

Thomas Kottke, MD

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

Thomas Kottke was born in Minneapolis, Minnesota, on September 18, 1948. He attended the University of Minnesota for his undergraduate and medical degrees, receiving his BA in anthropology in 1970 and his MD in 1974. He did his residency in internal medicine for two years at McGill University's Royal Victoria Hospital (1974-76) and then spent two years at University of North Carolina-Chapel Hill (1976-78). At UNC-Chapel Hill, he received his MSPH in Epidemiology and was a Robert Wood Johnson Clinical Scholar. In 1978, he returned to the University of Minnesota and completed a three-year fellowship in cardiology and preventive cardiology. He then joined the staff in cardiology in the Department of Medicine. While a medical student at the University of Minnesota, Kottke helped established the Council for Interdisciplinary Health Programs (CHIP). In 1987, he moved to the Mayo Clinic.

Interview Abstract

Thomas Kottke begins by discussing his background, including his education and why he became a physician. He discusses his time as a medical student at the University of Minnesota; going to McGill University for his residency; some of his experiences as a faculty member at the University of Minnesota Medical School, and getting the Preventive Cardiology Academic Award and his work on tobacco control and smoking. He described his impressions of the new Medical School curriculum as a student, his experience at a Sexual Attitude Reassessment Seminar, his experiences on the Council of Deans and Directors as a student representative, the perceived shortage of doctors in the 1960s, the relationship between the Medical School and the Mayo Clinic, and the reorganization of the health sciences in 1970. He discusses the Council for Health Interdisciplinary Participation (CHIP), family medicine, the recruitment of minority students, women students, and the affiliated hospitals. He discusses his father, Frederick Kottke, and his father's connections with Democratic Congressional members, including Hubert Humphrey.

Interview with Thomas Kottke

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at Health Partners Headquarters

Interviewed on March 25, 2010

Thomas Kottke - TK
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor Thomas Kottke. We're at Health Partners Headquarters at 8701 Thirty-Third Avenue in Minneapolis [Minnesota]. It is March 25, 2010.

Thank you, Doctor Kottke, for letting me interview you today.

TK: Sure.

DT: Just to cover a little bit of background, could you, perhaps, tell me where you were born, where you went to school, and why you went into medicine?

TK: I was born in Minneapolis. I went to West High School in Minneapolis, to the University of Minnesota undergrad, and, then, the Medical School at the University of Minnesota, two years of internal medicine training at McGill [University] at the Royal Victoria Hospital [Montreal, Canada]. Then, I was a Robert Wood Johnson Clinical Scholar down at Chapel Hill, the University of North Carolina. I received a master of science in public health (MSPH) [degree] there. Then, I came up and did my cardiology training at the University of Minnesota, was on the faculty there for about six years, and, then, went down to the Mayo [Clinic, Rochester, Minnesota] for seventeen years, and, then, came up here to Health Partners.

I was interested in medicine from the beginning, but particularly encouraged by my mother. She sort of had plans for everybody, and the plan for me was medicine.

DT: Were you the oldest?

TK: No, I'm the youngest.

DT: Oh, okay.

What was it like being a medical student at the University? Do you have any memorable experiences from your time there?

TK: Yes, in several areas. One of the overriding themes was the Vietnam War, troops on campus, and those kinds of things. That polarized the student body a whole bunch. The politics didn't really get into student/faculty relations, but there was a lot of questioning going on about the role of medicine in society and society in society.

I do recall on a different topic that we did sort of a skit presentation very early on called the Health Care Team as a Myth. We talked about the team. It seems to me there was somebody from Family Medicine who organized it. I can't remember his name now. It was the beginning of the team concept. It actually probably started in Physical Medicine and Rehabilitation, which was collaborative care. What you hear about today, now, is of primary care teams and accountable care organizations and trying to get beyond the doctor in isolation and the patient having to direct their own care and, basically, make the initial diagnosis and figure out which doctor they ought to go to so they don't end up with a series of visits at high expense that end up with the doc saying, "Your problem is not my problem."

DT: It's interesting that you bring that up. You were a medical student from 1970 to 1974, is that correct?

TK: Right.

DT: Nineteen seventy is when the health sciences were reorganized into the Health Sciences. One of the driving principles for that, at least in terms of what is in the archival record and speaking to people who were involved in administration at the time, was this drive to incorporate a team concept into the Health Sciences, both in education and in practice. So did you see this plan out? It sounds like not if your skit was the Health Science Team as a Myth.

TK: Yes, the Health Care Team. That was to address to start asking the question. [pause] It's obviously, what, forty years later now, and we're still talking about it, but there's a lot more appreciation. For example, like Health Partners Medical Group is a multi-specialty group. We all share the same electronic medical records, so we can look and see what somebody else said. We have access to those records. It's very clear when we have people come in from outside the system what a problem it is to access those records and figure out what's happened to the patient outside of the system.

DT: When you were in medical school, were you having much interaction with the other health science students? Did you take classes with dental and nursing students, for example?

TK: There was talk about doing that. Everybody starts out at the same level and, then, sort of peels off. I don't recall whether there were dental students in our classes or not. I did have some friends who were in Dental School at the same time I was in Medical School. My impression was that Dental School may even have been more rigorous than the Medical School. The Dental School over there is very rigorous. I think where the idea sort of runs into trouble is that like the nurses—I'll get in trouble for saying this—are not academically at the same level, and they don't need to be or, if they would, they'd be in medical school. So, the Medical School curriculum would immediately take a deeper dive into, let's say, physiology than the nurses would. The nurses would be lost and the docs would be bored or behind. So the idea, while it was floated around, was never implemented, and the lack of implementation is probably appropriate.

DT: Also, when you were here at the University as a student, the Med School had recently introduced a new curriculum, which is part, also, I think of the reorganization effort. It's hard because this was the only curriculum that you knew, but what were your reactions to that curriculum? Did you and your colleagues realize this was something new that they were trying?

TK: Oh, yes. We were told it was new. I think we were the second year. There was Phase A and Phase B, and, then, Phase D. Phase C kind of disappeared somewhere. Yes, they had reorganized.

They also had—I'm not sure if everybody was in groups—I remember, a discussion group with Pearl Rosenberg, which was very interesting. My academic career has been trying to figure out how to help doctors do what they want to get done. I remember in that group saying, "I want to figure out why doctors do what they do," and Pearl said, "That sounds pretty dangerous to me."

DT: [chuckles]

TK: She was very supportive.

Later on, when I was on the faculty, I had a patient who was a sociologist who had diabetes and had heart disease. I asked him who to read. He suggested Eliot Freidson. Freidson is probably one of the only sociologists who has really investigated physician behavior. We have guys like Charles Bosk, excellent stuff. I always recommend it to my residents as a survival tool, if nothing else, you know, understanding how to survive in medicine. He's absolutely right. But, then, there's *Boy's in White* [: *Student Culture in Medical School* by Howard Becker], that Kansas thing. Then, there's that ethnography from Canada, something like *Becoming Doctors: Assuming the Cloak of Competence* [*Becoming Doctors: the Adoption of a Cloak of Competence*]. That got those guys [Jack Haas and William Shaffir] in big trouble because the title was, basically, a double-

entendre. It was ambiguous. It looks like they sort of had a chip on their shoulder, and that these docs really don't know what they're doing...the cloak...hiding, assuming. So they weren't invited back.

DT: [laughter]

With the curriculum, do you recall how the balance of the basic science versus the clinical science was within that and, then, the amount of clinical contact that you were having as a student?

TK: Yes, the effort was to introduce clinical content much earlier. We always asked the question of relevance. Is this relevant? Is this relevant? It was the beginning of course evaluations, where we could evaluate the course, rather than just being evaluated by the course. Up to that time, basically, bench scientists could claim some lecture time. My understanding is you had a right to teach and the teaching justified your existence to an extent. Now, they may argue the other way around. There was that whole thing that you just had a right to teach. So there were course evaluations. It clearly was not as sophisticated as it is today. They post evaluations online, that kind of stuff. It was the beginning of that.

DT: Do you feel like the faculty were responsive to the evaluations as far as you can tell?

TK: Yes... [pause] There was this question of who was steering the boat. Have you talked to Mick Belzer?

DT: No, I haven't.

TK: Oh, you ought to talk to Mick [Michael] Belzer down at Hennepin [County Medical Center]. He's the chief of staff at Hennepin. I sat on the Council of Deans and Directors for the Health Sciences. I can't remember what the name of the committee that he sat on; it was like the Academic Standards Committee, or something. My father [Frederic] chaired that when Mick was there. Mick and I were kind of buddies at that time and did a lot together. We organized CHIP [Council for Health Interdisciplinary Participation] together, that kind of stuff. He's still very involved with the Medical School, so you ought to talk to him.

I remember Mick talking to B.J. Kennedy about this. B.J. said, "Well, every ship needs its captain, and I'm the captain." There's always that generational tension. I think that the academic faculty at the University really was very committed to the school and to the students and to the state. I read the interview with my father—can't forget that—and he talked about resources. We probably didn't understand. It wasn't until I went to Mayo that I really understood how much effort it took, or it takes, to keep an organization afloat, people just sort of drilling holes in the boat or trying to rock it, and the current issue of conflict of interest policy. What happened was that they decided that it should be a business incubator. Well, it got a little overboard. [chuckles] So it's back and forth.

But I think the faculty was very committed to the students and committed to producing doctors for the state.

The other problem, frankly, the two new medical schools opened right at that time, one in Duluth and one in Mayo. I think Mayo, basically, was able to get twice the per capita support as the U from the state. That did not sit well with the University of Minnesota, for good reason I think.

DT: Do you have any insight in how Mayo managed to get that higher per capita rate?

TK: Mayo is very good at spin. They're just very good at it. That's all I can say.

DT: Another thing that I recall from the curriculum is that, during your time there, there was a lot of debate over whether to include behavior science instruction in the curriculum. It was introduced in 1973 but this, obviously, would have been when you were in your clinical rotations. Do you have any recollection of any of that discussion?

TK: I do. I wasn't part of that discussion. I do recall having at least one and probably more lectures in medical sociology, early on. It probably wasn't greeted with enthusiasm by a majority of students. I don't know what all the majors of the students were. Obviously, I have more experience recently with medical students down at Mayo. Every once in a while, somebody will roll through from the social sciences. Right outside my door, hanging on my wall, is a quote from Rudolph Virchow that says, "Medicine is social science in it's very bone and marrow."

DT: [chuckles]

TK: People who go into medicine and don't understand that it is a social science are very disappointed and don't do well until they come to appreciate that. That's probably part of the problem that we're having in American medicine is we think it's a pure biological science and somebody else should sort out the sociology.

DT: Sort of related to that... You had mentioned, in the interview that I read that you had done with Ann Pflaum about what became the program in human sexuality, the seminars: Sexual Attitude Reassessment [Seminars].

TK: Yes, yes.

DT: This was something that, obviously, was really being incorporated just as you were a medical student. That seemed to take off. Was that your sense? How did you find those seminars and how do you feel that the other students and faculty responded to them?

TK: Well, they were quite novel. There was a Rick Chilgren and Mary Briggs and Pearl Rosenberg. There were probably some others. I can't remember. There was a psychologist who was in my father's department. We sat around on pillows. [chuckles]

We watched movies and talked. There was a lot of homophobia among the medical students. It was an attempt to get the students comfortable at talking about sexuality with their patients, which I nearly never do now.

DT: [chuckles]

TK: It's also a dangerous thing to bring up in the office, for various reasons. I think it was a good idea; it is a good idea. I think that some docs are more comfortable than others, but when faced with the issue, the doc should be able to be comfortable talking about sexuality and their own feelings about it. It was probably a pretty good program and I think it still is. Isn't it over WBOB [West Bank Office Building]?

DT: Yes, I think so.

TK: My daughter, Sarah, is a psychiatrist. She was over there in the program in human sexuality doing counseling and stuff. Then, Don [Donald] Hastings was doing the sex changes while I was in medical school. Well, he wasn't doing them, but he was the psychiatrist. That was good for discussion over coffee.

[chuckles]

DT: Did you feel like your colleagues viewed the program positively, even those who were homophobic or uncomfortable talking about it?

TK: Yes, I think it was viewed quite positively. It certainly was a break from biochemistry.

DT: [laughter] Did you get any sense about the attitude of the faculty, other than those obviously involved both directly?

TK: Joe [Joseph] Westermeyer was also involved, wasn't he? I think Westermeyer is out at the V.A. [Veterans Administration] now, if I recall correctly.

The faculty didn't really tell tales out of school, so there was a bit of that divide, which was probably appropriate, that the students shouldn't be dragged into—quote—discussions about curriculum.

DT: I noticed that later on in the 1970s that a couple of the regents and some members of the public became quite opposed to the program human sexuality and were threatening to cut off federal funds. I'm not sure if this would have been when you were doing your cardiology training or if it was when you were away.

TK: Yes, I was not aware of that. I'm not surprised, but I wasn't aware of it.

DT: Were there any particular faculty members that stand out to you as having been particularly effective teachers?

TK: Pearl Rosenberg was, obviously, quite involved and, then, she became an associate dean or an assistant dean. [pause] Who did I really like? Believe it or not, I can't remember teachers that I particularly liked. I was going to say that I tried to stay under the radar screen.

Frankly, I didn't go to class the second year of school, because we had the syllabi. I remember one of the pediatricians—I was taking pediatrics—and one day we were sitting, a group of three of us, two students and him, and he said, "Your mother read to you when you were a child, right?" I said, "Yes." He said, "Every time somebody starts reading to you, you start falling asleep." It's true. To this day, I still do it. My mother read every night for years and years and years. Read to me in bed before I went to sleep, so, yes, there is this conditioned response. I won't dispute that. I go to church and the minister starts droning on and I fall asleep or if somebody starts droning on in a lecture I fall asleep. So I found it was much more efficient to get up early and study the courses. Then, we were working for CHIP and the faculty and the associate employees, they work eight to five. You don't call them up in the evening. You don't call them up on weekends. So the work I wanted to get done, the extra curricular work, had to be done during the day. I could study at night. I could study before hours or after hours, which I did. I just found it a frustration to sit in class and have the instructor, the professor, basically, read out of the Bible; I mean just read the notes. I can read faster than he can talk, and, plus, I don't fall asleep.

DT: [chuckles]

TK: Then, I can do other work.

The people who stick out in my mind... Carl Heggstad, I think he was the Phase A director. Does that ring a bell?

DT: It does, yes.

TK: We worked with him a lot. He worked very hard to—I want to be sympathetic to him—defend the program and to try to make us happy and stuff. One mistake I think he made was that he sort of tried to be goalie and stop all the pucks rather than say, "Okay, you guys have this complaint. Come up with something that's different. If you don't like it, come up with a positive suggestion."

Don Robertson was one of my favorites. He was smoking cigarettes. He was in Anatomy. He was really nice, and he was willing to talk. He wasn't defensive, and he was just really a nice guy.

Wallace Armstrong was the head of Biochemistry. We always called him Wally, just to sort of goad him—we should have called him Doctor Armstrong, respected him. We did it just to remove the difference in rank, to be egalitarian. He exhibited some pretty good humor about that. He didn't tee off on us like he should have.

[H.] Mead Cavert, on the Council of Deans and Directors, always was the guy who asked, “Well, how is this really going to work?” [laughter] Mead and June [Mrs. Cavert] were really nice. They always would have the students come over to their house. He wasn’t the most creative, but he was the most down to earth, and every team needs a down-to-earth person who says, “How is this really going to work?” The history of things gone bad, like the housing bubble, like...is where the down-to-earth guy is forced out of the group, and it’s just the visionaries who are sitting around hyperventilating and, you know, seeing things in the air, believing that they are real.

I was unofficially asked to leave Medical School three times.

DT: Wow.

TK: I think Carl asked me once. He said, “If you don’t like school, you can leave.” You know, I was really critical of the curriculum. I thought there wasn’t enough social science. I thought there was not enough political science in there. I was pretty critical.

I remember Vince Hunt, who was a Family Medicine physician. We were standing at the elevator down by the adytum there, and he said, “If you’re so unhappy here in Medical School, why do you stay? Why don’t you just leave?”

Cedric Quick, who was in ENT [Ear, Nose& Throat]... My wife-to-be was in Europe at the time. She had just graduated from undergrad. We had three or four weeks off between quarters. But there was a week off and, then, the ENT test. I said, “Hey, I’m going to Europe and Algeria. I’ll take the test beforehand or I’ll take it afterwards, but I’m cannot see any reason why I should sit on my hands for a week and waste this week.” So I met with Cedric, and he said, “You applied to us. We did not invite you.” I said, “Well, we’ll roll the dice with the Academics Standards Committee. They can either slap my hands or whatever.” I don’t remember if I took the test before or afterwards.

The other thing I did that freaked some people out is I took Part One of the boards after the first year. It’s supposed to be taken after the second year. My girlfriend was in Europe and I had that summer with little to do. I didn’t want to have them hanging over my head, so I just studied all summer and laid out a plan, a better plan than I’ve ever done in my life...

DT: [chuckles]

TK: ...since or before, and passed the boards. Then they were out of the way.

My other sort of brush with death was the night before the Phase B cardiovascular exam. To brush up on cardiology, I read Joseph Conrad’s *Heart of Darkness*. There were no questions on the exam about *Heart of Darkness*.

[chuckles]

TK: Russ Lucas called me and he said, “You didn’t do so well on this test.” I said, “Yes, I know.” It was funny, because I ended up practicing cardiology.

DT: Ironically.

TK: ...and I ended up being a cardiologist.

[W. Albert] Sullivan, I really liked and Bob McCollister. Bob McCollister wasn’t well respected because he was friendly. You could go in and could talk to him. He was sort of like a big teddy bear. He’d absorb the blows; they’d bounce off him. Somebody’s story was they went in there and they were flunking out and, finally, Bob said, “What do you think you can be?” He said, “Well, I suppose I could be a dean.”

[laughter]

TK: All those guys had more patience than I do. I really respect them for putting up with us when they probably shouldn’t have.

DT: So you feel like it was the students who lacked a little respect for Doctor McCollister rather than the faculty?

TK: Oh, yes. The students were a bunch of wild people. Yes, totally. At least a significant portion of them, probably me included, lacked appropriate respect for what the faculty were doing. That, then, reflects back to the faculty trying to get money from the state and the students simply would not—I remember my father talking about this—go over to the Capitol and lobby for more money. We just didn’t understand. I mean, we thought we had all the answers, and we didn’t understand what the problems were and how hard it was to get money and keep the ship afloat, all that kind of stuff.

DT: How did you end up on the Council of Deans and Directors as a student representative?

TK: [pause] At that point, the position was open. This was when they had, I think, a student regent, which is a good idea. At least it shuts some people up. It reminds me of an... Somebody said—this is rather crude—when Lyndon Johnson became president, his first advice was, “Fire J. Edgar Hoover.” He didn’t. They said, “Why didn’t you?” He said, “I’d rather have him in the tent pissing out than out of the tent pissing in.” To get the activists onto the committees to say, “Okay, you’re on the committee. Do something positive. You have a voice. Do something other than yell.” I think it’s an effective way rather than trying to stop everybody. I remember for this Academic Standards Committee, or whatever it was called, standing up before the class asking to be nominated. I was already on the Council of Deans and Directors. The reaction was, “you shouldn’t be on all the committees,” so Mick [Belzer] was on the Academic Standards Committee. Regarding the Council of Deans and Directors, I probably just said, “I’d like to do this,” and the class said, “Okay.” I really don’t recall.

Thinking of the Council for Health Interdisciplinary Participation, CHIP, I don't recall how they got started. We had strong support from Lyle French and an administrative assistant, Diana Lilly, Sue [Susan] Rader later on.

My undergraduate was in anthropology and in culture change and development. This was interesting to sort of shake things out, the idea of developing interdisciplinary collaboration. So we worked with the students from Public Health and there were Nursing students and Pharmacy students on various projects.

DT: I know you don't recall exactly how it was started, but do you recall whether it was mostly a medical student initiative or were these students from the other health sciences at the same time thinking that this was needed?

TK: I have no accurate idea what the attitudes of the other medical students were. I think they thought we were just a bunch of crazy people. There was Belzer and me from Medicine in particular, Katie Gruenberg from Public Health, Frank Tsai, T-s-a-i from Public Health. Rich Fox was a medical student a little later. He came in. Jim Flax was a little less involved. Bob Muscala and Peter Maisley were nursing students. There were probably less than a dozen of us who were the core group of activists. I think Muscala's thing was drugs and counseling. We had a program and we'd go out and talk to high school students about sex and prevention of venereal diseases and look at all these scantily clad girl high school students, hardly being able to believe it.

[chuckles]

TK: We were only in our twenties at the time.

What else did we talk about? That poster is from that era.

DT: Oh.

TK: We didn't make that poster. We had Andy Weil come in—he was either at Harvard or National Institutes of Mental Health at the time—talking about altered states of consciousness, interesting stuff about marijuana in academic settings where marijuana was used for pain control in cancer. With kids, it works great. I think it was at Mayo they'd use it in old farmers. It induced panic because there was the expectation. You're taking this demon drug to control your pain. Weil said that he taught reform school kids how to induce hypnagogic states without drugs, how you can alter your consciousness without drugs if you practice it.

[pause]

DT: With your involvement with CHIP, do you feel like that influenced how you, then, went on to practice medicine, the fact that you'd had this collaborative experience, this socially activist experience with other members of the health team?

TK: Ummm... Off the cuff, I'd have to say not really. I remember thoracic surgery at the V.A. and we tried to do team things and we sort of bumbled around. The problem was that if it wasn't clear who was really responsible, then things could get dropped. I mean it was fine to do team effort kind of stuff, but if you didn't know who exactly who would do what... This has been a problem with communication. It's improving now. When I was down at Mayo, the residents figured out that sign out, this is huge where balls get dropped and, now, formalizing how you go about sign out and what needs to be done for the next shift. The same thing with nursing. They've changed the sign out for nursing. For a long time, they used tape recorders and it was more efficient. Patients described on tape...up and about, a nurse walks in and they're unconscious. The nurse who is coming on duty thinks, "What the hell? Is this new? Is this not new?" So they're doing sign out rounds at the bedside.

Going back to like what Freidson said, if you want to know how a doctor practices, don't look at their education, don't look at their parents, don't look at their religion. Look at the people that practice with him. That's the way it was. When I graduated from Medical School and went up to McGill, I decided, okay, I've got to get serious about learning medicine. Here I'd been sort of dinking around in Medical School and doing a whole bunch of other stuff. So I really focused on medicine up at McGill and Chapel Hill.

In the third year of medical school, I ended up in Finland sort of by accident. It was a very international time at that time. The war was going on, but travel in Europe was safe, much safer than it is now. Then, I hitchhiked across North Africa. I actually hitchhiked from Algiers to Oran in the middle of the night.

DT: Wow.

TK: Yes, middle of the night.

DT: I don't think you'd do that now.

TK: No, I'm not going anywhere near Algeria. I went down and stood on the King Hussein Bridge in between Jordan and Israel and came back to Beirut. The vice counsel at the American Embassy said, "Don't *ever* do that again."

DT: [laughter]

TK: All such crazy stuff.

I remember picking up my father from the airport one day. He was coming back from some lectures or something. He said, "If you're really interested in health services delivery, go to Finland." At that time, I believed we knew what to do, we just didn't know how to get it done, you know, the organization of medicine. I had read some stuff, for example, by Virgil Slee up at [the University of] Michigan. He pointed out that when

medicine failed to deliver, in most of the cases it wasn't that people didn't know what to do. It was that the system failed to get it done. I actually believed our professors who said, "We know what to do." I thought the biggest problem was how do you get it done? So I was very interested in the organization of medicine and stuff. My father said, "Boy, you ought to go to Finland because they have a very interesting organization of medicine." There are national mandates for the level of care, but each one of the counties has the opportunity or right to implement them how they want. So I went over there. I'd just gotten married. They sent us up to Kuopio, which is a province in east central Finland. They said, "There's this new project going on, the North Karelia Project. We don't understand anything about it, but you might be interested in it." It was, obviously, very interesting—heart disease prevention—and we've been involved with it ever since. I just got back from Helsinki ten days ago. I'm still involved with them. Much to my surprise, there's a lot we didn't know back then. We know a lot more now than we did back then about health and producing health and that kind of stuff.

After McGill, I went down to Chapel Hill. I had intended to do a Robert Wood Johnson Clinical Scholar program up at McGill, but, then, Bob and Sue Fletcher, who are now at Harvard, were up there and said, "Well, you know, you can look around. You don't have to do it at McGill." So I looked at Yale and Chapel Hill. John Cassel and his group down at Chapel Hill were very active in the issue of social determinants [of health]. If you read Cassel's "Wade Hampton Frost Lecture" and stuff, there are studies showing that sort of the same workers... They had this population that basically come out of the hills to work in the cotton spinning plants, the cotton mills. The second generation people were always healthier than the first generation no matter how much you adjusted for everything you could think of adjusting for. The theory was that understanding your culture gave you a leg up, understanding what was expected of you.

You probably appreciate this a little bit. Like, oh, the chap [Edward T. Hall] who wrote *Beyond Culture, Hidden Dimension*, and all that. Who was it that wrote it?

DT: I don't remember his name.

TK: He says, "Culture really is those things that you cannot explain." They are so tacit, so deeply engrained, you only understand when you have a culture conflict. It's like walking into a glass door. It's bam! What the hell happened? The first response is anger. If you're talking to somebody and suddenly they become angry, you know you've got a cultural issue. Nobody may be able to explain it. People can't explain their own culture because the assumptions are things that are not even questionable. We did a lot of work with the American Indians down at Mayo through the Cancer Center and the issue came up. Nobody else was interested in this question but me. The question was, "can you volitionally change cultures?" I would say the answer is "no." Your culture is those things that are unquestionable. If you can question them, you're not part of the culture. It's sort of like climbing in a hole and pulling the hatch over and, then, losing track where the hatch is. You can't get out. You simply cannot get out of your own culture...

DT: Interesting.

TK: ...because of the assumptions. They're not the unquestioned but the unquestionable assumptions.

DT: Yes.

TK: If you go out and ask a bunch of people at church, "Why do you believe in God?" They'll get really pissed at you."

DT: [chuckles]

TK: Right? If you ask a bunch of guys in the NRA [National Rifle Association], "What is it about guns?" They'll get really pissed at you because you're questioning their culture. You know, like Americans and progress. We just believe in progress. Things will get better. They always get better. They have always gotten better. That's an aside.

DT: So why McGill?

TK: I had thought of going to Montefiore [Medical School] in New York City in the social medicine residency program. My father-in-law [Richard A. Theye] was chairman of anesthesiology at Mayo, and he was on the American Board of Medical Specialties long range planning committee with John Beck, who was chief of Medicine at McGill. My wife and I used to drive down and have dinner and stay overnight with my in-laws and drink Scotch and talk about health care and health policy. Dr. Theye was very active in planning at Mayo at that time, being a department head. He, also, was active nationally in the American Board of Anesthesiology, so he was the American Board of Anesthesiology representative on the long range planning committee. He knew Beck and he was very impressed with Beck.

I was thinking about family medicine. My wife thought that was just the worst. I was thinking about family medicine or psychiatry. At that point, I was very interested in the question of community mental health defined as "why do some communities have high levels of poor mental health while others have good mental health?" But it turned out psychiatrists had no clue, no idea about that question. I mean that wasn't even a question for them because they were oriented to one patient at a time. Probably the communities with the poorest mental health are the Indian Reservations. They're stuck in a bind, they have predators and that kind of stuff, just communities of alcoholics, and it has to do with control and domination and all that kind of stuff.

So I went up to McGill to interview and I tried to interview Beck, and, then, had to start over and answer a bunch of questions. He said, "Get out of the match. We'll take you up here." I liked the idea of McGill. It was different. It was Canada. Also, at that time, like at [Johns] Hopkins [University], you didn't go home the first year. You did not leave the hospital the first year. You were expected to stay and I didn't want to do that. I was very concerned with the problem of coming to hate patients because of my training.

My favorite cartoon at the time was a *New Yorker* cartoon where these guys are waiting in line at a marquee at a theater, a big line. The marquee says something like, “This will change your life,” transform, you know. All these insects are coming out. One insect turns around and says, “Go back! Go back! We were real humans like you are.”

DT: [laughter]

TK: So that was the paradigm for me. The movie was the medical school. I was *very* concerned that it would transform me into something I did not want to be. I could see that a number of doctors and residents were, in fact transformed, where there was transference to the patient of the negative affect from the training experience. People hated the patients because they saw the patients as the source of all their dysphoria and their wrecked marriages and their this and their that. I didn’t want to do that.

At McGill, you were off for the weekend. You were off. You worked five days. Now, we, on certain rotations, took two out of five call coverage. You were either on call or you were post call. You had one day and then you were pre-call and, then, you’re on call again. So one day a week, you’re sort of either recovering or warming up to. Overall, McGill was quite a human experience. They went at it with a little more equanimity or something.

DT: You attribute that to the Canadian system of health rather than the McGill specifically?

TK: Well, I think it was the Canadian system of training. The Royal Victoria Hospital up until very recently was *the* hospital in Canada. There was a lot of pissing and moaning there or, you know, “they don’t treat us with respect.” Montreal General [Hospital] is just down the street and probably was equally as good. Toronto was developing and the University of British Columbia, so there were other... This has been an age-old problem. This occurred right in Minneapolis where some of the guys from the U and the V.A. went over to Abbott [Northwestern Hospital] and set up a program and, suddenly, you had competent physicians competing with the University.

This is part of what the University has to do today is redefine itself as unique. What can they do that the practitioners in the community can’t do? I think they’re not sure what that is.

DT: Actually, that brings up another question I wanted to ask about your experience primarily at Medical School but, also, subsequently in your career. When you were at Medical School, there were some issues affecting the Medical School more generally and kind of the medical politics in the Twin Cities at that time. Were you familiar as a student with what was going on and the fact that there was an effort to get a second medical school within in the Twin Cities, for example?

TK: I wasn’t even aware of the second medical school issue. I am aware of the recent one, where they were talking about the University of Saint Thomas having a medical

school, which is about the dumbest idea... I think the Abbott Northwestern program in internal medicine was just being organized. Then, of course, family medicine and emergency medicine were emerging specialties. Tom [Thomas] Ferris said, "In emergency medicine, all you need is a large bore needle and a jumpsuit."

DT: [chuckles]

TK: That attitude created a problem for the University. So the University, basically, abandoned emergency medicine and they said, "Let somebody else. Let Hennepin [County General Hospital] handle that or Saint Paul Ramsey [Hospital] handle that," at the time. So they lost access. Then, the family medicine programs got set up at North [Memorial Hospital] and other places. So the University lost a lot of their patient base. It was harder to get to, harder to park at the University. They were less friendly, more hostile, big issues.

DT: Just a couple years before you began as a medical student, the U had established the Department of Family Practice and Community Health. But, in those early years, there was a lot of wrangling from the local general practitioners and criticism about the way the University was running the program. Did you have any insights into any of that?

TK: I know there was a lot of... [pause] Who was the head at that time? Ed...

DT: Ciriacy?

TK: Ed Ciriacy, yes. His goal—I had talked to him—was to get practitioners out into the field, family-medicine trained practitioners in the field. I was interested in basically reorganizing the world, good or bad. He wasn't interested in reorganizing the world, reshaping. It was just get more doctors out there.

The other mentor I should mention who was really a pretty good friend was John LaBree. He may have been later when I came back. He was a great guy. He organized the outreach programs. He really worked hard. He had organized Park Nicollet [Health Services] and had come back. He was a very thoughtful cardiologist. He had been over at Saint Mary's [Hospital], too.

There was a real fight of what family medicine was. Then there was General Internal Medicine that came out. Jay Cohen once in a conference said, "Gee, we're good general internists, right?" I don't think so. I wouldn't consider myself a good general internist—a good general cardiologist, but not a good general internist. I guess this probably was more a sense when I came back after being in four years of training that a lot of the medicine faculty at the University sort of defined themselves as Renaissance men. What that meant operationally is "if it's important, I do it; and if I don't do it, it's not important." Down at Mayo, they don't have that. The nice thing about Mayo was that everybody recognized they were not competent in most areas, so you could just pick up the phone and key in five digits and talk to somebody and say, "I have a question." They'd say, "Sure, what is it?" There was that great interchange. Now, Health Partners

is the best place to work. I think they're even better than Mayo, but not for the rarer, dread diseases, but as a health system, particularly because of their focus on community, their recognition that you're well or sick in part because I'm well or sick. The community you and I live in has a *tremendous* impact on our health.

DT: Did you participate in the Rural Physicians Associate Program?

TK: No. I considered it, but that was a year out there, so I didn't do that. Yes, I just didn't want to take that year out there.

DT: This ties in with the student activism that you talked about earlier. The Medical School, or the Health Sciences more generally, had established a program for minority students in 1969...

TK: Yes.

DT: ...and were trying to recruit minority students. Were you aware of that or did you have any involvement with it or any sense of how effective they were with that program?

TK: Yes. I knew a lot of the guys who were recruited because of it. We studied with them. It was a challenge, and probably not so much because of intellect and stuff, but of sort of role models and beliefs. My father was an academic physician and my mother was a public health nurse and my sister [Jane Margaret Kottke de Vries] had gone through nursing school and my uncle was a doctor and I had a cousin who was a doctor. I knew what it was like to be a doctor. Plus, I didn't have any money hassles. I didn't have any family relying on me for income. A lot of my classmates who were African American or Indian, they either had kids or everybody else of their age cohort was out earning money for the family by that time. So of the family was sort of saying, "Well, what the hell is this? You're siphoning off resources lickety split, and what for? What is this doctoring stuff?"

Certainly Tuskegee [Institute] had come out right about then. There wasn't a great deal of trust between medicine and the African American community.

There was a... What was his name? Ellis? His last name was Ellis...maybe a surgeon, an African American surgeon.

DT: Oh, yes, Mead Cavert told me his name. Cassius Ellis.

TK: Cass Ellis, yes. He was able to crack these guys' heads. They'd come in and they'd whine and this and that about how hard it was, and he'd said, "I don't care what color you are. Unless you're a good doctor, you're not going into my community to practice." [chuckles] He was able to really kick their asses.

They couldn't cry "Racism," or anything else. He was a big guy. He was probably six [foot] four [inches]. This is my memory of him, six four, six five, and close to three hundred pounds. He was an imposing figure. When he said, "Rrrrr..."

Those kids had a lot of disadvantages that we didn't have. They lacked a lot of the advantages, and had a lot of disadvantages.

DT: It sounded like numbers-wise in those early years of the recruitment efforts, there weren't a large number of African American, Native American students. Do have any sense of how many?

TK: I can think of eight. Vince Tookenay was Native American from Schreiber, Ontario. There was a Terry Hope from New York City. I think her father was like an orthopedic surgeon or something. She was really sort of incensed that she was considered part of this deprived group, and she definitely was not deprived. She went to University of Rochester. Others were Freddie Daniels and John Bruce; Oliver Cunnigan, David Gearing, Melvin Green, Ronald Skyes, I don't know how many got through.

DT: Were there many women in your class?

TK: It was mostly males. Counting from the entering class book, there were 21. It's fifty percent women now. Yes. Maybe it was twenty percent. There weren't just one or two, but it wasn't fifty percent.

DT: I remember later in the 1970s seeing that there was a controversy about one female African American student. I can't remember her name [Marguerite Gamble], but she, I guess, had been told to leave the Medical School for academic reasons, and she filed a suit against the Medical School for discrimination, basically. I'm not sure if this would have been when you were back as a fellow?

TK: I don't think I remember, if I did it would be like my daughter says, "Falsely recovered memory."

Well, you know the other lawsuit that wasn't at Minnesota was I think [Allan] Bakke. I think it was Stanford or someplace where he sued *Regents of the University of California v. Bakke*. It was sort of like the Providence [Rhode Island] firefighters suit. [chuckles] There were comments like, "Well, he was kind of grumpy in his interviews. He shouldn't be excluded from medical school because he was grumpy." His argument was he was excluded because he was not a minority

DT: Interesting.

TK: Yes.

DT: This would have been when you were at McGill, but there was the 1975 admissions scandal because one of the state legislator's sons had been granted special admission with

a handful of other students who had only done three years of undergraduate and, then, the medical students protested vociferously and were quite effective in their protests. But this was after you were away.

TK: So I wouldn't have known about that.

DT: Did you have a sense when you were in Medical School, you and your colleagues, about concerns that there was a shortage of physicians?

TK: Yes. Our class, probably a number of us, perhaps me included, thought that we got into the Medical School simply because the class had been increased by, what, fifty percent that year? There was a huge bump in the class. Yes, we were all acutely aware that there was—quote—a shortage of doctors.

DT: Did it influence how you approached medical school at all, or how you felt about your career?

TK: Umm...I don't know. I think a number of us... I can't say whether we really felt this way or not. I don't know. I number of people sort of felt that they were in there only because of the expansion and sort of that made them kind of nervous or insecure or something like that—but everybody was insecure.

[chuckles]

TK: They were afraid of flunking out.

DT: Obviously, your father was a prominent faculty member at the time.

TK: Yes.

DT: Did you feel that his presence on the faculty in any way influenced your experience at the Medical School?

TK: [pause] Umm... If the question is did I get special treatment, I don't think so. I was always concerned that I had gotten special treatment because of it, and I needed to establish myself as a separate entity. I don't know. If you asked other people, "How did you put up with him in the class?"...

DT: [laughter]

TK: ...it's quite possible.

DT: I wasn't necessarily thinking special treatment. I was curious because obviously you were an activist within the medical student community, so I wondered if you somehow felt more able to do that because your father was on faculty.

TK: I don't think so. It was only very much later that I was all chatty with my father. I was not chatty with my father growing up in fact, because I never knew when the cannon was going to go off. It was better not to be around, better to be out of range.

DT: [chuckles]

TK: So the discussions I had about medicine would be with my father-in-law, much more. We'd go over and we'd have dinner with my parents every Sunday, but we didn't really discuss the Medical School. There were no heavy discussions.

[laughter] Going back to the earlier question... I remember I had been talking to my mother about careers. One day, we were having Sunday dinner, and my father put down his fork and, then, he put down his knife, and he said, "Mother tells me you're *not* going to medical school...rrrr, rrrrr."

[laughter]

TK: "Well, I'm thinking about anthropology." "Anthropologists are usually broke." I always sell myself as somewhat of an ascetic. You know, we all have our lies about ourselves, our self-myths. Yes. I suppose... Well, I was able to borrow his car, take it out of the U garage if I'd ask him or if he wasn't looking. On at least one occasion, he was expecting to go to the airport and his car was gone.

DT: [laughter]

TK: I think he tolerated... My impression of the way he ran his department was if you had a good idea and you were willing to run with it, he'd let you do it. If you consider the people who were in the department at the time... Jim [James R.] Boen had been through there; he was in biostatistics. Pearl Rosenberg. There was another guy, a psychologist, Allan... I can't remember his name. Coming in physical medicine, which was very new, they had the polios. They had the spinal cords. They had the cerebral palsies. They were willing to try a lot of stuff, and he was pretty willing to support people and let them try things.

DT: It was my sense from reading the archival material that he's a real leader nationally within physical medicine...

TK: Oh, yes, sure.

DT: ...and rehab, and, then, obviously, all that he did at the University, as well.

TK: Yes. Yes, he organized the department. Ray Amberg was his guardian, his rabbi, or whatever. Ray Amberg was interested in physical medicine, so it happened. My father put in the energy and Amberg set the agenda.

Incidentally, this is what happened with the stuff we were doing in North Karelia. Martti [J.] Karvonen was the old guy who said, “Hey, we don’t have to have this heart disease” and Pekka Puska was the young guy with the energy. That’s the way it is. You can go all the way back to Martin Luther when Frederick of Prussia was pissed off at the Pope and protected Luther. One hundred years before, [John] Huss got burned at the stake for the same stuff. So it’s always good to have a patron. Even the baboons do that, the little baboon and the big baboon. The big baboon is going “Rrrr,” but the little baboon gets to do some things.

DT: A few of the people that I’ve spoken with who were on the faculty or in the dean’s office in the 1960s have commented that your father—I think even in the voice mail you left me—had really close connections with Democratic congressional members. I did ask your father about this, and he wasn’t able to elaborate too much on that. I wonder if you have anything to say about those connections that he had and how he was able to achieve so much for the University from the state and nationally.

TK: Well, yes, yes. Wow. He and my mother lived down the street from Hubert and Muriel Humphrey in the 1940s. They used to go down and drink coffee together. See, Maurice Visscher was probably the *grand patron*, too. Visscher liked the idea of group health. It all comes around here; you know Health Partners is Group Health. So Humphrey would come over to Physiology and talk about these ideas. Visscher was there, and, then, my father was there. I don’t know exactly when my father met Humphrey, but it was probably before he [Humphrey] was mayor [of Minneapolis]. They were very good friends. In fact, Muriel Humphrey and my mother shared the same hospital room when Skip Humphrey [Hubert H. Humphrey III] and my sister were born [1942], so they were that close.

Then, there were these RT-2 grants for rehabilitation. Humphrey was very effective in the [United States] Senate, so I think Humphrey was the source of the federal support

DT: One of my interviewees said it must be the children’s rehab...

TK: Yes.

DT: ...building. That was your father’s building that he basically singlehandedly got the money for that.

TK: Yes. I don’t think that would be disputed. That was part of the grant program. I won’t say there was a lot of money; there was money.

A short day for my father was Sunday; it was only eight hours. Typically, he’d leave the house at seven-fifteen in the morning and get home at probably a quarter to seven or seven at night, and, frequently, go back to work at the office till ten or work at home till ten. He always worked at least or ten hours on Saturdays, and usually eight hours on Sunday. For him, the job was a seven-day-a-week job. He worked tremendously hard.

DT: That's got to be difficult for a family.

TK: Well, yes. You know... But he had a strong hand at home.

[chuckles]

TK: You did not discuss things with him.

DT: How did you find, when you were either in Medical School or when you came back for your cardiology training, relations were with some of the affiliated hospitals and, just in general, the local medical community?

TK: Cardiology trained at the V.A., Hennepin, Ramsey, and the U. I don't know much about the politics. Ramsey was very active, was a very nice place to train. The V.A. was [a] nice [place] to train. A number of docs had left the U and the V.A. to set up Minneapolis Cardiology, the Minneapolis Heart Institute. There was...

[break in the interview]

TK: One of the problems the University had adjusting was the feeling entitled. I mean it seemed crazy to me at the time...somebody saying—I think it was David Brown—"The practitioners in the community have an obligation to send us their patients." Well... The contract between the patient and the physician is a personal contract. The obligation of the physician is to the patient. This is not Abraham and Isaac. The obligation is to the patient, the best care for the patient. If the University has to compete, there has to be some value. There frequently is or in the past there has been. But, there's no obligation on the part of the practitioner to send patients to the University.

DT: I've interviewed a few people who were in private practice in the 1950s and 1960s and 1970s, and one of the criticisms they had of the University physicians was that were maybe more interested in their research than they were in the clinical care.

TK: For sure. For sure, yes. In fact that Jay Cohen had this that the line up was this way—vertically—where the researchers are here and you gradually got down to primary care physicians down at the bottom of the heap. I see it as the spectrum is horizontal. Yes, we need researchers and we need primary care physicians. We need cardiologists. But it's not who's better than the other. A lot of the attitude was, well, we can do everything those guys can do plus more. That was the big tension between like Family Medicine, Family Medicine trying to establish themselves as a particular specialty. You still see that today, that the family physicians *are* specialists. And they are.

DT: Another thing I'm curious about is... We talked a little bit about the state and how difficult it has been for the Medical School to secure money from the state. It's a two part question, really. What was your sense of the Medical School's relationship with the

state during the 1970s, and, the second part being, did you see the local physicians having some kind of influence on the state's attitude to the University?

TK: I don't think we were aware of that. I think we just lacked awareness, sort of like kids lack awareness of their parents' financial problems. You weren't sensitive to that. You could consider it was our fault that we were but, also, I think that...

I remember Westerman at the very first orientation. He said, "Society invests more in doctors than in any other profession, than Air Force pilots." He compared the cost of training of fighter pilots. We were special, but it also gave us a sense of entitlement, that we were very special. You know, we're special.

[chuckles]

TK: Treat us specially. We deserve special treatment. You know, you don't have a lot of time to sit around and talk to everybody, but I don't recall that we were really strongly invited... Students were trying to force their way in the door at that time...the sit down strikes. Up to that time the academic paradigm was, you come, do as we say, get your degree and you go out.

DT: During the 1970s and then when you were at Mayo, how did you find the relationships were between the Medical School and the Mayo Clinic?

TK: Mayo is sort of... They do a nice job of portraying themselves as somewhat magical, even in the Health Care Reform...oh, the Mayo Model. Obviously, the Medical School didn't like the idea that Mayo got twice the capitation for medical students. When I was at Mayo, there weren't really hurt feelings, but there was this... Mayo had been part of the graduate program at the University of Minnesota. Then they split off, I think probably because they thought they weren't getting value. I wasn't part of that decision at all, but that's what people said. There's no value here, and they wanted to establish their own brand and stuff. When I was down there, every once in a while investigators from the U would call us up and say, "Here, can you do something for us for free?" We didn't have extra money floating around there either. There's a lot of collaboration, good collaboration that goes on, but there's also a lot of misunderstanding that goes on, that the other guy ought to do it for free. Do it for me.

DT: What was your experience like when you returned to the Medical School as... Well, I guess you did your cardiology training and, then, you were on faculty for about six years?

TK: Yes.

DT: What was that experience like as a faculty member?

TK: I came on with a Preventive Cardiology Academic Award, which is a federal KO7 or something. It's basically a training grant. The perception at the NIH [National

Institutes of Health] at the time, which was accurate, was that there wasn't enough training for preventive cardiology in the curriculum. Henry Blackburn helped me get the award; he helped me write it and negotiate with Jay Cohen. Before I applied, I think Henry Blackburn in Public Health actually paid my fellowship for training in cardiology. He had to negotiate with Jay, which was fairly unique. I got the Preventive Cardiology Academic Award, another RO1, the doctors helping smokers trial. But they said, "Okay, you can have the Preventive Cardiology Academic Award, but you can't teach medical students. You can't have time in the curriculum." So I did teach a course called "Studying the study and testing the test," which was about critical reading of the literature. I recruited a bunch of people to lead discussion groups about the science. How do you look at science? How do you read an article and figure out if it's true or not?

Not having class time was sort of a blessing because then I started working with practicing physicians and asking, "Why can't physicians get done what they want to do?"—I told you about the sociologist who recommended Freidson, and looking at the environment—I recruited a bunch of volunteer docs who were very interested in helping their patients quit smoking, but they seemed not to be able to get the job done. We asked them all these things, what's important, duh, duh, duh, and at the end, we said, "Is there anything else?" A bunch of them wrote in and said, "I don't have time to do it." What! What is this? There's universal agreement that smoking kills, and they don't have time? Well, time is somebody else's priority. Is it part of your job description? Do you have the resources? Do you have the support, all those kinds of things?

So we spent a lot of time in the Preventive Cardiology Academic Award and the other studies working with community physicians, particularly primary care docs in private practice, trying to understand how to organize practice so they could provide preventive services. That's sort of been a career theme.

DT: It sounds like when you're talking about preventative health, you're talking about collaborative efforts obviously with public health. Did you have a lot of interaction or did you work in an integrated way with, say, nursing and public health or was this primarily a physician-oriented approach?

TK: The stuff at the U was... Well, the clinical trial of doctors helping smokers was just medicine. We didn't work with the Nursing School. We didn't work with any of other academic units. In fact, we were way out in the field. We worked with the rest of the staff. We came to appreciate how important it was to involve *all* of the staff so they understood what the heck was going on. I was president for a while of the Minnesota Smoke-Free Coalition, and we worked with the [Minnesota] Public Health Department and came up with a paper, I think in 1981, "The Minnesota Plan for Non-Smoking and Health." Andy Dean, over at the State Health Department, was on that. Peggy Craig was very active in the Minnesota Medical Association. She was a regent, and she just happened, also, to be a classmate of my father in Medical School. I didn't know that until many years later. Stu [A. Stuart] Hanson, who was at Park Nicollet, was very active

in tobacco control. So the tobacco control effort was a big part of the Preventive Cardiology Academic Award.

We were sort of luckily denied access to the medical students. I'd still say that was good because if you design the work setting and the work process the way you want to, put the person into it... It does help if they understand what the expectations are when they get into it. That's how I felt. If you don't have the right work setting and processes in place, all the training in the world won't help.

DT: This, obviously then, is a focus on understanding, as you say, the work processes and the way that work is organized and structured. How were receptive were other faculty members to that approach?

TK: Umm... Do you mean when I was on the faculty?

DT: Yes.

TK: I was viewed as a space-occupying lesion.

Basically, when I got the RO1, Tom Ferris said, "You have the grant, but we do not have space for you." So I went over to Tony [Anton] Potami and he said, "We got this grant. We're going to find space for you." Neither Jay Cohen nor Tom Ferris were supportive. They, at best, tolerated me.

I came up for promotion and Jay said, "Well, I'm going to have a real"—I had a bunch of publications—"hard time supporting this." I had been on an American College of Cardiology Committee with Robert L. Frye, who was chairman of Cardiology at that time at Mayo. I remember talking to Jay, and I said, "We're really interested in this whole idea of population health." He said, "Well, we don't have a population here." I said, "Jay, this is a land-grant university. We've got the state." He said, "Well, we choose not to see it that way." The core statement of why the University was in trouble with the legislature: "We choose not to recognize that you give us support. We choose not to say, 'Thank you.'"

I was on the United States Preventive Services Task Force at the time. I got a call from Dr. L. Joseph Melton at Mayo Clinic Rochester. I had interviewed down at Mayo before, and we agreed that the time wasn't right. I felt that I hadn't established myself enough and that I would have been too molded by Mayo. They said, "Well, you can compete for twenty percent research time," but I didn't want to go into full time practice. They said, "Oh, Mayo is great. Rochester is a great place to raise kids." Well, I was thinking maybe I'd move to Montreal, move back to Montreal.

Several years later I got a call and they said, "Hey, we're looking for a cardiac epidemiologist, duh, duh, duh. Got any ideas?" I said, "No, but let me come down and talk to you and I'll see what you need." Being naïve, I had no idea what that meant, what the question really was. I went down there and gave a talk on the systematic practice of

preventive cardiology. We had been working with the question, “what are the factors that need to be in place, environmental factors or within the physician?”

Half way through this lecture, I had this, I guess you would call it, epiphany. I said, “This is the place to be, because these guys *want* to practice medicine.” You can do *everything* you want and if a doctor *doesn't* want to practice medicine, you're not going to be able to change their practice. My definition of a professional is somebody who can always think of one more reason *not* to do what you want them to do that you can think of why they should do it. They say, “Well, the patients don't want it. Well, it's not part of my job. It's not interesting. Academically, it's a dead end.” They can always think of one other reason to trump your argument. To work with physicians to figure out how to deliver preventive services, you need somebody who wants to do it. I'll probably regret saying this, but I had the general feeling...nobody at the U wanted to practice medicine. All they wanted to do was their research. So the practice was withering. I had days on service when I was on the faculty where I had four residents and *no* patients...no patients in the hospital on my service. Yes. [John] Najarian had gotten so into transplants that they didn't have any general surgeon patients. They were all being done at Abbott or North [Memorial Medical Center] or Regions [Hospital] and now at Mercy [Hospital] and [Fairview] Southdale [Hospital] and [Health East] Woodwinds.

DT: The fact that your research focused so much on getting practitioners to be better at their practice is why your other faculty members didn't really consider what you did as...?

TK: Well, everybody did their own thing at the U. Everybody had their own lab. My lab was out in the community. They could care... I gave grand rounds on smoking interventions, and they said, “You really ought to work with the kids.” What that meant is basically, “Go play in the street. I don't see kids, therefore, it's not my problem. If I'm not a pediatrician, then you go away.” I've gotten that from other people, too. Down at Mayo in the community, they say, “Go work with the Somalis.” There's 600 Somalis in a population of 120,000, plus, what do you know about diffusion of innovations? It's downhill. It's true, you do have to work with minorities if you want minorities to benefit from various programs, you have to work with them. But the population attributable risk is in the white community in Olmsted County. With less than one percent minority, they could all die tomorrow and you wouldn't even see a blip on the radar screen.

DT: Do you recall, while you were on the faculty at the Medical School, any issues that were particularly prominent for the Medical School during your time here?

TK: When I was on the faculty or a student?

DT: Both, actually.

TK: As student, it was the reorganization of this whole thing of the dean and directors, the reorganization of services and trying to figure out what that meant, and this team practice. I guess I don't have a lot to say about when I was on the faculty. It was who

was going to get promoted and this and that, and this idea of emergency services, that all you needed was a large bore catheter and a jumpsuit. I'm not being very nice to those guys, but there was a real smugness. [chuckles] You've heard that from other places.

DT: Oh, yes. [chuckles]

TK: Today, it breaks my heart. The University of Minnesota is a second-tier medical school. It is not a first-tier medical school anymore. I will say that wasn't my father's fault. Eighty-hour weeks were short weeks for him. But there was a certain smugness, which was too bad. I actually don't know what a first-rank medical school is. What do they turn out? I really haven't had much contact with them recently, so I can't comment on them, but you really need to interview Mick Belzer. He's very active and, hopefully, will tell you some things. He's very committed.

DT: In terms of the reorganization... I realize as a student you didn't have the same exposure to what the motivations were for the reorganization, but did you get a sense that the reorganization was a good thing, that it benefitted the health sciences?

TK: Yes, I think so. We're doing studies here of pharmacists managing blood pressure, this one-stop shopping, and pharmacists managing cholesterol. My nurses on my care teams are critical, having competent nurses. They have a question, I say, "Do it this way." They're in direct contact with the patient; otherwise, I'd have to make all the calls. Yes, this is modern medicine.

An example, I could give is that Mayo has the best heart transplant outcomes in the world, and the reason is every morning they sit down as a team and discuss each patient. According to Ed [Edward] Wagner and his chronic care model, (paradoxically, from the opinion of most doctors,) the most efficient and effective care teams are those that meet the most. You've probably heard this in operating rooms, reducing errors where everybody introduces themselves and checks out, so that everybody has spoken up and their role is recognized. Without these teams, we could not deliver the care that we deliver today. It's just too sophisticated.

DT: You already mentioned this that there's been a lot of discussion of the Mayo model. Also I know Atul Gawande, his most recent book, *The Checklist Manifesto* [: *How to Get Things Right*] relates to this.

TK: Yes.

DT: It's been a lot on MPR [Minnesota Public Radio]...

TK: Yes, yes.

DT: ...in recent times.

Do you have anything else you'd like to share about your experiences?

TK: No, I think I've talked about all I ought to talk about, and probably a little more.

DT: [chuckles]

You mentioned Mick Belzer. Is there anyone else that you would recommend that I speak with?

TK: I don't think so. I think Mick is the one guy that... He's been chief of staff down at Hennepin for years. He was very young. He's an oncologist, went to Medical School with me, and then went down to North Carolina and, then, I think, out to Los Angeles for a while and came back and was practicing oncology. When the position of chief of staff was opened, he was very young at that time, but ran for it, and has been chief of staff since. He also does a lot of teaching and has a lot of awareness of the medical students currently. He quotes surveys that show that they're much more interested in lifestyle; I mean their own lifestyles, which is fine.

We are thinking this through, that the guys who... Life my father-in-law had been in Korea or in Japan during the Korean War. The guys who came out of World War II, they were in the field for years. So having Saturday afternoon and Sunday off probably seemed just rosy. Compared to us, we think, gotta work Saturday mornings? You see your patients and you sit around and discuss things for a couple of hours. What the hell? What kind of nutty stuff is that?

DT: [chuckles]

TK: It's sort of getting back to reality here of, oh, you do have a family. When you think from the perspective of people who were in the European or the Pacific Theater for two or three years...yes, being home a day and a half a week looks pretty cushy.

DT: Yes, that's a really interesting point.

TK: I think that's where it came from.

The other thing about the lists... The list thing is very interesting. When I was in medical school, basically there was a very strong pushback against standing orders. You were supposed to reinvent every time. Standing orders were for mental midgets. The departments were small and the department head *ran the ship*. "This is the way you did things." It was "my way or the highway," that kind of stuff. So to unfreeze procedures, you have to say, "We've got to get away from standing orders." So you could rethink things.

I was talking to one of the surgeons once. We were flying around and discussed how Owen Wangenstein came up with this gastric freeze. People laughed at it. What this surgeon said was that the gastric freeze didn't work, but what Wangenstein gave the surgical community, and patients in fact, was the justification *not* to do a gastrectomy.

Up to that time, not to do a gastrectomy for a bleeding ulcer was considered malpractice, unethical. Wangenstein was another tremendously creative guy. I never met him. He let people rethink things.

So I think that was the pushback against the standing orders. With standing orders, you do it this way. Not having standing orders let you rethink. Then we obviously see that if you have to reinvent every time, you're likely to screw up. Humans...if you have to write down a hundred numbers, you'll write five of them wrong, at least. We know that... We have done this work, too, that if you show practitioners a series of cases, they'll agree with themselves about sixty percent of the time.

That's about it.

DT: Well, thank you so much. This has been very interesting and helpful.

TK: Good!

[End of the Interview]

Transcribed by Beverly Hermes

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