

**Edith Leyasmeyer, MPH, Ph.D.**

Narrator

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

Interviewer

**ACADEMIC HEALTH CENTER  
ORAL HISTORY PROJECT**

**UNIVERSITY OF MINNESOTA**

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

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

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

Edith Leyasmeyer received her BA from Baldwin-Wallace College in Berea, Ohio, in 1958; her MPH in Hospital and Health Care Administration from the University of Pittsburgh in 1961; and her PhD in Hospital and Health Care Administration from the University of Minnesota in 1968. From 1961-64, she was Director of Education at the Cleveland Hospital Council. From 1968-71, she worked as the Director of Educational Programs at Northlands Regional Medical Center in St. Paul, Minnesota. She then joined the faculty of the School of Public Health (SPH) at the UMN as a research associate in Public Health Nursing (1971-72). From 1972-81, she worked in the Area Health Education Center at the UMN, first as the Associate Director then as Director. In 1980, she joined the Dean's office in the SPH, working as the Interim Dean, Associate Dean and Executive Officer, and Dean (starting in 1996). She retired in 2001.

### **Interview Abstract**

Edith Leyasmeyer begins by describing her background and why she went into public health and health care administration. She describes her experiences as a graduate student at the University of Minnesota, as director of education programs at Northlands Regional Medical Center, working with the Minnesota Medical Association and Mayo Clinic, as faculty in the School of Public Health (SPH) at the UMN, and in the SPH's dean's office. She discusses the Hospital Administration Program, the Area Health Education Center, the Rural Physician Associate Program, the town/gown relationship with the UMN Medical School, SPH funding and budget, relations between divisions in the SPH, space, shift in philosophy in the SPH from a priority on teaching to one on research, relations between the SPH and other health sciences schools, recruitment of minority students and faculty in the SPH, attitudes toward women at UMN, changes in the SPH and the public health field, and HIV/AIDS. She talks about James Hamilton, Neil Vanselow, and other faculty at the UMN.

**Interview with Edith Leyasmeyer**

**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 June 7, 2011**

Edith Leyasmeyer           - EL  
Dominique Tobbell         - DT

DT: This is Dominique Tobbell with Professor Edith Leyasmeyer. It is June 7, 2011, and we're in my office at 510-A Diehl Hall.

Thank you for meeting with me today. To get us started, could you tell me a little bit about where you were born and raised and your educational background?

EL: I was born in Latvia. I've lived in North Carolina, Cleveland [Ohio], Boston [Massachusetts], Philadelphia [Pennsylvania], and here. My final degree is a Ph.D. in health services administration.

DT: What led you to enter health care administration?

EL: My master's really was in medical care administration, I was interested in hospital management. When we moved to Minnesota, there was an excellent program here [at the University of Minnesota], and I decided to pursue it, and here I am.

DT: What brought you to Minnesota in the first place?

EL: My husband [Archibald I. Leyasmeyer] who had accepted a faculty position at the University.

[chuckles]

DT: As I understand it, James Hamilton was director of Hospital Administration when you were a student.

EL: Yes.

DT: Can you tell me what he was like as a professor?

EL: I was in the Ph.D. program. I really didn't have him as a professor. He was with the master's program. I found him a very fierce, very dominating, and domineering presence. He made the students really toe the line. People had to dress in a business kind of attire. I didn't care for him very much; but people in the master's program just loved him.

DT: [chuckles]

What about other faculty that you encountered as a student?

EL: Here, it was Doctor [E. Gartley] Jaco, who left. He was very good. I also had Ted [Theodor] Litman, who is still around here, and Vernon Weckwerth. Obviously in the Ph.D. program, one took classes all over the campus. That was so long ago, I don't remember all the faculty.

DT: You got your Ph.D. in 1968?

EL: I believe that's correct.

DT: Bright Dornblaser took over from Hamilton as director of Hospital Administration.

EL: Yes.

DT: Did you have much experience with him?

EL: Not as a faculty member, no...not in a student/faculty relationship.

DT: Sure.

Gaylord Anderson was director of Public Health at that time. Did you have any perception of him?

EL: No. Not at that time. Regrettably, I never had any personal contact with him.

DT: My understanding of the School of Public Health is that the divisions within the school were quite autonomous or quite contained within themselves, and, perhaps, there wasn't as much engagement?

EL: Well, the Hospital Administration Program was always more separate than the rest of the School of Public Health programs. As a student, one really...you're just a student. You really don't care or don't mingle and don't know the politics in the school.

DT: What did you do for the Ph.D.? Did you work in the hospitals at the University?

EL: I took a lot of courses, outside the SPH as well, and I did research projects in a hospital setting. My dissertation was on Management Training.

DT: Once you got your Ph.D., you became director of education programs at Northlands Regional Medical Center?

EL: Correct.

DT: What did you do there?

EL: Basically, this was a federal program that attempted to provide linkages of Mayo Clinic, the University, and other entities that focused on cancer, stroke, and heart disease. My job was to work with the Minnesota Medical Association, the Mayo Clinic, and the University to develop, basically, continuing education programs and linkages. So I traveled throughout the state to some extent, and got to know people involved in those fields and institutions

DT: It was just focused on Minnesota and not any other...?

EL: Minnesota. There was a kind of national relationship as well, but...

DT: That was the NIH's [National Institutes of Health] regional medical program? Is that what the funding came from?

EL: I don't know.

DT: It sounds like it. I think that was passed in 1965 or 1968. I'm just trying to piece it together in my head.

What were your experiences like working with the Minnesota Medical Association and Mayo?

EL: And, obviously, the University as well. It was interesting in the sense that the focus was really on linkages and reaching out. I don't think that the University nor the Mayo Clinic, at that point, were that much interested in forging very many tight linkages or in reaching out. They were entities unto themselves, and they did fabulous things, so it was really work to get them to meld certain activities and become interested outside their own institutions. Outreach was really a difficult challenge. The Medical Association was the one organization that was truly interested in building relationships, It should also be noted that Mayo was somewhat more committed to developing external relationships than the University of Minnesota.

[chuckles]

DT: Part of that outreach, was that geared towards improving healthcare access like in other parts of the state that weren't covered by the Mayo Clinic and the University of Minnesota?

EL: I suppose that was the intended outcome. My task was really to make sure that the medical communities, including some nursing components got to know each other, were able to form relationships, and also had increased opportunities for continuing education.

DT: You mentioned nurses. I know that around the time then that you were working at Northlands, the School of Nursing here was, I think, working with Northlands to increase nursing education and setting up kind of off-site campuses around the state to allow nurses to train for their RNs [registered nurse] and for their master's degrees. Were you involved in that?

EL: No, I was not. I basically involved in the medical component.

DT: You were there for a few years, is that right?

EL: I think so.

[laughter]

DT: I found a CV [curriculum vitae] of yours in the archives, so I have all the dates.

As I understand it, you, then, left Northlands and joined the School of Public Health.

EL: Right.

DT: What led you to move to the University?

EL: The dean [Lee Stauffer] of the School of Public Health was also on the advisory committee of the Northlands Regional Medical Center. He thought I could make a contribution to the School of Public Health. He encouraged me to come over here—my husband was on the campus already—so I did. Then, I was in the School of Public Health for a while.

DT: That was Lee Stauffer, the dean?

EL: Yes.

DT: I had the good fortune of speaking to him recently. He spoke very warmly of you.

[chuckles]

Were you aware of—I realize you weren't at the University when Lee Stauffer was appointed as dean—him being appointed dean replacing Gaylord Anderson?

EL: No.

DT: What were your responsibilities when you got to the School of Public Health?

EL: Initially, my responsibilities were really to work with the Public Health Nursing Program. They were just starting out with the nurse practitioner program, so I was working with them in setting up some research projects and, also, the dean, Lee Stauffer, asked me to do a lot of things for him in the School.

DT: Are you able to shed any light on what led to the establishment of the nurse practitioner program in Public Health Nursing?

EL: No, not really.

DT: I've actually been curious about public health nursing within the School of Public Health. At least in the 1970s, it was, obviously, it was in the School Public Health and not in the School of Nursing. Did that present any challenges for the nurses on campus? Were they interested in kind of working collaboratively across the schools?

EL: I think there was some interest, but, again, I wasn't involved at that level, so I can't comment on that. I don't remember. I retired some eleven years ago and all this took place decades ago.

[laughter]

DT: Sure. That's fine.

I have it that you were associate director and then director of the Area Health Education Center [AHEC] at the University.

EL: Yes.

DT: As I mentioned on the phone to you, I'm really curious about AHEC. I've seen its name but I haven't got a sense of what it was. Could you talk about that?

EL: Yes. That reported directly to the vice president of health sciences, Lyle French. It was a federally funded program by the NIH, Bureau of Manpower Education. The intended outcome was a better distribution of health professionals, especially physicians and dentists, in underserved areas, thereby improving access and quality of health care.

It was a nation-wide pilot endeavor with a particular focus on outreach and linkages. It was based at the University. The most central focus was on the Medical School. Its purpose was to establish healthcare and educational relationships with outstate



communities and practitioners. Our strongest link was with St. Cloud. It was close, and that meant that students could easily transport themselves in a day back and forth. We also established some other centers within reasonable driving distances. Students were placed outstate for training periods. There were also faculty consults, continuing education offerings, and quality assurance programs. The big challenge there, too, was outreach. The University medical school, in particular, was focused inwards, so to do anything outstate was not really a priority at all, even though that is where they were looking for patients. The relationship with local practitioners was quite strained. It was constantly a struggle to create linkages that were perceived to be of value by both town and gown.

DT: I can imagine. You said the priority was really the Medical School and physician education.

EL: Yes.

DT: How did this relate to the Rural Physicians Associates Program?

EL: We worked with Doctor [Jack] Verby quite a bit and linked in with his efforts. We also affiliated with a dental program that had students going outstate for training. We were likewise able to arrange for other health sciences students to experience education at the community level.

DT: The difficulty that you mention... I'm not surprised, because my understanding of it in the 1960s, which is before you would be dealing with any of this, is a lot of local physicians were frustrated with what the Medical School was doing and demanded that they train more physicians, primary care physicians, this kind of town/gown tension.

EL: Oh, yes, it was very distinct. Also there was a pretty callous attitude here that was noted by physicians outstate. If they'd refer a patient here, they didn't always hear back as to what happened with the patients. There were problems getting records and issues with referrals. There really wasn't an attentiveness to or collegueship with practitioners outstate. There was a great deal of suspicion outstate, as well, since this was a federal program. There were concerns about possibly being exposed to numerous federal mandates. So that was a challenge, particularly in St. Cloud, which was a hospital that had just been turned from Catholic ownership to a community one. There were a great deal of questions about medical students and residents coming from the University and potentially teaching patients and performing procedures that were against the Catholic faith. [chuckles] So it was interesting.

DT: [chuckles]

I understand this was a federally funded program. Did you have any interactions with the State Legislature about this?

EL: No.

DT: One of the things that I learned about the 1960s and, I guess, to an extent the early 1970s, too, is that the Minnesota Academy of General Practice was very effective at lobbying the Legislature, to then lobby the Medical School and the University to be responsive to their demands. It seems like what you were doing in AHEC really would have suited some of their concerns.

EL: Yes, right.

DT: Why do you think the emphasis was on the Medical School rather than the other healthcare professions?

EL: Nationally, that certainly was the focus. It seemed that the medical manpower was a primary concern outstate. Clearly, they could use all other professions, but the physicians were the primary ones that they were interested in.

DT: Actually, it makes me think that the work you had first done in the School of Public Health with the nurse practitioner program would have fit quite well, because, as I understand it, a lot of nurse practitioner programs were established so as to meet the need in outstate areas.

EL: Yes. But that wasn't the focus.

DT: When you started at AHEC, that was really immediately after the health sciences had been reorganized and the Academic Health Center [AHC] created and Lyle French was vice president for health sciences.

EL: Yes, right.

DT: Again, it strikes me that AHEC really fit with some of the mandates that the AHEC was created for, which was to improve cross-disciplinary collaboration and education across the health sciences. Do you have any sense of how AHEC fit within the AHC more generally or whether there was support for what you were doing?

EL: I thought highly of Lyle French but he was somewhat hands off. AHEC and outreach were not a priority within the Health Sciences. There wasn't really any specific involvement or any particular support. We were on our own. I think AHEC managed to accomplish quite a bit given the climate.

DT: Who else did you have working for you within AHEC? How many people?

EL: It kind of depended. We had contracts with a lot of physicians in the Medical School and we had contracts, obviously, with physicians outside. There were also paid part-time faculty throughout the Health Sciences. On the staff, we had, besides myself, a fulltime nurse and physician, medical records people who dealt with quality care, and

support staff. We also had contractual relationships with outstate health care organizations and health care professionals.

DT: Did you have any interaction with other area health education centers in the region, say in the Upper Midwest?

EL: Not regionally but nationally. We had national meetings and developed colleagueships. The Washington [D.C.] funding agency really held tight control and they regularly monitored our activities.

DT: Was it then that you had to be responsive to whatever federal government...?

EL: Yes, oh, yes. [chuckles]

DT: Was there any opportunity for you to say, "This is what is happening within the state," and "This is what the state needs," and have that influence what the federal mandates were saying, or was it very much this is top down?

EL: It was probably joint, but with extensive Washington direction. The biggest challenge I, frankly, had was with the Medical School here, getting them to be full partners of whatever we were trying to do rather than fighting the outreach. I can understand. To really pay attention to an outstate physician's clinic took away time from teaching and research and their patient care here. So it was a difficult linkage to attain.

DT: You mentioned Jack Verby and it sounds like he was somewhat supportive.

EL: Yes.

DT: Were there other faculty that you could say were supportive of what you were doing and were more open to what you were trying to do?

EL: We had a couple people from Psychiatry with whom we worked with very closely and they took responsibility for a diverse group of students from all disciplines. School of Nursing faculty were likewise actively involved. We also had relationships with the Health Sciences Continuing Education Office and the Allied Health Manpower Office.

DT: In terms of the other AHECs nationally, did you get a sense for how Minnesota was doing in terms of its outreach and getting physicians out into rural areas, vis-à-vis what some of the other states were managing?

EL: I think we were sort of in the middle area. North Carolina, in my estimation, did about the best job. They had really a great deal of university support. Actually, the state was involved in funding their project. I think they accomplished a lot. We compared notes and we were sort of midpoint in terms of achievements.

DT: With it being area health, it was just limited to Minnesota or...?

EL: Minnesota.

DT: Okay.

As I understand the federal program, there were maybe twelve centers nationally?

EL: Something like that, yes.

DT: Do you know if there was a plan to have AHECs in every state, eventually, or was it only ever going to be a handful?

EL: Well, the federal government was hoping that the states and the universities or the academic health centers would take this pilot program and really grow and maintain it, subsequently, with their own funding. In this state that did not happen; in some states, I think it did. AHEC never really grew very much after the federal funding stopped. It was much too expensive. NIH and the Bureau of Health Manpower had envisioned that AHECs would become a national phenomenon, but that did not happen, again due to cost constraints.

DT: Yes. When did the federal funding end? Was it after you...?

EL: Yes, after I left.

DT: Okay.

DT: You left there in 1981 and, then, you were appointed interim dean of the School of Public Health?

EL: Associate dean, I believe, at that point.

DT: Can you talk a little bit about that transition from AHEC to the dean's office and what led to that move?

EL: I think one factor was that we had had a five-year contract with AHEC and it was coming to a close. It was a question of do we want to reapply given the lukewarm support on campus. We did not reapply and I returned to the School of Public Health fulltime.

DT: What were your responsibilities as associate dean?

EL: [pause] I think, basically, in charge of all kinds of problems that arose, and anything the Dean asked me to take of. I remember budgets, space, accreditation, etc. I am not certain of the time frame, but sometime during my tenure at the SPH and/or AHC, I

worked with the Medical School's Phase B curriculum and spent a considerable amount of time with the Health Sciences Strategic/Long-Term Planning effort.

DT: When Lee Stauffer resigned as dean, you were then appointed acting or interim dean?

EL: I believe so, yes.

DT: You were acting dean for three years. Did you ever have any interest in being more than acting dean?

EL: Not at that point .

DT: Why did it take...? Three years is a fairly long time...

EL: Was it three years? I don't ever remember that. It could be.

DT: Nineteen eighty-two to 1985. That's a long time to be acting.

EL: I thought it was like acting for three different occasions, but I don't exactly recall.

DT: Yes, I know you've got several, over two decades' worth.

[chuckles]

DT: You were acting for as long as you were in that first session because they were searching for a replacement, and it took...

EL: For Lee Stauffer, right.

DT: It just took that long?

EL: I think so, yes.

DT: I don't know if you care to talk about your first tenure as acting dean. Were there particular challenges you faced, at that time—or the school faced, I should say?

EL: [pause] I don't think the school faced any particular challenges anymore than usual. Finances and space are always an issue. I think the challenge that I faced is that I hadn't been in the School very long and people didn't really know me. I was appointed as acting or interim dean and needed to establish credibility. Things went pretty smoothly and there were no major issues. I do believe that we had an SPH accreditation during my tenure as an acting dean. That also went without a hitch.

DT: As I understand it, the early 1980s were... I know financing of the School of Public Health had always been challenging, because most of the money came from non-state sources.

EL: Right.

DT: I think at one point in the 1960s, ninety percent of the school's funding was from non-state funds.

EL: It's pretty close to that now, too.

DT: Yes.

There was retrenchment going on in the early 1980s. Was that a particular concern or challenge to you, given that you took on the acting deanship during this period of retrenchment?

EL: Well, the challenge that was and still continues in the School of Public Health is that, as you noted, the majority of the funds are not state money, so that the dean doesn't really control the budget. It's a budget of those people who earn it in terms of their research projects or training grants or what have you, all of which is under their control given the mandates that come with it. So then to make any kind of a budgetary decision, one only has X amounts of money to work with. It's a challenge to figure out if one has to cut where can one cut. There's so much you can't touch. That is a difficult proposition to ensure that the core components of the School are funded and make the necessary retrenchments due to budgetary constraints, all the while dealing with the egos and tenure lines. That's the job that has to be done.

DT: There were so many different divisions within Public Health. How were relations, from your perspective in the dean's office, between the different divisions, particularly as you tried to deal with these budget issues?

EL: Everybody is defending their own turf, obviously, and unwilling to absorb any cuts in funding. One tried to be rational about it and establish a formula to present to faculty as to why certain units will be diminished and other programs would remain unscathed. Clearly no one ever was happy about budget cuts or program elimination, but hard decisions had to be made by the dean.

I think the other issue was space. The school never had enough appropriate space—still doesn't—as to who got what space and where did people align themselves. That was always a very difficult thing to do with, again, egos involved.

[chuckles]

DT: I interviewed Robert Howard, who was dean of the College of Medical Sciences in the 1960s...

EL: Yes.

DT: ...and he made this observation that has stayed with me. Your comment reminds me of it. He said that as dean, the only power he had was over space and how to assign space. I wonder if that's something that you kind of relate to.

EL: Well, yes. People were already in a space when I arrived, so to shift them around, it's near nigh impossible. [chuckles] But we received some new space from Health Sciences, and so we had to give up some space in return. Then, it was up to me to figure out who would have to move and where that group would go. That never was pleasant.

DT: I'm curious if you had a kind of high performing division in terms of the federal grants that it was getting, and you had, say, another division that wasn't getting the same kind of research grants, and then trying to figure out the budget, was there ever a way that the kind of high research-funded division would help take care of some of the less research-funded divisions?

EL: Oh, the units would never do that on their own. That's an interesting question. For example, to be honest, Epidemiology has always been a top-ranking division, and I think still is in terms of research, in terms of productivity. They also had the greatest amount of federal grants. Yet, for the school to be accredited, we needed to have certain other things in the school that were not funded by research very well. At least, it didn't support them. One, indeed, had to shift some funds into the areas which were less productive research-wise, but which were absolutely essential for the educational component and for the School's accreditation. It's a hard thing to explain to the researchers that you're doing a great job; however, we need to move some funds elsewhere. That just had to be simply done at times.

DT: That's not something I fully appreciated—obviously, accreditation is vital—that that influences budgets so much.

EL: Yes, it does to some extent, right, and also affects some faculty hiring. You have to hire people in certain disciplines to make sure that you're accredited, irrespective of a unit's scholarly productivity.

DT: I've heard from several people I've interviewed who were involved with Public Health during the 1960s, 1970s, and 1980s, that there was this general sense that the philosophy or the approach of the School of Public Health shifted from one where its priority was on teaching, training practitioners to one that was more research oriented. I wonder what your thought about that was.

EL: I think so. As federal grants became more available in the height of federal funding, we were able to hire individuals who were more attuned to good research. So I think it did shift. Money was available, so we moved in a new direction and we got criticized by the Minnesota Public Health group that we aren't training practitioners anymore, that

we're not focusing on helping the state, and that we were only interested in doing research. Yes, we could receive praise for our scholarly accomplishments and damnation for our lack of responsiveness to the community.

DT: That's one of the things that I find so interesting about Public Health. It's so interdisciplinary, but, also, the fact that people who work in the public health field are practitioners...I don't know if to any greater or lesser than physicians or nurses, but there just seems to be at the core of public health that is about going out.

EL: Yes, do-gooders, in a sense, if one puts a label on that. Yes, that's the philosophy. That's the mantra. That is very different from somebody who does research or somebody that is a very skilled teacher.

DT: Yes. So I can well imagine that kind of perceived shift or real shift in philosophy and approach would be felt harder within the School of Public Health, because of its traditional orientation...

EL: Yes.

DT: ...and particularly its commitment to the state.

EL: Yes, and we would certainly hear from alumni, hear from the local associations, so there was always juggling. There was an expectation that we would be engaged in public service but there was no money to support that effort. Essentially we were funded only for student education/training and for research. Also faculty were not rewarded in an academic setting for community service, although the tenure code does pay some lip service to that component.

[chuckles]

DT: I've actually had a number of people refer to Hospital Administration alumni. Why is it that that division's alumni were so influential, powerful, or effective at fundraising?

EL: I think Hamilton was very forceful and he really set them apart from the School of Public Health. They, obviously, were well trained and they got excellent, high paying jobs, so they had money to give. *Public healthers* really aren't in especially well-paying jobs unless they marry well, so they are not major donors. That's the truth of it.

DT: [laughter] I'm laughing because, yes, it's so true.

Again, that point brings me to another question I have about the potential for hierarchy within Public Health, because you have professionals with very different orientations and educations. You have M.D.s. You have administrators. You have engineers. And you have Ph.D.s. Do you have a sense for how those entities worked together or whether there were some perceived hierarchy among the professions?



EL: Oh, I'm sure there is and was. The physicians are probably still at the top of the hierarchy. No surprise there. The cultures are very different in terms of language, in terms of expectations, and the way they work. They worked well together as colleagues, especially on research projects where each discipline had a different contribution.

DT: I've been in the dean's office. I presume that you had a fair amount of engagement with the other deans within the health sciences then.

EL: Yes.

DT: That kind of speaks to how Public Health may have interacted with the other schools, colleges within the health sciences. I wonder if you could talk about that and where Public Health fit within the broader health sciences.

EL: In terms of the deans, I think Public Health held its own very nicely. I think we were respected among the deans. It was a good School. It had good faculty. We eventually became really renowned for doing a lot of research. We had collaborative relationships—teaching and research—across the AHC schools, as well as with academic units in other parts of the University.

DT: Did you get a sense of what the AHC encountered as major challenges in the early 1980s? Is there anything that comes to mind? I know Lyle French stepped down and Neal Vanselow replaced him.

EL: Yes. I was not that close to the AHC to note its particular challenges at that time.

DT: Do you have any recollections of those times?

EL: Vanselow was a bit more hands on and I think, at that point, we were starting to deal with a lot of space issues. During his tenure, the School got the Mayo compound that was to be remodeled. The federal funding ran out when it was our turn to get the building that was in the AHC plan and we never did. We did receive some space that was relinquished by the Medical School.

The same with parking. The key parking spots were assigned by the health sciences. They all pretty much went to the Medical School.

DT: I know Epidemiology and some other units are over in WBOB, now, the West Bank Office Building. Do you recall when that space became available? Was that in the 1990s?

EL: Probably in the mid 1990s, I suspect.

DT: It just seems like Public Health has always been so dispersed...

EL: Oh, yes.

DT: ...physically, more so than any of the other health sciences.

EL: Exactly. At one point, we were going to be consolidated in the Health Department Building that was on Delaware Street.

EL: I guess we never got that one either, and there's no facility that is sufficiently large to really put us all together in one spot. And I think that's the way it's going to be in the future as well.

DT: That's got to make it challenging though for real inter-collegiality within the school.

EL: It makes it difficult. When I was at the school, there used to be a van shuttle. I don't know if that's still here or not. At least, it brings people back and forth, but it's not that easy for students or faculty.

DT: They do still have that shuttle which is nice.

Was it during Lee Stauffer's tenure that Epidemiology and Physiological Hygiene were merged?

EL: I believe so.

DT: Now, it's hard for me to keep track of when certain things happened and under whose deanship.

EL: For me as well.

[laughter]

DT: Like which tenure was it under? So bear with me if I ask things that weren't under your tenure. It's hard to keep track.

Robert Kane was hired as the dean in 1985.

EL: Yes.

DT: What did you do when he came in? Were you still in the dean's office?

EL: Yes. I was associate dean.

DT: At some point, the division of Hospital and Healthcare Administration was moved to the Carlson [School of Management].

EL: I don't think it was under Kane. It was probably later, but it happened. Yes, it happened.

DT: Maybe under Stephen [C.] Joseph?

EL: It could be or it could have even been under my tenure.

DT: Do have any recollection about why that move happened?

EL: I believe so, but... I think I know the genesis of it, but I'd just as soon not have it on tape. Suffice it to say that Health Administration faculty believed that the Carlson School would be a better fit and provide their students more grounding in finance and management science.

DT: That's fine.

I know you had involvement with Public Health Nursing, obviously before you went to AHEC, and, then, Public Health Nursing was within Public Health. In the late 1970s and early 1980s, the School of Nursing was trying to establish a Ph.D. program in Nursing. I don't know if you had any awareness of that or any...

EL: No, I wasn't involved in that. But I believe it was the School of Nursing that was exploring as PhD in Nursing.

DT: This is another thing where I'm not clear on the dates.

But, eventually, Public Health Nursing did move into the School of Public Health

EL: Into the School of Nursing.

DT: Yes, School of Nursing. Can you talk about that move?

EL: I probably wasn't very involved in that. I am really not quite sure why that happened.

DT: I've been trying to tease it out and there are not a lot of people that seem to know.

EL: Yes.

DT: Do you remember approximately what date that...? No. It's amazing how it can be really hard to track down specific dates, particularly with such recent history. A lot of those records aren't necessarily available.

EL: Yes, right.

DT: I think it's this timeframe.

When you're in the dean's office, particularly in the early 1980s, did you have much interaction with John Westerman and the University Hospitals?

EL: Only at the Dean's Council and at the Health Sciences Strategic Planning sessions. Nothing else, though.

DT: I suppose his involvement would have been at the division level with Hospital Administration.

EL: More likely, yes.

DT: How did you find the associate vice presidents...how they responded to what your needs were within Public Health? Did you have much engagement with like Cherie Perlmutter and...

EL: I had worked more with Dave Preston on Strategic Planning than with Cherie Perlmutter. The AHC was always more concerned with the Medical School and the Hospital than with the other units.

DT: Again, I'm not sure if you'll be able to say anything about this, but, I've talked to a few other people about Robert Kane's tenure as dean. I know that there was some tension or dissatisfaction among the faculty that culminated in him stepping down as dean. Again, it's okay if you don't want to comment on that. I don't know if you can shed any light on that process as you were in the dean's office.

EL: What you've said was true and it did happen. He is a brilliant researcher.

DT: As I understand it, your next term as interim dean was from 1994 to 1996, and, then, finally, in 1996, you were appointed as full dean. Can you talk about what led to you going from interim to full dean? Did you decide that you were comfortable taking the job on permanently?

EL: I was asked if I wanted to consider that position or to apply for it, if you will. I thought about it for a while, and decided to do so, having had considerable experience in the job, so to speak.

DT: Did that create any kind of functional change in what you were able to do from your position now that you were a full-fledged dean?

EL: Sure. I could make more decisions and more changes, which I did.

DT: As dean, and not just in the 1990s but throughout your time in the dean's office, I'm wondering if you had much interaction with the presidents or the regents.

EL: Regents, to some extent. Deans would make reports periodically and I developed friendships with a number of them on a personal level. I met with the president as part of

the Dean's Council and I was also on some separate special committees, so I did get to know the presidents quite well. I was also elected Chair of the Twin Cities Deans' Council for a period of time, in which capacity I had extensive dealings with the Presidents.

DT: What about with the State Legislature? Did you ever have to present before the state or testify before the state?

EL: A few times, yes, but not that often. Basically, the Academic Health Center wanted specific faculty to talk about their particular projects which were either likely to be funded by the state or were of special interest to the legislators, such as environmental issues, school nutrition, or health care cost analyses.

DT: They weren't really interested in hearing from the deans who dealt with the budgets...

EL: No. .

DT: ... and big-picture issues?

[laughter]

EL: No.

DT: They didn't want to hear the hard truth.

I know that another of the changes that seemed to take place or several changes that took place through the 1980s and 1990s, related to the Center for Health Services Research. Again, I'm not clear on kind of the sequence of things. There was a name change. Then when Healthcare Administration came back from the Carlson, as I understand it, they merged with Health Services Research?

EL: Yes, right. The Center for Health Services Research initially reported to the Vice President for Health Sciences. I'm not certain why the reporting line was changed to the School of Public Health. The Health Services Research faculty always had SPH faculty appointments.

DT: Can you shed any light on that, what led to that merging, if you're able to?

EL: I was gone by that point. But I would conjecture that the Center for Health Services Research was the only logical division to accommodate Healthcare Administration, given the disciplines within SPH. I don't believe the School was interested in setting up Healthcare Administration as a freestanding unit.

EL: I also understand that Healthcare Administration was not very happy at Carlson and Carlson wasn't very happy with them.

DT: I'm also interested in what the school did, but also what you perceived the Academic Health Center did with regards to increasing recruitment of minority students and faculty. I think there were some specific programs the School of Public Health had towards recruitment.

EL: Yes. We had somebody in charge of that in the school and they went out and put on programs, visited high schools, and that sort of thing. The Academic Health Center also had a program—there were two—for faculty and for student recruitment.

DT: Do you remember the name of the person who did it in the School of Public Health?

EL: Not off the top of my head. Sorry. There were quite a number of individuals who served in that capacity over the years.

[laughter]

DT: I know.

EL: I erased all that.

DT: I'm putting you on the spot. I'm sure I'll be able to do some digging around.

Do you feel that the school or the health sciences more generally were successful at improving recruitment of minorities?

EL: Yes and no. Many of our students in the health sciences come from the State of Minnesota and if one looks at the population, it's a majority of whites—or was, at that point. One always has to look in terms of the context of geography. Now, faculty, obviously, were ones that were recruited nationwide. We did advertize in various newspapers or publications that were minority focused. I think everybody tried. Sometimes, it just didn't work. Probably, we fell short, but we did try.

DT: Something that does strike me in Public Health maybe more so than other school in the health sciences is that it seemed that increasing numbers of female students would come to the School of Public Health. Obviously, the fact that you're a woman as dean was something quite significant. I wonder if you have any reflections on attitudes toward women in academia, in Public Health, and health sciences during your time.

EL: Well, in the School of Public Health, I would venture to guess that the majority of the students generally would have been female, maybe except for Environmental Health and Biostatistics. If you look at nutrition, maternal-child health, and public health administration, there are some men, but it's sort of a woman's profession, very much so.

So that's always been there. I don't want to attribute that to any women being in leadership positions in the School. I think it's just the nature of the field.

DT: Yes.

DT: I don't know again if you would be comfortable in speculating or saying anything about this, but was what it like to be a woman in a high place administrative position in terms of your experiences in terms of gender and the challenges that you maybe encountered that a male in your position wouldn't have.

EL: I guess I've lived in that through most of my life. I was the first and only female in my master's program and the first and only female in my Ph.D. program. It's always been sort of... oh, there's a woman here. I think in terms of administration, probably there was some discomfort by men in higher positions or higher titles, let's say MDs, in working with a female Ph.D. At times there was a period of getting used to me as a different individual. But I think in the end we worked together very well.

DT: In some of the reading that I've done just in teaching and thinking about gender and science and gender and health care, a lot of what I've seen talked about is that when women start entering a field which has previously been dominated by men that there are channels of communication that men have developed that are not in the meeting rooms. They happen outside the formal meeting areas, that classic old boy's network.

EL: Yes.

DT: Do you feel that was a problem or something that you encountered or some of your other female colleagues may have encountered during your time?

EL: Maybe I was just obtuse. I wasn't particularly aware of that. Clearly, I didn't go hunting or fishing, but I wasn't aware that, for example, that many deans went hunting and fishing. I'm sure that there was more collegiality between guys, because they share more of the same things. As I mentioned previously, I was elected by the Twin Cities University of Minnesota Deans, predominately male, to Chair the Dean's Council and to represent them. I probably missed a few things, I'm certain of that, but I wasn't really acutely aware of any particular challenges by being a female.

DT: Did you have any female colleagues in other schools within the University or other institutions that you saw as colleagues or mentors or that you were able to develop your own kind of informal... Network isn't really what I want to say in terms of making decisions, but just resources that you could call upon?

EL: I was quite active in the Dean's Council here at the University and there were a number of female deans on campus, so we formed a little group and would have lunch once in a while. It wasn't a network; it was just sort of friendship. But, I also had great male colleagues with whom I could discuss things.

[break in the interview – knock at the door]

EL: Then, within the University, there was also a group of women administrators: women vice presidents, women deans, and women heads of large programs or units.. We met about once every month or so for a social event.

DT: It sounds like that was a positive opportunity.

EL: Yes.

DT: I wonder if you have any reflections, given that you were involved with the School for several decades, on how you saw things change over those decades in terms of the School, in terms of public health as a field that you might want to share.

EL: The School, obviously, got more prominent, became more renowned in terms of what it was doing. More research was being undertaken at the School. More students and more faculty were added, particularly the last few years. I think public health as a field—we can't call it a discipline—really has become more visible nowadays with all the publicity about food poisoning and HIV [Human Immunodeficiency Virus], infections, and environmental issues. Public health has attained national prominence. Now, whether that will translate into more federal—research is one thing—support for training public health people, for public health activities, I'm not sure. It's more prevention than treatment and treatment always gets the top dollar, because it's very immediate. So I think the school has really risen into a public eye and the public is much more aware of public health than they were years ago. The SPH has also become more recognized for its research productivity within the University. Given the current discussions about health care costs, SPH faculty continue in a visible role both at the state and the federal level.

DT: Yes. That paradox that public health faces as a field is that it's so important, but what public health does so well is to prevent. You don't prevention. You only see when public health is absent or it didn't work.

EL: Right.

DT: It's always a harder sell. Treatment is always easier, it seems, for people to justify spending on.

EL: Oh, yes, and you need it right now.

DT: People don't fully appreciate the value of prevention.

EL: So fundraising for the school has always been a difficult problem. Whom do you tap and how do you sell it? When I was there, almost every year, we had a change in development officers because they couldn't make it. They did their best and they used their best ideas and then I said, "Well, I have to move on." [chuckles]



DT: You brought up HIV-AIDS [Acquired Immune Deficiency Syndrome] as something that, obviously, has made the importance of public health all the more visible. I wonder if there was any immediate impact at the School during the 1980s when HIV-AIDS were first identified and whether you felt there was some specific role that Minnesota played in that story.

EL: Our people really collaborated, especially Epidemiology, with the Medical School. Obviously, we didn't do the treatment component, but we did some of the research on prevention. I think we were in the news quite a bit in that collaborative effort. We did get some money to do more HIV research and our faculty and graduates were in a leadership position with reference to policy formulation.

DT: This is, obviously, after your time, but I think even just last year with the H1N1 [Hemagglutinin Type 1 and Neuraminidase Type 1, also known as swine influenza] concerns, the School of Public Health and Public Health faculty members were often featured on NPR [National Public Radio] about that, it seems.

EL: And Mike Osterholm continues to be featured now with the e-coli outbreak and doing his part in Public Health and has been for... I think he joined the School probably about ten years ago.

DT: It really does seem that Minnesota, specifically has built, as you say, a national reputation.

EL: Yes, I think so.

DT: Do you have any suggestions for who else I should speak to about getting information about Public Health, but also about any other areas that you think would be important to cover?

EL: I don't know whether you want to interview Robert Kane.

DT: Yes.

EL: He's here. You've met Stauffer.

DT: Yes.

EL: I'm sure you've interviewed like Henry Blackburn and people like that.

DT: Yes.

EL: [pause] What are you particularly interested in finding out. [laughter]

DT: The idea is I might uncover things that I don't know exist. But, basically, I want to make sure I have a representative sample of people I've spoken to, so that I'm not just getting one perspective, that I'm making sure I'm covering other perspectives that maybe aren't as dominant in narratives. I don't want to just talk to the big names or the people who are most vocal, but make sure I get other perspectives, too. It doesn't have to be people who are in leadership positions. I've spoken to people in the Medical School who didn't hold leadership positions per se, but they had very long tenures in the school. So I had them comment a lot about just changes institutionally in those times. Even if there are people that you think of who are faculty members that were here for a substantial period or have particular insights or perspectives that I may not have encountered already, then, I'd be interested.

EL: Well, is [Bright] Dornblazer still around?

DT: I did speak with him.

EL: [pause] Too bad they don't have any more of the Nursing people around. Oh, Barbara Leonard. She was in the School of Nursing and she's still around. She was the head of the Pediatric Nurse Practitioner Program in the School of Public Health. Then, she went to the School of Nursing with a program. I don't know whether she's retired or not. She might really know why they all went over to the School of Nursing.

DT: Yes, I really want to know. [chuckles]

Well, if you think of anyone else, just let me know.

EL: Okay. Other individuals who come to mind are Robert Veninga, former associate dean, Russell Luepker, epidemiology, and Robert (R.K.) Anderson, Veterinary Medicine and Public Health, Donald Vesley, Environmental Health. I am sure you have already talked to Mike Osterholm, and John Finnegan.

DT: Is there anything else that you would like to share that I haven't asked questions about?

EL: [pause] Probably not.

DT: I very much appreciate your time. It's been very helpful, so thank you.

[End of the Interview]

Transcribed by Beverly Hermes

**H**ermes Transcribing & Research Service  
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124  
952-953-0730 [bhermes1@aol.com](mailto:bhermes1@aol.com)