

**Bright Dornblaser**

Narrator

**Dominique A. Tobbell, Ph.D.**

Interviewer

**ACADEMIC HEALTH CENTER  
ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

## **ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT**

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

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20<sup>th</sup> 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**

Bright Dornblaser was born in Minneapolis, MN. He received his BA in 1949 and his Masters in Hospital Administration in 1952 from the University of Minnesota. From 1952-54, he worked as the secretary of the Board of Health in Philadelphia. He then briefly returned to the UMN as an instructor in the Program in Hospital Administration in the School of Public Health (1954-55). From 1956-60, he was the Assistant Administrator in the Danbury Hospital in Danbury, CT. From 1960-67, he was the Director of the Franklin County Public Hospital in Greenfield, MA. In 1967, he again returned to the UMN as professor and Director of the Program in Hospital and Health Care Administration in the School of Public Health. He retired in 1998.

### **Interview Abstract**

Bright Dornblaser begins by discussing his background, including his education. He discusses why he returned to UMN as a faculty member in 1967; his experience as a graduate student and faculty member in the School of Public Health, including commenting on faculty and deans such as Gaylord Anderson, Lee Stauffer, Edith Leyasmeyer, and Robert Kane. He also discusses the first vice president for health sciences, Lyle French. He describes relations between divisions within the School of Public Health and relations with other colleges within the Health Sciences; funding of the School of Public Health; the Hospital Administration Program; shift in focus in the School of Public Health toward research; the Ph.D. program in hospital administration; the relationship between the Hospital Administration Program and the University Hospitals; public health nursing program; space in the School of Public Health; the position of the School of Public Health within the Health Sciences; the program in health care administration's time in the Carlson School of Management and its move back to the School of Public Health and into the new division of Health Policy Management; the Alumni Association of the hospital administration program; and recruitment of minority and women students.

**Interview with Bright Dornblaser**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed at the Office of Dominique Tobbell**

**Interviewed on February 25, 2011**

Bright Dornblaser - BD

Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Professor Bright Dornblaser. It is February 25 [2011]. We are in my office at 510A Diehl Hall [University of Minnesota campus].

Thank you, Professor Dornblaser, for meeting with me today. To get us started, could you just tell me a bit about where you were born and raised?

BD: I was born in Minneapolis, Minnesota, and lived here until 1946.

DT: And then, you went...?

BD: I went into the service, World War II, and, after that, returned to get my master's degree here, and, then, left until coming back to be director of the graduate program in hospital administration.

DT: Your master's was in hospital administration?

BD: Right.

DT: What led you to pursue that as your master's and eventual career?

BD: I was drawn to the health field. My father was a physician. It's a service to people and, also, I enjoyed the management role.

DT: What did you study as your undergraduate?

BD: The BBA in the School of Business Administration here, industrial engineer.

DT: After you got your master's, you then went to Vermont? Is that right?

BD: I was there for administrative residency as part of the master's and the rest of that is in this first paragraph [referring to Professor Dornblaser's written account which he has submitted with this interview].

DT: When you came back to the University of Minnesota, what led you to come back here?

BD: Well, the original program director resigned and I was asked to consider becoming the next one.

DT: So you were hired as the director of the division?

BD: Right.

DT: Can we talk a little bit about your experiences here as a graduate student when you were in the hospital administration program? Were there any notable faculty that you worked with during the master's?

BD: Certainly, the director of the program, James Hamilton, was one of those towering figures in the field of health care management. There were other faculty. His primary associate was James Stephan, but there were a number of other people in his consulting firm who also were faculty, as well as visiting people who were brought in.

DT: Did you have any experience with Gaylord Anderson as a student?

BD: We took his class in public health. That was the extent of my experience with him.

DT: Did you get any sense about what the culture of the School of Public Health was like when you were a master student?

BD: Not much. We were located in Temporary South of Powell Hall, which was a temporary building all by itself located away from everything else, so we were kind of isolated.

DT: When you returned to the University to direct the Division in Hospital Administration, Gaylord Anderson was still dean?

BD: He was.

DT: What was your experience like of him as a director of a division?

BD: Well, I comment about him in my written testimony, but I might add he was a pleasure to know. I think he was always fair-minded, obviously deeply committed to public health and to the school and to the University, very supportive of our program.

DT: What were relations like between the different divisions within the school?

BD: Cordial.

DT: Was there any sense of hierarchy between the divisions?

BD: No, not that I recall. It was very compatible.

DT: One of the things that strikes me as so interesting about public health is that there's such a mix of disciplines that constitute public health. You have MDs [medical doctors], engineers, administrators, researchers.

BD: Yes.

DT: It's a really good example, I guess, where all those different professions are collaborating together.

BD: Yes, we worked well together.

DT: With the reorganization of the health sciences that took place just after you returned here was there any change in the way in which the School of Public Health fit within the health sciences, did you find?

BD: No, not that I recall.

DT: When you first returned here, public health was within the College of Medical Sciences?

BD: Yes.

DT: How did Dean [Robert] Howard regard the school, as far as you could tell?

BD: Very highly...very highly regarded it.

DT: How did the school relate to the other schools, to medicine, to nursing?

BD: You're asking me to think about things I haven't thought about before now. [pause] I don't recall that there was a very close working relationship even though we were part of the school. It was cordial, but the working relationship wasn't that close. We did develop some while we were there, but it wasn't a primary orientation.

DT: Did that change at all in the 1970s once the College of Medical Sciences was disbanded and the Academic Health Center was created?

BD: No, I don't think so.

DT: After you'd been back at the school for a year or two, Gaylord Anderson retired.

BD: It was longer than that, I think. When did he retire?

DT: Nineteen sixty-nine or 1970.

BD: Hmm.

DT: I think 1970.

BD: All right. I don't really remember the other deans that well. I'd have to go back to the School of Public Health and look at their photographs, which I've been meaning to do.

DT: [chuckles] I know Lee Stauffer was appointed dean...

BD: Oh, yes, oh, Lee, sure.

DT: Were you involved in or were you aware of any of the decision making that led to Lee Stauffer's appointment?

BD: No. Well, I say, "No." I assume that it followed that the programs directors were asked to comment but we, obviously, were positive. We'd known him from before, so it wasn't an issue.

DT: Was Lee Stauffer's way of being dean in any way different to how Gaylord Anderson had run things?

BD: I think Gaylord was more directive. Lee was a very open, friendly fellow. There was, perhaps, more give and take with him than before.

DT: What did you perceive to be some of the major challenges confronting the school and the Division of Hospital Administration in particular during the 1970s?

BD: I've covered that in there.

DT: Okay.

It seems that there were several new programs set up within hospital administration during that decade, like the Long Term Health Care Administration Program. I may have that wrong. Can you comment at all on the decision to establish...?

BD: That's all in here, too.

DT: Okay.

How was it running the program given that there were a lot of budget cuts happening in the 1970s? It seems that the state and the Federal Government were curtailing a lot of its funding.

BD: I also comment on that. It was precarious as it has been before and will be in the future.

DT: Did you feel public health was in a particularly precarious position? I saw from records that I think it was ninety percent of the school's funding came from federal funds, soft money, research grants, and less so from state funds.

BD: That's interesting, because Gaylord did not want to take federal funds. But, even today, we're precarious because of that. Half our funding is from research grants.

DT: Why did Gaylord Anderson not want to take federal money?

BD: He was part of the federal establishment and I think he felt this was a state school and a state obligation.

DT: The fact that this was a state school clearly influenced how Anderson then perceived the function. Do you think it continues to influence...?

BD: He was an internationalist, but he thought it was a state responsibility.

DT: Were there a lot of relations with the State Health Department during this time?

BD: There were, but I can't be very specific.

DT: With the Program in Hospital Administration, were you working a lot with the area hospitals?

BD: Very much so.

DT: To what extent were you working with them?

BD: As I discuss in here, basically, they provided our residents with their residency opportunities.

DT: Yes. I heard from someone else that I spoke with that the Hospital Administration Program was so important. It was producing the hospital administrators throughout the state and that a lot of your graduates then went off to positions elsewhere, as well.



BD: That's correct, yes.

DT: I saw in the archives that there was some discussion of changing the name of the program to Health Care Administration in the 1970s. Do you recall that?

BD: There always was a program in hospital administration. The focus did shift from being exclusively hospitals to being concerned with other health care organizations as well.

DT: That didn't create any tension?

I seem to recall that there were efforts in the early 1970s to create a school of allied health sciences and you were particularly supportive of having the allied health sciences be situated within the School of Public Health.

BD: [chuckles] I haven't thought about that in decades. I can't recall exactly what I was thinking at the time, but I'm sure I, obviously, thought it was a good idea, and I can understand how I must have felt that way.

DT: It seemed like there were some people who really supported the idea and, then, others who were actually working in the allied health sciences who... I remember seeing material from medical technicians who worked in the Department of Physical Medicine and Rehabilitation, for example, where a lot of the allied health sciences were, and in the Pathology and Laboratory Medicine Department who actually wanted to stay in their departments and didn't want to be in the school.

BD: We were not really involved emotionally in that political kind of discussion.

DT: It seemed that there was a real concern through the 1960s and 1970s that there was a shortage of public health workers for the state and nationally. Do you remember that at all and how that may have influenced how the programs were run?

BD: Well, I comment in here about how the school was a professional school, so it was, obviously, concerned about that and had a responsibility to answer that need.

DT: I've heard from a few other people that I spoke with that there was a shift in the priorities of the school from the 1970s onwards where it originally had been a professional school training professions and the emphasis at the school was on training and, for various reasons, the school shifted towards being a research unit. Can you comment on that?

BD: That's accurate, as well. The shift has continued, so now it's much more of a research institute than it used to be.

DT: Do you think that was a beneficial change or do you think there were some downsides to that shift in focus?

BD: The plusses were and are that it provides funding and research is needed, that research faculty in theory can bring results of that to the classroom. The downside is that it diminishes the emphasis on teaching.

DT: Given that public health is very much a professional orientation, as you say, about producing people who go out and work as professionals in the field, that seems like that could present difficulties.

BD: That didn't affect us at all.

DT: Oh, that's good.

Do you recall when the Ph.D. program in hospital administration was...?

BD: About 1962.

DT: You weren't here at that time.

BD: I was.

DT: Oh, you were. Okay.

BD: No, I was not here when it was developed. That's right. That's correct.

DT: Do you recall the rationale for creating the doctoral program?

BD: I think Jim Hamilton felt that we ought to be preparing those people to be faculty for the programs that we were wanting to professionalize.

DT: How were the relationships between the program and University Hospitals during your tenure?

BD: Very close. Our grads trained there. The CEO, whose name escapes me, was the one who brought the money to the University for many years and was very close to the program.

DT: John Westerman?

BD: He was one of our grads. He was later. This was before that. The one who was there for many years preceding him was the one who really did much to bring money to the University because he knew all the legislators.

DT: Ray Amberg?

BD: Ray Amberg.

DT: So Westerman was a graduate of your program?

BD: Yes.

DT: Did he train under you when you were director?

BD: Yes.

DT: That's great that one of the graduates went...

BD: There are many who have done very well.

DT: One of the things in the School of Public Health I've been interested in is the place of public health nursing in the School of Public Health rather than in the School of Nursing. Do you have any perspective on why public health nursing was in the School of Public Health and, then later, moved?

BD: Well, I don't know, but my presumption is that Gaylord felt that public health nursing was certainly a part of public health and that's where it ought to be, so that's where it was.

[laughter]

BD: He wanted to prepare people who had a strong focus on being out in the community and doing nursing in the community, as opposed to going into the hospitals.

DT: Yes. I've heard from several people that regard public health nurses as being really a primary force within public health.

BD: No question. No question at all.

DT: Were you aware of why public health nursing eventually was transferred to the School of Nursing, I think in the 1980s?

BD: I have no idea.

DT: With the reorganization of the health sciences, did you perceive there to be any significant changes in the way the school, but also the health sciences more generally, were functioning in the 1970s?

BD: I can't help you.

DT: I know that during the 1970s, Lyle French had to do a lot of work with the Legislature.

BD: Yes, he did, and quite effectively.

DT: Did you ever have to go in front of the Legislature or was that really reserved for the deans?

BD: It was the dean and did not affect us.

DT: What was your impression of Lyle French?

BD: Obviously, he was extremely competent in his profession and very likeable as a person and quite effective in terms of thinking strategically as far as we could tell with the Legislature, very highly regarded.

DT: I know that at some point toward the late 1970s, obviously, the Legislature had helped fund a lot of the reorganization and the expansion of the health sciences, but that a few state senators or legislators were starting to complain that the University was getting too much money, and they were trying to limit the amount of money that the health sciences were getting to continue their expansion. Do you recall those debates?

BD: No. I'm sure I paid attention at the time, but it didn't impact us particularly—not that they weren't important, obviously, but I was not personally involved.

DT: It seems that space has been at a real premium in the health sciences' history. You mentioned that hospital administration was, at one point, in kind of an isolated part of the campus. Did the Public Health and hospital administration have particular struggles to get space? Do you think that impacted how the school functioned or how the program operated?

BD: Certainly, it impacts how the school functions and still does. As far as we were concerned, it did not adversely affect us.

DT: Can you say more about the ways in which the space issue impacted how the school functioned?

BD: Well, then, as now, it's more difficult for people to physically get together and relate to each other, and that makes a difference in some programmatic relationships. It continues to be a problem as it was then.

DT: Has the school tried at various times to get relocated into a central space?

BD: Endlessly.

DT: [chuckles] Why do you think the school hasn't been successful in that effort?

BD: Public health doesn't have a high priority.

DT: What units do you see as having been prioritized?

BD: Oh, the Medical School, obviously. The Dental School next. Nursing has done very well, as it should.

DT: Where do you see public health having fit on this kind of hierarchy then within the health sciences?

BD: In terms of clout, obviously, it's not been high. It's been low, even though now our faculty bring in more research money per capita than anyplace on the campus. So that helps. We do have a very good dean [John Finnegan, Junior] now. It's the problem public health has had since it began.

DT: Do you have any explanation for why public health has struggled to have adequate prestige given to it?

BD: It's easy for the public to see the results of the medical interventions, surgical intervention. Preventative disease is harder for the public to understand. A few issues more recently like tobacco and healthy living have gained a little more prominence. It's a public good that is hard for the public to really see the benefit. They enjoy the benefits. To make the connection is very difficult.

DT: Yes, if you're prevented from experiencing something bad like a disease, as you say, you can't understand the absence of it. You don't see the value of...

BD: We take our sanitation system for granted.

DT: Yes. But if it suddenly had problems, then you might get more appreciation.

[laughter]

DT: If you're confronted with significant epidemic, then, suddenly, people realize what public health...

BD: Yes. Somehow, that doesn't translate to the full in saying public health in general is vital. Dealing with this epidemic at the moment is useful, but does that mean that the congress should spend more money for public health? Yes, we have an epidemic, but public health is amorphous.

DT: Yes. Really, it's been a perennial problem for public health to get the kind of recognition, political and public recognition, because, as you say, the medical intervention, the surgical interventions, and dental interventions, are a lot easier to see. It's been really difficult, and it's not unique to Minnesota, by any stretch?

BD: Oh, no. No. No. That's right.

DT: That point you made about how now the School of Public Health is bringing in more research grants per capital than any other place in the University, several people have told me this. So that's been the case for quite a number of years, too.

BD: That is the result of the school becoming more of a research institute.

DT: But, yet, despite the amount of research funds the school is bringing in, that hasn't had a commensurate impact on the recognition that it receives?

BD: I think it has though in recent years. Dean Finnegan is very well respected and has done a good job communicating the importance of public health and the money it brings in. Under his leadership, there had been made connections with other parts of the health sciences, so it's regarded more central and the subjects that are being researched are currently subjects of interest nationally.

DT: It seems that health services research has become a significant focus in the last several decades.

BD: Yes, it has. Epidemiology does very well, for example.

DT: Yes. Was it Len [Leonard] Schuman who was involved in a lot of tobacco, cancer and tobacco?

BD: He was. Yes.

DT: When you look back at the School of Public Health's history, there's been some real significant national and international figures, deans within public health that Minnesota can be very proud of.

BD: That's right. That's right.

DT: Did you have, as a student and then as a faculty member, any interaction with Ancel Keys?

BD: Not as a student. My connection was in program director meetings and the School of Public Health meetings. We did provide a graduate who served as administrative person when they were in Stadium 18, or whatever it was, but that was the extent of it.

DT: It seems like the different programs within Public Health were fairly independent.

BD: They were. We certainly were. Our original program director wanted it that way. I say in here that I made some changes in that regard, but it was very, very simple.

DT: You directed the Hospital Administration Program from 1969 to 1980?

BD: Nineteen sixty-eight to 1981.

DT: What led you to step down?

BD: The administrative side of that role was not very appealing.

DT: Anything in particular?

BD: No. I became less interested in spending time doing that.

DT: So, then, you returned to teaching?

BD: Yes.

DT: When did you retire?

BD: Nineteen ninety-eight.

DT: Were there particular changes in hospital administration that you saw through your career?

BD: Yes, I comment about those in here.

DT: Okay.

Dean Stauffer stepped down, I believe, in 1980 or thereabouts. Then, Edith Leyasmeyer...

BD: Yes.

DT: ...was acting dean.

BD: For the first time.

DT: Yes. It seems like she was acting dean a number of times.

BD: Yes.

DT: Can you comment at all on the different deans that ran the school through the 1980s and how their leadership styles maybe influenced the program and the school more generally?

BD: As I said, I have a hard time actually remembering who some of them were.

[chuckles]

BD: I was discussing this with my colleagues. We all have some difficulty. We liked Edith [Leyasmeyer], after all she's one of our graduates.

[laughter]

BD: But, also, her style. She would listen and was good at involving various people in the school's management. With some of the others, my recollections are that they were not very helpful to the school while they were here in their periods of time either because of interests elsewhere or being short term here or their style of management did not draw much participation or support.

DT: I've heard from several people that Robert Kane's leadership of the school led to some dissatisfaction among various faculty members.

BD: Yes. He's a research-oriented fellow and he's, obviously, very, very talented in that regard. He's very bright. He thinks very clearly and he's worth listening to. He is today. But his orientation towards research was very different from the history of being a professional school and a strong teaching school, so that change was difficult.

DT: I heard from a couple of people that in the end the faculty, basically, revolted and encouraged him to step down.

BD: Yes.

DT: I think it was during his tenure...wasn't the program in health care administration moved to the Carlson School of Management [correctly: this occurred in 1997 during the tenure of Dean Leyasmeyer]?

BD: Yes. We lived in there for a time.

DT: What led to that? Why did the program move over there?

BD: There was a recognition that if it was in the Carlson School there was special expertise and specialized skills, and it would make it useful to connect with those. It turned out it was not a very wise decision.

DT: Why was that?

BD: The dean [David Kidwell] that was there when we moved left and the subsequent dean [Lawrence Benveniste] did not see any need for our program to be there. We were a generalist degree. The other degrees were all specialist degrees. It was hard for him to wrap his mind around the generalist degree. Then, of course, he tried to take our endowments from us to the Carlson School.



DT: I would imagine that's hard... Well, aren't endowments attached to specific programs or there were ways of skirting that, I suppose.

BD: He was finding ways to constrain. I don't recall the specifics now, but it was clear that we were not going to get the support from them that we had anticipated.

DT: Was it relatively easy to move back to Public Health?

BD: Yes, and it was very comfortable. We had to bring the alumni along with us that we had worked to move with us to the Carlson School...

[laughter]

BD: ...and then bring them back about four, five years later. It's turned out to be a very good move. There is a large faculty, very compatible. We were four or five faculty as a program. We're now part of the division that has twenty faculty. We're back in the public health orientation. Still have a concern for business, of course.

DT: Again, it goes to the issue of how interdisciplinary public health is and, then, how hospital administration... It's not surprising that one would think that the School of Management might have something to offer, but, at the same time, they don't have the health component that Public Health does. It seems by virtue of the program's interdisciplinarity it puts it in an interesting position.

BD: Their research, by and large, was not in the areas of health. There was a [unclear] specialist. We're able to carry those areas just fine in the School of Public Health.

DT: I'm glad that you brought up the program's alumni, because I've seen in the archives and heard from various people that the alumni of hospital administration have been a very important group for the program. Can you say a little bit more about how the alumni has functioned?

BD: I comment about that in here. Jim Hamilton started the Alumni Association, probably about 1950. As I comment here, it was based on the Dartmouth [University] model. It's always been an essential part of our program life.

DT: Given how successful the program has been at training leaders, national leaders, it seems help keep the program here in the national spotlight and international spotlight.

BD: Absolutely.

DT: It's quite impressive.

BD: Yes.

DT: I don't recall the exact date, but, at some point, Health Care Administration merged with or was grouped with a division, and a new division of Health Policy Management was created.

BD: I don't recall the particular date.

DT: Do you recall any of the decision making that went into the merging of the two programs?

BD: To become part of the division?

DT: Yes.

BD: That was part of the deal coming back to the School of Public Health. That had its plus because it gave us a larger faculty piece.

DT: I spoke with John Krlewski recently. It seemed that the setting up of the Center for Health Services research in the 1970s was an important development for the school. It seems that the remnants of that center are now contracting within the division of Health Policy and Management.

BD: That's right.

DT: Do you have any comments on the role that Health Services research has played over the last few decades?

BD: Well, clearly, it's an important research area and continues to be.

DT: You said earlier that it's worked well being in this division now.

BD: Yes, I think that's where it should be. In fact, I think that's where it should have been from the beginning.

DT: What kind of students has the program attracted? Is it generally someone who comes out of their undergraduate degree and then goes in to get the degree in hospital administration or is it more typical that people have worked in the health care field?

BD: I comment on that here.

DT: Something that I'm curious about... I know that during the 1970s in particular, there were efforts made in the health sciences more generally to their increase recruitment of minority students and minority faculty.

BD: Yes. I didn't mention that as much as I should have. In fact, I didn't mention it, other than women. I meant to go back before I talked with you and count the number of women by class, which I could do if you're interested.

DT: Yes. Yes, I'd love to know, yes.

BD: Again, we had an interest in attracting minorities. It becomes, in part, a function of their acceptance in the field, so there had to be social changes that affected the minds of those who employ our graduates. Someone like Archie Givens made his own way. As you may know, he's been very prominent in the Minnesota Alumni Association. We pushed the envelope a bit and we found some good people and encouraged their being accepted or employed.

DT: Were there any specific strategies that you and the program used to recruit minorities or to try and convince employers that they should hire your minority grads?

BD: That's a good question. [pause] I don't know that we had any in the earlier days. As we began to get some interest in minorities, we would ask them to help in finding others. The obvious approach.

DT: I'm curious about whether you had much success with training or recruiting and then getting jobs for Native American students, because, Minnesota, obviously, has a large Native American population and the Indian Health Bureau has... I wonder if there was much training in those areas.

BD: No; although, we did ask the grads to go do administrative work in the reservations. By and large, they would not have met our division criteria.

DT: That's the dilemma, I suppose, in trying to increase recruitment is how to balance your efforts to recruit with some of the educational deficits that minorities come with because they don't have that the same high school educational opportunities that non-minorities do.

BD: That's right.

DT: Do you think there is any way to resolve dilemma?

BD: Do a better job of educating before [they get to the university].

[laughter]

DT: Yes.

I would love it if you can provide that information about the number of women in the classes, if it's not too much trouble for you to do it.

BD: No.

DT: Do you have any further thoughts about the school's history and about the health sciences that you would like to share with me?

BD: Not other than what I may have mentioned already.

DT: I'm really grateful that you wrote down your recollections. That will be very useful to have as a resource.

BD: Well they don't address some of the school interrelationships in the health sciences because, as you said, the programs were quite self contained, and while we would make comments as program directors when meeting with the deans, I don't think that had much impact on what was actually decided.

[laughter]

DT: I suppose if it wasn't to the detriment of each program to be self contained, then...

BD: Well, I, obviously, got along very well being self contained. [chuckles]

DT: In medicine and nursing, there's a shared body of knowledge that everyone can at least identify and come together around within Public Health. It just seems hard to have a shared body of knowledge for all disciplines within Public Health.

BD: The accreditation requires that we would have courses in each of the areas in the School of Public Health. To that extent our students became aware of those.

DT: I found it fascinating.

BD: Yes, but in terms of beyond that, in the operation of each department, they were quite self-contained.

DT: Can you think of anyone else who you think I should talk to about this history?

BD: You've already talked to Vernon Weckwerth.

DT: Yes.

BD: Ted [Theodor] Litman may have some comments about your questions about interrelationships among the schools in the health sciences. I'm not sure. He was mostly concerned with the doctoral program and was director for a number of years. [pause] I assume you will be talking to Lee Stauffer.

DT: Yes, I talked to him already.

BD: And the other deans, Edith, and so forth?

DT: They're on my list.

[long pause]

BD: There may well be other program directors during my time and subsequently that would have more to say about the health sciences and so forth than I have.

DT: If you think of anyone else, please, don't hesitate to let me know.

Thank you. I really appreciate your time and I really appreciate the written comments that you have.

BD: I won't be commenting on a number of the areas on which you had questions.

DT: I'm looking forward to reading them and they will be very useful. Thank you.

BD: All right.

How long have you been here?

DT: Two and a half years.

BD: What brought you here in the first place?

DT: Well, the job. [chuckles] I got hired here. I came from Philadelphia. I did my graduate work at Penn [the University of Pennsylvania].

BD: In what field?

DT: History and Sociology of Science.

BD: And here you are.

DT: Yes.

[laughter]

DT: This was ideal for me, this position. I get to teach the history of medicine and also get to do this oral history project, which I think is really valuable.

BD: Yes, I'm sure. When you're teaching the history of medicine, what is your approach?

DT: Right now, I'm teaching a graduate course on disease and the culture and politics of health. Ideas about disease and the ways to treat and prevent disease have changed over time. We started looking at the Black Death, but we're really focused on the nineteenth

and twentieth centuries. We've been reading about polio [poliomyelitis] in the early twentieth century and public health efforts and changes in public health theories and practice in response to germ theories. Then, we'll look at the social context in which diseases are experienced.

BD: Yes.

DT: I've also taught courses on the history of medical technology and how health care has become increasingly technological and what the implications have been for the patients, for the practitioners, and policy measures.

BD: Very good. So you're being very current, as well as historical.

DT: Yes. Yes. I do a lot of contemporary, more recent history, too.

BD: Good for you. Who are your students?

DT: We have graduate students in the program, the History of Medicine, so I've got a few of those, and the undergraduates who tend to pull from any of the pre-health sciences, and some history students. We do research lectures for medical students, too.

BD: As well as talking about technology for patients, do you see application of technology for teaching?

DT: I try to incorporate technology as far as possible. In my teaching, what I actually do is I bring a lot of the artifacts into the classroom so the students can interact with some of the older medical technologies. That's pretty neat. Then, in terms of looking at how technology is being used in the education of students, say, medical students, I haven't done that to a great extent, but the fact that we have simulation labs now where medical students can practice simulation, that's something that I should really think about.

BD: Yes, fascinating.

DT: Thank you, Professor Dornblaser.

BD: It was a pleasure. I'm sorry I couldn't be more help in the areas of your questions.

DT: Oh, no, you were great. Thank you so much. Bye, bye.

[End of the Interview]

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