private practice in the community, many of whom were faculty. You have to remember that education was occurring all over the Twin Cities. It was very dependent on specialty type of practice, how closely the private community physician, and whatever group they were with, felt in their ties to the Medical School and the University and experiences.

So if you sent one of the faculty a patient, and they said to the patient, "Thank God, you came because he was killing you," you'd probably have relatively poor relationships.

DT: [chuckles]

RD: That did happen, and, by the way, it happened everywhere around the country. It happened in Colorado. If you had a patient referred and you never sent him back, it didn't really develop good relationships. If you had a patient referred and you sent him back, but you never sent the letter or discharge summary, that probably didn't do much good either. The lot of it was the set of interactions that occurred and they could be at the individual or they could be at the group level, or they could be the local physician called and the chief resident wouldn't let them talk to the attending. "I don't need to talk to a damn chief resident. I'll never send you another patient again." So a lot of it came to that.

On a more macro scale, they sometimes—I'm not sure if it's often—got tied up with certain hospital competition. So two hospitals are jockeying with each other regarding whether we're doing bone marrow or should you do bone marrow, and the physicians sort of line up with them, or they don't line up with them and that gets even more confusing. All of that sort of goes into the town/gown mixture. It's *very* confusing. It's not a single pattern. It is true, by and large, that for years, the University did not adequately pay attention to the faculty's communication and nurturing of the referring physician. Lots of effort went into trying to turn that around. Sometimes successfully and sometimes not.

DT: Did you have a lot of involvement, discussions with the Minnesota Hospital Association and Nurses Association and the State Medical Association?

RD: About?

DT: In general.

RD: Yeah, I was on the boards and committees and stuff like that, the Hospital Association, certainly. Nursing Association, not that much. We needed to be active in, especially, the hospital realm, because there were relatively few public players and you could get lost. You at least wanted them to understand the implications before they took a position.

DT: Did you find them generally receptive to the University Hospital and its position?

RD: Ummm... I don't think anybody was antagonistic to the University or wished ill for the University. I really don't. They didn't want the University to prosper at their expense. That's a rational position. I think, sometimes, while they heard, understood, and were sympathetic to some of the dilemmas we faced because we were the University, and we were public, and we did get state monies, etcetera, etcetera, they really didn't feel like it was something they had to worry about. Again, I don't blame them for that at all. It's just like I don't worry about your union problems. Your union problems are your union problems and your medical staff problems are your medical staff problems. I'm sympathetic. I'll give you my encouragement and my advice, which is worth what you pay for it.

DT: [chuckles]

RD: But I'm not going to go home and lose sleep over it. I think that was true when they looked at the University. And, you know, everybody seems to survive and continue. So the evidence is usually, gee, you worry too much or, gee, you figure out a way to do it and so on.

The dilemma of any leader, administrator, manager, whatever, is to understand what may happen, to share and communicate that, and, then, to make themselves look like a fool by making sure it never happens.

DT: [chuckles]

RD: Think about it. So if any politician... The city is facing a \$2-billion deficit, portends of doom, tah dah, tah dah, tah dah, tah dah. Two months later, we figured out a way to deal with it. Why did you stand up and say the world was falling apart? Part of the reason is if I hadn't stood up, I never would have gotten to that point. A good leader always makes themselves wrong. It is frustrating at times. People sort of keep getting on your back for being a naysayer and a doom and gloom person. Even when you're optimistic, they don't give you any credit for that stuff.

[chuckles]

RD: Obviously, other people do that. I try and be very realistic about that. I think the single biggest mistake a lot of people make at upper levels of management is to use the word I instead of we. Truthfully, *I* never did anything alone in my career. I really didn't. I was part of teams, groups, sometimes just another person, and did all kinds of

wonderful things and, sometimes, some very stupid things. I, sometimes, got credit, blame and that's fine. That comes with the turf. But I need to be realistic and know that there's always a *we* in that. If you don't recognize and acknowledge that, you really don't do a very effective job. I think we've got a lot of *I* people floating around right now. I think it's part of the problem we're facing.

DT: What led to your decision to step down at Minnesota and take the position at the Association of American Medical Colleges [AAMC]?

RD: There's always a push and pull on every job change. When I went to Colorado, the pull was a really challenging opportunity to be a CEO and so on and the push was I'd probably done most of what I had hoped to do. I had sort of ended the building project approval process and it was a good time to move on.

AAMC was a little different because a couple things were going on. One, I was a CEO when I was a kid. I was thirty-five, thirty-six, something like that. I sat around one night and I said, "Do I want to be a CEO for thirty-five or forty years?" My wife has always been incredibly supportive said, "Oh, that's reasonable. What do you want to do?" I said, "I have no idea." I spent the usual mulling-it-over period and came up with nothing. I didn't want to go back to school and be an attorney. I really didn't want a for-profit business. If I had lots of money, I would have done some things, but I didn't have lots of money. It boiled down to, I'm not sure I want to do this the rest of my life, but I can't think of anything I'd rather do.

Then, Bob [Robert] Petersdorf, who ran the AAMC, came along and said, "Why don't you come and work for the AAMC? I need a new person to have the clinical component to the association." I said, "No," for all kinds of reasons. My daughter's going to be a senior in high school, and I didn't want to be an association person. I wanted to run things, get my name on buildings and all that stuff. We had a couple more lunches and dinners, and he sicced a couple more people on me. I finally concluded this was really an interesting opportunity, because I could take all the knowledge base I had developed in academic medicine and use it in a totally different position at the time when we were just entering the Clinton Healthcare Reform debates, and I would lead the association effort on that, and it would give me time to play in the policy world, which you don't get very often at a fairly high level. I was arrogant enough to believe that I would bring a real world perspective to these theoretical debates, to the degree I was involved with them, and, actually, that would be good, too.

So I decided I'd go to the association for three years and, then, I'd go back into management. I knew if I stayed on too long, it would be hard to go back into management. It was wonderful. It was just wonderful. I did use everything I knew. I really got immersed in the Healthcare Reform debate. I think *we* had some impact on the way the legislation was shaped. I think *we* were able to really help our members think this through and anticipate and understand, whether it passed or not, what it all meant. *We* did a lot of other stuff.

Three years passed and five years passed. I was sort of out of the CEO job mainstream now, would get an inquiry now and then. It didn't seem all that interesting. I spent sixteen, seventeen years there. It was a unique opportunity. So that was one reason. The other reason was I was discouraged, because I hadn't been successful in doing what I thought my primary job was. It was unclear to me if and when I would be successful and whether it would be at a point in time when it was because we had to rather than we should join with somebody and do a transformative process. So that was the push and the pull was the opportunity.

DT: Before asking a little bit more about the AAMC, by the time that the Hospital merger happened with Fairview, do you think that was the point where the University Hospital had to do it, that there was no longer a choice, and they were doing it from a weak position relative to if they'd done it earlier?

RD: It was certainly weaker than if they'd done it earlier. I should be clear... Whether they *could* have done it earlier, if *we* could have done it earlier, I don't know. You cannot have a merger of equals. That is a great myth that has no basis whatsoever. One or the other is going to die, but what role the University could have had and the impact and how it was shaped, I think, could have been different. They did what they should and needed to do. They could have let it drift even more and let more damage occur. So I don't think anybody erred. If anybody erred, it was me.

DT: This wasn't just Minnesota that was merging its University Hospital with a health system?

RD: Right.

DT: It seemed this was happening elsewhere?

RD: It was and it was happening in different ways. If you want to take a minute—since I'm now a scholar on all this stuff—...

DT: [chuckles]

RD: ...having worked in the association so many years—there are really several periods of university hospital transformation. There is one that is the early 1960s to mid 1970s and that was the separation of the state university hospitals and one private from the university, so Florida, Maryland, Arizona, West Virginia, a couple others, where they took a public institution and made it not-for-profit. The University of Chicago was a private. That was done really for those governance reasons, focused governance, ability to borrow money, ability to just do business, enter into a contract, set personnel salaries, etcetera. It's when Colorado should have done it, but they were late on that cycle. The second cycle is the one that Minnesota was involved with.

By the way, Minnesota's developed the board of governors in the first cycle. So it was a different response.

The second cycle going back to some of the early healthcare reform debates. We're going to be all capitation. We're going to be all HMO. Where do you want to be in the food chain, etcetera? I need geographic reach. I need depth. I need mass. I need to be able to borrow money. I need a primary care network, etcetera. So university hospitals looked around and said, "Do I buy or build or join?" All of those were out there. Some acquired a number of hospitals. They purchased some. Some built networks, just merging straight out without money and built new hospitals. Some merged into really community networks. So Minnesota joined Indiana which did that and some others that went into community networks. They were all byproducts of the community, the state, the history, the local dynamics. There isn't a right answer in that set. Really they were what can we do? What opportunities exist? So, really, the only question isn't should they? It's when they should have done it and could they have done it in a different time frame or with some different things better? I have perfect hindsight, so the answer is always yes.

DT: [laughter]

RD: But I can tell you, at least with me as CEO, it couldn't have been done earlier up to the time I left. Now whether they could have captured it in a year or two or three or whether, with somebody else there, they could have done it earlier, I'll never know.

DT: You said there were three transformations?

RD: Two.

DT: Okay, two.

I don't know how much time we have.

RD: We can go maybe twenty minutes more.

DT: Okay.

You mentioned your responsibilities at the AAMC. Can you talk about, in terms of the early Clinton healthcare reform efforts, what the position of the AAMC was and how you were involved in that policy-making process? Can you give a bit more detail?

RD: We were very supportive of the need to undertake reform. We generally did the classic thank you, great plan, but... [chuckles] Our butts were in the areas where we had expertise and that was how do you fund graduate medical education and the differential missions of teaching hospitals and research and so on? Basically, the Clinton plan still envisioned that there was more money. So our task was to get our members to agree on how to divvy up the bigger pot, which is no easy task.

[chuckles]

RD: If there's ten bucks, well, I want ten. The hospitals and medical schools are squared off with each other, as you might expect. We had some very late night debates, but we were successful. We sort of shaped how the money should be divvied up and how the mechanism should exist for communicating the money. So, for instance, at that point, in history there was a group who said, "You should send all money to the health science center. Then, they'll allocate it out." Well, there are a couple problems with that. The biggest one is, I haven't the foggiest idea of what the health science center is. I know what a medical school is; it's accredited. I know what hospital is; it's licensed. Tell me what a health science center is. What's the legal definition...? Who do I send a check to? The University of Minnesota Health Sciences? That's not a legal entity. Oh, so you want the check to go to the University? *No!*

DT: [laughter]

RD: Our members said, "I don't want it to go to the University, for god's sake! They'll keep it all. They don't let any of it float out." People get caught up in talking about terms that have no meaning. We tried to straighten out that language. The question was who should pay for the residents? We came up with this incredibly novel answer. Whoever pays them. If you incur the cost, you should get the money. If you don't incur the cost, you shouldn't get the money. A lot of people were unhappy with that. I mean that was a big debate, because, as you would expect, we had a number of medical schools who wanted the money but the hospitals should pay for the residents. They do all kinds of good things for the patients and stuff. Those were the types of issues. How do you divide the pot? How do you flow the money and so on?

Then, there was this whole issue of, we're going to have too many physicians, if you recall that. Physicians are going to be driving taxicabs and so on. This was the early 1980s. All the studies were done using Kaiser Permanente's physician-to-population ratios in their closed system. When they do that, we had way too many physicians, already. So Macy [Josiah Macy Foundation] proposed, the commission proposed we should cut Medical School enrollment. Then we have this...generalists should be fifty-five percent and there's all this stuff they were going to propose in legislation, you know. So you'd sit down at a meeting—this is where I think the pragmatic side came in—and I say, "Okay. Fifty-five percent generalists. At what point?" They'd look at you and say, "What do you mean?" I'd say, "Well, do you want fifty-five percent to enter residency as generalists?" They say, "Yes." "Okay. You want fifty-five percent of all physicians to be family practitioners?" "No!" "Well, if they go into internal medicine, they may sub specialize. If they go into pediatrics, then may sub specialize." "Oh. Well, we'll measure at the end of their residency." "Okay. So at three years, if they go into practice, they're generalists? Okay. What if they go back to specialty training?" "What do you mean?" I was a generalist for a year. Now, I'm going to do a residency in cardiology. Do they pay back money?" "I don't know what to do on that." "What about ten years into..." "Well, that would be good." "So you want to shape who you give money now based on what you project they're going to do fourteen years from now?" It helped. They sort of said, "Oh, okay. I get it. Maybe we shouldn't be so prescriptive. Maybe we should set goals

and aspirations and targets and not try to do...” So I think that’s the type of stuff we tried to shape so that you could live with it and everybody wouldn’t go crazy. Research, how to make sure NIH [National Institutes of Health] continued to have flexibility and sufficient resources, that it was adequate, intramural, and extramural monies and so on.

DT: The position of the AAMC, how did it jive with the AMA’s [American Medical Association] position?

RD: Actually, on the workforce stuff, five of us got together and shaped a common policy on the workforce: ourselves, the AMA, the Association of Academic Health Centers, the American Hospital Association, and the osteopaths, which was a pretty big achievement.

DT: Other than the workforce issues, there were lines of disagreement?

RD: I would say that we were pretty much in alignment with each other, but did it a little differently with different specifics and so on. Usually, where we breached with the AMA was sort of private physician practice versus how do deal with physicians who are employed. They didn’t like employed physicians. We had employed physicians. Now, it’s changed a lot, because a lot more physicians are being employed.

DT: What about some of the other healthcare reform...Medicare prescription drug benefit?

RD: We would take positions on all major public policy issues. Some of them were more important to us than others. The prescription drug benefit was not a fundamental issue for us. What we would do on that is try and offer our best thoughts on *if* you’re going to do this, here are things we think you should do or consider in what you’re going to do. You couldn’t be against the prescription drug benefit, but you could say, “We don’t want a hole,” and so on and so forth.

DT: Were there other significant pieces of policy that you...?

RD: Well, physician payment is a big issue, because that affects all physicians, including faculty. The fact that we still have this cliff-hanging scenario every year of how we’re going to cut physician compensation in Medicare thirty percent, we took the positions on that all the time and formed coalitions with other groups and the AMA and all of that. None of us were successful in that and they’re still screwing around with it.

Then, some of the fundamental issues in Medicare: how to handle DSH payments, Disproportional Share [Hospital] payments; how to handle geographic distribution in terms of adjustments for geography. Urban/rural issues would crop up and since most academic centers are urban, we’d take positions on that. Medicaid, in terms of dealing with graduate medical education [GME] and so on, a children’s [hospital] GME, because, strangely enough, most children’s hospitals don’t have a lot of Medicare patients.

[chuckles]

RD: A whole lot of issues. This was not my bailiwick but very active in research policy in terms of conflict of interest, distribution of funds, V.A. research. We also spent a lot of time on V.A. in terms of their ability to participate and fund the academic and research activities. We were probably one of the biggest advocates for the V.A. outside of the V.A. groups, the veteran's groups.

DT: That just reminds me of one question about the University Hospital...

[break in the interview]

DT: Can you explain what the relationship was to the V.A. Hospital in those decades that you were involved in Minnesota?

RD: They were always good. It was always a major affiliate. It was the other University Hospital in many ways. The V.A. faculty were like University faculty. They were often one and the same. There was always this question of should we try and combine the facilities? In fact, when we first were doing the planning for the renewal project, there was a very active proposal to combine—the V.A. was planning a new facility—the two. There were drawings with a common support base and two towers, one for the V.A. and one for the University. Actually, John and I spent a full day in Washington [D.C.] meeting with [Minnesota Senator] Dave [David] Durenberger and testifying before the V.A. committee on that proposal. It was really fascinating. It was a hearing. It was primarily staff who were there. Planning agencies...we testified. Everybody said, "It makes sense." Then the veteran's group said, "No! No! No!" [Mister Dickler pounds his hand on the table three times]

[laughter]

RD: And that was it. That was another lesson.

DT: They wanted the V.A. to have its autonomy?

RD: Yes. There was always lots of fear the V.A. would combine with everybody else losing their focus on the veterans and so on and so forth. I understand that. But I think the relationships were always good. I was very good friends with [Robert A.] "Randy" Petzel who actually became the CEO at the V.A. and, then, the regional director. We collaborated to the degree we could, especially on specialty services. So I'd say the V.A. was a good relationship.

The one person we really haven't talked about is Lyle French...

DT: Yes.

RD: ...and Dave [David] Preston, Cherie Perlmutter. Lyle was absolutely exceptional. I think the success of the University of Minnesota health sciences and the planning and the building program and all the progress that was made, it isn't a single person but without Lyle French, it never would have happened. Lyle was a born leader. He knew how to stay out of things. He knew how to play people against each other. I still remember being in meetings with the clinic chiefs and they'd all say, "You've got to make a decision. "You've got to make a decision." "You've to make a decision." He'd say, "Yup, it's my decision," and he'd stand up and walk out.

[laughter]

RD: We'd all just sort of sit there. The message was clear. You guys decide. I'm not going to tell you what to do.

He let the units do their job. He didn't try and make the vice president's office the corporate office, finance in the corporate office of human resources, and the corporate office of this and that. He worked well with the Legislature. He worked well with the president and the other officers of the University. David and Cherie and others, [Villis] "Vik" Vikmanis, really did a yeoman's job. I visited a lot of health centers, and I think they set the mark and should be acknowledged for that.

DT: I've heard that from pretty much everyone I've spoken to, about almost the uniqueness of Lyle French, but, also, the fact that he had Dave and Cherie behind him, too.

RD: It was a great team.

I worked as much with David and Cherie as I did with John, in many cases. It was almost seamless. It wasn't, I work here and you work there and you work there. We really just aggregated around what needed to be done and rarely, rarely, did anybody say, "You do that because I'm here and you're there," or "Because I told you to do it." There was a level, especially for a young guy, of respect and the ability to really be a full participant, which was priceless, *absolutely* priceless. I don't think it could have been any better than it was.

John was absolutely the very best and worst mentor I could ever have initially. No ego. Best delegator I've ever seen. He let me participate in anything and everything, but let me hang myself... I learned from that.

DT: [laughter]

RD: On a couple occasions I wish he would have sort of stopped me from doing myself in. A little more direction, John.

DT: [laughter]

RD: I didn't need that lesson.

DT: We've covered all the ground. Is there anything else you want to add about the history of the University Hospital and the AHC [Academic Health Center]?

RD: No, I don't think so. I think it's really a good history. I think Minnesota is still a first class institution. I'd like to see it be a little stronger than it is now. I'm not sure what it would take to do that. I've been away now a long time. I wouldn't begin to try and second-guess what anybody should be doing at this moment in time.

I owe a lot to Minnesota. I got a great education there. I got great opportunities there. And we raised our daughter there, a terrific place to raise a family. For a guy who grew up in the city of Chicago, I even learned how to backpack.

DT: [laughter]

RD: It was really fun.

[End of the interview]

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