

**John Kralewski, 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**

John Krlewski was born in Wisconsin. He received his BS in Pharmacy in 1956, his MHA in 1962, and his Ph.D. in 1969, all from the University of Minnesota. From 1957-60, he worked as a medical administrative officer in the US Air Force. In 1964, he joined the faculty of the UMN's School of Public Health in the Program in Hospital Administration. He moved to the University of Colorado Medical School in 1968 as a professor in and as director of the Division of Health Administration. In 1977, he returned to the UMN as Assistant to the Vice President for Health Sciences and Professor and Director of the Institute for Health Services Research of the School of Public Health. He remained in these positions until 1998. He was named William Wallace Professor of Health Services Research and Administration in 1985.

## **Interview Abstract**

John Krlewski begins by describing his background, including his education, his service in the Air Force, his early career, and why he went into the health sciences. He discusses his experiences as student in pharmacy and then in hospital administration at the UMN. He discusses the Program in Hospital Administration at UMN; hospital administration as a field in the 1960s and 1970s; the School of Public Health; funding; his research; efforts to introduce mandatory generic prescribing in the 1960s; pharmacy as a profession; nursing; the divisions within the School of Public Health in the 1960s; leadership in the health sciences at the UMN; University Hospitals; other hospitals in the Twin Cities; and the University of Minnesota's decision to sell University Hospitals to Fairview. He talks about Gaylord Anderson, James Hamilton, Cherie Perlmutter, Stephen Joseph, Lyle French, Frank Cerra, and others in leadership and administrative position in the Health Sciences.

In his second interview, John Krlewski discusses his experiences as assistant vice president for Health Sciences. He talks about the Center for Health Services Research; health services research at Minnesota and around the country; working with the Minnesota state legislature; rural health care; the Health Information Foundation (at the University of Chicago); moving the Center for Health Services Research out of the vice president's office and into the School of Public Health; the Hospital Administration program; graduate programs in Public Health; relations between the Academic Health Center administration and the state legislature; the relationship between the health sciences units, and health sciences education and funding. He discusses Lyle French, Neal Vanselow, and Robert Kane.

**Interview with Doctor John Kralewski**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed in the Phillips Wangensteen Building  
University of Minnesota Campus**

**Interviewed on February 14, 2011**

John Kralewski - JK  
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor John Kralewski. It is February 14, 2011. We're in the conference room of the Center for Health Policy and Management in PWB, the Phillips Wangensteen Building.

Thank you for agreeing to meet with me today.

JK: You're quite welcome.

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

JK: I was born and raised on a farm in western Wisconsin and came over here to go to Pharmacy School [at the University of Minnesota]. The reason I came here is because this is a first class Pharmacy School, number one, and, number two, it's in a large enough city where you can get a part time job and make some money to go to school, because I needed to, at least in a good part, support myself as I went through. I did that and graduated from pharmacy school here and was, actually, thinking of going on for a Ph.D. in pharmacology, but I had an Air Force commitment and I got called up.

I went in the Air Force for three and a half years and while I was in the Air Force, I was in a hospital as a hospital administrator a year and a half in the notorious Selma, Alabama, and a year and a half in this wonderful, Chateauroux, France, about seventy miles south of Paris in the Loire Valley. The colonel, who was the administrator of the hospital in France, was a [University of] Minnesota grad from their Hospital

Administration Program, convinced me that I should go back and get that degree before I'd start doing anything else in life. I did that. I came back here got the degree in hospital administration, now called health administration.

The second year of that, the Kellogg Foundation came along and said, "We need teachers and researchers in this newly developing area of hospital administration. If you'd be interested, we'll fund you for four years. That sounded pretty good, so I did just that. Kellogg had devoted a fair amount of money to starting these master's programs in hospital administration, and, then, they put some money into Ph.D. programs to train the faculty for them later on. I got into that curve, so they funded me, and I graduated from that program. At the dissertation level, I joined the faculty here and was here for about three years; delaying the dissertation, which was a mistake, but, nonetheless, that's always the case.

I got offered a job at the University of Colorado, went out there, and was in the School of Medicine at Colorado for ten years.

Then, I was recruited back here to start a Center for Health Services Research with Lyle French. He was, as I'm sure you know, the first vice president for health sciences. Lyle was a real visionary and a highly respected neurosurgeon. He said, "We have here a pretty good clinical research area, good basic science research, but we don't have research focused on the cost, quality, and delivery of health care. That's what he wanted. He convinced me to come up here and said he was going to go to the Legislature and get money to support it, which he did. We had a state special, which is still around here, directed to health service research, and we started building a center. That's kind of my history in a nutshell.

DT: [chuckles] Let me ask you a few additional questions to follow up. Why did you initially pursue pharmacy as your degree?

JK: I grew up in rural Wisconsin, and worked—this is more of a story than you want to hear, probably—part time in a canning factory. They canned peas and beans for human consumption. The guy that I worked with, the supervisor...his son was a pharmacist in that town, and he had gone to the University of Minnesota. This guy would come up to the factory and see his dad, and we were visiting about what I should do in life. We always ask our graduate students, "What is your plan for life?" If anybody would have asked me that, I would have said, "Oh, I don't know." This guy said, "You really should think about pharmacy. That's a good profession, and you can do a lot of things with a pharmacy degree." I said, "It costs a lot of money. I'm not sure I can do it." He said, "Go to Minnesota, because they reciprocate in the tuition." They didn't quite then, but they were pretty liberal about it. You'd come one year and, then, you could be a resident.

DT: Oh.

JK: He said, “You can get a job right around there in those pharmacies. They’ll hire you part time so you can pay your way.” At that time, at the University of Minnesota, you could go here for, like, two hundred dollars a quarter. Yes.

DT: That was a while ago.

JK: People could do that. I applied and was accepted...and the rest is history.

DT: Were there any memorable faculty that you took classes with while you were here?

JK: That are still here, do you mean?

DT: Oh, just in general, were there any notable teachers that you had?

JK: Ah! Yes. I’m not sure I can remember the names of them, though. The pharmaceutical chemist was first rate, and that’s why I was thinking of pharmacology, as a matter of fact. I can’t remember his name. He was an outstanding professor and had an extensive research program. As I recall, I believe one of his contributions was that he discovered one vitamin or something to add to white bread that extended its shelf life.

DT: Oh, good.

JK: I suppose if I thought enough I could find his name. He was really a great guy and was very helpful in my career.

DT: When you came back to do your master’s in hospital administration, were there faculty in that program who stood out to you? What kind of classes were you taking within that program?

JK: That program was pretty insular. The courses were all pretty much taught by the faculty from within the program. They were pretty shallow, to be honest with you. Coming out of Pharmacy School, which was science-based and pretty rigorous—very rigorous, as a matter of fact—this was pretty easy for me. The courses were less than what you’d expect for a master’s degree program, but that’s the way it was. That’s the way the field was, at that time.

Do I remember some outstanding professors? That would be hard to say. There were some folks that were helpful and were good teachers, but they weren’t known for their outstanding academic contributions. We had a guy from Epidemiology that taught a very good course, and we had a course in Environmental Health that was very good.

The issue, at that point in time, for schools of public health was that they were still trying to find themselves as academic units, not just here but at all universities. Gaylord Anderson was the dean. Gaylord was a good guy and highly respected in public health circles, but not an academician. Jim [James] Hamilton headed the Hospital

Administration Program. Similarly, he was not an academician, and I don't think he had any respect for research or even intellectual inquiry, in general.

The positive thing they had was that they had a good reading of where the field was going. So Gaylord Anderson hired Hamilton to come to start a Hospital Administration Program, because he could see that that was an area that was rapidly developing. Hamilton took it and ran with it. He was turning out graduates as one of the first two or three programs in the nation and placing them in high-level jobs. These graduates would go out and get jobs *way* beyond their capabilities. But, somehow, they survived. Then, the second job, they would be even better at it, you know. Hamilton, of course, took that and formed a consulting firm tied back to the graduates. [chuckles] He had everything locked up and made not only millions, but tens of millions. Who knows how many millions? The administration knew that he controlled a lot of the jobs, or not so much controlled them but had access to them. When they wanted to build hospitals, and there was a huge wave of building hospitals, they hired his consulting firm to do the studies for them and work with the architects, the whole thing. Those projects were, every one of them, two or three million dollars. In fact, when I joined the faculty here...

Is this too rambling for you?

DT: No, this is perfect.

JK: When I joined the faculty here, after I was at the dissertation level, and they needed some help, and they asked me to join them, one of my roles was to work with the boards of hospitals across the country when they needed administrators. I'd get these calls from high level business people in Wichita [Kansas] or California, wherever, "Could we come and meet with you on Saturday and see who you've got that you'd recommend?" Can you believe this kid?

[laughter]

JK: I was placing high level jobs, "Yes, well, I think that's a good guy and he'd do a good job for you." "Oh, okay." God. [laughter] I think back and I'm sure I must have made some horrendous mistakes. That's where the field was. Whoever they hired did better than what they had before, because what they had before was a retired doctor or a part time nurse or the local banker who was trying to make sense out of that hospital and make it go when the whole field was overrunning them, you know. So hiring someone that had some training, at least, they were way ahead of the game.

DT: That's a good way to put it. This was the era of Hill-Burton, so I suppose there were, as you say, a lot of hospitals being built in the late 1950s and early 1960s.

JK: The field was booming and there was a lot of money available for it. Local hospitals could raise money from their communities and borrow money. The era of insurance was coming in, so they could make it back and lay it onto the insurance programs. It was just gangbusters, yes.

For the school and the department... Actually, it wasn't a department; it was a program. In the school, at that time, I'm not sure they had many departments.

DT: I think it was always divisions.

JK: Yes, something like that. I'm not sure it was even a division of Hospital Administration, but maybe it was.

They were making the transition from programs that were very applied, not very strong, no research base, not a lot of intellectual activity, not just here... Yale had a program and they didn't even offer the master's degree. It was a certificate. The [University of California] Berkeley program was run by a lady who had a master's degree in hospital administration from here. The universities were developing those programs because there was a need or they could create a need, at least, and they were short on faculty to run them.

DT: That's the thing with public health in general, but particularly the hospital administration, it is more practical, because you're not training, at least at the master's level but you're training practitioners rather than academicians, as you say.

JK: Yes, I think that's right, and it's also, by the way, the shortcoming that's showing up these days.

It was painful going through those eras of shifting more toward an academic base. The University was more and more concerned over having programs and having faculty that were out consulting more than they were here and had not published anything in the last five years. They had to address those issues. That was painful in terms of the transitions; no question about it.

DT: Yet, in that period, the 1950s and 1960s, when Gaylord Anderson was director of the school, the school seemed to have a very good international and national reputation.

JK: Well, they had a fair amount of international students, for one thing. The Environmental Health faculty was doing work in other countries, and Epidemiology, a little bit, but not too much, and Hospital Administration was not doing anything internationally, at that point in time. They did later, but not at that point. Gaylord was highly respected in public health circles and leadership positions in the United States. I don't think he spent much time in international affairs, but he got a lot of students from other countries. They got this master's degree in public health and went back home and worked in health departments and hospitals, in a whole range of things.

He was always quite pleased that he never asked the state for any money or very much money. He could bring in a lot of federal money, because federal money was available, and they were putting it into public health. They had a history of putting money into funding schools of public health. So, he'd write those grants, which were, essentially, per



capita kind of grants for students, at that time, and brought a fair amount of money into the school. He never really placed the school into a position where it had very much hard-money support. They had some, but not very much. That was a tremendous detriment when he retired and they started to try to recruit someone to replace him, because that person said, “What kind of resources are available?” “Well... maybe some, but we’re going to have to go get them.” That was a problem, I think.

DT: Yes. From the archives, it looked like during the 1960s, ninety percent of the school’s funding came from non-legislative funds, soft money. It was incredible.

JK: Yes. It was a style. I liked Gaylord; although, I never knew him closely, but I knew him. He was still the dean when I was on the faculty here in my early years. He didn’t know what I was doing, but nonetheless he was always a nice person. I don’t ever remember him having a faculty meeting. I don’t think he ever did. I don’t think he ever had any meeting of the division heads. He just kind of ran things from the top and that’s what Hamilton did, also. Hamilton never had a faculty meeting. He just told everybody what to do.

[chuckles]

JK: And, in most cases, they did it, not too well all the time, but they did it. There was a significant amount of discrimination that went on, not gender but other. I won’t go further into that.

DT: What’s your sense of the funding situation at the school? Was it similar to, say, what you encountered in Colorado, or was Minnesota particularly unique for the lack of state funding that it got?

JK: Actually, the University of Minnesota had more state money than most other state universities. Now, when I was in Colorado, I was in the medical school. They didn’t have a school of public health. We never could figure out the funding of that school, because they had state money. They had money from tuition and tuition was fairly high and they had a lot of students. Then, they had clinical income. Totally disorganized, a total lack of leadership, and high dean turnover. The dean, they looked at as an honorary position rather than directing something. Actually, when I left there, they had borrowed upward of a hundred million dollars to keep going. The legislature was cutting them back, because they were in a fight. It was that kind of a thing. I think that they, finally, worked themselves out of that. That was thirty years ago. They formed kind of an HMO [health maintenance organization] out of the faculty and got some different leadership at the department level and so forth. It was a totally different environment to come to Minnesota. When I came to Minnesota, it was fat city compared to Colorado. We all do—it’s just part of our role—site visits at other universities for their grants and for accreditation and things like that. Minnesota was in really good shape compared to others.

Lyle French said, "I'll go to the Legislature and we'll ask them for a state special." I thought, yes, good luck. He came back with a \$250,000 to start, which grew to close, I guess, over \$700,000, at the time when I left the directorship of the Center. He was able to do that.

John Westerman was the director of the hospital here. That hospital was in such good shape financially that if you wanted something... I was afraid what to ask for because the next day, he'd get it for you, you know. When I arrived on the scene, he said, "Well, how are you? What can I do for you?" I said, "Oh, nothing. I'm doing okay." He said, "You got space?" "Well, you know..." "Where are you parking?" I said, "They gave me over here and I walk a ways." "Tomorrow, you can park right here," in a heated parking garage underneath the Mayo Auditorium. I said, "What!?" He said, "Yes, no problem." He just picked up the phone and called a guy and said, "Kralewski, give him a card. He'll get it tomorrow." I parked there for twenty years, heated garage.

DT: [chuckles] Oh, that's very nice.

JK: And hated by every division head in this school, by the way, except the docs who could park down there, too. The School of Public Health docs could park down there because they said, "We see patients." They didn't see patients, but they could park down there. Otherwise, it was limited to the Medical School docs.

DT: Sure.

JK: So the Medical School docs and me and John Westerman parked down there.

[laughter]

JK: The other division heads raised such hell about it that they, finally, could park down there, too.

DT: Parking spaces are at a premium.

JK: Heated ones, yes, when it's twenty below.

DT: Yes, heated and close. You don't have to go outside.

JK: Things were good. The Pharmacy School and the Nursing School and the Dental School, Pharmacy and Nursing in particular, God, they were almost totally hard money and highly respected, by the way, across the country. I always asked myself that question: what happened on that little twenty- or ten- or fifteen-year interim in there when those schools got pretty much all hard money and the School of Public Health got all soft money? It probably was Gaylord Anderson and what he thought was the right thing to do. He didn't have to ask the state for money or something like that. I don't know, but it came back to haunt them when federal money started changing or getting tougher to get and so forth.

DT: As you point out, at that time, there was a lot of federal funding available for public health, because there was so much concern about a shortage of health care workers, in general, including public health people.

JK: Yes, and they had student support and all that. That was helpful. That probably was part of it.

DT: When you did your Ph.D., what was your research area?

JK: I started off by working on a project of a hospital...two streams. One was a hospital in Saint Paul that built circular nursing units and there was an evaluation project on it. There was a guy here that Hamilton recruited. His name was E. Gartley Jaco. He got a grant to evaluate that nursing unit to see if it created efficiencies or not and better quality care. You could stand in that unit and see all the patients all around you, if the curtains were open, by the way. Everybody else that came in there could see them, also. That was a little bit of a problem. I was a researcher on that to gather the information about what happened, the time and motion studies and all that kind of stuff. So I'd go over to that hospital and every hour or something like that would have walk on the unit and record what everybody was doing. I interviewed the nurses and all that. That was one of them.

Then, the other one was the joint purchasing of drugs for hospitals, because of my pharmacy background. Again, Jaco had a project on that funded. The hospitals were each buying drugs separately from the drug companies and, then, each of the physicians were responding to the sales detail men. So they were buying small quantities. Not only were they buying individually, they were buying small quantities of each one because this doctor wanted that one and this doctor wanted this one. We went to their pharmacists and said, "Suppose we get five hospitals to buy them together, first of all, and secondly, if we can get them to agree on one brand, then we can buy huge amounts and we'll save a lot of money." Well, the docs got very upset over it. "No, I can't use that other brand. It doesn't work for my patients." "Well, how come this one works for these other patients?" You can't make sense out of this. You know the saying that they were getting gifts and everything else, free stuff. It was a jungle out there. We said, "Okay. We'll just see if we can arrive at a lesser amount and a good variety." [chuckles] For some of these, there's only one brand. Then, you don't have a choice anyhow. We'll take that and go in for bids. They reluctantly agreed to that. So we got those hospitals together and, then, we went to the drug companies and they wrote irate letters back, "What are you guys doing? This is un-American." We wrote back and said, "Wait a minute. That's what entrepreneurship is all about in America is price quality and quantity." We got a ton of them. [Eli] Lilly & Company would not participate, but they had to later on. They had to cave in, because everybody else did. We had drug companies where they had the only brand and they knew that in those four hospitals—it was four of them, not five that were coming together—they had that whole market anyhow. They still would bid on the darned thing and gave us a ten or fifteen percent discount, because we could say to them, "We're going to buy from you this coming year x thousands of dollars," or

whatever. Then, we came up with this great idea... We had no place to store this. So we said, "We don't want it all now. We'll be ordering each month." [laughter] They said, "Okay." They could count on it then. They could count on a year's sale right there signed and agreed upon at a certain price and that we'd be calling on it each month. Actually, that whole idea, took off and other places bought into it also, this idea of buying in quantity and ordering it each month rather than having to have a warehouse of your own. Those were the two that I worked on.

Then, I got interested in medical group practices when I went to Colorado to work on those. When I came back here, I worked on a lot of different projects here, because I really needed to satisfy different constituencies. But the medical group practice stuff is what I worked on for fifteen years and tried to understand why some practices are lower cost than others and higher quality.

Do you get the *Minnesota Medicine Journal*?

DT: Yes.

JK: We have an article in that one this month...

DT: Oh, great.

JK: ...on the latest part of that study, and two others going out shortly.

And I've worked with Family Medicine over here on the adoption of electronic health records in medical group practices and the sharing of the data. It has all been group practice oriented, pretty much.

DT: I'm really interested in both of the studies that you were involved in for your dissertation work, because my own research area is on the history of the pharmaceutical industry and the relationships between the drug companies and researchers...

JK: Oh, really.

DT: ...particularly during the 1950s, 1960s, and 1970s and the political...

JK: I saw that. I'm glad you reminded me of that. Whenever we finish here, I want to see if you'll do a seminar for Medica.

DT: I'd love to.

JK: Can you do March 1st?

DT: I should be here, so, yes—and the talk is ready to go.

JK: Boy, that is terrific! Do you want to wait till the end...?

DT: Yes, we'll figure it out at the end for sure.

The debates over hospital formularies in the 1960s, about efforts to introduce mandatory generic prescribing, and the resistance of physicians saying that brand names weren't always equivalent to the generic drugs or the generics weren't equivalent...so I'm fascinated by your telling of the work that you were doing.

JK: It was interesting. It seemed like such a huge issue at the time. Then, once we kind of got the docs to realize that they could save some money... The question they always asked was, "For who? Who are we saving money for? Blue Cross? They've got plenty of money, don't they?" It was the patient that was paying for this whole thing. We started to come down to the issues of free this and free that. It's a jungle out there. When we tried to figure out just the cost of drugs in those hospitals, the first thing people came in and said was, "Here's how much it costs. See the bill there?" I started thinking about that a while. I had worked in a hospital part time while I was in pharmacy school. So I thought, I know that we used to buy this stuff in the hospital pharmacy and, then, at the end of the year, there was some kind of rebates or something. I asked about that, and, "Oh, oh, yes. Well, we get rebates at the end of the year." I said, "We've got to figure that cost also, then." "Well, we give those away free." "Who gets them?" It's just *incredible* when you start unraveling the whole thing. The docs, the same thing... They said, "Oh, well, those are free samples that we get." "Who gets them?" "Oh...oh...well, we give them out occasionally here and there. We give them to the low income." Sure they do, you know. Some of them—the hospital pharmacy, for sure—wasn't giving them out at all. They were charging for them. [laughter] Oh, yes, charging for them, at horrendous markups...

You're probably not interested in this.

DT: I am.

JK: We used to buy at Swedish Hospital [in Minneapolis] multiple doses of penicillin, the multiple dose ones. We could get that price down to less than a dollar for each one of those and we charged \$12.50 for them.

DT: That's interesting.

JK: Fifty or sixty went out of there everyday.

DT: That's incredible. I've focused on the [Estes] Kefauver Hearings in the early 1960s and a lot of that was about how much prices were being marked up. Of course, pharmacy prices were excluded from these hearings, but the drug companies and physicians said that the price of prescription drugs was so high because pharmacists were marking up the costs so much.

JK: Yes.

DT: Here it sounds like that was, indeed, the case.

JK: When I graduated from Pharmacy School... There were only thirty of us, by the way. It was a tough school. There was over, I've forgotten now...fifty of them that were in pre-pharmacy and only thirty that got accepted. Every one of them were guaranteed to become millionaires. We all had multiple offers to go to drug stores. We had a reunion here a year ago now, and about two thirds of the class got together. They're all millionaires, at least...some of them multimillionaires, some of them because they bought property and sold property, too, and things like that. It was a gold mine. You could not own a drug store in Minnesota unless you were a pharmacist. So they had the whole thing locked up.

I remember when we took the pharmacy boards, we went in there for our practical, a whole day on the practical, and we recognized stuff right away that was in our last year of our pharmacy, and we all passed it. These poor guys from the Dakotas or Wisconsin, whatever, that came in here to try to take the boards, this was a mystery to them.

[chuckles]

JK: About a third of the things that were asked to do, they didn't know how to do it or they did it and it was wrong. The whole thing was locked up and almost criminal.

I worked in a drug store for a while before I went to the Swedish Hospital when I was in Pharmacy School. I'll tell you one thing I learned is I didn't want to do that. It was sell as much cosmetics and anything as you can. You spent a little time with prescriptions, not much.

DT: By that time, all the compounding was being done by the drug companies and not...

JK: Absolutely. Buy it in a big bottle and put it in a little bottle and double the price—at least. That didn't make any sense. The hospital one, I kind of liked, but I thought it's partly boring. [chuckles]

DT: I worked at a pharmacy for some time in high school, because I thought I wanted to go into medicine. This was a different experience, but I had the same feeling that it would be quite boring.

JK: Yes. That's kind of how that worked itself out.

DT: When you were talking to the four hospitals trying to get them to go in together and purchase drugs collectively, how did the hospital pharmacists and the administrators feel about it? Did they take some convincing?

JK: The administrators said, "It's about time we're getting something out of this project," because I think they were putting some money into it. Jaco was—I don't

know—he had some kind of deal where he was getting some of that money in addition to his salary from over here. We never knew about that but... The administrators..."It's about time we're getting something out of this. You guys going to save us any money?" I said, "Well, it's possible." The pharmacists, about half of them, were excited over it. It gives them something more professional to do. They took it to their pharmacy committees and tried to convince those docs. They carried a lot of the water on that. I'll tell you they went to the docs and worked with them and found docs that they were friendly with and who would help them and work through finding common ground on the whole thing. As I recall, I did meet with a couple of the physicians, but not very many, because they had their drug committees or pharmacy committees and so forth in the hospital. They met once a month or something, and they don't let outsiders into those. [chuckles] The pharmacists did a nice job on that. When it was finally worked out, they got a lot of visibility on it, too. That's something I learned early in the game working with folks like that on research: give them a lot of visibility. Why not? I could care less if those hospitals like me or not later on, but the pharmacists cared a lot whether they liked them. So give them...and let them make the presentations, and I stayed in the background.

DT: Which hospitals were they that were involved?

JK: That was Swedish, and Saint Barnabas, and Eitel, and Abbott [all in Minneapolis]. Of course, they all kept merging later on. I don't think Northwestern was part of that. Northwestern Hospital was still there [in Minneapolis] but I don't think it was part of it. There was a Jewish hospital [Mount Sinai in Minneapolis] there, at that time. Oh, wait, I think Saint Mary's [Hospital in Minneapolis] was part of that, too.

DT: You'd mentioned that working in a drugstore would have been maybe a little boring and that the compounding was gone. But, the other issue that I understood to be an issue within drugstores, at that time, was that from the mid 1950s there were pharmacy chains that were on the scene and that supermarkets were starting to have their own pharmacy counters. So there were these commercial threats to small pharmacies. Did you encounter that at all?

JK: That was a little after I was involved in this. In Minnesota, those stores couldn't have a pharmacy in the early days.

DT: Oh.

JK: They got that law changed, and so they could.

DT: But that came later.

JK: They started forming pharmacies and hired pharmacists to run them. That diluted the market a lot; there's no question about that. The fact is the millionaires that were at our reunion, that's where some of them made... Well, they made a lot of money before that, but they sold their drug stores out to these chains. That's what they were doing.

They got a big chunk of dough for them, you know. They could see the writing on the wall that the good days were coming to an end, so they sold them out.

Those chains...uh...they cut the price on some of that stuff though, and they could buy, clearly, more efficiently. It's still an issue about where it's all going to go, to be honest with you, right now even, because the drugs are still an expensive, very expensive part of health care. The little pharmacies are closing up because they can't afford to stay open because the payment is so low. The services that you get at these Wal-Marts and all that is so shaky that...I don't know. Fortunately, with the EMRs [electronic medical records] and E-prescriptions coming and so forth, you get a lot of controls at the other levels. The whole idea of your pharmacist keeping track of your drugs for you and advising you on them and so forth, boy, I don't know, it's just hard to do when they're so busy and their margin is so low that they've just got to keep churning prescriptions. So they've got aides that hand it to you and say, "Do you have any questions?" "No." Or the pharmacist will come and say, "You're taking an antibiotic here. Are taking any Coumadin? You shouldn't be taking those two together," and things like that. If they say, "Yes," then where do you go? You need the antibiotic anyhow. The drugstore can't up your Coumadin for you. You'd have to go back to the doc. The doc is seeing a patient every twelve minutes. Where is this whole system going to go? [laughter]

DT: I know that in the 1970s, pharmacists were trying to establish—at least from what I understand—their role within that kind of health care team...

JK: Yes.

DT: ...to say, "We're the ones who should be tracking adverse reactions, should be talking to you about how to take your drugs." That's not something that the physician is best equipped to do and to know which version of the drug to prescribe.

JK: I think that's right, and, in some cases, they are doing that in the large group practices, because they have their own pharmacy then and pharmacists and so forth. But, again, they've got to give them the time to do it is the problem. The pharmacy school here has this program, which you may know about, where they market it starting with the UPlan where patients with multiple prescriptions... Do you know about that plan?

DT: Yes.

JK: You can sit down with a pharmacist and go over the whole thing with you and find errors or things you shouldn't be doing and things you are doing and, maybe, even recommend a different drug, and talk to the doc about it. It's an expensive program. But maybe it saves some money and maybe it improves the use of those drugs, I don't know. I'm anxiously waiting for some good evaluation of it, which they're doing themselves, I guess. It is an issue about where that should take place. I think at the clinic level is probably the most effective, because, if you're visiting with the pharmacist, then they just call the doc right upstairs and get the nurse and say, "Ask him..." Otherwise, if you're at a drugstore, you call in and you're going to wait two days to get a response.



DT: It's a nice idea to have that clinic model be more widely adopted so that you have everyone in the same location for these reasons.

JK: You've got to get to a certain size to be able to do that. Like the Park Nicollets [Park Nicollet Clinic], they can do it, and the HealthPartners [HealthPartners Clinics and Care System] and so forth. This study right here, where we're looking at cost and quality, they aren't the lowest cost practices at all. Some of those physician-owned medium-sized practices are, actually, the lowest cost.

DT: This is why health services research is so interesting, I think, and asking these critical questions.

So with the nursing study that you were involved in with the circular ward, what hospital was that at?

JK: The nursing study was a dissertation. That was the nursing strike.

DT: Oh.

JK: Is that the one you're referring to?

DT: No. You said for your Ph.D. work that you had been involved with assessing whether the circular ward was more efficient...

JK: Oh, that was over in Saint Paul. That was at the United Hospital.

DT: Do you remember whether that circular ward was more efficient?

JK: [chuckles] I do remember, as a matter of fact. It had several very serious issues. One of them was that if the nurses at the station wanted to be able to see what everybody...you had to keep all the curtains open, and, then, everybody else could see everybody see, too, which was not good at all, because particularly if someone passed away. Then you had to close all the curtains and everybody knew if you closed the curtains, this was a bad thing. It didn't work out real well from that point of view. Then if you wanted to go to that patient over here, you can jump over the counter if you want to—no, you don't want to do that. You have to go back to one of the outlets—it didn't save any time.

[laughter]

JK: The distances were about the same as if you were on a regular ward. In fact, they're not stupid. They figured it out by themselves, which was the most efficient. If you look at a hospital today, they've got these units that are rectangular, beds on each side and the nursing station is right in the corridor. They've got two nurses or three of them and they take care of that whole unit. Then, you go to the next wing and you've got another

nursing unit. They used to be out front and, of course, then, you walk a long ways, and you can't see them in their room. They kind of figured it out to get the most efficient... It had some possibilities. You could, particularly in the evening with everybody sleeping, have those small lights on and a nurse could watch that whole thing. If somebody was restless or whatever, they could go on over there and see if there was something... It never turned out to be a very effective architectural design.

One of the categories on the interview was exchanging pleasantries versus talking to a patient, giving drugs, etc. I learned there was a lot of exchanging pleasantries that goes on in those units, because particularly after it's nine o'clock or something and things quiet down totally. Everybody is sitting around trying to stay awake.

[laughter]

JK: That was part of it.

For my dissertation, I studied the nursing strike.

DT: Oh, okay.

JK: There was a strike here. I tried to figure out why. Well, we knew why. It was money. They went to resignations. Some resigned. Some didn't. I studied who resigned, who didn't, and why did they. Some of them went back to work before it was over with and so forth. When they had the threatened strike here, they were picking that up again and asked me to come and give them some advice at the Abbott Northwestern [Hospital] on the strike and what they should do. But, you know—as I say, you can edit this however you want—these administrators are so stupid that it's hard to be of any help to them without insulting them. They have no rapport with their nurses. They say we're doing the important things. And they're doing the important things. That's what it's all about. Some of them, we pay them a lot. Actually, they do pay them quite a bit, but it's not just money. People want camaraderie. They want to feel part of something. They want to be respected. They want to respect their organization. How do you tell those administrators that without insulting them? Why haven't they been doing that? One CEO [chief executive officer], said he's not taking a salary until this is finished. I blurted out, "If I was those nurses, I'd see how long that guy could last."

DT: [laughter]

JK: I thought, oh, John, why did you say that? They said, "Well, he's using his vacation." Yes, sure. So he's getting paid anyway, the jerk. [laughter]

DT: It seems like nurses have always been in something of a predicament when it comes to their workplace situation. This came up in the discussions around whether they would strike or not last year. Well, what about patients? What happens to the patients? Nurses don't want to put the patients in jeopardy, but they, also, want to try and create a better

work environment for themselves. My understanding is it was a lot about nurse to patient ratios, too, which is inherently about patient safety.

JK: That's what this guy says to me, "Oh, they just want more money. They want more money." I said, "I thought that it was some staffing issues." "Staffing has no problem here." I know a guy from my breakfast club is on their board, [sounds like Sol-vig]. When the strike was settled, he said, "Okay, that's settled now." I said, "If those administrators believe that that's settled, they have got their head in the sand." Staffing on the West Coast...they're passing state laws. I said, "If you guys don't jump out in front of that right now and get your nurses involved and develop staffing levels that make sense, they'll pass laws here and demand it for you." He said, "We can't have staffing levels that they want." I said, "Sit down and work with them and see if there's a common ground. They're not stupid." They see the docs walking through there each making \$300,000 and \$400,000 a year and they say, "Why can't we have another nurse in this place?" [chuckles] I don't know...that's why they wonder about me.

DT: I was going to say you occupy this curious space where you're talking to the different health professions and the administrators and, in many ways, it sounds like you try to mediate between them in a way to show them how they can get out their situations.

JK: But only if they want to, you know. The administrators, we train a lot of them. I asked this question several times when I was on the faculty full time here, but nobody wants to bite into it: What are we doing wrong? Are we training leaders? Everybody runs around, "Oh, we're training leaders. We're training leaders, executives." These kids, a lot of them, shouldn't even be in graduate school. They are just not intellectually inquisitive. They want to get that degree and get out and make money, get a job. The MBAs, they're the worst. This program was in the business school. I taught a course in there. God Almighty! they just killed me. It was the worst reviews I've ever gotten. I was proud of it, actually. These guys and women made it clear early on that this course that I was teaching, a policy course which they had to have to graduate, was of no value to them. They want courses that will teach them to make money and get out of here and do that. They're so rude. They'd bring their laptops in there and play games on it. I threw three of them out. Get out.

DT: Good for you.

JK: "Get out of here. We don't want you here." "Well, you can't do that." "Watch me. Get out. If you want to come back, leave your laptops somewhere." "We can't leave them. People steal them." "Goodbye." The next time they come back, no laptops. Boy, they killed me at the end reviews. Just incredible, they were.

What are we doing wrong? I don't know what we're doing wrong to be honest with you. Maybe we're not selecting them right. Maybe we're not teaching them right. Maybe I am way off base and they're doing the right thing. I don't know. It's a real possibility that I've lost my perspective on what the place should be doing. Anyway, the program has a national reputation, the Minnesota Health Administration Program. It has trained a

lot of administrators that were in leadership spots, no question about it, some of them very good administrators who did have value systems that were different. They did very well and created good work environments with their medical staff and with the nurses and the whole thing. But it's almost the exception rather than the rule. The national reputation meant that they were attractive to students so they got a lot of applicants but other programs don't. It means that they got jobs for their grads then, because their grads hire them back up.

[laughter]

JK: The system, it works.

DT: Yes.

JK: In between, it was, as I said, for me coming over from pharmacy, disappointing at how easy the courses were and how shoddy they were and how favoritism was... Hamilton would identify certain people that were going to be important in life and they got everything.

DT: In the 1960s, what was your sense of the relationships between the different divisions within the school?

JK: Ah, good point. They were pretty autonomous. As I said, I don't think there were any division head meetings whatsoever and there were no faculty meetings. There were never any get togethers except the end of the year kind of thing at Gaylord Anderson's house. Other than that, there was very little interaction among the faculty at all, very insular.

Environmental Health had pretty good leadership. They were doing some good stuff. It was kind of attractive to me in pharmacy because they were doing stuff that would borderline get into the drug area and so forth. We had one course from them and no other contact with their faculty or their students.

Epidemiology was run by... I can't remember that guy's name.

DT: Was it Leonard Schuman?

JK: It was Len Schuman. He focused on cancer and was well known in that field, and I think did some reasonably good research in it. He never was able to gather a good faculty around him, first of all, because he was such an irascible old bear. What is really interesting to me also about leadership is that the people, as they say, that can surround themselves with faculty that are smarter than they are, that's the gold standard. Well, they surrounded themselves with faculty who were inferior to them. I'm God and you're lesser folks and that's fine. That's the way it was. He tells them what to do. He had a shoddy faculty, to be honest with you. They did have some decent cancer work and were known for it nationally.

The Lab for Physiological Hygiene, that one with [Henry] Blackburn was similar, as a matter of fact, run from the top down. Blackburn was able to recruit some good faculty, Russ [Russel] Luepker and those folks, around him. Still, they were in fights all the time. I remember Russ Luepker coming in here and saying, “I’m going down and let the air out of his tires in the garage, right now, the s.o.b. [son of a bitch].” That’s the kind of relationship they had. [laughter] They were doing the cholesterol studies and all that. That was out front and they did a lot of good stuff in that whole area. They never were able to really convince the medical establishment about all of this, which was really a tragedy, because it was only in the last, what, fifteen years or whatever, that cholesterol became forefront in controlling and reduce heart disease and all that. Before that, they were running around saying, “Look what we found. Look what we found,” and nobody did anything about it. When you talk about translation of research into practice, boy, I’ll tell you, that’s a big issue. It’s a tremendous issue for all of us. Really, the way cholesterol came into medical practice was when the Medical School started doing work in it and, then, teaching the students and saying, “Okay, here it is,” and so forth. That changed things an awful lot. Then, quality measures and all that, later on...

In those two units, we had little to do with—nothing to do with, as a matter of fact, at the master’s level. At the Ph.D. level, I did work a little bit with one of their faculty members in Epidemiology, because I was kind of interested in the Epidemiology approach to things in health services, like accidents, and things like drug errors. There is an epidemiology method that you can look at that. They kind of had overrun their methodology capabilities and that hurt them a lot. Epidemiology was looking at a lot on associations. They were doing the clinical trials—Blackburn, also...clinical trials—and that’s important, and that’s good epidemiology. But when they started talking about associations, then it got to be really murky. That’s when you read an article one day and coffee is bad for you, because all these people who drank coffee, they also had whatever. Then, the next day, you read an article, oh, coffee is good for you. The next article on coffee, it doesn’t make any difference. They were never doing that kind of stuff, which Bryan Dowd just outlined for us here on this project [signaling a document on the table], where you put it into the regression equations and you’ve got methodologists that go far beyond just the associations. But, they did good basic work back in the days. They were insular, did their thing. Nobody asked them a lot of questions. They brought in a ton of grants and they supported themselves and faculty.

In Epidemiology, Leonard Schuman was a pretty good teacher. I liked him as a teacher. Nobody could challenge him because he’d jump all over you.

DT: [chuckles]

JK: That was okay.

Biostatistics was always a good department. We didn’t have a lot of relationship with them, which was too bad, by the way, because Hamilton had decided to hire his own biostatistician. That’s [Vernon] Weckwerth. That was unfortunate, because Biostat was

a good department and had really good teachers over there. We would have benefitted by those courses rather than having one of our own that was kind of watered down. That, I think would have helped the whole student body, also, because it would have ratcheted things up a little bit and would have helped in terms of training a little different kind of a person. This article that you'll read in *Minnesota Medicine*, that editor said, "This goes to administrators. They aren't going to understand these correlation tables that you've got in here. You've got to put more text in there about how to read these." That's where it is out there, I guess. When you try to get them to participate in research, you get the same thing. "No, I don't think we need that stuff." [chuckles] "We're doing okay." I guess they are doing okay, so they don't need it.

So those were the departments. I think that's about what there was and still is, as a matter of fact.

DT: What about Public Health Nursing, at that time?

JK: Ah! good question. Public Health Nursing was an important area here, and they were doing very well, by the way, from what I understand. They had some good faculty who we worked with. They were smart, and they were aggressive, and had a lot of money. I'm not sure why it got phased out. It got expanded a little bit into the nurse practitioner kind of approach, which also made sense, by the way. I'm not clear on just what happened in between that. It was going along and they were doing some work in rural areas. They had, I think, significant funds from the Legislature to support it. They closed it down or pretty much closed it down, at least. I don't think there's anyone training public health nurses in the School of Public Health anymore. In the Nursing School, they're getting training that's quite similar to it and they take courses over here. It's a little different than it was. I think Bob [Robert] Kane did that, as a matter of fact, when he was dean, but I'm not totally sure about that.

DT: That was my understanding that it was either Bob Kane or Edith Leyasmeyer when she came in after Kane. Yes, that was my understanding that they ended up moving into the School of Nursing while some faculty stayed here and some went to Nursing.

JK: Yes, and then they phased out the ones who stayed here.

They narrowly averted a political catastrophe with the Legislature, because they phased it out but kept the money. Later they did the same thing with the Center of Health Services Research. In fact, they took the name Health Services Research out of this unit. There is still \$300,000 or \$400,000 state special here. Frank Cerra told me last year, "Man, I don't know how I'm going to continue to defend that with the cutbacks from the state." Well, I don't know. One of these days, they're going to grab it probably. Somebody is going to discover it, and it will be gone.

DT: Yes, sure.

JK: Do you need to go, probably?

DT: I'm fine. I can go as long as you're happy.

JK: Let's go for another half hour. Then, I probably need to run.

DT: Okay. Yes.

JK: If you look at the health sciences and the School of Public Health the same way, the thing that strikes me is their inability to recruit leadership at those top spots, and, then, even division heads. As a result of that, it was a bit of a floating along for a while and some loss in momentum in terms of the kinds of things that were being done. Why did that occur? I ask myself that question a lot, and I don't know. I think, in some ways, there was no planning for transition. That's kind of one aspect of it. It just kind of happened, you know. Hamilton retires with a big party and ceremony. Oh, we've got to get a committee together now and recruit. Then, they recruit someone to run the program or whatever it was called at that time or division. I'm not sure. They had some pretty good Ph.D. folks nationally who were interested in the job. But, they talked with the alumni and they said, "No, we know this guy who's running a hospital. He wants to do more stuff now, so you should hire him." And they did. This was [Bright] Dornblaser.

DT: Yes.

JK: He was totally overwhelmed by the job. This was when there are programs at other universities who were bringing in the Ph.D.s and trying to create research. He just couldn't quite get a hold of it—never could, as a matter of fact. The program simply went downhill. They never recruited any good faculty. They never had any research. They never had any grants. Jaco was here and left, went to California. They never developed that intellectual base for the program or research that goes along with it.

Now, almost the same thing happened when Lyle French retired. They go out for these searches and they just don't turn up anyone, for some reason. I think part of it is that they didn't have a good strategy for searches. They bought into some search firms. I've been on almost all of those, when I came back here, and ended up on the vice president level working on every committee around here. I discovered those search firms, they had their pets that they were grooming. This person is the person for you. Well, that person didn't fit, you know. I was getting more and more believing that you've got to groom someone from within rather than doing these national kinds of searches, because they just weren't finding anyone.

I'm a student of the John Deere Corporation. I collect John Deere tractors, antiques. When you look at how they manage that company, it was only in recent years that there wasn't a family member that was chair. That person that became chair had been there twenty years. They move them into those positions. Still, though, at Medtronic, they were able to recruit from outside. Win Wallin was a spectacular success there. They brought him over from General Mills.

So it's a mystery as to why we weren't able to recruit good talent. We went through a period with the health sciences when we just didn't have the leadership. We went through one vice president after another very quickly; they turned over very quickly. Cherie Perlmutter was acting vice president more than the vice presidents were in that role. She was overwhelmed by the role, a nice person. I liked Cherie. We always got along very well. All the space was given to us by Cherie, by the way. That's another story. But she was overwhelmed by the job, which you can understand because she came from an administrative kind of a role to be acting vice president. Then, you've got people like John Najarian, all those big bears that are bears. They're hard to get along with. They're world famous and had tons of money coming in and research grants and all that. She just wasn't up to asking the tough questions of them when they got into trouble with the NIH [National Institutes of Health] selling the...

DT: ALG [Anti-Lymphocyte Globulin].

JK: Right. That hurt everybody. The clinical chiefs were getting really kind of out of line with the things they were doing, because of the way they were handling the income. John Westerman was still here as the hospital administrator. We were good friends. John said, "Boy, I don't know..." Nobody worried about them making a lot of money, which they were because they had all that clinical income and they were dividing it up, keeping most of it, giving a little back to the hospitals or laboratories, but they were leasing cars for their wives. You can't do that stuff. Then the press picked it up and it was bad news.

The School of Public Health went through some of the same thing. I think it was a little different with the School of Public Health, though. I think there, we were stuck with these requirements from the University about these search committees we had to have, a representative from everybody on them. You could hardly get through those committees.

I remember distinctly a friend of mine—he wasn't a close friend—a really good guy, who was a Ph.D. researcher, had been at a university and, then, went to work for Aetna for a while and ran their research program, then he applied for the deanship here. He came in for an interview. The guy had a little bit of a hearing problem and I knew that. I was sitting toward the front trying to make sure he heard or repeating things if I needed to and so forth for him. We had this minority on that committee who was hard to deal with on anything and his English was not good at all. He asked this long rambling question and the guy couldn't make sense out of it. I was trying to say to him, "It's about this." "It's about that." He tried to respond to it. After the guy left, this guy said, "'He's out of here. I'll boycott the whole thing if you offer him anything. He doesn't respect minorities." I said, "The guy's got a little bit of a hearing problem." "He doesn't respect minorities." I said, "I'm just telling you this is a good guy." He was out.

Then, we went through a couple other candidates. They threw Edith Leyasmeyer out of there right away, because she wasn't capable. Then, we couldn't find anybody else and asked her to come back in and gave her the job. She was one of the weakest deans we ever had. [chuckles] Bob Kane was the worst dean, but not incapable. He was the worst



for other reasons. He had no sense of being able to work with people. He comes in and stomps over all of everyone. Oh, my.

We had a hard time finding deans. That's when they hired Stephen Joseph.

He came in here and tried to merge us with the Hospital Administration program. He said, "They don't have any research going. They don't have any intellectual environment down there. So we'll merge you guys underneath them and that will give..." Wait a minute, now. Is there some reason they don't have any research and we do? That's number one. Number two, the associate vice president from the University told me later, "I sat down with Steve [Joseph] and said, 'Do not do this. Do not do this. The health services research center faculty are well known in the Legislature. They're well known by the *president* himself. Do not do this.'" Cherie Perlmutter would not say a word to him. She said, "I can't tell a dean what to do." Come on, you can tell a dean what to do. The guy, essentially, lost his career over it.

DT: Was this [Robert] Anderson?

JK: No, this was Stephen Joseph. He was the dean of Public Health before Edith Leyasmeyer.

DT: Oh, Anderson was v.p. [vice president for health sciences].

JK: Yes.

Stephen Joseph was a physician. At the end of the fight, he had a call directly from the president of the University saying, "Stop this nonsense. You're going to wreck one of the best units we've got." This guy was so stupid. He thought that you had to make that decision the first week he was here; otherwise, you can't do it. You've got to change things right now, which is totally the opposite of what leadership is all about. Walk in the shoes for a year before making changes. The president called him and said, "You're way out of bounds on this one." A year later, he left, because he knew that he that he was going to be jumped on for whatever he did at the president's level from then on in. We had a relationship with the president's office. There wasn't a month go by that he didn't call us and ask us for something such as going to a meeting and, "The presidents of universities are going to be talking about the health care field and where it's going. Can you give me a couple pages?" The leader in the Minnesota Senate and ask us, "Can you come over and just visit with our committees about what's going on in health care?" That's the set of relationships we had when we built the Center. We worked hard on it. If somebody wanted something, we didn't say, "No, too busy today." [chuckles] Can you imagine somebody so clumsy coming in and trying to merge us without taking a while to learn the ropes?

DT: As you say, though relationships with the president, but particularly with the Legislature, that's so important for the institution's future, not just your unit or even the school. It's for the AHC, more generally. It seems very problematic.

JK: Problematic...it's stupid. You wonder why people do that kind of thing. I guess because they thought they could. I think he had bad information from a couple people in the school that just thought we were uppity, so to speak. Arrogant, I believe is the word.

[laughter]

JK: Good researchers are arrogant in some ways. They know so darn much about something. Many of them are; they're nice. But there is an arrogance, and I regret that I suppose we had that occasionally displayed it.

The issue is leadership and recruitment, recruitment, recruitment of those division heads. The division heads—I was one of them at that time—looked at the candidates. There were three of candidates and we eliminated one of them, John Finnegan. We sent a message forward saying, “Of the other two, some of us like this one better; some of us like this other one better. But we don't think Finnegan... “He just didn't have enough experience at the moment—maybe five years out—to take that job, and Frank gives him the job.

[laughter]

JK: The division heads looked at each other and said, “What the hell were we meeting about? Why interview people?” We asked Frank, and he said, “I think he's the best one, plus these other guys wanted commitments for resources that I didn't think I could give them.” We thought, oh, oh, Frank is writing us off, which turned out to be pretty much the case. “Guys, do your thing. The big issue is the Medical School and that's what I've got to wrestle with.”

Then, they hire the dean of the Medical School [Deborah Powell] and she didn't turn out well. I liked her, as a matter of fact. She had a good reputation where she came from. Somehow, it was not a good fit. That transition took place without a lot of visibility and ended then with Frank becoming dean.

Yet, in the most recent handling of the whole thing, we have a president who sends us all emails saying that Frank is retiring. He's recruited an excellent person, the chairman of Pediatrics to be dean and vice president. This guy is wonderful and on and on and on how great he is.” He'd only been there like six months...I don't know. Paragraph one. Paragraph two: “I will be retiring and I will emphasize the need to do a national search for a new vice president of health sciences and dean of the Medical School.” I thought if this poor guy reads that, what's he thinking? He should have just walked over there and said, “Excuse me, I'm out of here. I can't live under that kind of stuff. What can I do?” But he doesn't! That signals to you that the guy wants the job so bad that he's willing to put up with stupidity, in my estimation. Does it bode well for the future? [laughter] Then, the third memo that comes out says, “Okay, now we've worked out this arrangement where each of the schools will report directly to the president's office.” So, now, not only does the guy question his future, but the schools don't report to him

anymore. I saw Frank in the hallway, and I said, “Frank, what the hell is that all about?” He said, “Oh, well, that’s the way the schools wanted it.” I said, “Frank, there’s no way greater time in the health care field for integration than now. The schools have got to come together: Pharmacy and Nursing and Nurse Practitioners and the Medical School. That’s what the field wants out there is someone that’s together. Now, they’re apart.” He said, “I had nothing to do with it.”

DT: That’s my understanding that that was what prompted the reorganization of the health sciences in the later 1960s and...

JK: Exactly. It was at the president level and at the school level. There was a feeling that, first of all, that the schools were booming and needed some more coordination and, secondly, that they were in-fighting with each other for money. So bring that together and act as a group. That was Lyle French, and he was uniquely fitted for that job, as far as I could see, because he was a highly respected clinician, first of all, so he could stare down the senior medical faculty. He could also go over here and talk to the School of Public Health and Dentistry. They all liked him...and Nursing, and go in with budget requests...got the money, built the hospital.

I had a big part of my reputation on the line on that hospital. I wasn’t involved in the planning of it or anything. Westerman was. Westerman left that kind of slip away from him and let his underlings do a lot of it and hired a consultant. They went around to each of the Medical School departments and said, “How many beds do you think you’ll need?” “Oh, I want 10,000 and I want...” It’s that kind of thing. They had designed a hospital. It was a little too big, maybe. Then, the hospitals in the community, they don’t want competition, started to lobby against it. They contacted their legislators, so the Legislature said, “Well, this seems like a bad idea. What are you guys doing? We’re going to stop that.” Lyle called me and said, “We need your help.” Oh, oh. [chuckles] I was over there at the Legislature and the HMO people over there were saying, “It’s going to be HMOs throughout the whole state, and they use twenty percent fewer hospital beds. This will be empty. There will be no patients there at all. You’ll be broke,” and so forth and so on. I had to follow and say, “Number one, the HMOs use fewer hospital days, but maybe they’ll use this one more than others.” That was the wrong thing to say, because the administrators, “Oh, oh, that’s what we’re afraid of.”

[chuckles]

JK: “Secondly, the HMOs will never, in my estimation, dominate the scene in Minnesota.” This guy said, “What? Who are you? What kind of data are you looking at? They’re growing.” I said, “They haven’t grown in the last two years.” Park Nicollet is now phasing their HMO down, because they were losing money on it. We had those arguments in public at the Legislature, and that was not good news. But I got through it without making very many enemies. The administrators didn’t like me much, but the Legislature was okay with me, which was important.

Then, they wanted another consultant to look at it again. He came in here and said, "Let me see all your data that you have." I said, "Wait a minute. You're getting paid for this."

[chuckles]

JK: I'm not getting paid at all. He said, "Come on. Give us your data that you got from the community here, the studies you've done and everything." I said, "Oh, okay. Here it is." He concluded, "It's hard to say. Maybe the hospital will be okay the way it is, but the university is not going to be able to sell it now to the Legislature. We'll go in and cut it back a few beds," so he did. Lyle said that after carefully reviewing the need we're going to reduce the size to make sure it fits. Then, everybody wanted it and they built the hospital. And the hospital did all right.

But now, Westerman was going to be leaving the hospital. Lyle was retiring...The utilization was going down. All the hospital ? scurrying around making sure that they protected their own turf.

The Jewish hospital was wondering if they could survive. They asked me to come down and consult with them on what they should do. I went down and met with their board and I said, "You know the way things are changing, it's going to be tough for a hospital of your size. But, I'll tell you what, I don't want to take your money. Let me go dig out some data, and I'll come back in a month and meet with you, and see if we should do a study or not." I went out and I looked at everything, and I said, "There's no possible way that this is going to work." I met with them the next month at their board meeting, and I said, "I've got good news and bad news. The good news is I'm not going to take your money to do a study, because the fact is I can tell you what I'm going to find and that is that it's going to be really, really tough for you to survive here unless you each want to throw in hundreds of thousands of dollars a year." They were putting in personal money to keep it going, the Jewish community. One of them said, "What do you recommend?" I said, "Well, why don't you go over to the U and recommend that they put another floor on the University Hospital and call it the Jewish University section, floor, service, Eye Institute, because you've got one of the best eye institutes in the country, and you'd be in business there, and, then, you will be in perpetuity and you'll be in good shape." This one guy says, "We're not going to move. We'll keep this hospital going regardless of how much we have to put into this." Some of the others were shaking their heads. "I think we better listen to him. But no way. Thank you, Doctor Kralewski. We appreciate your coming down, appreciate what you did, but we're going to stay here." Of course, they couldn't, unfortunately. They merged with Abbott Northwestern, I guess, and lost their name totally. It's Allina [Hospitals and Clinics] now. The [Phillips] Eye Institute is there; it's a good one, too. That was the kind of thinking that was floating around.

Then, two other things happened. One of them was that the one vice president we had, whose name I can't remember now... It was the one that when they went down to New Orleans...

DT: William Brody?

JK: No. No.

DT: Before that? [Neal] Vanselow.

JK: Vanselow.

DT: Okay.

JK: Brody was another issue.

Vanselow decided that they should buy an HMO. A bunch of family practice physicians had put one together. At that time, everybody was trying it out. So he asked a couple of us from our Research Center to sit down with him, Westerman and the whole crew. He said, "We can buy that thing." I think it was only a couple hundred thousand dollars or maybe it was a little more than that. It might have been \$500,000 or more than that even. But they had a ton of money; the hospital had a ton of money. I said, "I'll tell you, I'm really nervous over these things, because Park Nicollet is saying they're going to get out of it...somebody as big as they are. Our neighbor was a physician there, and he said they had these agreements, their capitation, and docs had agreed to it and everything. They never changed their behavior is what happened. So at the end of the year, our neighbor doc said, "I had to put \$50,000 of my personal income back into the pot. That was my share." We were at their house for dinner and his wife said, "Yes, you're damn right. There's no more of that, I can tell you that. We'll move back to California."

[break in the interview]

JK: No Mercedes for her. [laughter] Long story short, Roger Feldman was with me. Roger said, "you know I'm nervous over it too. Bryan Dowd was with me." These are the old time folks here that I had brought in. They knew what was going on. I said, "I think we better be careful." "Oh! We're going to capture that money and bring those patients in here. They'll all come here for care." I said, "They're located all over, and they're not going to come over here for care unless they want the high tech specialty kind of stuff." "We can just tell those physicians that this is where they'll hospitalize their patients." That's the same mistake that Park Nicollet made. [laughter] They were selling their plan even to rural areas. Those patients will come to us now. Well, those docs sent them where they were sending them before. They aren't going to change overnight because you have some kind of a signed paper in front of you that says now you're part of our HMO. They bought it, and, less than a year later, they closed it down, a total loss. That went bad.

Then everybody got nervous over could that hospital survive or not. I never saw the financials on that hospital—never asked for them. They never asked me for anything on it. But some of those that were in administration here told me that the hospital was in good shape financially. It just was that the patient load was declining. Everybody was

running around saying, “Gosh, what are we going to do? What are we going to do? We’re going to go broke.” Then, it got into this, well, it will take the whole University down with it. It wasn’t going to take the whole University down. They could close it up and they’d be all right. They only owed, I don’t know, \$100 million on it, less that that, probably, on the whole darn thing, and had a lot of money in the bank and revenue was pretty good. It caught kind of a wave of the sky is falling. The sky is falling. We’ve got to do something about this. We’ve got to do something about this. Okay. They asked me to come in and talk with them about what we should do, the board. This was that person who chaired that at that time, a lovely person. Oh, gosh, I can’t think of her name. Pillsbury.

DT: Sharon Pillsbury? Sally Pillsbury?

JK: Sally. Sally and I became good friends. She’s a wonderful person. She said, “Sit down with us and talk about this. What can we do? What can we do?” I said, “Why don’t you explore the possibilities of linking with various hospitals out in the community? You could be the tertiary part of this whole thing, so you aren’t interrupting a lot of their business. They’re still out there doing okay, but you bring in the high tech stuff, and a brand new building, and all that.” She said, “That’s sounds like a good idea. How can we do that?” I said, “One thing, you’re not going to be able to go to the Abbott Northwestern and say, ‘We’re going to now do all the tertiary eye care,’ unless you say to their physicians, ‘You can come here, too.’ So we’ll open it up to them. And the heart surgeons...” She said, “Well, they tell me they’re not as good there as here though, so patients will come here.” I said, “We *train* them. You’re going to tell me now that they’re not good? We trained them!”

[chuckles]

JK: They’re just as good as here. Clearly. They aren’t doing some of the research, but some of them are doing research also. I said, “That’s the key, it seems to me is you go to the clinical chiefs here and you say, ‘Okay, we’ve now worked out an arrangement where selected physicians there will have appointments here and bring their patients here.’ Maybe they don’t do research here. Maybe they don’t want to do research here. But they’ll see their patients and we’ll have to find some title for them then.”

Boy, these guys went ballistic. Everyone would have to go through a search process. Yes, everyone would have to go through a search process and, then, we would select the ones we want and the others we won’t grant privileges to. I said, they’re not going to do that.

Sally had a lot of power. She could have brought down the wrath of God on these guys, but she didn’t. Because she thought that maybe they were right, too, you know. I acknowledged that maybe I was wrong on this. But that would be one way to do it is to keep an open link in here, build this as the Mayo [Clinic] of Minneapolis and Saint Paul. They’re really good. I also said, “You’ve got to get these university docs in here on a

different payment system, get them off this foolishness before they get into more trouble than they're into. That ended our conversation.

DT: I interviewed Bob Howard who was dean of the College of Medical Sciences, and he tried very hard to change the faculty practice issue, the finances, and had not been successful. But it seemed that that issue of how the clinical faculty were being paid has been a recurring issue, problem.

JK: Yes. I think now they've got it pretty well settled now, but not entirely. The answer is so simple, but it takes an incredibly skilled leader. You just say to them, "We're going to be like Mayo." Mayo, would you come in here and tell us what you pay your folks? That's what we're going to pay ours.

I made that pitch once, also by the way, and nobody liked it at all. I said to them on this whole process, "Why don't we go to the state and tell them, 'This is what we're going to do. All the income, hospital, all of that is going to be pooled. We're going to put everybody on a salary. We're going to take care of all the low income, Medicaid patients, and all that again free, but you guys have just got to give us the money to fill in that gap so that we fill in that gap between how much we bring in and those salary levels. There's going to be a public announcement, support the hospital, and you appropriate those funds for us, and we'll provide all the care for the low income people in Minnesota and there will be no charge whatsoever.' You'd have it settled once and for all." There isn't anybody that liked that idea. No one.

[chuckles]

JK: The Medical School didn't like it. The Legislature said, "You're going back to the days before we opened up the Medicaid where everybody can go anywhere they want." Where can they go? They go to the emergency room, because they can't get an appointment someplace, and they can't get any dental care, which is even worse. Anyhow, I lost that one. But I didn't try real hard. But it was a thought.

Then, we went on to what to do about the hospital. The hospital administrators that would talk to you said, "It's okay. That thing is going to be okay. The patient load is declining, but it will level out. The population is aging and Minnesota population growing, if they don't build any more hospitals, this thing will work itself out."

Then, we get Frank Cerra as senior vice president for the health sciences. I was on that search committee. Frank, by the way, was being criticized for some darn thing that was happening in the Emergency Department. There was some misuse of drugs or something. I can't even remember what it was, but he went through some tough hearings. He applied for this job and Roby Thompson applied for it. I like Roby. Roby didn't interview well, unfortunately. I don't think he wanted the job, frankly. He said, "I went to a military institute and that's the way I would administer." Thanks a lot, Roby.

[chuckles]

You're interviewing for a job here. We came down to not a lot of candidates. Frank was one and they liked him. I kind of liked him, also, in a way, because he was a personable kind of guy, and I thought he could do it. He interviewed all right and he had a lot of clinical experience. I was worried about his administrative experience, of which he didn't have very much. Grilling him during the committee meetings and asking those questions, he convinced me that he was the kind of guy that would seek a lot of administrative advice and help. I even mentioned to him, remember the old saying about Indians walk in their moccasins before you can tell anything about anyone and things like that. Oh, yes, that's a good saying.

So they hired him and the first thing he said is we've got to solve this hospital problem. He made the huge mistake that people who aren't accustomed leaders, comfortable leaders in roles such as that make; that is, they think that they have to do something quickly to show people that they're decision makers. (This was the same as the dean of the School of Public Health, Stephen Joseph, who, you know, said we're going to merge you guys. He announces, "We're going to merge.") Frank Cerra said, "We're going to sell the hospital to Fairview." It was the worst decision that has been made in the health sciences for a long, long time. First of all, HealthPartners was totally ballistic, because they wanted a relationship. Secondly, they sold the thing to Fairview for twenty cents on the dollar. Fairview just picked up... I always kept saying around here, "A bunch of us should have gotten together and bought the darn thing." We could have borrowed the money from somewhere. The debt wasn't that high and the whole thing was worth a lot of money, and they had a lot money in the bank! So Fairview took over all that money in the bank and took over that new building, took over everything. What did they give back? Some veiled promise about putting money into the educational program each year. That has now been looked at four different times, because they say, now, Fairview isn't putting in the money that they promised. What was the formula? Well, we're not sure what the formula was, but we think it is... I was on a committee to study it and everybody threw up their hands and left, nothing decided. So now they have it.

Now, the Medical School is hurting for money and the hospital is making money for Fairview. They tell me that the darn thing is a cash cow for Fairview now. It's draining off money from the faculty clinics, because of the way the labs and all that are organized. Fairview bills for it and they keep the money. That's a classic kind of thing that happens. The Medical School is tied to them and every thing that they do when these other hospitals would be offering them all kinds of opportunities.

I don't know if you know Bobbi Daniels?

DT: No.

JK: She heads the University [of Minnesota] Physicians. Roby Thompson did, and she worked with him. Now, she's taken over. Roby and I were good friends. I met with them, and Frank and so forth. I said, "You've gotta buy that thing back somehow." They said, "What are you talking about? You can't buy it back. This is a sealed deal. It's



gone.” I said, “How did Stanford get theirs back? How did those places get theirs back?” “Well, I don’t know, but we can’t do that.” I said, “Don’t say can’t. Maybe you should explore it, or at least threaten it with Fairview and you’ll get one more bargaining in the whole thing.” It didn’t go anywhere. So we have no University hospital.

The negotiations were so poorly handled that they couldn’t even, at the end of it when the deal was signed, determine what it would be called. Fairview was advertising that it’s Fairview physicians located at the University. Finally, Frank jumped all over them and said, “You can’t do that! These physicians didn’t go along with that.” “Well, yes, it’s all part of the hospital.” [chuckles] They aren’t part of the hospital. They’re separate. They’re not Fairview physicians. Ahhh!

DT: [chuckles] I’ve been curious about what happened with the hospital, because I haven’t gotten any kind of sense of it. So I’m glad that you’ve been able to shed some light...

JK: If you want to interview people from the outside—you probably don’t want to do that—John Westerman is still around.

DT: Oh, I do want to interview...

JK: He’s retired.

DT: Yes.

JK: John will tell you a lot about that. He’s in Florida now.

What I’m telling you is biased, obviously, because I didn’t think they should do it. You’ll, obviously, keep that in mind when you look at all this. Other people might say that was the smartest move they ever made over there. But I can’t see it.

Boy, that deal financially was really badly handled. They could have...they should have come out of there with a lot more money and a lot more commitment for money.

It is probably going to get worse because with these hospitals, the Fairviews, the Allinas, all of them, are loaded with high-cost technology now. If [President Barack] Obama is going to come through with his cutting back on payments for Medicare and all of that stuff, these guys are going to be in bad shape. This one is doing okay. Why? Because it’s got this high technology for the transplants and this and that that makes it work. If they ever lose all that, it will be big trouble.

It’s five o’clock.

DT: Time flies. We’ll reconvene another time.

JK: Sure. Whenever.

[End of the Interview]

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**Interview with Doctor John Kralewski, Part Two**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed in the Phillips Wangensteen Building  
University of Minnesota Campus**

**Interviewed on March 24, 2011**

John Kralewski - JK  
Dominique Tobbell - DT

DT: This is Dominique Tobbell with Doctor John Kralewski. It is March 24, 2011. We are doing round two of our interview. We're on the fifteenth floor conference room in PWB [Phillips-Wangensteen Building].

Thank you for meeting with me again.

JK: It's my pleasure.

DT: We covered a lot of ground last time. Where I want to start today is talking a little bit about how it was that you came to be appointed assistant vice president for Health Sciences and what your responsibilities were in that role.

JK: Good question. At the time that I was being recruited here, I was at the University of Colorado and reasonably happy there. It was a good job, good spot to live, but a second tier, maybe third tier health science center. [chuckles] Lyle French was the vice president for Health Sciences here, and he was recruiting me. In the recruitment process, we always talked about director of the Health Services Research Center that would be located in the vice president's office and he talked about getting an appointment in the School of Public Health as a full professor, which is what I held at Colorado. So I was going down that route and really never asked about being assistant vice president. Then, on the final days when we were making agreements, he said, "It's going to be very important for you to have an appointment here in the vice president's office because it gives you all kinds of different things that you're able to do without clearing them with

deans and other vice presidents. So it was kind of by accident...not by accident, but him saying that you really need this rather than me bargaining for it.

As it turned out, it was a very important aspect of the appointment, because, then, you could approach granting agencies without getting clearance from the deans and even the president of the University. They had agreements with the various granting agencies like the Bush Foundation that there would be only a limited number of people from the University that would approach them. So a faculty member here could not. I think it's still true. They can't put a grant into one of those agencies without getting it approved up the system as being on the agenda for the grants that go to them for this coming year and so forth. So that gave me a lot of running room there.

It also gave me equal status with the deans, which was very important in my negotiations with them and keeping them in the loop on things, because I could go to their meetings and things like that. It turned out to be a very key element in being able to get the Health Services Research [Center] put together and being able to maintain it. One of the spinoffs is we went to the Bush Foundation and they gave us a grant, liked what we were doing, and they funded us, I think, continuously for, like, ten or fifteen years. Even at one of their meetings with the University, they told the president that this was one of their most successful projects at the University. So they were quite proud of us and we were very pleased to be proud of, so to speak.

[laughter]

JK: It was an important piece of cash for us for a long time.

Also, at that level, you worked with the Legislature. Again, in those early days, the director of the Center had a lot of running room and was part of a very interesting and important network. I may have mentioned in our previous interview when [Nils] Hasselmo was here as president, I don't think a month went by that we weren't on the phone with each other over some issue and, generally, some national issue. "What can you tell me about this? I'm going to a meeting and they're going to raise the issue of health care cost. Can you give me one page?" That kind of stuff. That's first class in terms of being able to do that. With the Legislature, they would call us and say, "Can you give us help on this issue?" or "Come on over and provide a couple hour seminar with a few of our key people here." A lot of times, you'd get there and there's only two of the senators that would show up, but most would be their staff. Nonetheless, they all went back home and said kind things about us. It was useful.

DT: It's really necessary because of the type of research that you were doing that you needed this level?

JK: It's how you conceptualize health services research. We were conceptualizing it, at that time, as a health sciences wide activity, work going on in the School of Public Health, work going on in Nursing, Pharmacy, Medicine, Dentistry, related to health services. So we needed to develop some kind of a mechanism not so much to coordinate

that, because faculty do not like to be coordinated, but to have a focal point for it, to help them expand what they were doing, and get the projects off the ground, manage the projects after they came in, and make sure that they complied with regulations, and to keep the program going health sciences wide.

That was, of course, Lyle French's vision. He had a lot of insights about how health sciences worked and what it took to keep them hung together, the schools. Although, I think at that time, it was a lot easier to have the schools work together than it is probably today. I think the funding was better. It would be interesting—you'll probably learn about that in your interviews—as to what changed to cause the schools now to be reluctant to work together. If you do anything with anyone, they want to know right away how much money for us, that kind of thing.

DT: [chuckles]

JK: That *never* came up when we were running the Health Services Research Center out of the vice president's office. I think if it would have come up, Lyle would have jumped on them and said, "This isn't dollars; this is intellectual activity. This is like the Cancer [Research] Center." That's what he always kept saying. "This is like the Cancer Center." "Oh, okay." [laughter] Now the center concept is gone. I guess it's no more, because they don't have a Center director. It's now a division in the School of Public Health. It's like another division of health management policy that most major schools of public health have, and there's good research going on in it, but there's not the focal point for the School of Medicine to look for collaboration.

Now, it's interesting—you can change this if I go on too long about this—to me... I just met with Connie Delaney [dean of the School of Nursing]. With her role with the [Health] Informatics Institute and, then, the Center for Translational Research, she's talking about health services research. That is a health sciences activity, and this may reform health services research, eventually, as a health sciences activity there. She pointed out a very important issue, which, of course, I'm very attentive to, but I was amazed that she picked up on it without any prompting; that is, who does the press or whoever call when they have an issue or they want to talk with someone about health services research. I said, "I don't know. I guess they call whoever might have published something recently or something like that." She said, "A lot of times they're calling [Lawrence] Jacobs over in the Humphrey Institute." [laughter] That's probably all right, except that as a health sciences of the magnitude of this one with the kinds of activities going on here, it certainly would be good to have a focal point, you know.

DT: That raises a lot of questions about kind of the nature of health services research, not just at the University but in the field more generally. I guess my first follow up question would be then how typical was the University's approach to health services research when you came back here in the late 1970s. Was that unique to Minnesota or was that something that was more broadly appreciated in the field?

JK: No, this was pretty unique to Minnesota. In fact, I'm not sure there was even any other centers going at the time. About five or ten years before that, the Agency for Healthcare Research [and Quality]—it wasn't called that then; it was called something else, [Agency for Healthcare Policy and Research] but that's what it was—funded health services research centers. They provided base funding for them. There was one here in Minnesota. What was the guy's name? He was out at Christmas Lake [in Shorewood, Minnesota]. You'll run into that name. I'll think it was Paul Edward. I'm terrible on names.

DT: [chuckles]

JK: He had a center funded with federal money from the Agency for Healthcare Research. Seattle had one. There was about four or five of them around the countryside. When the money phased back, they all folded up. Not quite all of them, but most of them did. They organized them to get that money, and when the money was gone at the universities, there was no institutional support.

When I was interviewing with Lyle, I said, "If you want to have this thing go, you've got to put the support underneath it; otherwise, it will fold up after a few years or whatever." It's interesting... He said—maybe I'm repeating stuff here—"Well, we're aware of that. We'll put about \$100,000 or maybe \$200,000 into it. That will pay your salary and things like that and start up costs. Then, of course, when you get grants and all that other people will bring their grants here from the other schools and so forth. It will really work." I told him, "It won't work. That's not enough. Why would they want to bring their grants here? Why would they want to work with us? They've got to have a lot more support than that." He thought about that after I went back home. I essentially told him I wasn't interested. He came back and said, "I think you're right. We'll go for a state special." That state special, at one time, was like \$800,000 or \$900,000. When you plug that in with the Bush Foundation support and other support, we had a lot of money. Then the grants started coming in and we had a lot of grant money.

To specifically answer your question, was there anything else like this going on? Not really. There might have been one other one, but none at the health sciences level. Then, North Carolina started one at the health sciences level and Alabama started one at the health sciences level. I'm not sure that there were any others than that, as a matter of fact, and they're still going. In fact, they're still going very well, because they had, again, institutional support similar to what Connie Delaney got over here right in the floors below you, a nice area and a reception area, the whole thing. Well, that's what each of them have. So they're doing very well. There's a lot of health services research going on across the country, but it's not generally organized as a health services research center at a health sciences level as we had conceptualized it and as Alabama and North Carolina and a few places like that.

DT: In those other instances then is it within the school of public health?

JK: At Penn [University of Pennsylvania], it's in medicine. At Seattle, it's public health, but, also, the school of medicine. Colorado now started a school of public health, so they've got some research going on there. It's a different focus because, first of all, it's not a highly coordinated effort. I use that term carefully. If you have a center, you don't need to use a heavy hand to coordinate things, just having your luncheon meetings that they come to talking about research and providing them some help to get a project out the door and things like that attracts the faculty from all the different divisions and schools. So at Colorado and Seattle, they're doing stuff, but it's more sporadic, and it doesn't get down to what I think has to be done and, that is, streams of research that takes you out on the cutting edge. That's what the important research is going to be. Michigan now has, I don't know if they call it a center—they might call it a center but I'm not sure what that means—for health insurance innovation. It's focusing on health insurance. Mayo [Clinic] and Dartmouth [College] and Geisinger Clinics and a few of those folks are starting a research program on value-based practice performance, value-based issues. That's what they're going to focus on and they'll pour millions into that, and NIH [National Institutes of Health] will probably match it with millions. That's probably what it takes. These issues are so darned complex that one... The grant we're just finishing here for Robert Wood Johnson is finding some *very* important things but the most important thing is it provides direction for the next layer of research. But it's hard to get streams of research funded.

DT: What did you see in the 1970s as the core theme, core questions that health services research was interested in? What were the organizing principles?

JK: It was largely, still then, cost, but, also, there was the issue of professional person power. How many do we need? How many physicians do we need and was there enough? What is the shortage in rural areas? All kinds of issues around that, and, then, the nurse practitioner role. What role do they play? What role should they play? Those were important issues at that time. The physician supply is still an issue, but it's more of a political issue than it is a *real* issue. Primary care physicians feel as though this is their chance to get a lot more money, for one thing. Oh, we're now very important in managing care, so we should make as much as the surgeons. No, you're not going to. [chuckles] Maybe the surgeons are going to make as much as the primary care. The field was going in the opposite direction. [There also were issues related to the development of HMOs (health maintenance organizations). Did they save money and what about quality, etc?]

[chuckles]

JK: Those were the issues and cost was beginning to become a major issue. We were looking at cost and working with some health insurance plans, Blue Cross mostly, to look at trying to get a hold of what was happening on cost and why, why the costs were going up and the like. We started out pretty much focusing on economics. We were hiring economists and that served us very well. We decided that we needed to diversify and start hiring sociologists also. In retrospect... I speak openly; I hope that's okay with you.

DT: Perfect.

JK: In retrospect, I think that was a mistake. First of all, they just simply don't get along very well with each other. They bring totally separate perspectives of things, and if they're fighting for resources, it creates a lot of anxiety. Then, when you go up for promotion, one group doesn't understand... If you've got two economics articles in the top economic journals, you're an important person in that field. A sociologist doesn't even know what those journals are, and they say, "Wait, you have only three publications," or five or a dozen or whatever. You needed twenty. So I think it hurt us a little, but it was what we did. The place grew and developed, so it was okay.

I think the agenda changed a bit then to health insurance coverage, more patient-level stuff that sociologists were doing and looking at the uninsured and why they are uninsured and things such as that. That was an important aspect of health services research.

The agenda also started to focus on physician practices. I had been interested in the question of group practices for a long time, and we did work on group practices. We probably have the most extensive work on group practices than anyone in the United States and probably know more about how they function. That doesn't say that we know a *lot* about it, but we know more than anybody else.

[chuckles]

JK: That became an agenda item.

Then, we spent some time, because of being part of the Academic Health Center, looking at academic health centers: their funding, their management. There wasn't a lot that we did on it, but we did some studies about their decision-making structures and things such as that. It never turned out to be really good research, because there were just too many personalities involved that you couldn't deal with, you know—or you didn't want to deal with. I'll put it that way. You can't say, "The guy at wherever doesn't know what he's doing." You've got to make them all look good, and that was not easy.

Part of that was built into research with the University Hospitals, too. There was an Association of University Hospitals and John Westerman was prominent in it. So he would get them to fund research for us, but, again, they didn't want to ask the tough questions about funding at these places and particularly the relationship of University physicians to the hospital and the residency programs. I'll tell you it was a jungle—still is a jungle. We did some studies on that [but they never went very far because of the complicated political milieu].

We did some of the basic studies on building the new University Hospital. They wanted to hire an outside consultant and did and paid them... I don't know, it must have been \$700,000 or \$800,000. It was a *huge* bill. They were out of Texas and they assigned a



person to live here for a year in the area—yes, everyday, he was over here interviewing and writing and so forth—to come up with a design. It was too many beds, by the way. Then, the Legislature jumped on it and the community jumped on it...didn't want all that competition. Then, unfortunately they asked us to come into it and look at it. I spent a lot of time on that, about six months probably, going to the Legislature, testifying and all that. The community was arguing we're going to have everybody in HMOs [Health Maintenance Organizations] and they don't use many hospital services, so we don't need another hospital. I was arguing that, first of all, they won't all be in HMOs. Some of them will but not all. Secondly, the population is growing and aging and so forth. You need these hospitals and you need the *University* hospital. A first class University hospital [is essential to a first class health sciences center]. They downsized it a little bit, but, finally, went along with it and did build it like that.

Then, of course, the patient population did slip and, then, they thought the sky was falling. [laughter] That would be something that could be looked at on our leadership project. They should have toughed it out. The hospital had a big debt but comparatively not a lot. The patient load was sliding downward, and they were, "Oh, by God, it's going to go into the ground. We're all going to go broke," and all that. They weren't going to go broke. They had a superb medical staff. This is the only place that some of the procedures could be done, but they would have had to make some changes to make it go. Again, I think I mentioned this to you before... There's just two things and one is that they were unwilling to bite the bullet and make the changes they needed to make internally, and, secondly, it looked as though selling it was really good idea, and we'd get some money and get it off our back and we're out of it.

[laughter]

JK: ...or the bad things we've done, depending on how you look at it.

DT: It's really clear from your description of health services research that it has been and continues to be so important for federal and state and municipal governments to be paying attention to the products of health services research. It is about access and about ensuring appropriate and wise delivery.

JK: Cost and delivery. If you saw the paper this morning with [Governor Mark] Dayton... We've got to control these costs somehow and we're going to go to competition. Well, nobody thought that Dayton would ever say that. Plus, by the way, they love to live by sound bites. Competition? Uuhhh, excuse me. I'm not so sure that that's going to do very much for them, a little bit maybe, but there would be a lot of other ways that they could save a lot of money if they decide to do it. But each of them has a political toll.

You're exactly right that for the state, local, and national governments this is vital stuff for them, but those milieus are so political. I should say that in the early days when Lyle was here and I was in the vice president's office, I worked *extensively* with those legislators here, just to keep our relationship with them. It's just amazing how if you've

got a piece of research that supports their political view, you're a giant...they parade it all over and thank you and all that. But if it doesn't, it's buried.

DT: Yes, what happens when there's obviously partisan politics going on within the Legislature, too? How did you negotiate?

JK: Very carefully, as they say, so you don't get into trouble with them.

The closest I ever came to getting into trouble was... Again, if I've told you these things, forgive me. I can't remember all we talked about. [chuckles] Anyhow, there was a big issue that came up in the state about rural healthcare. We don't have enough physicians and the Medical School is not doing its job. We need to pour in millions. Well, the Medical School thought that's not a bad idea, you know, if they pour in millions. [laughter] But trying to get them to go to rural areas is a different story. One of the legislators said, "Would you guys take a look at that?" Some rural group did a study for them and they showed that they needed like four hundred more physicians in rural areas. What they did was surveyed the hospitals and said, "How many more physicians can you use in your community?" Well, every hospital said, "Ten more." They never asked them, "Where are those patients coming from?" The hospital thought they're coming from other communities if we get the physicians. Well, the other community asked for ten more, too. [laughter] Not ten, but, you know... So they found that they needed four hundred more family practitioners. Come on. They asked us if we'd take a *hard* look at it and let them know. We did that. I headed that study. We approached it by taking a hard look at trade areas where people go for their care, which the Legislature didn't like and public health didn't like at all. They keep saying, "They should go here." Excuse me. People go where they want to go. They're not going to call up public health and ask them, "Where should I go for care?" That's the public health value system: we should tell people what to do.

Excuse me, but you can take that off the tape.

[laughter]

JK: That's their philosophy.

Anyhow, we did that study, and we came up with the estimate that they probably could use another hundred physicians, and they wouldn't even need that if they'd hire nurse practitioners, maybe fifty, if they'd hire nurse practitioners.

[laughter]

JK: So I presented that report and this guy jumps up and he says, "We've got to suppress that. We can't let that get out, because it will hurt our getting money from the Legislature for rural healthcare. We've got to suppress that and we've got to do it fast." Fortunately, the chair of the meeting just said, "Okay. Next issue." He went right on, and they never came back to it. But that was close.

As you may know, this University would not let them suppress it. They got into a fight over that earlier with the Humphrey Institute doing a study and found things that one of the state agencies didn't like and then said, "You can't publish it." The University went to the wall on it and won.

So we squeaked through that one. I think we did publish it, actually, come to think of it in a national magazine, but, of course, nobody here then read it probably. It was following the idea that you should conceptualize services from a *trade* area point of view. It's interesting... One of the rural hospital administrators said to me, "They don't go to these trade areas. They don't go there for their healthcare." I said, "They're going there for their food." Why are they going there for their food? For the big food marts. Why are they going there? For Menards rather than the local hardware. The world changed. The John Deere... I'm a farmer at heart.

DT: [laughter]

JK: We farm yet.

John Deere's local dealers are closing. They're now centralized in one of those trade centers. And healthcare is going the same way. So you can't say they've got to have two doctors or a doctor in each one of these little towns. People don't use them that much, except for some emergency. The moms take their kids to a pediatrician just like they do here, so if they have to drive thirty miles, they drive the thirty miles anyhow for other things, so why not?

DT: Yes, that makes sense.

When was this study done, this rural study?

JK: That might have been fifteen years ago.

DT: The University, since the last 1960s at least, has been fairly good about trying to increase the number of physicians going into practice with the Rural Physician Associate Program that I think started around the late 1960s, early 1970s...

JK: Yes.

DT: ...obviously, with the Duluth Medical School starting up. The Medical School was getting a lot of pressure from rural physicians by the Legislature to be more attentive and to train more rural physicians, and they have been fairly responsive.

JK: They've done that and I think those are good programs. They're getting better, as a matter of fact. They were a little shaky at first, but they're getting better. They're getting physicians out into those rural areas. I think they're doing a good job at it. At the moment, there are still some areas that are having trouble recruiting and they're

overworked and things like that. Part of it is their own fault. If they'd hire nurse practitioners or just fund some local people to go back to school to become a nurse practitioner and come back home, things like that, they could solve a lot of the problems.

DT: Do you know anything about the Health Information Foundation?

JK: Which one?

DT: I only know it was established in the 1950s and Odin Anderson was the director of it, initially.

JK: Down at Chicago [University of Chicago]?

DT: Yes. They were doing a lot of health services research.

JK: They were. Odin was funded by, I think, a drug company.

DT: Yes, it was drug companies who were. That's why I know about it. It was a group of companies that got together to fund it.

JK: Yes, and funded it for a long time. They did a lot of good research in there. That was, as I recall, located in their business school.

DT: I think so.

JK: It was never a center or anything like that. They did good research and they had good funding for it for a long time. He was basically a sociologist so he didn't do a lot in the economics area; although, he did work with some other economists to do some economics research.

DT: I just throw that question in because it's my own research interest, so I was curious from a health services research perspective.

JK: He was a good guy.

DT: You talked about the fact that there was a Center for Health Services Research here and it now is being dissolved, disbanded, and reorganized, and, now, you're part of the School of Public Health. Obviously, Lyle French had been the one who wanted it as a center for research for all the reasons you've already discussed. So what explains that change in attitude toward health services research at the U?

JK: I think it's leadership at the health sciences level. When Lyle retired, we just had a series of short term vice presidents who hardly even got their feet on the ground before they moved on or decided that wasn't for them or whatever. I can't even remember all their names. You'll run into them, I'm sure, as you go through your interview process. There were at least two, maybe three, before they got to [Neal] Vanselow. Vanselow was

simply just, basically, not a leader of any nature compared to Lyle French. So he had a hard time keeping anything together here in the health sciences. He had a very hard time trying to develop any kind of a strategic plan that would make any sense. When the School of Public Health dean turned over, he went out to recruit. He found Bob Kane. Bob Kane applied. He was at RAND [Corporation]. Everyone told him, “Bob Kane is very hard to deal with. He does good research, but he just shouldn’t be in an administrative leadership spot.” Vanselow, “Oh, no. He’s a physician. We need a physician in here,” and all that. Bob Kane said, “I won’t come unless that Research Center becomes part of the School of Public Health,” because he was doing health services research at RAND. He said, “I want to bring that into the School of Public Health. That will be just great.”

So Vanselow said, “Look. What about that? Are you going to help me recruit? Then, you can be assured of tremendous financial support and everything. This guy will be just great if given all this support, space, and money you need and so forth.” I was reluctant for a long time. The faculty didn’t care. The faculty were doing their thing, having a good time, and we kept them supported. Well, they had faculty appointments in the School of Public Health. We did some teaching in the Ph.D. program, so we had kind of the best of all worlds. So reluctantly, finally, I agreed—a huge mistake on my part. When I talk about lack of leadership, well, there was a flaw on my part. I should have said, “No.” Although, I might have got fired if I’d done that, because we didn’t have enough support from the deans and there was a complete turnover of deans. But that’s okay. I don’t mind. I mean, I do mind being fired, but, nonetheless, I don’t know if he had enough power to do that or not, actually. Later on, I was fired—or tried to be. The president of the University said... [laughter] This is a long story. Anyway, we became then a Center of Health Services Research in the School of Public Health and, then, I was on the level with the department heads in the School of Public Health. They weren’t sure they liked this, first of all, because we had more money, and more context, and more everything, space, parking, etc.

Unfortunately, Bob Kane *never* gave us anything. In fact, when I had an opportunity to recruit one of the top economists in the United States, Will Manning, I went to Bob and said, “We can get Will Manning here.” Bob had worked with him. He said, “Oh, he’s a great guy and all that, but uhhh...how can you afford it?” So I laid out a whole budget of what our grants were and projections and the hard money we had and so forth. We could do it, but also he’d bring in money of his own. Bob came in, “Nooo, I don’t like that yet.” Obviously, after the third try, I concluded, “He’s not going to approve it.” And Will went to Michigan instead. Later, we did get him down here because Michigan lied to him. So Bob was being a jerk—not just to us but to everyone and was asked to resign, which was traumatic.

And they said, “Can he be with you? “ Us?...because he needs a home!

[laughter]

JK: I said, "Yes. The guy is a good researcher, but, now, I'm the boss." [laughter] So we did that, and it actually turned out reasonably well.

Rosalie [Kane] came along with it. That's a different story. She couldn't be here when they moved here because she'd be working for Bob. You can't do that at the University. You can't hire a spouse or a relative. I don't know how far it goes on relative. Then, she could come over here when he stepped down, and they worked for me and were, well, not easy to deal with but very productive.

If you want to be diligent in this type of a job, at least at that point in time with the University, you're going to take a fair amount of heat. I didn't mind doing that—I mean I did, because everybody wants to be liked. But there's certain standards that you try to live up to. I tried to live up to those standards and I took at least two or three law suits. The University, by the way, would not support you on them.

So Rosalie came to us. I gave her a big salary. The salary increases were like three percent or four. Then, you had one percent that you could divide among people. I always gave it to the top productive faculty...divided that up. She said, "That's not enough." I said, "Well, Rosalie, your pay is as much as anybody else in here." "Oh, that's a woman's thing." I said, "You're paid as much as the men." "The economists get more." A couple of them did get more, but these guys had multimillion dollar grants and all that. So she complains to the school. The school says, "It looks as though its fair." She complains to the University. The University says, "It looks as though you've been treated well." She files a formal complaint. Then they gathered data nationally. It turns out she was making more than most of her peers. She wasn't making more than the economists. "Well, look at the economists at Harvard, what are they making?" "You're not an economist." [chuckles] So the University, finally, said "Here's another five hundred dollars a year," or something, and the suit could be cancelled. That was the kind of thing they'd do. I wanted to fight it right to the end.

We did okay. We did *very* well, as a matter of fact. We were ranked in the top five in the nation for health services research centers. There was about twenty then or thirty, something like that. Universities were developing them, either as centers or research groups, one way or another. We got a lot of grants, had a lot of support.

We had other faculty problems. We had a faculty member that didn't get any grants and said it was our fault they didn't get them and didn't get promoted and sued us. The school then by passed us and promoted him and sent him back with tenure. Yes. Well... Every year, he wouldn't even send his material to us for review. We'd sit down with each faculty member at the end of the year and review their productivity. I'd say, "You've got to get some grants." "Why?" I'd say, "This is a research university." "I like to teach. I'll teach." But we didn't have any courses for him to teach. Then, I discovered he was contracting to do research with another group as a consultant to them and keeping the money. It was just incredible stuff like that.

We, at one time, had five of the roughly, I suppose, dozen top health economists in the United States, if not the world. We had five of them. Three of them are still here, as a matter of fact: Roger Feldman right next door; Bryan Dowd; Jon Christianson. [chuckles] These guys are just incredible. That's kind of a measure of how an organization...how good it is, also. If they come and go and come and go, you've got to worry about it. But we've got people who stay here for their entire career.

The instability of the School of Public Health was also a problem. The School of Public Health had a change over of deans right and left with little leadership. They had a division of Public Health Administration and a division of Hospital Administration. Then they merged those two and they didn't get along.

Then the director of the Hospital Administration program got into a fight with the dean [Edith Leyasmeyer] and moved to the Business School, which it never should have done. They took \$900,000 of state money with them and an \$18 *million* endowment with them that they had been able to get from their alumni. When they decided that they wanted to move over...the Business School said, "Oh, yes, we want to get into the health field. We'll bring you over here." So the associate dean of the Business School was on the negotiating committee and the dean of the School of Public Health sent an administrative assistant. The Business School just walked off with all the money, and the program moved over there. The program with all that money decided they wanted to do health services research and started recruiting health service researchers and set up an endowed professorship and recruited from us!

DT: Wow.

JK: They hired one of our top economists to move over there, paid him another \$50,000 a year. I had a call from the vice president here at Central Administration who was an economist. He said, "What the hell is going on? Those professorships like that are supposed to recruit nationally. You bring national people here." I said, "I can't stop it." He said, "Do you want me to stop this? This is foolishness." I said, "I can't ask you to do that. I can't get myself to do it. It's wrong, but this guy has decided he's going to go over there and what can I say?" So he did go over there, and then he recruited an economist. Then they were developing grant applications in competition with us. [laughter]

Then, when they moved, the school moved the Public Health Administration program into our division because they didn't have a home anymore. We still called ourselves Health Services Research but we added Administration at the end of it. Then we had a graduate program that we were running, not a very good one either, by the way. It still isn't very good. It's public health people that come in and get a master's degree and go out to work in various public health agencies. They need a degree so they take a few courses here and there and so forth. It's gotten better [but it still isn't high level graduate education].

Then, what, five years later, maybe six years later, they get a new dean at the Business School and he says, “Why are we in this business?” Then, the hospital and health care administration program asked to come back to the School of Public Health. I was retired. We had an acting director here. That person was a good enough person, but didn’t have the skills of an old hand who could pick up the phone and call the president, things like that, you know. That’s what you needed. Instead of them forming a new division then for that program and leaving health services research alone, they mooshed them all together [with little thought about the conflicting values or culture]. Then, the faculty who moved over here from the Business School negotiated deals. They were ready to go up for promotion but didn’t have any research or publications, some but not enough. They negotiated *delayed* reviews. They’re still around here working hard now because they want to see if they can get tenure.

Then we have a faculty meeting of the whole crew and one of them says, “This name doesn’t make any sense.”

[chuckles]

JK: We had an acting director who should have said, “Well, that’s it buddy. You came in here. You live with this at least a year or so.” Instead, he said, “I don’t know.” And they voted to change the name to Health Management and Policy and dropped Health Services Research...totally gone. Can you believe that? If we tried to understand that, then, why would the dean sign off on that? Because he doesn’t know any better. Deans have a lot of other things going on [and this apparently didn’t seem to be that important]. That’s what the faculty wanted. Oh, okay. Why would Frank Cerra sign off? Probably because of the problems with the Medical School. The School of Public Health, whatever they want as long as they stay off my back, it’s okay. He signs off on it.

DT: It’s such a difference from when Lyle French first recruited you and created the institute. It sounds as though it has completely changed.

JK: Completely changed. I don’t mean to harp on this, but that’s why I wanted to consider doing this other study. It’s a question of leadership in these academic institutions. What causes folks to get into those leadership spots and leave their brains at the door. I don’t know. They do crazy things and some of them did tremendous damage to themselves. Edith Leyasmeyer was asked to resign. It’s always a little bit questionable about that, but, nonetheless, she retired and left. We had a dean that was before her in Public Health, he wanted to merge us under the Hospital Administration Program, because they didn’t have any research going. Well, then, you guys can bring research to them. I said, “Yes, but they don’t have a research culture.” He was the one that the president of the University called and said, “You know, this doesn’t make sense.” He left then because he knew he was dead, you know, when you’ve got the president telling you you don’t make sense.

DT: Was that Stephen Joseph?



JK: Yes. You wonder... I actually got to like the guy after this all was settled. We used to hunt together. I'm an outdoors person and he is, too. I never could get anyone to tell me why he made that stupid decision. The way he made it, it was like the first month he was here. His secretary called, "Will you come down? He wants to chat with you." I said, "Should I bring budget material?" "Yes, you can if you want to." So I bring budget stuff. I thought it was... "What are you guys doing?" He said, "I'm merging you guys under Hospital Administration. They don't have any research going and there's a leadership problem. You guys will strengthen it." "What!?" Yes, there is a leadership problem and that's why they don't have any research. Why merge us under them?

DT: I've heard that from people that I've interviewed who were in that division. A couple people have spoken about the shift in orientation of the School of Public Health from training practitioners to training academics and that it took time for that shift to really take hold, especially in some of these other divisions.

JK: Yes, I think that that's right. The Ph.D. program played an important role in that. That's where we did help them a lot. The program was limping along, and they asked us to be on the faculty, and we said, "Fine." We then were part of the faculty. It was very clear that the program was in trouble. First of all, it had no full time students; it had part time students, and most of them would take a course here and a course there. Almost all of the courses were taught by two faculty members: Vern Weckwerth and Ted Litman. They taught all the courses. It was their sandbox, you know. But the courses weren't very good, so the students were kind of shortchanged. They couldn't recruit good students, and they had no support for them. We went through that about a year, and our faculty said, "We've got to change leadership." Of course, we had enough votes to do it, because you vote for the chair.

So they pressured me to do it. Nobody wanted to do it, because they wanted to do research. It takes a lot of work to run a PhD program. I finally got talked into it and took it over, and, then, wrote grant applications for student support and got some! Everybody was surprised. We got it because we outlined a new curriculum that the faculty was going to be teaching. It was a little bit of fantasy, but we were going to do it, and did do it. We were going to recruit full-time students. We got the training grant and over the years, I don't know, it probably brought in a hundred million dollars. This was, what, twenty-five years ago? And they still get it. It renews every four years. Then we got a post doctoral grant attached to it, so we could train physicians in health services research, and we got those students coming here. We had a lot of stuff going on. We restructured the whole program. We were told by places like RAND that we were one of the few health services research programs that they would even interview someone from; otherwise, they'd go to econ [economic] departments and engineering to recruit. They would recruit from us because they were such good methodologists. That's because of Bryan Dowd here. He's a superb methodologist, and he teaches the course on research methods. It's tough, but they know how to do research when they get through. We did okay on that.

The PhD program has been reorganized now and it's in a little trouble again. Part of it's a leadership issue, but I think that it will work it out. It's a philosophic issue about should students all take pretty much the same base courses or should they split out early on, and the ones that are interested in this take that and so forth. My philosophy is if you come to a health services research program for that kind of a degree, you better all take a lot of basic courses together before you go into any other area.

DT: It seems like those kinds of curriculum struggles happen a lot, especially in interdisciplinary research programs.

JK: Yes, you're exactly right...exactly right. Again, that's probably because we branched off into a couple disciplines. If we'd stayed health economics, that wouldn't have happened. We would have been generating health economist and that would have been fine.

Then the school with John Finnegan as the dean was hell bent on the way we become important in the world is through volume, so they doubled their student enrollment. I was on some of those committees and I always said, "The way you become important in the world is your quality." Tell me where your Ph.D. students went for their jobs, not how many, but *where* they went for their jobs. How many of them went to a major universities, were hired at major universities in faculty positions? Actually, the school doesn't turn out that many Ph.D.s. We're the largest Ph.D. program that they've got. Ours, at one time, had like two thirds of our students going to academic settings. They're not anymore. Because we have so darned many of them, they're going everywhere...Blue Cross, United Health Care, and so forth. That's probably a contribution, but if you're fighting for *national* recognition, it doesn't add much. The master's in public health program was expanded tremendously, and they now have a lot of those students in each class. When you get a lot of students in there [the quality of graduate education declines].

I argued, "If you're going to do that, then offer honor's programs, so you've got then the top forty percent or something that you can put into a different level of courses." Some of your courses were watered down so that everybody could handle them.

My R.A. [research assistant] on this project was a T.A. [teaching assistant] also. She was grading exams for one of those courses. She couldn't work on my project because of the grading deadlines. "I can't do your analysis because I'm grading these exams." I said, "How are they going?" She said, "I can't believe anybody can give anyone a master's degree with this kind of garbage." [chuckles] She was a Ph.D. student. She's like, "Oh, my God," you know. "These answers don't make any sense. How can you grade them?"

DT: That's always interesting when you've got the Ph.D. students saying that of the master's students.

[laughter]

JK: Then, in addition to that now, we offer masters degrees off campus. There has been a lot of interest from physicians. They sign up for it because they need the credentials. Then, they move on to administrative spots in all these different health organizations. So they need this degree to go along with it. One of our faculty members told me, “They gave me the exams to grade. I couldn’t make any sense out of the damn things, so I just gave them all a B.” [chuckles]

I’m probably telling you more than you want to know. No? Probably. Well, you can erase this.

DT: No, no, this is good.

JK: You’re at an advantage. You can erase things. [laughter]

DT: No, this is good.

JK: You’ve got to protect me.

DT: It raises the issue of how to maintain standards for off campus, online education, when master’s programs tend to have economic benefits to the institution.

JK: Oh, yes. Oh, they make a lot of money on it. That’s exactly right. Yes.

I don’t know... You could profitably do a whole other study on the role of academic institutions in education. I go to a breakfast club on Wednesday mornings and they’re all, except me, multi millionaire retirees, head of this, head of that and all that. Not all of them are retired, but they’re all movers and shakers, you know. This guy says, “Where is education going? We’ve got all these kids that we’re trying to get them to go to college, go to college, go to college, and they can’t get jobs when they get out.” They should be going to Dunwoody, a lot of them. That’s where the jobs are. He said he knows kids that got degrees over here at the U or wherever and, then, went to some of those technical colleges to get a degree in computers or...not the degrees in them but to get the training in them. Then, they can get all kinds of jobs. [laughter] Maybe that’s okay, because they got an education that was broadening and, then, they got technical training. Well, what is the role of education versus technical training?

DT: Yes. The education landscape has changed and, obviously, the job market has changed a lot.

Going back to the Center for Health Services Research... You said at the beginning that, obviously, one of the reasons Lyle French created the health sciences level and appointed you the v.p. [vice president] level was so that you were able to operate, basically, more autonomously and without so much political wrangling.

JK: Yes.

DT: How did the move into the...the disbandment of Institute and being put in the School of Public Health...? Did that change the ability of you and your unit to do research?

JK: Well, it changed but they didn't tell us what to do for research. We still had our own space and things like that; although, we took a lot of heat over it. What it changed is that if you wanted to go to a foundation for support, you needed to then apply through the dean and, then, they coordinated it and all that up through the president's level.

We had a foundation ask us for a proposal. It didn't get enough support upstream to get it out. Subsequently, though, when I explained to the folks that they're actually asking for the project, they did move it up on the agenda, because they're not stupid, you know. They want to get the money. At the University level, they see all the money flowing to the health sciences [and they tend to give us low priority because they think we're rich]. Everybody else is a little nervous over the health sciences always, because we are paid more over here. It's true—not so true anymore. You get all these grants, so you don't need state money. The state money should go to the Humphrey Institute. Those poor guys, and Political Science because they can't get any money. Well, if they'd get off their rear ends and apply for it, they could get money, too. But why not? If the state is supporting you, why not? That's a little unkind, because there are good folks in those units who are good friends of mine. But if you're an aggressive researcher looking for funding, it gets a little frustrating to go through those obstacles. Plus, I just was no longer on the major committees [or in the loop with the legislature or the president's office]. The other schools look at you differently because you're in public health. Before they looked at me as in the vice president's office.

The Pharmacy School had graduation and Lyle was out of town to confer the degrees, so they asked me if I could come confer the degrees. I said, "I don't even know what you do." "We'll show you how." So the dean introduces me and there's a speaker and all that bit and, then, you've got to stand up and say, "On behalf of the University..." [laughter] That's the level I was running at. Almost all of the major research committees, I was on them, not very functional sometimes, but, nonetheless, I was on those committees and all of the strategic planning committees.

The health sciences deans and directors would go up to the Carlson Conference Center on Lake Superior, the Carlson Company. They let the University use the center. We'd go up there once or twice a year, the deans, chairs of the major clinical areas—and me. [chuckles] Sometimes, I'd take a faculty member along also. We were always asked to present a session on the healthcare field, where we think it's going, what implications it would have and all that. That was when big discussions took place of what to do and so forth. I'm still on first name basis with John Najarian and people like that. That's the people we ran with. That's the way we interacted. I don't remember that happening after we became part of the School of Public Health.

Vanselow, though, had a meeting at the Carlson Center and I was at that meeting. It was getting down to the issues of what to do with this hospital and all that. I had a faculty

member with me, and we outlined pretty much what we thought they were going to have to do, but, boy, they did not like it at all. The clinical chiefs did not like it. In fact, one of them at the coffee break—we had flip charts and all that—went up and ripped them off and crumbled them and threw them away. He said, “This negative talk is terrible. This negative talk here is just *terrible*. This University is strong. Our physicians are better than anyone else and patients will always come here.” The vice president, Neal Vanselow, he’s sitting there. If that had been French, he would have stood up and said, “Put those back up there, you jerk. I don’t care how you feel about this negativity. It’s not negative talk. It’s realistic talk. Now, where shall we go from here? What part are you going to play?” That’s what Lyle would have done. But no more. They had multiple opportunities to salvage the hospital and turn it around. I think, again, it goes back to my wanting to study leadership in more depth. Fundamentally, it was that they just could not convince themselves that they had to change. They thought it would all go away, that it would be okay, and would be all right for some reason, that the patients will *insist* that their physicians send them over here. Yes. You can’t find the place. You can’t get into the place. You can’t find your way around but they all will come.

DT: [chuckles]

JK: You can sit there and waiting hour before your doc will even see you. Try to say that in the nicest way... “Well, it’s traffic over here and things like that. They can go right to Southdale and park right by the hospital and walk in.” “Yes, but they don’t have the physicians.” “Well, they have physicians who were trained by us. The surgeons were trained by us. They must be pretty good.”

[laughter]

JK: The nice part of the Carlson Center is you do this kind of exchange and, then, at the evening cocktail hour with drinks and dinner, everybody becomes friends again. You can say things and get away with it. [laughter]

DT: That’s at least good.

Yes, it was quite a change in terms of responsibilities and support then when we moved into the School of Public Health.

JK: Yes.

DT: You were an assistant vice president until 1998. Is that right?

JK: That’s right.

DT: Was that after your tenure as director of health services research?

JK: I went on sabbatical and came back and said, “This doesn’t make sense to carry that title anymore.” The vice presidents were turning over... They were just shedding themselves of everything. It had no meaning anymore.

DT: You mentioned that you were on the search committee and went to a lot of committee meetings. Were there any other responsibilities that you had in that position in the v.p.’s office?

JK: I’ve got to think back. Other than advising... The executive group, which was made up of Lyle French and John Westerman, the director of the hospitals and, then, whoever it was from the medical group that was elected to be head of their University physician’s groups, they met and I was part of that. It was never very successful meetings and I never did much for them. They were all meetings that were dealing with specific problem areas. Should we add another clinic dealing with pediatrics? I went to the meetings, most of the time. [I also was part of the clinical chiefs weekly lunch where they discussed funding and administrative issues. My role was to keep them informed about changes in the health care field. I was also on several short-term committees in the medical school such as recruitment and teaching health services content for students and residents.]

[chuckles]

JK: I had a car, by the way. You get all the perks that goes with it. A parking spot in the heated garage.

DT: You were telling me that last time, yes.

JK: It made a lot of enemies among my peer group, I’ll tell you that.

[chuckles]

DT: When Health Services moved into the School of Public Health, were you still on call with the State Legislature a lot?

JK: Quite a bit, yes. That was in some ways profitable. It was important. You’re influencing policy and they appreciated it. I was able to develop, you know—I don’t know what to call it—an approach or a philosophy or whatever that enabled me to work with them productively. What I mean by that is in the initial stages when they say, “Come over and make a presentation,” I’d go over and make a presentation, and they’d have a committee of a dozen and only two would show up and the rest of them were their staff. I was wondering what am I doing wrong? A senator said, “You’re not doing anything wrong. That’s the way we function. Don’t take offense at it. That’s what happens to everybody.” Okay. All right. Or you make a major—I did it for Lyle French—presentation to them about this hospital, and these guys are sitting there reading the morning paper. Yes! They’re so impolite. What a bunch of jerks. We come over there, flip charts and all that. Lyle French makes a presentation and introduces me and

they're sitting back there reading the paper and writing letters. [laughter] Well, you've got to get over that part of it. Once you get over that part, you can work productively with them. Sometimes it was a close call.

We had budget meetings which I always went to with Lyle. He'd call on me at strategic times, when they were saying, "Why don't you guys do this?" "Why don't you guys do that?" "John can answer that." "Doctor Kralewski can answer that," about whatever, you know. You had to always sit there worried about what he was going to ask next.

[chuckles]

JK: We had one of the budget committee members that had told one of the vice presidents at the president's office that they'd be willing to put some more money into health services research. He read something... I don't know what he picked up but he liked it. This was when Vanselow was here. So I told Vanselow that, and he said, "No. We can't put it in the budget this year. We're going to fund a center for ethics. We're asking for money for a center for ethics, so we can't put health services research in there." I said, "Well, okay." Then, I get a call from the School of Public Health and they say, "Can you be at the budget meeting in case this comes up?" What the heck can you say? "Yes, I can." I told the dean of Public Health, "I'll go over with you and see what happens." "Okay." We go over there and these guys are going through these budget things are that thick, you know. They say, "We don't see anything in here for health services research." Vanselow said, "We're not asking for any money. We want money to fund the ethics center." "Well, what's that going to do?" "It's going to do this and that and so forth." He said, "Well, okay, if that's what you want. It's up to you." We left. Out in the hallway, this vice president came out and said, "What the hell went on in there? You guys could have gotten another hundred thousand dollars by just simply saying, 'We appreciate that, and thank you. We want the ethics center, but the research center can use some more money,' and you would have gotten another hundred thousand dollars. God what is wrong?!" I said, "Don't ask me, buddy. I'm just doing what I was told." Can you believe that? Vanselow totally misunderstood how the Legislature works.

Again, Lyle—I don't mean to keep talking about him; he's a big hero to me, I guess—I remember one of those meetings when he was trying to get more money for the research center. They were saying, "Well, Lyle, we'll see what we can do. We'll see what we can do." So we walked out of those hearings, and three of them followed us out in the hallway. They were saying, "Thanks, Lyle, for coming over." The other guy said, "Lyle, my cousin up in wherever... She's having a hard time getting a diagnosis. I was wondering if you could tell me what to do." Lyle says, "Here's my personal number." [laughter] He could have said, "Come on down and we'll go over to medicine and get an appointment there and they'll take care..." "Here's my personal number." Boy. They told me later that he personally walked the patient over to the medicine clinic [and she was greeted by the chair of Medicine].

DT: Obviously, Lyle French had a lot to do with... I've heard from others, too, about what an important and effective leader he was and his relations with the Legislature were really critical.

JK: Yes.

DT: Yes, there's an element that the leadership at the Health Sciences level changed, but is it also possible that there were changes in the Legislature that also contributed to this maybe shift in relationship?

JK: Yes, I think maybe so. It does change around a little bit. However, a lot of the legislators in Minnesota stay around a long time, as you probably know. They do change over, but I don't think it's the change-over that made the difference. It was how you nurture the relationship with them. That's what it's all about. I don't think that our current president [Robert Bruininks] has done a very good job of that either, as a matter of fact. I think [Nils] Hasselmo... Hasselmo went out of here with people saying, "Oh, he never was a powerful leader. He didn't change. He didn't get rid of the programs that should have been cut back," and so forth and so on. I don't agree with that. He rebuilt the relationships with the Legislature. They were angry over the previous stuff, you know, the guy [President Kenneth Keller] that built...and overrun millions of dollars on his kitchen [Eastcliff renovation] and stupid things such as that. He rebuilt those relationships so that they liked him a lot. Nurturing those relationships takes a lot of time and, I suppose, a certain personality. But, man, that's important stuff.

DT: Given the degree of state funding that the institution gets as the state University, the University presumably has an obligation to fulfill the needs of the state, so it seems having good relations with the Legislature would be important.

JK: And they don't like surprises.

There's still a state special in here for a Center for Health Services Research; it's called that. One of these days, they're going to discover that there isn't any center here. The school is going to lose another...I suppose three or four hundred thousand dollars. It keeps getting cut back.

There was a special for nurse practitioners in the School of Public Health to train nurse practitioners, and a dean, who shall go unnamed, decided to close it and transferred the money over to a general fund. There was one legislator that wanted his head on that. The only thing that saved him is that the School of Nursing picked up the whole program and started training them. Well, it is on the forefront now, but it was going on. The Legislature gave them a bunch of money for it. It was a close call though.

DT: I'm curious about the relationships, actually, between the different health sciences units, if you can talk a little bit more about that. How did Medicine, Public Health, Dentistry, Pharmacy interact?



JK: In the early days of the Health Services Research [Center], they were all on the Advisory Committee. We met every month. We'd have lunch at the Faculty Club. They would keep their folks back home advised about opportunities with the Center and how they could work with us. I don't know if it was the funding issues or what it was, but the deans were, at that time, highly committed to collaboration. The dean of the Medical School, when Lyle was trying to add money to our state special, agreed to have it taken out of the Medical School's budget.

DT: Wow.

JK: Yes! If anybody would have found out about that, they would have killed him.

DT: Was that Neal Gault?

JK: That was Neal Gault. He said, "No, I think that this is a very, very important thing, and you need to move another two hundred thousand over there." Yes. Can you believe that?

DT: That's incredible.

JK: The Pharmacy School was incredibly supportive. It was that kind of a milieu.

Now, at the next level down, again, the clinical chiefs met every week for lunch in a dining room downstairs. Lyle and John Westerman at the hospital would invite me to come to those. The clinical chiefs, I got to know them pretty well, and they had a lot of questions about where is the field going and what should we do and so forth, so I off and on was helpful to them. So we had a pretty good relationship with the clinical chiefs.

Now, Peds [Pediatrics], great. I worked with them on several things. John Najarian, he's a good guy and we got along fine. He's kind of an irascible bear, but, nonetheless, all surgeons are. We got along well. Medicine was always hard to break into, for some reason, and still is. Family Practice is easy to deal with and we've conducted research projects with them. I just finished with them. But Medicine was a tougher one to deal with. I wrote a chapter in a book with the physician who headed the Lab Medicine and Pathology Department. He liked health services research. The whole Lab Medicine thing got them into the Informatics. That's where Informatics started. He was really interested in information technology. We had a close working relationship with those folks.

To follow your question... When you get to the next level down, I think that there was some interaction between Public Health and Nursing and some with Pharmacy, but not much. Public Health and the Medical School did not have a lot of interaction. It's unfortunate, because there was Epidemiology, which should have been working more with the Medical School. Not so much Environmental Health. Biostatistics did work with the Medical School, because, a lot of times, they needed that kind of help on their research projects. Biostatistics had a lab that would do work for you. You would buy

services from them. They worked with a lot of the clinicians on research projects. When they established the Cancer Research Center, there was more interaction between Public Health and the physicians and Pharmacy, too, with drugs. That, I think, helped it a lot in terms of that integration at the department level than at the faculty level.

One of the big problems is that with grant-supported schools, everybody worries about where the overhead ends up. The funding system here is not a good one. It causes a lot of balkanization of the different groups. We have tried to do things across the river in the Business School. You talk to them about doing a project and the first question they ask is, "How much money do you have?" [chuckles] They didn't ask, "What is it you'd like to do?" or "How can we help?"

DT: Whenever you get research grants, the research grants cover a certain amount but they don't cover the overhead? Then you have to go to your general operating funds?

JK: It's the other way around. If you get an NIH grant, in addition to your grants, you get a forty-eight percent overhead. If you bring in a million dollars there, the University gets four hundred and eighty thousand dollars. Then, they give some of it back to the school and, then, the school gives a little bit back to the division. If you're going to get a grant with the School of Business, who gets the overhead?

DT: Yes.

JK: Okay. Then, you split it according to how many people are on each side. It's a major issue. I think it's a major issue; others probably don't.

I think that Frank Cerra tried to do a lot to bring about more integration. One of his philosophies was to integrate education in the health sciences, and that in some of the beginning courses, the physicians and nurses and pharmacists should take the same courses. They would then work as teams and that's what they are going to be doing when they graduate. I'm not sure how far he ever got. I don't think he got very far on it, but was working on it. But, of course, just the economics of the whole thing was overwhelming and the turn over of the deans and him taking over as medical school dean, and, now, another new dean who will also be a vice president; [the training integration gets a back burner].

Now, as I understand it—I can't believe this, but I just saw someone in the hallway that reaffirmed this for me—the deans of the schools are no longer reporting to the vice president for health sciences for their budgets. There is no greater time when they need to come together. The new vice president for health sciences, [Aaron] Friedman, is going to have to deal with that. I don't know if he has that kind of ability or not.

I visited yesterday with Connie Delaney, because I'm doing some work with the Medica health insurance plan. They want to see if they can line up with her Center for Translational Research. They'll put money into it, by the way. I told her that one of my daughters is a pediatric nurse practitioner. She chose that over going to medical school,

because of its style of life. She said, “I’m very high on that.” She said, “Boy, it’s just amazing that the health sciences hasn’t heard about it yet.” I took that as an indication that not much has changed. Nurse practitioners...that’s what the field is clamoring for. I note that in Family Practice, their clinics are staffed by physicians and nurse practitioners and so is general medicine. At that level, they’re finding and hiring nurse practitioners, and are retraining them to work together.

[laughter]

JK: Retrain the physicians and the nurses, both.

DT: I guess it just shows that things are different when you’re out in practice, that you can have a different perspective and you see the usefulness of the nurse practitioner if you’re the family physician that you might not have seen when you were going through your training.

JK: I did three studies for the health sciences—the one before, I was in Public Health and the two afterwards. We brought physician leaders and administrators in from community practice with the whole idea of trying to identify how the field is changing and the implications for clinical education. Boy, those were good meetings. Those folks had all kinds of ideas about where the field is going and everything. But trying to move this large institution is not easy.

I have two friends...one of them is on the board of [University of] Saint Thomas, might be on the finance committee, and the other one is a physician who worked with that guy’s brother who works with Saint Thomas also. When they were thinking of starting a medical school... Remember that?

DT: Yes.

JK: They came over and we had lunch and they’re saying, “What do you think? What do you think?” I said, “It’s a great idea.” He said, “But it’s so expensive. Can we do it? Allina says they would put some money in. But how much? What about the clinical side of it and so forth?” I said, “You know, here’s why you should. It’s almost impossible to change these existing institutions.” It is like the guy... Who was the famous guy at either Harvard or Yale, one of those, who wrote about these things? [Arjay Miller at Stanford University] He said, “It’s like moving a cemetery.”

[chuckles]

JK: So I said, “You guys start a new one and do it right. You can be on the forefront of primary care physician training, nurses, pharmacists, the whole thing.” “Uhhhh, I don’t know. It’s so expensive.” Then, Allina said, “We’re maybe not sure that we can commit what we’re talking about, a hundred million. That’s not going to be enough. We don’t know if we can go more than that.” Saint Thomas could have, in my estimation, raised

the other hundred million. They could have put two hundred million under it easily. That might not have been enough. But it's getting up there where it would get attention.

DT: That actually was my last question, so if you...

JK: Was it? I'll do this again with you.

DT: This is great.

JK: I love to talk with you. It's reminiscing. I hope it's not boring.

DT: No, it's fascinating. Because you were in the v.p.s office, too, it gives a very different perspective than what I've seen before now. I'm fascinated by health services research.

JK: I'm presiding at the next seminar at Medica and the topic is "What is health services research and why is it important?" I'm trying to pull my thoughts together on that.

DT: That's great.

Well, thank you so much again. This was great.

JK: My pleasure. If you want to meet again, just give me a holler.

DT: Sure.

JK: The next couple weeks, I'm jammed but then after that, I've got plenty of time.

[End of the Interview]

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**Interview with Doctor John Kralewski, Part Two**

**Interviewed by Dominique Tobbell, Oral Historian**

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

**Interviewed in the Phillips Wangensteen Building  
University of Minnesota Campus**

**Interviewed on March 24, 2011**

John Kralewski - JK  
Dominique Tobbell - DT

DT: This is Dominique Tobbell with Doctor John Kralewski. It is March 24, 2011. We are doing round two of our interview. We're on the fifteenth floor conference room in PWB [Phillips-Wangensteen Building].

Thank you for meeting with me again.

JK: It's my pleasure.

DT: We covered a lot of ground last time. Where I want to start today is talking a little bit about how it was that you came to be appointed assistant vice president for Health Sciences and what your responsibilities were in that role.

JK: Good question. At the time that I was being recruited here, I was at the University of Colorado and reasonably happy there. It was a good job, good spot to live, but a second tier, maybe third tier health science center. [chuckles] Lyle French was the vice president for Health Sciences here, and he was recruiting me. In the recruitment process, we always talked about director of the Health Services Research Center that would be located in the vice president's office and he talked about getting an appointment in the School of Public Health as a full professor, which is what I held at Colorado. So I was going down that route and really never asked about being assistant vice president. Then, on the final days when we were making agreements, he said, "It's going to be very important for you to have an appointment here in the vice president's office because it gives you all kinds of different things that you're able to do without clearing them with

deans and other vice presidents. So it was kind of by accident...not by accident, but him saying that you really need this rather than me bargaining for it.

As it turned out, it was a very important aspect of the appointment, because, then, you could approach granting agencies without getting clearance from the deans and even the president of the University. They had agreements with the various granting agencies like the Bush Foundation that there would be only a limited number of people from the University that would approach them. So a faculty member here could not. I think it's still true. They can't put a grant into one of those agencies without getting it approved up the system as being on the agenda for the grants that go to them for this coming year and so forth. So that gave me a lot of running room there.

It also gave me equal status with the deans, which was very important in my negotiations with them and keeping them in the loop on things, because I could go to their meetings and things like that. It turned out to be a very key element in being able to get the Health Services Research [Center] put together and being able to maintain it. One of the spinoffs is we went to the Bush Foundation and they gave us a grant, liked what we were doing, and they funded us, I think, continuously for, like, ten or fifteen years. Even at one of their meetings with the University, they told the president that this was one of their most successful projects at the University. So they were quite proud of us and we were very pleased to be proud of, so to speak.

[laughter]

JK: It was an important piece of cash for us for a long time.

Also, at that level, you worked with the Legislature. Again, in those early days, the director of the Center had a lot of running room and was part of a very interesting and important network. I may have mentioned in our previous interview when [Nils] Hasselmo was here as president, I don't think a month went by that we weren't on the phone with each other over some issue and, generally, some national issue. "What can you tell me about this? I'm going to a meeting and they're going to raise the issue of health care cost. Can you give me one page?" That kind of stuff. That's first class in terms of being able to do that. With the Legislature, they would call us and say, "Can you give us help on this issue?" or "Come on over and provide a couple hour seminar with a few of our key people here." A lot of times, you'd get there and there's only two of the senators that would show up, but most would be their staff. Nonetheless, they all went back home and said kind things about us. It was useful.

DT: It's really necessary because of the type of research that you were doing that you needed this level?

JK: It's how you conceptualize health services research. We were conceptualizing it, at that time, as a health sciences wide activity, work going on in the School of Public Health, work going on in Nursing, Pharmacy, Medicine, Dentistry, related to health services. So we needed to develop some kind of a mechanism not so much to coordinate

that, because faculty do not like to be coordinated, but to have a focal point for it, to help them expand what they were doing, and get the projects off the ground, manage the projects after they came in, and make sure that they complied with regulations, and to keep the program going health sciences wide.

That was, of course, Lyle French's vision. He had a lot of insights about how health sciences worked and what it took to keep them hung together, the schools. Although, I think at that time, it was a lot easier to have the schools work together than it is probably today. I think the funding was better. It would be interesting—you'll probably learn about that in your interviews—as to what changed to cause the schools now to be reluctant to work together. If you do anything with anyone, they want to know right away how much money for us, that kind of thing.

DT: [chuckles]

JK: That *never* came up when we were running the Health Services Research Center out of the vice president's office. I think if it would have come up, Lyle would have jumped on them and said, "This isn't dollars; this is intellectual activity. This is like the Cancer [Research] Center." That's what he always kept saying. "This is like the Cancer Center." "Oh, okay." [laughter] Now the center concept is gone. I guess it's no more, because they don't have a Center director. It's now a division in the School of Public Health. It's like another division of health management policy that most major schools of public health have, and there's good research going on in it, but there's not the focal point for the School of Medicine to look for collaboration.

Now, it's interesting—you can change this if I go on too long about this—to me... I just met with Connie Delaney [dean of the School of Nursing]. With her role with the [Health] Informatics Institute and, then, the Center for Translational Research, she's talking about health services research. That is a health sciences activity, and this may reform health services research, eventually, as a health sciences activity there. She pointed out a very important issue, which, of course, I'm very attentive to, but I was amazed that she picked up on it without any prompting; that is, who does the press or whoever call when they have an issue or they want to talk with someone about health services research. I said, "I don't know. I guess they call whoever might have published something recently or something like that." She said, "A lot of times they're calling [Lawrence] Jacobs over in the Humphrey Institute." [laughter] That's probably all right, except that as a health sciences of the magnitude of this one with the kinds of activities going on here, it certainly would be good to have a focal point, you know.

DT: That raises a lot of questions about kind of the nature of health services research, not just at the University but in the field more generally. I guess my first follow up question would be then how typical was the University's approach to health services research when you came back here in the late 1970s. Was that unique to Minnesota or was that something that was more broadly appreciated in the field?

JK: No, this was pretty unique to Minnesota. In fact, I'm not sure there was even any other centers going at the time. About five or ten years before that, the Agency for Healthcare Research [and Quality]—it wasn't called that then; it was called something else, [Agency for Healthcare Policy and Research] but that's what it was—funded health services research centers. They provided base funding for them. There was one here in Minnesota. What was the guy's name? He was out at Christmas Lake [in Shorewood, Minnesota]. You'll run into that name. I'll think it was Paul Edward. I'm terrible on names.

DT: [chuckles]

JK: He had a center funded with federal money from the Agency for Healthcare Research. Seattle had one. There was about four or five of them around the countryside. When the money phased back, they all folded up. Not quite all of them, but most of them did. They organized them to get that money, and when the money was gone at the universities, there was no institutional support.

When I was interviewing with Lyle, I said, "If you want to have this thing go, you've got to put the support underneath it; otherwise, it will fold up after a few years or whatever." It's interesting... He said—maybe I'm repeating stuff here—"Well, we're aware of that. We'll put about \$100,000 or maybe \$200,000 into it. That will pay your salary and things like that and start up costs. Then, of course, when you get grants and all that other people will bring their grants here from the other schools and so forth. It will really work." I told him, "It won't work. That's not enough. Why would they want to bring their grants here? Why would they want to work with us? They've got to have a lot more support than that." He thought about that after I went back home. I essentially told him I wasn't interested. He came back and said, "I think you're right. We'll go for a state special." That state special, at one time, was like \$800,000 or \$900,000. When you plug that in with the Bush Foundation support and other support, we had a lot of money. Then the grants started coming in and we had a lot of grant money.

To specifically answer your question, was there anything else like this going on? Not really. There might have been one other one, but none at the health sciences level. Then, North Carolina started one at the health sciences level and Alabama started one at the health sciences level. I'm not sure that there were any others than that, as a matter of fact, and they're still going. In fact, they're still going very well, because they had, again, institutional support similar to what Connie Delaney got over here right in the floors below you, a nice area and a reception area, the whole thing. Well, that's what each of them have. So they're doing very well. There's a lot of health services research going on across the country, but it's not generally organized as a health services research center at a health sciences level as we had conceptualized it and as Alabama and North Carolina and a few places like that.

DT: In those other instances then is it within the school of public health?



JK: At Penn [University of Pennsylvania], it's in medicine. At Seattle, it's public health, but, also, the school of medicine. Colorado now started a school of public health, so they've got some research going on there. It's a different focus because, first of all, it's not a highly coordinated effort. I use that term carefully. If you have a center, you don't need to use a heavy hand to coordinate things, just having your luncheon meetings that they come to talking about research and providing them some help to get a project out the door and things like that attracts the faculty from all the different divisions and schools. So at Colorado and Seattle, they're doing stuff, but it's more sporadic, and it doesn't get down to what I think has to be done and, that is, streams of research that takes you out on the cutting edge. That's what the important research is going to be. Michigan now has, I don't know if they call it a center—they might call it a center but I'm not sure what that means—for health insurance innovation. It's focusing on health insurance. Mayo [Clinic] and Dartmouth [College] and Geisinger Clinics and a few of those folks are starting a research program on value-based practice performance, value-based issues. That's what they're going to focus on and they'll pour millions into that, and NIH [National Institutes of Health] will probably match it with millions. That's probably what it takes. These issues are so darned complex that one... The grant we're just finishing here for Robert Wood Johnson is finding some *very* important things but the most important thing is it provides direction for the next layer of research. But it's hard to get streams of research funded.

DT: What did you see in the 1970s as the core theme, core questions that health services research was interested in? What were the organizing principles?

JK: It was largely, still then, cost, but, also, there was the issue of professional person power. How many do we need? How many physicians do we need and was there enough? What is the shortage in rural areas? All kinds of issues around that, and, then, the nurse practitioner role. What role do they play? What role should they play? Those were important issues at that time. The physician supply is still an issue, but it's more of a political issue than it is a *real* issue. Primary care physicians feel as though this is their chance to get a lot more money, for one thing. Oh, we're now very important in managing care, so we should make as much as the surgeons. No, you're not going to. [chuckles] Maybe the surgeons are going to make as much as the primary care. The field was going in the opposite direction. [There also were issues related to the development of HMOs (health maintenance organizations). Did they save money and what about quality, etc?]

[chuckles]

JK: Those were the issues and cost was beginning to become a major issue. We were looking at cost and working with some health insurance plans, Blue Cross mostly, to look at trying to get a hold of what was happening on cost and why, why the costs were going up and the like. We started out pretty much focusing on economics. We were hiring economists and that served us very well. We decided that we needed to diversify and start hiring sociologists also. In retrospect... I speak openly; I hope that's okay with you.

DT: Perfect.

JK: In retrospect, I think that was a mistake. First of all, they just simply don't get along very well with each other. They bring totally separate perspectives of things, and if they're fighting for resources, it creates a lot of anxiety. Then, when you go up for promotion, one group doesn't understand... If you've got two economics articles in the top economic journals, you're an important person in that field. A sociologist doesn't even know what those journals are, and they say, "Wait, you have only three publications," or five or a dozen or whatever. You needed twenty. So I think it hurt us a little, but it was what we did. The place grew and developed, so it was okay.

I think the agenda changed a bit then to health insurance coverage, more patient-level stuff that sociologists were doing and looking at the uninsured and why they are uninsured and things such as that. That was an important aspect of health services research.

The agenda also started to focus on physician practices. I had been interested in the question of group practices for a long time, and we did work on group practices. We probably have the most extensive work on group practices than anyone in the United States and probably know more about how they function. That doesn't say that we know a *lot* about it, but we know more than anybody else.

[chuckles]

JK: That became an agenda item.

Then, we spent some time, because of being part of the Academic Health Center, looking at academic health centers: their funding, their management. There wasn't a lot that we did on it, but we did some studies about their decision-making structures and things such as that. It never turned out to be really good research, because there were just too many personalities involved that you couldn't deal with, you know—or you didn't want to deal with. I'll put it that way. You can't say, "The guy at wherever doesn't know what he's doing." You've got to make them all look good, and that was not easy.

Part of that was built into research with the University Hospitals, too. There was an Association of University Hospitals and John Westerman was prominent in it. So he would get them to fund research for us, but, again, they didn't want to ask the tough questions about funding at these places and particularly the relationship of University physicians to the hospital and the residency programs. I'll tell you it was a jungle—still is a jungle. We did some studies on that [but they never went very far because of the complicated political milieu].

We did some of the basic studies on building the new University Hospital. They wanted to hire an outside consultant and did and paid them... I don't know, it must have been \$700,000 or \$800,000. It was a *huge* bill. They were out of Texas and they assigned a

person to live here for a year in the area—yes, everyday, he was over here interviewing and writing and so forth—to come up with a design. It was too many beds, by the way. Then, the Legislature jumped on it and the community jumped on it...didn't want all that competition. Then, unfortunately they asked us to come into it and look at it. I spent a lot of time on that, about six months probably, going to the Legislature, testifying and all that. The community was arguing we're going to have everybody in HMOs [Health Maintenance Organizations] and they don't use many hospital services, so we don't need another hospital. I was arguing that, first of all, they won't all be in HMOs. Some of them will but not all. Secondly, the population is growing and aging and so forth. You need these hospitals and you need the *University* hospital. A first class University hospital [is essential to a first class health sciences center]. They downsized it a little bit, but, finally, went along with it and did build it like that.

Then, of course, the patient population did slip and, then, they thought the sky was falling. [laughter] That would be something that could be looked at on our leadership project. They should have toughed it out. The hospital had a big debt but comparatively not a lot. The patient load was sliding downward, and they were, "Oh, by God, it's going to go into the ground. We're all going to go broke," and all that. They weren't going to go broke. They had a superb medical staff. This is the only place that some of the procedures could be done, but they would have had to make some changes to make it go. Again, I think I mentioned this to you before... There's just two things and one is that they were unwilling to bite the bullet and make the changes they needed to make internally, and, secondly, it looked as though selling it was really good idea, and we'd get some money and get it off our back and we're out of it.

[laughter]

JK: ...or the bad things we've done, depending on how you look at it.

DT: It's really clear from your description of health services research that it has been and continues to be so important for federal and state and municipal governments to be paying attention to the products of health services research. It is about access and about ensuring appropriate and wise delivery.

JK: Cost and delivery. If you saw the paper this morning with [Governor Mark] Dayton... We've got to control these costs somehow and we're going to go to competition. Well, nobody thought that Dayton would ever say that. Plus, by the way, they love to live by sound bites. Competition? Uuhhh, excuse me. I'm not so sure that that's going to do very much for them, a little bit maybe, but there would be a lot of other ways that they could save a lot of money if they decide to do it. But each of them has a political toll.

You're exactly right that for the state, local, and national governments this is vital stuff for them, but those milieus are so political. I should say that in the early days when Lyle was here and I was in the vice president's office, I worked *extensively* with those legislators here, just to keep our relationship with them. It's just amazing how if you've

got a piece of research that supports their political view, you're a giant...they parade it all over and thank you and all that. But if it doesn't, it's buried.

DT: Yes, what happens when there's obviously partisan politics going on within the Legislature, too? How did you negotiate?

JK: Very carefully, as they say, so you don't get into trouble with them.

The closest I ever came to getting into trouble was... Again, if I've told you these things, forgive me. I can't remember all we talked about. [chuckles] Anyhow, there was a big issue that came up in the state about rural healthcare. We don't have enough physicians and the Medical School is not doing its job. We need to pour in millions. Well, the Medical School thought that's not a bad idea, you know, if they pour in millions. [laughter] But trying to get them to go to rural areas is a different story. One of the legislators said, "Would you guys take a look at that?" Some rural group did a study for them and they showed that they needed like four hundred more physicians in rural areas. What they did was surveyed the hospitals and said, "How many more physicians can you use in your community?" Well, every hospital said, "Ten more." They never asked them, "Where are those patients coming from?" The hospital thought they're coming from other communities if we get the physicians. Well, the other community asked for ten more, too. [laughter] Not ten, but, you know... So they found that they needed four hundred more family practitioners. Come on. They asked us if we'd take a *hard* look at it and let them know. We did that. I headed that study. We approached it by taking a hard look at trade areas where people go for their care, which the Legislature didn't like and public health didn't like at all. They keep saying, "They should go here." Excuse me. People go where they want to go. They're not going to call up public health and ask them, "Where should I go for care?" That's the public health value system: we should tell people what to do.

Excuse me, but you can take that off the tape.

[laughter]

JK: That's their philosophy.

Anyhow, we did that study, and we came up with the estimate that they probably could use another hundred physicians, and they wouldn't even need that if they'd hire nurse practitioners, maybe fifty, if they'd hire nurse practitioners.

[laughter]

JK: So I presented that report and this guy jumps up and he says, "We've got to suppress that. We can't let that get out, because it will hurt our getting money from the Legislature for rural healthcare. We've got to suppress that and we've got to do it fast." Fortunately, the chair of the meeting just said, "Okay. Next issue." He went right on, and they never came back to it. But that was close.

As you may know, this University would not let them suppress it. They got into a fight over that earlier with the Humphrey Institute doing a study and found things that one of the state agencies didn't like and then said, "You can't publish it." The University went to the wall on it and won.

So we squeaked through that one. I think we did publish it, actually, come to think of it in a national magazine, but, of course, nobody here then read it probably. It was following the idea that you should conceptualize services from a *trade* area point of view. It's interesting... One of the rural hospital administrators said to me, "They don't go to these trade areas. They don't go there for their healthcare." I said, "They're going there for their food." Why are they going there for their food? For the big food marts. Why are they going there? For Menards rather than the local hardware. The world changed. The John Deere... I'm a farmer at heart.

DT: [laughter]

JK: We farm yet.

John Deere's local dealers are closing. They're now centralized in one of those trade centers. And healthcare is going the same way. So you can't say they've got to have two doctors or a doctor in each one of these little towns. People don't use them that much, except for some emergency. The moms take their kids to a pediatrician just like they do here, so if they have to drive thirty miles, they drive the thirty miles anyhow for other things, so why not?

DT: Yes, that makes sense.

When was this study done, this rural study?

JK: That might have been fifteen years ago.

DT: The University, since the last 1960s at least, has been fairly good about trying to increase the number of physicians going into practice with the Rural Physician Associate Program that I think started around the late 1960s, early 1970s...

JK: Yes.

DT: ...obviously, with the Duluth Medical School starting up. The Medical School was getting a lot of pressure from rural physicians by the Legislature to be more attentive and to train more rural physicians, and they have been fairly responsive.

JK: They've done that and I think those are good programs. They're getting better, as a matter of fact. They were a little shaky at first, but they're getting better. They're getting physicians out into those rural areas. I think they're doing a good job at it. At the moment, there are still some areas that are having trouble recruiting and they're

overworked and things like that. Part of it is their own fault. If they'd hire nurse practitioners or just fund some local people to go back to school to become a nurse practitioner and come back home, things like that, they could solve a lot of the problems.

DT: Do you know anything about the Health Information Foundation?

JK: Which one?

DT: I only know it was established in the 1950s and Odin Anderson was the director of it, initially.

JK: Down at Chicago [University of Chicago]?

DT: Yes. They were doing a lot of health services research.

JK: They were. Odin was funded by, I think, a drug company.

DT: Yes, it was drug companies who were. That's why I know about it. It was a group of companies that got together to fund it.

JK: Yes, and funded it for a long time. They did a lot of good research in there. That was, as I recall, located in their business school.

DT: I think so.

JK: It was never a center or anything like that. They did good research and they had good funding for it for a long time. He was basically a sociologist so he didn't do a lot in the economics area; although, he did work with some other economists to do some economics research.

DT: I just throw that question in because it's my own research interest, so I was curious from a health services research perspective.

JK: He was a good guy.

DT: You talked about the fact that there was a Center for Health Services Research here and it now is being dissolved, disbanded, and reorganized, and, now, you're part of the School of Public Health. Obviously, Lyle French had been the one who wanted it as a center for research for all the reasons you've already discussed. So what explains that change in attitude toward health services research at the U?

JK: I think it's leadership at the health sciences level. When Lyle retired, we just had a series of short term vice presidents who hardly even got their feet on the ground before they moved on or decided that wasn't for them or whatever. I can't even remember all their names. You'll run into them, I'm sure, as you go through your interview process. There were at least two, maybe three, before they got to [Neal] Vanselow. Vanselow was

simply just, basically, not a leader of any nature compared to Lyle French. So he had a hard time keeping anything together here in the health sciences. He had a very hard time trying to develop any kind of a strategic plan that would make any sense. When the School of Public Health dean turned over, he went out to recruit. He found Bob Kane. Bob Kane applied. He was at RAND [Corporation]. Everyone told him, “Bob Kane is very hard to deal with. He does good research, but he just shouldn’t be in an administrative leadership spot.” Vanselow, “Oh, no. He’s a physician. We need a physician in here,” and all that. Bob Kane said, “I won’t come unless that Research Center becomes part of the School of Public Health,” because he was doing health services research at RAND. He said, “I want to bring that into the School of Public Health. That will be just great.”

So Vanselow said, “Look. What about that? Are you going to help me recruit? Then, you can be assured of tremendous financial support and everything. This guy will be just great if given all this support, space, and money you need and so forth.” I was reluctant for a long time. The faculty didn’t care. The faculty were doing their thing, having a good time, and we kept them supported. Well, they had faculty appointments in the School of Public Health. We did some teaching in the Ph.D. program, so we had kind of the best of all worlds. So reluctantly, finally, I agreed—a huge mistake on my part. When I talk about lack of leadership, well, there was a flaw on my part. I should have said, “No.” Although, I might have got fired if I’d done that, because we didn’t have enough support from the deans and there was a complete turnover of deans. But that’s okay. I don’t mind. I mean, I do mind being fired, but, nonetheless, I don’t know if he had enough power to do that or not, actually. Later on, I was fired—or tried to be. The president of the University said... [laughter] This is a long story. Anyway, we became then a Center of Health Services Research in the School of Public Health and, then, I was on the level with the department heads in the School of Public Health. They weren’t sure they liked this, first of all, because we had more money, and more context, and more everything, space, parking, etc.

Unfortunately, Bob Kane *never* gave us anything. In fact, when I had an opportunity to recruit one of the top economists in the United States, Will Manning, I went to Bob and said, “We can get Will Manning here.” Bob had worked with him. He said, “Oh, he’s a great guy and all that, but uhhh...how can you afford it?” So I laid out a whole budget of what our grants were and projections and the hard money we had and so forth. We could do it, but also he’d bring in money of his own. Bob came in, “Nooo, I don’t like that yet.” Obviously, after the third try, I concluded, “He’s not going to approve it.” And Will went to Michigan instead. Later, we did get him down here because Michigan lied to him. So Bob was being a jerk—not just to us but to everyone and was asked to resign, which was traumatic.

And they said, “Can he be with you? “ Us?...because he needs a home!

[laughter]

JK: I said, "Yes. The guy is a good researcher, but, now, I'm the boss." [laughter] So we did that, and it actually turned out reasonably well.

Rosalie [Kane] came along with it. That's a different story. She couldn't be here when they moved here because she'd be working for Bob. You can't do that at the University. You can't hire a spouse or a relative. I don't know how far it goes on relative. Then, she could come over here when he stepped down, and they worked for me and were, well, not easy to deal with but very productive.

If you want to be diligent in this type of a job, at least at that point in time with the University, you're going to take a fair amount of heat. I didn't mind doing that—I mean I did, because everybody wants to be liked. But there's certain standards that you try to live up to. I tried to live up to those standards and I took at least two or three law suits. The University, by the way, would not support you on them.

So Rosalie came to us. I gave her a big salary. The salary increases were like three percent or four. Then, you had one percent that you could divide among people. I always gave it to the top productive faculty...divided that up. She said, "That's not enough." I said, "Well, Rosalie, your pay is as much as anybody else in here." "Oh, that's a woman's thing." I said, "You're paid as much as the men." "The economists get more." A couple of them did get more, but these guys had multimillion dollar grants and all that. So she complains to the school. The school says, "It looks as though its fair." She complains to the University. The University says, "It looks as though you've been treated well." She files a formal complaint. Then they gathered data nationally. It turns out she was making more than most of her peers. She wasn't making more than the economists. "Well, look at the economists at Harvard, what are they making?" "You're not an economist." [chuckles] So the University, finally, said "Here's another five hundred dollars a year," or something, and the suit could be cancelled. That was the kind of thing they'd do. I wanted to fight it right to the end.

We did okay. We did *very* well, as a matter of fact. We were ranked in the top five in the nation for health services research centers. There was about twenty then or thirty, something like that. Universities were developing them, either as centers or research groups, one way or another. We got a lot of grants, had a lot of support.

We had other faculty problems. We had a faculty member that didn't get any grants and said it was our fault they didn't get them and didn't get promoted and sued us. The school then by passed us and promoted him and sent him back with tenure. Yes. Well... Every year, he wouldn't even send his material to us for review. We'd sit down with each faculty member at the end of the year and review their productivity. I'd say, "You've got to get some grants." "Why?" I'd say, "This is a research university." "I like to teach. I'll teach." But we didn't have any courses for him to teach. Then, I discovered he was contracting to do research with another group as a consultant to them and keeping the money. It was just incredible stuff like that.



We, at one time, had five of the roughly, I suppose, dozen top health economists in the United States, if not the world. We had five of them. Three of them are still here, as a matter of fact: Roger Feldman right next door; Bryan Dowd; Jon Christianson. [chuckles] These guys are just incredible. That's kind of a measure of how an organization...how good it is, also. If they come and go and come and go, you've got to worry about it. But we've got people who stay here for their entire career.

The instability of the School of Public Health was also a problem. The School of Public Health had a change over of deans right and left with little leadership. They had a division of Public Health Administration and a division of Hospital Administration. Then they merged those two and they didn't get along.

Then the director of the Hospital Administration program got into a fight with the dean [Edith Leyasmeyer] and moved to the Business School, which it never should have done. They took \$900,000 of state money with them and an \$18 million endowment with them that they had been able to get from their alumni. When they decided that they wanted to move over...the Business School said, "Oh, yes, we want to get into the health field. We'll bring you over here." So the associate dean of the Business School was on the negotiating committee and the dean of the School of Public Health sent an administrative assistant. The Business School just walked off with all the money, and the program moved over there. The program with all that money decided they wanted to do health services research and started recruiting health service researchers and set up an endowed professorship and recruited from us!

DT: Wow.

JK: They hired one of our top economists to move over there, paid him another \$50,000 a year. I had a call from the vice president here at Central Administration who was an economist. He said, "What the hell is going on? Those professorships like that are supposed to recruit nationally. You bring national people here." I said, "I can't stop it." He said, "Do you want me to stop this? This is foolishness." I said, "I can't ask you to do that. I can't get myself to do it. It's wrong, but this guy has decided he's going to go over there and what can I say?" So he did go over there, and then he recruited an economist. Then they were developing grant applications in competition with us. [laughter]

Then, when they moved, the school moved the Public Health Administration program into our division because they didn't have a home anymore. We still called ourselves Health Services Research but we added Administration at the end of it. Then we had a graduate program that we were running, not a very good one either, by the way. It still isn't very good. It's public health people that come in and get a master's degree and go out to work in various public health agencies. They need a degree so they take a few courses here and there and so forth. It's gotten better [but it still isn't high level graduate education].

Then, what, five years later, maybe six years later, they get a new dean at the Business School and he says, “Why are we in this business?” Then, the hospital and health care administration program asked to come back to the School of Public Health. I was retired. We had an acting director here. That person was a good enough person, but didn’t have the skills of an old hand who could pick up the phone and call the president, things like that, you know. That’s what you needed. Instead of them forming a new division then for that program and leaving health services research alone, they mooshed them all together [with little thought about the conflicting values or culture]. Then, the faculty who moved over here from the Business School negotiated deals. They were ready to go up for promotion but didn’t have any research or publications, some but not enough. They negotiated *delayed* reviews. They’re still around here working hard now because they want to see if they can get tenure.

Then we have a faculty meeting of the whole crew and one of them says, “This name doesn’t make any sense.”

[chuckles]

JK: We had an acting director who should have said, “Well, that’s it buddy. You came in here. You live with this at least a year or so.” Instead, he said, “I don’t know.” And they voted to change the name to Health Management and Policy and dropped Health Services Research...totally gone. Can you believe that? If we tried to understand that, then, why would the dean sign off on that? Because he doesn’t know any better. Deans have a lot of other things going on [and this apparently didn’t seem to be that important]. That’s what the faculty wanted. Oh, okay. Why would Frank Cerra sign off? Probably because of the problems with the Medical School. The School of Public Health, whatever they want as long as they stay off my back, it’s okay. He signs off on it.

DT: It’s such a difference from when Lyle French first recruited you and created the institute. It sounds as though it has completely changed.

JK: Completely changed. I don’t mean to harp on this, but that’s why I wanted to consider doing this other study. It’s a question of leadership in these academic institutions. What causes folks to get into those leadership spots and leave their brains at the door. I don’t know. They do crazy things and some of them did tremendous damage to themselves. Edith Leyasmeyer was asked to resign. It’s always a little bit questionable about that, but, nonetheless, she retired and left. We had a dean that was before her in Public Health, he wanted to merge us under the Hospital Administration Program, because they didn’t have any research going. Well, then, you guys can bring research to them. I said, “Yes, but they don’t have a research culture.” He was the one that the president of the University called and said, “You know, this doesn’t make sense.” He left then because he knew he was dead, you know, when you’ve got the president telling you you don’t make sense.

DT: Was that Stephen Joseph?

JK: Yes. You wonder... I actually got to like the guy after this all was settled. We used to hunt together. I'm an outdoors person and he is, too. I never could get anyone to tell me why he made that stupid decision. The way he made it, it was like the first month he was here. His secretary called, "Will you come down? He wants to chat with you." I said, "Should I bring budget material?" "Yes, you can if you want to." So I bring budget stuff. I thought it was... "What are you guys doing?" He said, "I'm merging you guys under Hospital Administration. They don't have any research going and there's a leadership problem. You guys will strengthen it." "What!?" Yes, there is a leadership problem and that's why they don't have any research. Why merge us under them?

DT: I've heard that from people that I've interviewed who were in that division. A couple people have spoken about the shift in orientation of the School of Public Health from training practitioners to training academics and that it took time for that shift to really take hold, especially in some of these other divisions.

JK: Yes, I think that that's right. The Ph.D. program played an important role in that. That's where we did help them a lot. The program was limping along, and they asked us to be on the faculty, and we said, "Fine." We then were part of the faculty. It was very clear that the program was in trouble. First of all, it had no full time students; it had part time students, and most of them would take a course here and a course there. Almost all of the courses were taught by two faculty members: Vern Weckwerth and Ted Litman. They taught all the courses. It was their sandbox, you know. But the courses weren't very good, so the students were kind of shortchanged. They couldn't recruit good students, and they had no support for them. We went through that about a year, and our faculty said, "We've got to change leadership." Of course, we had enough votes to do it, because you vote for the chair.

So they pressured me to do it. Nobody wanted to do it, because they wanted to do research. It takes a lot of work to run a PhD program. I finally got talked into it and took it over, and, then, wrote grant applications for student support and got some! Everybody was surprised. We got it because we outlined a new curriculum that the faculty was going to be teaching. It was a little bit of fantasy, but we were going to do it, and did do it. We were going to recruit full-time students. We got the training grant and over the years, I don't know, it probably brought in a hundred million dollars. This was, what, twenty-five years ago? And they still get it. It renews every four years. Then we got a post doctoral grant attached to it, so we could train physicians in health services research, and we got those students coming here. We had a lot of stuff going on. We restructured the whole program. We were told by places like RAND that we were one of the few health services research programs that they would even interview someone from; otherwise, they'd go to econ [economic] departments and engineering to recruit. They would recruit from us because they were such good methodologists. That's because of Bryan Dowd here. He's a superb methodologist, and he teaches the course on research methods. It's tough, but they know how to do research when they get through. We did okay on that.

The PhD program has been reorganized now and it's in a little trouble again. Part of it's a leadership issue, but I think that it will work it out. It's a philosophic issue about should students all take pretty much the same base courses or should they split out early on, and the ones that are interested in this take that and so forth. My philosophy is if you come to a health services research program for that kind of a degree, you better all take a lot of basic courses together before you go into any other area.

DT: It seems like those kinds of curriculum struggles happen a lot, especially in interdisciplinary research programs.

JK: Yes, you're exactly right...exactly right. Again, that's probably because we branched off into a couple disciplines. If we'd stayed health economics, that wouldn't have happened. We would have been generating health economist and that would have been fine.

Then the school with John Finnegan as the dean was hell bent on the way we become important in the world is through volume, so they doubled their student enrollment. I was on some of those committees and I always said, "The way you become important in the world is your quality." Tell me where your Ph.D. students went for their jobs, not how many, but *where* they went for their jobs. How many of them went to a major universities, were hired at major universities in faculty positions? Actually, the school doesn't turn out that many Ph.D.s. We're the largest Ph.D. program that they've got. Ours, at one time, had like two thirds of our students going to academic settings. They're not anymore. Because we have so darned many of them, they're going everywhere...Blue Cross, United Health Care, and so forth. That's probably a contribution, but if you're fighting for *national* recognition, it doesn't add much. The master's in public health program was expanded tremendously, and they now have a lot of those students in each class. When you get a lot of students in there [the quality of graduate education declines].

I argued, "If you're going to do that, then offer honor's programs, so you've got then the top forty percent or something that you can put into a different level of courses." Some of your courses were watered down so that everybody could handle them.

My R.A. [research assistant] on this project was a T.A. [teaching assistant] also. She was grading exams for one of those courses. She couldn't work on my project because of the grading deadlines. "I can't do your analysis because I'm grading these exams." I said, "How are they going?" She said, "I can't believe anybody can give anyone a master's degree with this kind of garbage." [chuckles] She was a Ph.D. student. She's like, "Oh, my God," you know. "These answers don't make any sense. How can you grade them?"

DT: That's always interesting when you've got the Ph.D. students saying that of the master's students.

[laughter]

JK: Then, in addition to that now, we offer masters degrees off campus. There has been a lot of interest from physicians. They sign up for it because they need the credentials. Then, they move on to administrative spots in all these different health organizations. So they need this degree to go along with it. One of our faculty members told me, “They gave me the exams to grade. I couldn’t make any sense out of the damn things, so I just gave them all a B.” [chuckles]

I’m probably telling you more than you want to know. No? Probably. Well, you can erase this.

DT: No, no, this is good.

JK: You’re at an advantage. You can erase things. [laughter]

DT: No, this is good.

JK: You’ve got to protect me.

DT: It raises the issue of how to maintain standards for off campus, online education, when master’s programs tend to have economic benefits to the institution.

JK: Oh, yes. Oh, they make a lot of money on it. That’s exactly right. Yes.

I don’t know... You could profitably do a whole other study on the role of academic institutions in education. I go to a breakfast club on Wednesday mornings and they’re all, except me, multi millionaire retirees, head of this, head of that and all that. Not all of them are retired, but they’re all movers and shakers, you know. This guy says, “Where is education going? We’ve got all these kids that we’re trying to get them to go to college, go to college, go to college, and they can’t get jobs when they get out.” They should be going to Dunwoody, a lot of them. That’s where the jobs are. He said he knows kids that got degrees over here at the U or wherever and, then, went to some of those technical colleges to get a degree in computers or...not the degrees in them but to get the training in them. Then, they can get all kinds of jobs. [laughter] Maybe that’s okay, because they got an education that was broadening and, then, they got technical training. Well, what is the role of education versus technical training?

DT: Yes. The education landscape has changed and, obviously, the job market has changed a lot.

Going back to the Center for Health Services Research... You said at the beginning that, obviously, one of the reasons Lyle French created the health sciences level and appointed you the v.p. [vice president] level was so that you were able to operate, basically, more autonomously and without so much political wrangling.

JK: Yes.

DT: How did the move into the...the disbandment of Institute and being put in the School of Public Health...? Did that change the ability of you and your unit to do research?

JK: Well, it changed but they didn't tell us what to do for research. We still had our own space and things like that; although, we took a lot of heat over it. What it changed is that if you wanted to go to a foundation for support, you needed to then apply through the dean and, then, they coordinated it and all that up through the president's level.

We had a foundation ask us for a proposal. It didn't get enough support upstream to get it out. Subsequently, though, when I explained to the folks that they're actually asking for the project, they did move it up on the agenda, because they're not stupid, you know. They want to get the money. At the University level, they see all the money flowing to the health sciences [and they tend to give us low priority because they think we're rich]. Everybody else is a little nervous over the health sciences always, because we are paid more over here. It's true—not so true anymore. You get all these grants, so you don't need state money. The state money should go to the Humphrey Institute. Those poor guys, and Political Science because they can't get any money. Well, if they'd get off their rear ends and apply for it, they could get money, too. But why not? If the state is supporting you, why not? That's a little unkind, because there are good folks in those units who are good friends of mine. But if you're an aggressive researcher looking for funding, it gets a little frustrating to go through those obstacles. Plus, I just was no longer on the major committees [or in the loop with the legislature or the president's office]. The other schools look at you differently because you're in public health. Before they looked at me as in the vice president's office.

The Pharmacy School had graduation and Lyle was out of town to confer the degrees, so they asked me if I could come confer the degrees. I said, "I don't even know what you do." "We'll show you how." So the dean introduces me and there's a speaker and all that bit and, then, you've got to stand up and say, "On behalf of the University..." [laughter] That's the level I was running at. Almost all of the major research committees, I was on them, not very functional sometimes, but, nonetheless, I was on those committees and all of the strategic planning committees.

The health sciences deans and directors would go up to the Carlson Conference Center on Lake Superior, the Carlson Company. They let the University use the center. We'd go up there once or twice a year, the deans, chairs of the major clinical areas—and me. [chuckles] Sometimes, I'd take a faculty member along also. We were always asked to present a session on the healthcare field, where we think it's going, what implications it would have and all that. That was when big discussions took place of what to do and so forth. I'm still on first name basis with John Najarian and people like that. That's the people we ran with. That's the way we interacted. I don't remember that happening after we became part of the School of Public Health.

Vanselow, though, had a meeting at the Carlson Center and I was at that meeting. It was getting down to the issues of what to do with this hospital and all that. I had a faculty

member with me, and we outlined pretty much what we thought they were going to have to do, but, boy, they did not like it at all. The clinical chiefs did not like it. In fact, one of them at the coffee break—we had flip charts and all that—went up and ripped them off and crumbled them and threw them away. He said, “This negative talk is terrible. This negative talk here is just *terrible*. This University is strong. Our physicians are better than anyone else and patients will always come here.” The vice president, Neal Vanselow, he’s sitting there. If that had been French, he would have stood up and said, “Put those back up there, you jerk. I don’t care how you feel about this negativity. It’s not negative talk. It’s realistic talk. Now, where shall we go from here? What part are you going to play?” That’s what Lyle would have done. But no more. They had multiple opportunities to salvage the hospital and turn it around. I think, again, it goes back to my wanting to study leadership in more depth. Fundamentally, it was that they just could not convince themselves that they had to change. They thought it would all go away, that it would be okay, and would be all right for some reason, that the patients will *insist* that their physicians send them over here. Yes. You can’t find the place. You can’t get into the place. You can’t find your way around but they all will come.

DT: [chuckles]

JK: You can sit there and waiting hour before your doc will even see you. Try to say that in the nicest way... “Well, it’s traffic over here and things like that. They can go right to Southdale and park right by the hospital and walk in.” “Yes, but they don’t have the physicians.” “Well, they have physicians who were trained by us. The surgeons were trained by us. They must be pretty good.”

[laughter]

JK: The nice part of the Carlson Center is you do this kind of exchange and, then, at the evening cocktail hour with drinks and dinner, everybody becomes friends again. You can say things and get away with it. [laughter]

DT: That’s at least good.

Yes, it was quite a change in terms of responsibilities and support then when we moved into the School of Public Health.

JK: Yes.

DT: You were an assistant vice president until 1998. Is that right?

JK: That’s right.

DT: Was that after your tenure as director of health services research?

JK: I went on sabbatical and came back and said, “This doesn’t make sense to carry that title anymore.” The vice presidents were turning over... They were just shedding themselves of everything. It had no meaning anymore.

DT: You mentioned that you were on the search committee and went to a lot of committee meetings. Were there any other responsibilities that you had in that position in the v.p.’s office?

JK: I’ve got to think back. Other than advising... The executive group, which was made up of Lyle French and John Westerman, the director of the hospitals and, then, whoever it was from the medical group that was elected to be head of their University physician’s groups, they met and I was part of that. It was never very successful meetings and I never did much for them. They were all meetings that were dealing with specific problem areas. Should we add another clinic dealing with pediatrics? I went to the meetings, most of the time. [I also was part of the clinical chiefs weekly lunch where they discussed funding and administrative issues. My role was to keep them informed about changes in the health care field. I was also on several short-term committees in the medical school such as recruitment and teaching health services content for students and residents.]

[chuckles]

JK: I had a car, by the way. You get all the perks that goes with it. A parking spot in the heated garage.

DT: You were telling me that last time, yes.

JK: It made a lot of enemies among my peer group, I’ll tell you that.

[chuckles]

DT: When Health Services moved into the School of Public Health, were you still on call with the State Legislature a lot?

JK: Quite a bit, yes. That was in some ways profitable. It was important. You’re influencing policy and they appreciated it. I was able to develop, you know—I don’t know what to call it—an approach or a philosophy or whatever that enabled me to work with them productively. What I mean by that is in the initial stages when they say, “Come over and make a presentation,” I’d go over and make a presentation, and they’d have a committee of a dozen and only two would show up and the rest of them were their staff. I was wondering what am I doing wrong? A senator said, “You’re not doing anything wrong. That’s the way we function. Don’t take offense at it. That’s what happens to everybody.” Okay. All right. Or you make a major—I did it for Lyle French—presentation to them about this hospital, and these guys are sitting there reading the morning paper. Yes! They’re so impolite. What a bunch of jerks. We come over there, flip charts and all that. Lyle French makes a presentation and introduces me and



they're sitting back there reading the paper and writing letters. [laughter] Well, you've got to get over that part of it. Once you get over that part, you can work productively with them. Sometimes it was a close call.

We had budget meetings which I always went to with Lyle. He'd call on me at strategic times, when they were saying, "Why don't you guys do this?" "Why don't you guys do that?" "John can answer that." "Doctor Kralewski can answer that," about whatever, you know. You had to always sit there worried about what he was going to ask next.

[chuckles]

JK: We had one of the budget committee members that had told one of the vice presidents at the president's office that they'd be willing to put some more money into health services research. He read something... I don't know what he picked up but he liked it. This was when Vanselow was here. So I told Vanselow that, and he said, "No. We can't put it in the budget this year. We're going to fund a center for ethics. We're asking for money for a center for ethics, so we can't put health services research in there." I said, "Well, okay." Then, I get a call from the School of Public Health and they say, "Can you be at the budget meeting in case this comes up?" What the heck can you say? "Yes, I can." I told the dean of Public Health, "I'll go over with you and see what happens." "Okay." We go over there and these guys are going through these budget things are that thick, you know. They say, "We don't see anything in here for health services research." Vanselow said, "We're not asking for any money. We want money to fund the ethics center." "Well, what's that going to do?" "It's going to do this and that and so forth." He said, "Well, okay, if that's what you want. It's up to you." We left. Out in the hallway, this vice president came out and said, "What the hell went on in there? You guys could have gotten another hundred thousand dollars by just simply saying, 'We appreciate that, and thank you. We want the ethics center, but the research center can use some more money,' and you would have gotten another hundred thousand dollars. God what is wrong?!" I said, "Don't ask me, buddy. I'm just doing what I was told." Can you believe that? Vanselow totally misunderstood how the Legislature works.

Again, Lyle—I don't mean to keep talking about him; he's a big hero to me, I guess—I remember one of those meetings when he was trying to get more money for the research center. They were saying, "Well, Lyle, we'll see what we can do. We'll see what we can do." So we walked out of those hearings, and three of them followed us out in the hallway. They were saying, "Thanks, Lyle, for coming over." The other guy said, "Lyle, my cousin up in wherever... She's having a hard time getting a diagnosis. I was wondering if you could tell me what to do." Lyle says, "Here's my personal number." [laughter] He could have said, "Come on down and we'll go over to medicine and get an appointment there and they'll take care..." "Here's my personal number." Boy. They told me later that he personally walked the patient over to the medicine clinic [and she was greeted by the chair of Medicine].

DT: Obviously, Lyle French had a lot to do with... I've heard from others, too, about what an important and effective leader he was and his relations with the Legislature were really critical.

JK: Yes.

DT: Yes, there's an element that the leadership at the Health Sciences level changed, but is it also possible that there were changes in the Legislature that also contributed to this maybe shift in relationship?

JK: Yes, I think maybe so. It does change around a little bit. However, a lot of the legislators in Minnesota stay around a long time, as you probably know. They do change over, but I don't think it's the change-over that made the difference. It was how you nurture the relationship with them. That's what it's all about. I don't think that our current president [Robert Bruininks] has done a very good job of that either, as a matter of fact. I think [Nils] Hasselmo... Hasselmo went out of here with people saying, "Oh, he never was a powerful leader. He didn't change. He didn't get rid of the programs that should have been cut back," and so forth and so on. I don't agree with that. He rebuilt the relationships with the Legislature. They were angry over the previous stuff, you know, the guy [President Kenneth Keller] that built...and overran millions of dollars on his kitchen [Eastcliff renovation] and stupid things such as that. He rebuilt those relationships so that they liked him a lot. Nurturing those relationships takes a lot of time and, I suppose, a certain personality. But, man, that's important stuff.

DT: Given the degree of state funding that the institution gets as the state University, the University presumably has an obligation to fulfill the needs of the state, so it seems having good relations with the Legislature would be important.

JK: And they don't like surprises.

There's still a state special in here for a Center for Health Services Research; it's called that. One of these days, they're going to discover that there isn't any center here. The school is going to lose another...I suppose three or four hundred thousand dollars. It keeps getting cut back.

There was a special for nurse practitioners in the School of Public Health to train nurse practitioners, and a dean, who shall go unnamed, decided to close it and transferred the money over to a general fund. There was one legislator that wanted his head on that. The only thing that saved him is that the School of Nursing picked up the whole program and started training them. Well, it is on the forefront now, but it was going on. The Legislature gave them a bunch of money for it. It was a close call though.

DT: I'm curious about the relationships, actually, between the different health sciences units, if you can talk a little bit more about that. How did Medicine, Public Health, Dentistry, Pharmacy interact?

JK: In the early days of the Health Services Research [Center], they were all on the Advisory Committee. We met every month. We'd have lunch at the Faculty Club. They would keep their folks back home advised about opportunities with the Center and how they could work with us. I don't know if it was the funding issues or what it was, but the deans were, at that time, highly committed to collaboration. The dean of the Medical School, when Lyle was trying to add money to our state special, agreed to have it taken out of the Medical School's budget.

DT: Wow.

JK: Yes! If anybody would have found out about that, they would have killed him.

DT: Was that Neal Gault?

JK: That was Neal Gault. He said, "No, I think that this is a very, very important thing, and you need to move another two hundred thousand over there." Yes. Can you believe that?

DT: That's incredible.

JK: The Pharmacy School was incredibly supportive. It was that kind of a milieu.

Now, at the next level down, again, the clinical chiefs met every week for lunch in a dining room downstairs. Lyle and John Westerman at the hospital would invite me to come to those. The clinical chiefs, I got to know them pretty well, and they had a lot of questions about where is the field going and what should we do and so forth, so I off and on was helpful to them. So we had a pretty good relationship with the clinical chiefs.

Now, Peds [Pediatrics], great. I worked with them on several things. John Najarian, he's a good guy and we got along fine. He's kind of an irascible bear, but, nonetheless, all surgeons are. We got along well. Medicine was always hard to break into, for some reason, and still is. Family Practice is easy to deal with and we've conducted research projects with them. I just finished with them. But Medicine was a tougher one to deal with. I wrote a chapter in a book with the physician who headed the Lab Medicine and Pathology Department. He liked health services research. The whole Lab Medicine thing got them into the Informatics. That's where Informatics started. He was really interested in information technology. We had a close working relationship with those folks.

To follow your question... When you get to the next level down, I think that there was some interaction between Public Health and Nursing and some with Pharmacy, but not much. Public Health and the Medical School did not have a lot of interaction. It's unfortunate, because there was Epidemiology, which should have been working more with the Medical School. Not so much Environmental Health. Biostatistics did work with the Medical School, because, a lot of times, they needed that kind of help on their research projects. Biostatistics had a lab that would do work for you. You would buy

services from them. They worked with a lot of the clinicians on research projects. When they established the Cancer Research Center, there was more interaction between Public Health and the physicians and Pharmacy, too, with drugs. That, I think, helped it a lot in terms of that integration at the department level than at the faculty level.

One of the big problems is that with grant-supported schools, everybody worries about where the overhead ends up. The funding system here is not a good one. It causes a lot of balkanization of the different groups. We have tried to do things across the river in the Business School. You talk to them about doing a project and the first question they ask is, "How much money do you have?" [chuckles] They didn't ask, "What is it you'd like to do?" or "How can we help?"

DT: Whenever you get research grants, the research grants cover a certain amount but they don't cover the overhead? Then you have to go to your general operating funds?

JK: It's the other way around. If you get an NIH grant, in addition to your grants, you get a forty-eight percent overhead. If you bring in a million dollars there, the University gets four hundred and eighty thousand dollars. Then, they give some of it back to the school and, then, the school gives a little bit back to the division. If you're going to get a grant with the School of Business, who gets the overhead?

DT: Yes.

JK: Okay. Then, you split it according to how many people are on each side. It's a major issue. I think it's a major issue; others probably don't.

I think that Frank Cerra tried to do a lot to bring about more integration. One of his philosophies was to integrate education in the health sciences, and that in some of the beginning courses, the physicians and nurses and pharmacists should take the same courses. They would then work as teams and that's what they are going to be doing when they graduate. I'm not sure how far he ever got. I don't think he got very far on it, but was working on it. But, of course, just the economics of the whole thing was overwhelming and the turn over of the deans and him taking over as medical school dean, and, now, another new dean who will also be a vice president; [the training integration gets a back burner].

Now, as I understand it—I can't believe this, but I just saw someone in the hallway that reaffirmed this for me—the deans of the schools are no longer reporting to the vice president for health sciences for their budgets. There is no greater time when they need to come together. The new vice president for health sciences, [Aaron] Friedman, is going to have to deal with that. I don't know if he has that kind of ability or not.

I visited yesterday with Connie Delaney, because I'm doing some work with the Medica health insurance plan. They want to see if they can line up with her Center for Translational Research. They'll put money into it, by the way. I told her that one of my daughters is a pediatric nurse practitioner. She chose that over going to medical school,

because of its style of life. She said, “I’m very high on that.” She said, “Boy, it’s just amazing that the health sciences hasn’t heard about it yet.” I took that as an indication that not much has changed. Nurse practitioners...that’s what the field is clamoring for. I note that in Family Practice, their clinics are staffed by physicians and nurse practitioners and so is general medicine. At that level, they’re finding and hiring nurse practitioners, and are retraining them to work together.

[laughter]

JK: Retrain the physicians and the nurses, both.

DT: I guess it just shows that things are different when you’re out in practice, that you can have a different perspective and you see the usefulness of the nurse practitioner if you’re the family physician that you might not have seen when you were going through your training.

JK: I did three studies for the health sciences—the one before, I was in Public Health and the two afterwards. We brought physician leaders and administrators in from community practice with the whole idea of trying to identify how the field is changing and the implications for clinical education. Boy, those were good meetings. Those folks had all kinds of ideas about where the field is going and everything. But trying to move this large institution is not easy.

I have two friends...one of them is on the board of [University of] Saint Thomas, might be on the finance committee, and the other one is a physician who worked with that guy’s brother who works with Saint Thomas also. When they were thinking of starting a medical school... Remember that?

DT: Yes.

JK: They came over and we had lunch and they’re saying, “What do you think? What do you think?” I said, “It’s a great idea.” He said, “But it’s so expensive. Can we do it? Allina says they would put some money in. But how much? What about the clinical side of it and so forth?” I said, “You know, here’s why you should. It’s almost impossible to change these existing institutions.” It is like the guy... Who was the famous guy at either Harvard or Yale, one of those, who wrote about these things? [Arjay Miller at Stanford University] He said, “It’s like moving a cemetery.”

[chuckles]

JK: So I said, “You guys start a new one and do it right. You can be on the forefront of primary care physician training, nurses, pharmacists, the whole thing.” “Uhhhh, I don’t know. It’s so expensive.” Then, Allina said, “We’re maybe not sure that we can commit what we’re talking about, a hundred million. That’s not going to be enough. We don’t know if we can go more than that.” Saint Thomas could have, in my estimation, raised

the other hundred million. They could have put two hundred million under it easily. That might not have been enough. But it's getting up there where it would get attention.

DT: That actually was my last question, so if you...

JK: Was it? I'll do this again with you.

DT: This is great.

JK: I love to talk with you. It's reminiscing. I hope it's not boring.

DT: No, it's fascinating. Because you were in the v.p.s office, too, it gives a very different perspective than what I've seen before now. I'm fascinated by health services research.

JK: I'm presiding at the next seminar at Medica and the topic is "What is health services research and why is it important?" I'm trying to pull my thoughts together on that.

DT: That's great.

Well, thank you so much again. This was great.

JK: My pleasure. If you want to meet again, just give me a holler.

DT: Sure.

JK: The next couple weeks, I'm jammed but then after that, I've got plenty of time.

[End of the Interview]

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