John Westerman, MHA
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

John Westerman was born and raised in Minneapolis, Minnesota. After earning a bachelor of science in law from the University of Minnesota in 1954 and then attending law school for two years, he was called up as a member of the ROTC to serve in the Air Force. When he returned, he took additional coursework and earned a bachelor of business administration with a major in finance in 1958. He then attended the University of Minnesota for his Masters in Hospital Administration, which he earned in 1960. He then completed his administrative residency at University Hospital under Ray Amberg from 1959 to 1961. From 1961 to 1964, he served as assistant administrator, in a position akin to chief operating officer, at Strong Memorial Hospital in Rochester, New York, part of Rochester University. Westerman returned to the University of Minnesota to work with Dr. Richard Magraw, under Dean Robert Howard, on expanding the Comprehensive Clinic. As the project grew, he transferred to President O. Meredith Wilson's office as an executive secretary, serving as the coordinator of the Committee for Long Range Planning in the Health Sciences. After serving in this position from 1964 to 1966, he took over as general director of University Hospitals and Clinics in November of 1966. He served in this position until 1982. He then moved to Pittsburgh, PA to serve as president and CEO of Allgheny Health Services from 1982 to 1985. From 1985 to 1992, he served as president and CEO of The Hospital of the Good Samaritan, part of the University of California system, in Los Angeles, CA. He served as interim president for the Association of University Programs in Health Administration in Arlington, VA in 1993, and then moved to Hawaii where he served as CEO of Hilo Medical Center from 1993 to 1996 and then CEO of Hawaii Health Systems Corporation from 1996 to 1997. He continues to serve on a number of boards and trusts within the health care industry.

Interview Abstract

Westerman begins by discussing his childhood and youth in Minneapolis. He describes his time in the US Air Force and in Tachikawa, Japan. He discusses his time as a student in the Masters in Hospital Administration program and his interactions with James Hamilton and James Stephan. He describes Ray Amberg and other University Hospital administrators. He discusses being CEO of Strong Memorial Hospital and working at the University of Minnesota Hospitals. He describes the physical reorganization of the Health Sciences and the reputation of the PhD programs in other parts of the country. He discusses collaborations between the Mayo Clinic and the University of Minnesota. He describes the Hospital's referral system. Westerman discusses the atmosphere of the Hospital and its relationship with the Mayo Clinic in Rochester, MN. He discusses nursing at the Hospital and the influence of Marie Manthey and Florence Julian. He also discusses the role of Pharmacy and having pharmacy students in the Hospital. Westerman discusses abortions at the University Hospital. He also describes the increasingly competitive hospital marketplace in the 1970s. Finally, he discusses the Consortium of University Hospitals.

Interview with John Westerman

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at John Westerman's Home In Ponte Vedra Beach, Florida

Interviewed on April 20, 2012

John Westerman - JW
Dominique Tobbell - DT

DT: I didn't realize there was a Mayo Clinic down here.

JW: Most people don't. They do a wonderful business and they're very shrewd about blending in with the community.

The University of Minnesota did a site visit to Mayo [Clinic in Rochester, Minnesota] to [consult with Mayo representatives] about starting a medical school. That was quite interesting. [Our group was quite supportive of the medical school concept.] Why I was on it, I'll never know.

DT: Do you have any questions before we get started?

JW: I'll just make a general observation that I read a lot of history and I read a lot of science. Memory has come under a great deal of scrutiny, as you know, being an historian.

DT: Yes

JW: In fact, in case after case, police annals are being overturned, because of a flawed eyewitness account from fifteen years ago. So anything I say, I will try to document.

DT: Sure. That's great. That's fantastic. That's always the long caveat with oral history, that memories are fallible, but, hopefully, by interviewing enough people and combining it with the documents, we can…

JW: You can get a number of perspectives on things. Even looking back on this, I can think of people that have quite different perspectives on what went on…

DT: [chuckles]

JW: …from Wesley Spink and Lyle [French] and [Frederic "Fritz"] Kottke.

DT: I did actually interview Kottke, but he was not very forthcoming. I don't know if it was memory problems or he just was not very talkative.

JW: Hard to say. Fritz had his own world. He was close to [Hubert H.] Humphrey, was successful at getting money for his rehab program. He considered Lyle kind of a card-carrying neurosurgeon. When he saw Lyle blossom and the Academic Health Sciences come together, his thought, I think was a little bit, hey, that's what I do, physical medicine, occupational therapy, rehab nurses. Now, I'm just small potatoes. So he never was very supportive of Lyle and what was going on [the creation of the Health Sciences organization].

DT: That's interesting. That's a good perspective.

Well, to get us formally started. Perhaps, you could just tell me a little bit about where you were born and raised and your educational background.

JW: Sure. In fact, before you leave, I'll give you a CV—I haven't done a CV [curriculum vitae] for years but my last one—which will help.

DT: Excellent. Yes.

JW: You may have to copy it, I don't know, but that's okay.

[I was] born and raised in Minneapolis. My grandfathers…one was an engineer for Honeywell and one was a publisher in Omaha [Nebraska], a Danish newspaper, *Der Dankse Tag.* I went through public school in South Minneapolis, a very interesting, integrated neighborhood. South Minneapolis was the first place that had a large Catholic base around Annunciation Parish and, then, it had a large Jewish base. Jewish people of some economic stature moved from North Minneapolis to South Minneapolis. So it was a very integrated neighborhood with the exception, of course, of African Americans. I skipped a couple grades, because of the war years. I graduated from high school at sixteen and was determined to go away to college. Finally, it dawned on me that at sixteen, I'd better go to the University of Minnesota for a couple of years.

[chuckles]

JW: I started out in pre-dent [pre-dental]. My father had a large dental practice. He was also head of dentistry at the old Minneapolis General Hospital. In that capacity and even

before, he had a lot of friends at the [*Minneapolis*] *Star Journal* or *Tribune*, whatever it was called back then. So I remember growing up, my folks would let me sit around and listen to Joyce Swan [publisher] and all these people chat about world affairs and, particularly, President [Franklin D.] Roosevelt, whom they were not adamantly against, but they weren't too pleased about a third term. A lot of them seemed to be for [Wendell] Wilkie. All this talk in very reasoned, measured tones, which I found interesting, which one doesn't find very often today.

I switched then to pre-law, because I liked the courses. Then, after two years, I went into law school and into the ROTC [Reserve Officers Training Corps]. Remember, at that time, it was Korean War. I enjoyed law school very much, but I didn't want to be a lawyer. A trial lawyer really turned me off. What I discovered was people kept trying to shove me into these things I didn't want to do particularly. My father didn't influence me about dentistry; that was my choice. But in law school, there were a lot of people pushing me there. Then Professor Ben Sutton [of the Business School] wanted me to go into banking. Then, General Waldron, when I was in the Air Force, wanted me to go back to flight school. Then, Doctor [John] Romano wanted to send me to medical school when I worked at the University of Rochester [New York], because he said I had an unusual capacity for intimacy he hadn't seen very often and he would pay for it if I would take a psychiatric residency. Of course, by that time, I had four children.

[chuckles]

JW: Through that process, I discovered that I liked working with groups and organizations. That seemed to come easy for me.

I expected to go into the Air Force in June 1954 [but didn't receive orders until June 1955]. I was married in May 1955. So I went to business school in 1955 after graduating a two-year law degree in 1954. In business school, I doubled up. I almost got my business degree in 1955. I was twelve credits short. I took two correspondence courses in the Air Force. I went into the Air Force then thinking, well, it might be fun to be a pilot and an investor. [chuckles] We got out of pre-flight and they said, "Oh, by the way, we're reassigning half of you. You can go anyplace in the world." We said, "What?" We had no more planes. We only had planes for half a class. All my buddies that went in ahead of me in 1954 got to go through flight school, but I didn't [because of post-Korean War Department of Defense budget cuts]. My wife and myself thought about it and decided, why don't we go to Asia? Chances are greater we'll go to Europe on our own later in life. We were stationed in Tachikawa, Japan, for three years.

There, I came under the influence of some lawyers, some people in what they called JAG [Judge Advocate General Corps]. They got me transferred out of my squadron to the legal office, because they needed a base claims officer and I didn't need a law degree to do that. Then, I tried some cases, and botched them up terribly. [chuckles] But it was a good experience. These guys…one was on the *Harvard Law Review* and the other was… Have you ever heard of no-fault auto insurance?

DT: Yes.

JW: He was the co-author of that, Jeffrey O'Connell. We were social friends first and, then, they got me into their JAG office. So that was a very good experience. I think, again, by hanging out with those people [from JAG, one learned to appreciate the upside of being in the Air Force and to view operating issues in a more detached manner]. Others used to love to sit around the officer's club making fun of the Air Force or the Department of Defense and civilians working for the Air Force.

They taught me to keep my mouth shut, which I learned being younger than everyone growing up, but, also, to always look at the other person's point of view. Career officers appreciated this mature approach. It just wasn't good sense to make fun of them. You didn't have to like them, but you didn't have to comment on them either.

I was narrowing in on what I wanted to do when I got out of the Air Force. I thought very much of being a city manager.

One of the things that puzzles me today is the lack of innovative approaches in government organization and administration. I've been on the Accreditation Joint Commission, been on the accreditation team for graduate health administration. I've been acting president of AUPHA [Association of University Programs in Health Administration]. I'm conditioned to define issues and propose solutions. I think there are, perhaps, sixty accredited public administration/government/not-for-profit graduate programs and, they do not appear to have come up with a model for streamlining government. Whereas, in health management, oh, we've got the for-profit systems, big systems to little systems. There is constant change and graduate programs and health delivery organizations are always experimenting, always thinking about better ways to organize and deliver health care. I don't understand…well, I do understand how difficult it is to bring about change in the public sector.

[laughter]

I thought as city manager, you've got to have just the right balance to make that thing work. You don't have control over many of the variables.

DT: What were your experiences like then as an MHA [Masters in Hospital Administration] student? Were there notable faculty that you remember?

JW: The premier person was James [A.] Hamilton, who was a very powerful personality. He came from Amos Tuck [Amos Tuck School of Business Administration, Dartmouth College, New York, New York] and started the program.

What I do remember is I was elected class secretary. Why, I don't know. I was awfully busy. I was in the Air Force Reserves and I was one of two people in the class that worked. You weren't supposed to work and I worked Friday night and Saturday night from eleven to seven. We had school class on Saturday. Ahh! At any rate, we were

primarily veterans and kind of a different bunch than they'd had before. There was kind of a rah-rah spirit, you know, and do as we tell you to do. I've forgotten what Hamilton called us, something like the ornery class. As class secretary, I canvassed them and wrote a report about what we liked and didn't like about the program and what needed improvement. At first, Hamilton was not happy, but then he was. We talked about it. The trouble was I didn't have the energy to follow up the second year. They had the class secretary and the faculty meet once a year back then. I didn't have the energy to send out another survey. I was busy myself, so I couldn't see what changes they had made. Mister Hamilton didn't like the fact that they didn't give me credit for the changes that were made, which was fair enough.

[break in the interview]

DT: You did your administrative residency at University Hospital. Is that right?

JW: Yes. I signed up for Minneapolis General [Hospital]. The administrator there, Donald Smith, took another job. I'm not sure they had picked anyone yet, so they assigned me to the University [Hospital], which I think had been reserved for foreign students. Mister Hamilton and Mister [Ray] Amberg didn't like each other very much. There seemed to be some conflict. So Mister Amberg was happy to get a normal American boy.

The man who followed me, interestingly enough, was San Chan Kim. I was just with him three years ago, visiting him in Korea. He only went to the program because it was the only graduate program open to him at that time. He knew he couldn't advance in Korean society without an American degree. He had no interest in health particularly, but as he followed me there, my wife and myself took him under our wing and had him out to our house. He's a very nice man. Well, he became the president of the fifth largest bank in Korea, Commerce Bank or something like that. We had a wonderful day together with my son who was teaching over there.

He made an interesting comment that you don't hear—it drives me crazy—about North Korea and South Korea reunification. He had a driver. [chuckles] We were going someplace and I said, "What's the Reunification Center up to?" He said, "It's a joke." I said, "What?" He said, "We haven't seen any relatives there for fifty, sixty years. It's a game. The last thing China wants is reunification and a burgeoning democracy on their frontier. China is not going to let it go south. The south isn't going to go north. So it's just one great big joke." But Americans buy into it. The State Department buys into it time after time after time.

DT: [chuckles]

JW: Mister Amberg and Miss [Gertrude] Gilman, his assistant, couldn't have been more gracious.

Mister Amberg gave me many interesting assignments. I could do some writing. Mister Amberg hosted a meeting of University Hospitals' Executive Council [UHEC] in 1961. [UHEC was composed of five, big ten hospitals in addition to University Hospital Cleveland, University of Chicago Hospital, and Strong Memorial of the University of Rochester, New York.] Mister Amberg had me prepare a paper for this conference coming up. Ed Crosby was there, who was then the Executive Director of the American Hospital Association. Doctor Crosby liked the paper and selected me for a later assignment.

Mister Amberg kept me on a year after I finished the residency and he and Doctor Crosby sent me out to Washington, the State of Washington. The question they were puzzled by is that other states had so many hospital beds per population, but Washington had far fewer and more long-term beds. They wondered if that was the pattern of the future and what did people think of it. So they flew me out to Seattle to do the story. I remember John Bigelow was the publisher of the *Seattle-Post-Intelligencer*. His father had been ambassador to Russia, so we had a long talk about Russia and what was going on, which was very exciting then, of course, in 1961.

That was a great experience at Minnesota. I was exposed to a lot of people. Mister Amberg always included me. He was elected president of the American Hospital Association and Doctor Crosby was the full-time executive. Mister Amberg was very kind and included me in a lot of the discussions and luncheons with these important people as they came through.

One of the people I met through the many meetings was Doctor Robert Berg. Berg was the CEO [chief executive officer] and chairman of Preventive Medicine at the University of Rochester, Strong Memorial Hospital. So from the fall of 1961 to the fall of 1964, we moved to New York, Upstate. I worked as assistant administrator at Strong Memorial Hospital. That was a wonderful experience. I thought I was a millionaire, because I went from $5400 to $7500.

DT: [laughter]

JW: Do you want me to keep rambling?

DT: This is fine. Yes.

JW: Okay. I had a niche. It was really a wonderful experience. I, essentially, was the chief operating officer of Strong Memorial Hospital, which was one of that group of Ivy League hospitals that were part of the Council of Teaching Hospitals [CTH] where a group of CEOs met periodically to share the best practices and problem solve. I was twenty-eight and didn't quite realize that what I was doing was the chief operating officer. People said, "Geez, you're the chief operating officer." I said, "No, I'm just the assistant administrator." I thought that was wonderful experience, that I could be doing that forever.

Meanwhile, back at Minnesota, Doctor Richard Magraw had set up a very exciting academic program for medical students called the Comprehensive Clinic. He wanted to see how the comprehensive clinic would work if the outpatient clinic directors had a new building. Doctor Magraw got a grant from the Hill Family Foundation and hired me. I was really on easy street, you know, with some money. [chuckles] In that capacity, I started out working for Doctor Magraw and the outpatient clinic directors: Jim Carey in Medicine and Paul Quie in Pediatrics, the whole gang of directors representing all the clinical specialties.

At the same time, there was a huge push in the mid 1960s with Medicare and Medicaid, passed in 1965, 1966. People were saying, "Holy cow, whose going to take care of these people?" With that, Minnesota's response was "We'll expand the class size." Nursing said, "We'll expand." Each unit of the College of Medical Sciences, plus Dentistry and Pharmacy had expansion goals. President Meredith Wilson found he had his school requests for building plans among the health sciences, but the plans were not coordinated. President Wilson then said—in early 1965—"Will you agree to coordinated planning?" No one even talked about the health sciences then. "Hmmm, how do I know I'll get a fair shake," said Erwin [M.] Schaffer [Dean of Dentistry] and Larry [Lawrence] Weaver [Dean of Pharmacy]. President Wilson assured them. One of the ways he assured them was the wonderful Elmer Learn.

Is he still alive?

DT: Yes. I interviewed him about three years ago.

JW: Ah! Boy, you've been on this a long time.

DT: [chuckles]

JW: He said, "I'm going to appoint my assistant, Elmer Learn, as chairman. He has no favoritism among any of you. He didn't even know you. We'll use Westerman, the Hill Foundation planning person." So, they agreed and we set up the long-range planning committee for the health sciences and folded the Hill Family Foundation into that planning process. Al Heckman, Executive Secretary, and the Hill Family Foundation were pleased. Now, it became a bigger thing than just the outpatient. That went very well, thanks to Elmer and thanks to the individual chairs. Each school had a planning committee with cross representation from other health science units. The individual committees were coordinated by a steering committee comprised of the chair of each sub-committee. The group got along very well.

At the end of their report, legislation came out and many of us worked very closely with Senator [Hubert H.] Humphrey. He appointed us to his committees. There was a big heavy-set guy, Neal Peterson, on Humphrey's staff and they kind of took this under their wing. As it turned out, we applied for and got something like a $16-million grant, one of the first ones under the Student Expansion Act of such and such [Health Professional Educational Assistance Act]. We quickly came back and got another $16-, 17-million,

which raised the ire of our colleagues in other health sciences. At the time, I think Bill Stewart, Surgeon General, who was a friend of Magraw's… He was instrumental in steering us. He said to the other universities, "Well, we're only going to look at health sciences. We're not going to be a referee of school's jurisdictional fights. I don't want to have things up here from the Medical School, the Hospital, Nursing, Dentistry, Pharmacy, Vet Med [Veterinary Medicine] and then we decide who's worthy. You guys integrate it back there." Minnesota was the first one in the country to do it. We got those two grants to begin with. The Legislature was quite generous with us and built what was called the B-C Building [Phillips Wangensteen Building]. That was a very interesting proposition because the clinical faculty, the clinical departments were unusual if not unique in America for their strength and autonomy. The budgets they got from the University were dwarfed by the grants and the private practice income. I think we touched on this… The dean was always uncomfortable about the private practice income. And yet the in-patient oriented faculty gave approval of a new clinic facility as top priority for construction.

The Hospital's position, at that point, was we'll see how things are going and address in-patient needs later. One of the first things I did when I got there was to bring our rates up to the community average or a little bit higher on the basis of our patients' level of sickness. It was the purest referral hospital in the United States. No one could go to a university hospital, with exceptions, obviously, to the emergency room and I think OB [obstetrics] had an exception, unless a physician referred them. [Robert] Howard could never quite reconcile that with having a strong academic program and a strong private practice.

Lyle also lost on that issue. The person who knew Lyle best, of course, was David Preston. He worked with him closely. For years, David was on our staff and, then, Lyle recruited him. Well, Lyle wanted to move toward a Mayo Clinic model where the appointment system, billing, and referrals are all integrated.

I go to Mayo Clinic now and say, "I see your eyes got better." The cardiologist said to me, "Yes, that's unusual." At my last eye check, my eyes had improved, so I had to get new glasses. Not that they'd improved that much.

The departments hung onto their appointments. They never had central financial, so you'd pay each part, so you could have eight bills. It was time for me to leave anyway, but that was one of the reasons: I saw they weren't going to go any further. Lyle had been on the case and if he couldn't do it, I don't know who could. The Hospital recognized though that by raising those rates, the place wasn't going to grow and expand without a whole lot of operating margin, revenue from the Hospital. That's the great fun about not-for-profit: you work just as hard to make a margin, but you don't pay shareholders. You plow it back into your faculty. Minnesota was able to do that. It's always a bit of a cat and mouse game. We had to designate the money for a project and do some legal foot work; otherwise, the University Central Administration would try to take it away. [chuckles] That was always a battle. Of course, the bigger the pot got, the more Central Administration would drool about it and the people in the Business Office

would want at that money. We'd tie it up as soon as we could. That allowed the University of Minnesota health sciences to come into being in 1971.

DT: Nineteen seventy, yes.

JW: The planning worked so well. We got some money. It looked like we were getting money for Owre Hall, which was Dentistry and Basic Sciences. Pharmacy and Nursing were on the way. We talked to Dean Weaver and Dean Schaffer and said, "Do you have any interest in the health sciences?" They said, "Yes, but if we are part of the Vice President selection process."

Lyle got it, in part because of his work as chair of the clinical sciences planning committee and the support of pharmacy and dentistry. Lyle is pretty shrewd, a very shrewd politician. He had a genius for seeing the weakness in people. Sometimes, he didn't handle it all that well. He could be very caustic and short. For the most part, he figured out what people wanted, what they were after. He was a nicer version of the guy I worked for in California, who was Warren Buffett's partner, a Vice Chairman of Berkshire Hathaway, Charlie Munger.

DT: Oh [whispered].

JW: I worked for Charlie for several years. All of life was a deal to him, an investment. He could see the downside of an investment. As Buffett said, "He had the quickest thirty-second mind in the country."

[chuckles]

JW: Basically, Doctor French did a lot of entertaining in his home. He brought the team together. They all got along well, would golf. They continued the cooperative tone set by Elmer French. Weaver started one of the first Pharm-D [Doctor of Pharmacy] programs. He had students rounding with the medical students. There was a pharmacist there to advise about the drugs. Doctor Norm [Norman O.] Holte and Dean Schaffer in the Dental School put together several Hospital programs. It's quite a success story of not only planning together but, then, working together. Out of that came all sorts of informal things that aren't even recorded.

DT: When the Committee for Long Range Planning of the health sciences came together, what were the major challenges that that committee faced?

JW: The major challenge was we only had nine acres for the health sciences. We had to agree to share space. The clinic directors allowed some clinical offices to go into that building. Did the B-C Building become the [Phillips-] Wangensteen Building?

DT: Yes.

JW: Okay. Dentistry and Basic Sciences had to share some space. Eventually, Powell Hall had to be torn down for the new University Hospital. Then, in back of the Wangensteen Building was the Nursing School?

DT: Nursing and Pharmacy in Weaver-Densford.

JW: Seven years before, when we started the process, if you told Pharmacy they had to share a space with Nursing or vice versa, they'd say, "No way. We don't know what our future is going to be and we don't want to be blocked by… We're just going to end up fighting in here." Space was one [challenge].

Programmatic sharing was another. The issue of the day was, if there is integrated patient care, shouldn't there be integrated education? If students don't work together, how in the world are they going to know, in practice, when they get out, how to do that? Here you found in the Midwest, because of the Scandinavian heritage going out to Washington, an entirely different attitude on cooperation and integration. There were clinics, variations of the Mayo type thing, salaried people. They knew how to use non-physicians, relied on them. It was entirely different. When I was in Upstate New York, gad, it was like the 1930s. Everyone was in private practice. At most, they'd have a partner to share office rent. There were no clinics or anything approaching that. It was all solo.

There were also challenges of integrating with non-health sciences academic units. We are part of the University and let's make sure that we're available for the University, for the rest of the campus, and they're available for us. It meant reaching out to the Department of Psychology and other units.

But the big challenge was increasing numbers of students, getting them out the door to take care of the Medicare, Medicaid population.

DT: Your sense is that the potential shortage of healthcare professionals was the driving force for the committee and for the reorganization, that it was the need to produce more?

JW: Well… It wasn't for the initial stages of the committee. It was President Wilson's discomfort with having to be a judge among six applications.

I should mention Vet Med was part of this group. Doctor Lyle French invited them in and Dean [W.T.S.] Thorp would attend our monthly meetings. Of course, they played a vital role, as we used to say euphemistically, "We have over 15,000 pets a year that participate in our research program." Vet Med took care of that at the time a lot of universities got in trouble, because they didn't take care of the animals. The medical school would have an animal lab and hire animal keeper one and animal keeper two, but they weren't professionals. So having Vet Med, the University avoided all that.

DT: Were there particular personalities on the committee that were…? Were there any obstructionists to what you were trying to do?

JW: [pause] I'm sure there were moments in the deliberations, particularly as you got to the tougher issues where people acted out in their interest or their department's interest. But, by and large, "Minnesota nice" was what prevailed, which was kind of strange, because, as I said, the clinical departments were the strongest in the country and thought to be the most difficult to deal with. That's why Doctor Howard had a lot of sympathy in the American Association of Medical Colleges [AAMC]. He was dealing with one tough bunch of people. Also, the Basic Sciences were equally tough, because [Doctors Maurice] Visscher, [Cyrus] Barnum, [Wallace] Armstrong said, "We're not going to be just another Midwestern place that produces family docs or private practitioners. We want to be one of the top three public academic places."

That wasn't that hard to do, actually. They created a Ph.D. program in basic and clinical sciences and graduates flocked from all over the country, creating significant demand. The Medical School was primarily drawn from the local area whereas at the residency level, applicants came from a national base and also pursued a Ph.D.: Yale, Harvard, Hopkins, and Pennsylvania. So Minnesota was *the* place to go, because all the basic sciences were *very* strong, deep, rich, big. The clinical sciences, if you wanted to go anyplace, you hooked into a basic science. That was very, very popular.

I remember Al Sullivan… The kids we got out of New York City, Sinai [Mount Sinai School of Medicine], NYU [New York University], Cornell [University], Columbia [University] presented a bit of a problem. Sullivan used to complain about their lack of understanding of the upper Midwest culture.

Is he still alive?

DT: No, he's not.

JW: He called them, "Hot house roses." [chuckles] You had to teach them how to relate to patients. Sullivan sought to improve their bedside manner via orientation centers. They'd all had clerkships in, primarily, New York City hospitals, public hospitals where people complain. Here, we get some taciturn Scandinavian dying of pain and, "How are you doing today, Mister Swenson?" "Oh, fine." "Does it hurt?" "Oh, a little." [chuckles] They'd tell stories on themselves. Gene [Eugene] Pugatch and other residents were really funny. What a *shock* it was. Then, publication was always the driving force.

I remember President Wilson was more influential with me than you'd ordinarily expect, just because I spent a lot of time in his anteroom waiting for Elmer or something. He'd come by and chat. When he'd visit patients, if I were free, I'd meet him and walk him to the floor. He'd give me all sorts of advice. One of the things I remember he said, "When you get this job, you're going to be asked to be on many, many, many committees. Just don't accept. Only pick out the ones that mean something to you and mean something to our University." He was right. I turned down all requests the first couple years. I was never big in the American Hospital Association.

[chuckles]

JW: So I selected the Council of Teaching Hospitals of the AAMC. I was secretary of that. I was on the NIH [National Institutes of Health] Clinical Research Committee, site visit group. That was great. They'd send this big stack of all the papers of people doing clinical research around. I'd go into clinical chiefs and say, "What do you know about this?" or "What do you know about that?" Man, they were sharp. "Oh, yes, he's been doing that for three years now. There's nothing new there." "That is really hot. Our guys are on top of it all the time." They appreciated the fact that I was kind of testing them. I wanted to know their opinion about the entire application, although, I only judged the administrative part. In fact, my one recommendation that failed with NIH was… I said, "You ought to cap overhead tremendously." Harvard charged 115 percent and I hear it's much higher now. I said, "Cap it at 50 percent." Well, they couldn't do that. Where else did I go? Oh, I was on the Joint Commission for Accreditation of Hospitals from 1976 to1982.

I tried to follow his advice about limiting outside. I told you the story that I'd take President Wilson to patient rooms. Staff all knew me from before and they'd call me by my first name and chat. They didn't know who President Wilson was, of course. We walked out of there one day and he said, "John, I want you to remember something." I said, "Yes?" He said, "The day you walk out of this job, not one of them will remember your name." Good advice. Another time, I was testifying and doing a good job with the committee in the Senate, I think it was, for a Legislative appropriation. It got to be a bit humorous about something. He came up [unclear] and he'd say, "Okay, anything else?" And as I turned, he said, "You never tell them more than [you need to]."

[laughter]

JW: He had all sorts of one-liners. He was quite a guy.

[President Malcolm] Moos was good to work with.

DT: When I interviewed Bob Howard, obviously we talked a lot about the faculty practice issue and how that had kind of marked his entire tenure as dean. He mentioned that President Wilson had been one the people to encourage him to look into the faculty practice issue and Moos did, also. Do you have any sense of whether the presidents were interested in the faculty practice issue?

JW: Presidents Wilson and Moos were very sensitive to the fact that revenue from private practice could create an issue if not manage properly and that the autonomy of the clinical departments was a potential issue in fiscal management because you had multiple finance systems. Lyle solved that problem for the University by making everyone… Well, I guess the department collected them. They had to turn in their tax returns. He bundled them up and sent them off to an attorney. That gave the appearance of being on top, of monitoring private practice income. I guess about all the attorney could do is see that it fit tax code and that there was some accountability. I think the policy was, you

can't take any more in private practice than your University salary. So if you got $100,000, you could only take $100,000, *but…but* you could use private practice funds for educational conferences, travel, to augment your research lab, so there's a lot of wiggle room under that…to hire another lab assistant. The University's concern was not exactly the same as Howard's concern. He just found he had an ungovernable position. Lyle, of course, never was a medical school dean, so control over the departments was not his thing. He wanted it to be like Mayo, but he could never get them, so from the patient's point of view, there would be a single bill and a single office.

DT: What were relations like on the Committee for Long Range Planning and, then, beyond that, between Nursing, Public Health, Pharmacy, Dentistry, Medicine? Were there hierarchies? How do you think those relationships played out?

JW: Thanks to Lyle's personal touch, they all became social friends. We had a retreat every year, periodic dinners at Lyle's house. We had visitors from China.

That was one of the great stories. In Internal Medicine, Doctor [Yang] Wang accompanied the Chinese media delegation to the symphony. Doctor Wang and his wife had the Chinese delegation over to their house for a post symphony dinner. Of course, in those days, the delegation was controlled by a Communist Party official, and that party official took one look at the *lavish* buffet set up, and they all turned around and marched out.

The relations were quite good, I'd say. Under Marie Manthey in Nursing, Minnesota became the first place in the country to do primary nursing. That was big here. The medical staff *really* appreciated the quality of nurses here. At that time, nurses were hard to come by, but not at Minnesota. We had a glut of well trained, advanced degree, American-born nurses. The place, I didn't see it as very hierarchical. I think Edna Fritz and Nursing felt very comfortable around the medical staff. Public Health was just starting to explore cooperative relationships. Lee Stauffer was a very accommodating guy. Is Stauffer still alive?

DT: Yes.

JW: His wife died.

DT: Yes.

I think that Public Health was also very dispersed throughout the campus, too, in terms of their physical location.

JW: Yes, that's right.

DT: The Laboratory of Physiological Hygiene was under the stadium. It just seems there was a lot of dispersion.

JW: Yes.

I was going to mention the Mayo… In, I think it was, 1969, Mayo invited the University of Minnesota to Rochester to talk about, should they consider developing a medical school? Of course, the reason was… They had to talk the U, because it would be a University of Minnesota project. Mayo already had ties on the academic side at the University of Minnesota. So whether they thought it was a good idea or just political, probably a combination. Their problem was two-fold. One was we had just started the medical school in Duluth. I can't remember how large that was. Sixty students, maybe. That was not a branch of the health sciences. It was independent, but coordinated. Maybe they were coordinated at Lyle's office, under the budget. The State of Minnesota already had made an enormous investment in expansion from 170 to 232 here, 60, 70 at Duluth. Mayo's problem was they weren't recruiting enough U.S. medical school graduates into their residency programs and, in some departments, relied on a majority of foreign trained graduates. There was not the level of research compared to other leading academic centers. Teaching was also somewhat limited, except for the fellows. So Mayo wondered, would a medical school improve the situation in terms of getting more Americans into the residency and if you had a medical school, you'd have basic sciences, so it would stimulate more research. The Minnesota group's answer was, "Yes," a great relief to some at Mayo who were doubtful about garnering University support.

Mayo did start a medical school. The major advice from Minnesota was, "Keep it small. Don't get overwhelmed." If our faculty had a choice, they didn't want 232 medical students. They'd rather have 100. So Mayo limited it to 40 students per class and that seemed to do the trick. Within years, they were getting a much higher percent of American residents, getting a reputation. They invested in more research. It's not that they didn't have any, but it just wasn't very well recognized by the academic community. That was an interesting experience. The Mayo/Minnesota tie was never particularly competitive, because Mayo was nationwide. We were regional.

Also, we had a special thing called County Papers. Have you heard about those?

DT: No.

JW: I think Mister Ray Amberg secured legislative approval to keep us from going broke during the [Great] Depression, like Minneapolis General and Saint Paul Ramsey. He would get a special grant from the Legislature and that would go to the eighty-seven counties in Minnesota, or that was available to the eighty-seven counties, and it was matching. There would be no doctors' fees. If the county would pay half, the County Papers would pay half. It was quite clever. I think it went on some years past Medicare and Medicaid. [pause] The Hospital always recognized that it was a good idea to get as many private patients or patients with insurance as possible into the referral chain. The departments were very smart about that. They didn't go around the state talking to county societies about send us your poor and your starved. They wanted referral patients based on medical need. Future referrals depended on how they treated patients and referring physicians, so the market pretty much determined the strength of the

department's referral patterns. We used to track how many of the eighty-seven counties we'd get patients from. The start of the medical school in Duluth, of course, cut a big swag of that out, but, then, Medicare and Medicaid made another whole large group eligible. Again, what was driving it all was the need to have an operating margin that you could put into capital funds for future projects.

DT: You mentioned that the Hospital would only get patients if they were referred from other physicians outside the University.

JW: Yes.

DT: Did that referral system ever change? It sounds like if the Hospital and the medical faulty want to get more paying patients, then that's more of a challenge, because the outstate physicians were going to be referring to the local hospitals, community hospitals, I would imagine. How did the politics of the referral system play out?

JW: [pause] The department's—you've got to look at it from a department perspective, because that's how the system operated—pitch was subtle. You've got a patient you're not sure about…we'll take him on and send him right back to you. Sometimes, the patient could just be difficult. Sometimes, the patient demanded to be referred to the University. It was kind of a prestige thing. I'm not sure I'm being responsive to your question.

DT: That's okay. I know from other people I've spoken with that there was a lot of town/gown tension in Minnesota. I'm aware that because of the way in which Medicare and Medicaid changed things substantially… I think I saw somewhere that there was increasing pressure on the Hospital to take in more paying patients. So I'm just curious how that played out.

JW: I think at the time, we ignored the referral. The University Hospital was set up where it was so it couldn't expand. The state docs said, "Ahh, all right. We'll get a medical school but we don't want a colossus there." So the Legislature confined them to the [Mississippi River] bank without much room to expand. Starting from that point, it attenuated over time. So relations were, I'd say, quite good between the University and practicing physicians. In part, that was helped by Mayo. Mayo was more of a closed shop. They changed over time. I can only talk up to 1982. But to that point, they were a tight organization, tight control, all salaried. That wasn't exactly a winner with the State Medical Society; whereas, the University liked private practice and was open to address… Each department, in fact, tended to have fall symposia, invited in people, open registration for the state. They'd schmooze there. So they worked hard down there on their ties. If tension did come, I think it came post 1982. I don't know.

DT: What led to your appointment as Hospital director? You were funded in 1966.

JW: What led to my appointment?

DT: Yes.

JW: I was asked to apply. At that time, I didn't think I had much of a chance. What have I got to lose? My work is almost done here…a little more to do in Washington D. C. I think the fact that I'd worked closely with the faculty and reasonably successfully, their view might have been, well, the devil we know, you know. [chuckles] That's not enthusiastic, warm support.

[break in the interview]

JW: I think Doctor French had something to do with it or Doctor Learn had something to do with it. The search committee interviewed several experienced candidates who were already CEOs of University Hospitals.

DT: When you first took on the position, what did you see as the major challenges confronting you as Hospital director?

JW: The first one was to build up a staff. Tragically, Miss Gilman got cancer and died. I wasn't scheduled to take over 'til later. I was appointed in April and then by November, I was in the office. So the first thing was to build up a staff. That, I think, I understood reasonably well…to get good people. Then, once we got the core group… They all turned out to be very successful. [Dave] Preston went on with Lyle. [Peter] Salmon went to Mount Sinai. [Thomas] Smith went to Florida and became president of Yale [University] Hospital. I got one extra associate administrator position. We had plenty of money but you know, Human Resources… I said, "Look, I'm young, inexperienced. Miss Gilman and Mister Amberg could do with two, but I need three," because I wanted to hire Tom Smith.

Then, the real thing that made it work was we were the only university hospital, the only major academic hospital that I know of, that spent so much time on staff recruitment. The way we did it was through a fellowship program. The way we did that was we'd get the team together and say, "Okay, who are the top ten schools and who knows someone there?" As I went on, I was also on the accrediting commission for graduate education, so I got to know most of the program directors and other people on the staff knew them, too. We all got together and said, "Okay." Then, we'd come back and we'd all have interview assignments. I probably had more. We'd say, "Here's my report. These are the people I interviewed" and they recommended so and so. We said, "We want a fit." It didn't have to be the number one person in the class, but you know Minnesota and you know the staff. It's got to be someone who will fit in our team.

I'll give you a citation. We just published an article about mentoring.

DT: Hmmm.

JW: What I didn't anticipate… What happened was everyone became committed to the success of this fellow, or sometimes we had two, and gave of themselves to that fellow.

In all that time at Minnesota, I'm sure there were people that didn't particularly care for each other, but, by and large, it was an *extraordinarily* harmonious group, because of the way we went about it. Then, they got folded in; we were usually able to keep them on. It was just a natural evolution. Then, they picked the fellows. Their development was part of the job we all took on. Not many management teams gave of themselves like we did in Minnesota. That was a very unusual thing about us. As a result, we just turned out a *galaxy* of CEOs. Bob Baker went to Nebraska [University]. [Robert] Dickler went to Colorado [University, Richard Pierson to Arkansas University and Ed Howell to Virginia University]. I could go on and on and on. So it was a very simple thing, but you didn't see it in any other place.

There are a lot of kind of imperious CEOs. I took part of it to be a defensive posture against issues they were unsure about. These are highly competitive places and, of course, with the Minnesota clinical chiefs, ours had a reputation of being one of the most difficult. I remember Carl Platou and Bill Wallace would tell me, "God, I don't know how you stand it over there." [chuckles] I said, "What are you talking about?" They'd have a run-in with some staff member.

DT: As I understand it, you established a Tuesday lunch with the clinical chiefs as a way of…

JW: Yes, that was quite interesting. Early on, we had clinical lunch every Tuesday. Ah, maybe three or four would show up. It soon became a not-miss. [chuckles] Then, we turned it over, after about five years, into a clinical chiefs meeting. I wanted them to assume agenda responsibility. I was hoping to help Lyle get them to central appointments and billing. I think [Doctor John] Najarian was the first chairman. It didn't change a whole lot. He'd say, "Well, what are we going to do today, John?" He'd call me before. [chuckles] We'd always hand out reprints from the *New York Times* and the *Wall Street Journal*. The first meetings were quite interesting. "Oh, you live there?" "I didn't know that." "Well, our kids go to school together." These guys had never talked to each other. It's *amazing*. [chuckles] Lyle really blossomed in that atmosphere. He was invited. We started the chiefs meeting in 1967 and Lyle became vice president, so he was there as chief of Neurosurgery. Doctor Howard left, I think shortly after Lyle was appointed. But [Neal] Gault would come. We invited the dean, someone from Pharmacy, someone from Dentistry. It was a nice group. We'd talk over clinical problems, you know, what the medical staff, Hospital Council was dealing with, what was going on at the state level. There was lot to talk about…what was going on at AAMC. The intent was to have the most sophisticated knowledgeable group of clinical chiefs in the country, best educated about more than just their specialty.

DT: I heard it was a great idea. A couple people I've spoken to now mentioned that it was a great innovation, that it was a way to get the clinical chiefs to know one another better, as you say.

JW: Yes. You'd think it was commonsense. [chuckles]

DT: Were there other things that you changed when you arrived?

JW: Oh, yes. First of all, we were big supporters, although quietly, of the health sciences. Remember, the health sciences didn't come in 'til what, 1970?

DT: Nineteen seventy, yes.

JW: We came on board in 1966, 1967. It was 1967 by the time I'd hired everyone. We could see that it wasn't a good idea for the Hospital to be under an organization that didn't include Pharmacy and Dentistry after we had spent that time planning the future together. So we were very supportive of the health sciences concept.

Secondly, we went after governance. Being governed by the Board of Regents, three steps removed, hardly met the conditions of the CHO for Hospital Governance.

At the same time, I'm on other groups. I'm on a group with AAMC and they appoint me chairman to look at the Joint Commission and its relationship to academic health centers. I asked [Doctor Richard] Dick Varco, who was a tough guy, the conscience on our faculty… You've heard about Varco?

DT: Yes.

JW: I'll tell you one story. After I'd been there, it was the end of 1969 or early 1970, I'd been at a clinical chiefs meeting and I'd given Mister Amberg and Miss Gilman credit for something that had evolved and happened. I'm going back to my office and Varco says, "John, can I talk to you?" I said, "Sure." We go back to his office and he puts his arm around me. "I just want to tell you that you don't have to give Amberg and Gilman credit anymore." [laughter] "We know what you're doing and it's fine with us."

I had Varco on this committee because he was really clear-eyed, a Jesuit. This doctor from Loyola [University] in Chicago jumps on the Joint Commission and says, "They don't really understand academia and dah, dah, dah, dah, dah. I'd be just as happy if we withdrew from the accreditation process for them." Varco, when it gets around to him, says, "I've been around a long time, but I've never heard of anyone getting ahead by stepping on someone else's shoulders." This guy didn't say another word for two days. He was petrified of Varco.

[laughter]

JW: Then, our report came out, very measured. I had an appointment in the Vice President's office too. I had two staff. I had Jane Shapiro, who was Congressman Fraser's assistant and Karen Levin, who was a smart young lady out of Bennington [College, Bennington, Vermont]. As I recall, I took the assignment on the basis that they could edit what we wrote, but I didn't want an AAMC stenographer or staff person. I wanted Karen Levin. They said, "Okay, as long as we can see the script." They hardly

changed a word. The script came out and said, "The Joint Commission's standards are fine. The application is fine. The site visit teams could use some improvement."

I remember I took around a Joint Commission team for Mister Amberg in 1959 or 1960. They said, "John. John." I said, "Yes?" "Could you introduce us to Doctor [Owen] Wangensteen?"—[chuckles]—which was hardly the kind of rigor that you wanted.

By the way, the Joint Commission responded. They set up a vigorous, rigorous training program for their surveyors. They'd always had an orientation, but we made several recommendations. Our conclusion was the problem isn't the Joint Commission. The problem is us. Well, that was a bombshell, but it was largely because of Varco that carried the day. He'd say, "All right, Doctor. What don't you like about that? What's so difficult?"

That was part of the reason the Joint Commission appointed me a few years later, even though I wasn't an AHA [American Hospital Association] favorite. The AHA just had representatives from the community hospitals and there was no one from academia on there and they thought we ought to have someone from academia representing them, so I was appointed. Nineteen seventy-six to 1982, I was on that, the longest serving commissioner, because Doctor [George] Graham resigned in April 1976 and they appointed me for that one-year term, and, then, two three-year terms.

Where were we?

DT: You were talking about governance.

JW: As I became more familiar with the Joint Commission, I realized that our governance wasn't what it should be. Part of it was I was fearful of the continued fight with the University about human resources, purchasing, accounting, information technology. Part of it…they were always going after our capital funds.

JW: Doctor French supported a governance board for University Hospital and Clinics. He said, "Yes, it makes sense to me." What we did was appoint a person from each of the eight congressional districts and, then, filled in with some ex-officios. That was the first pure University Hospital Board in the United States.

DT: Did you encounter any resistance to that, say, from the Regents or the president?

JW: We wouldn't have advanced without the support of the President's Office. I think the first meeting was in 1975 in January. It was a wonderful thing. I'd go to these meetings and I remember the guy from Cleveland, Chuck Womer, who would say, "What's so goddamn wonderful about a board? We've got a board here at Western Reserve at University Hospital, Cleveland. I don't know why you'd want one. You're better off without one." We thought it was quite an opportunity to join the health sciences and have a hospital board.

Oh, I think it lists… [pause] That's not the list… We had about four major projects that we'd try to do every three years.

You get so busy in your new job and, also, I find, with regard to memory, that it's not a very useful thing to look back. You either tend to aggrandize your role in some happy moment or carry the burden of something bad that happened.
DT: [laughter]

JW: I was concentrating on today. Next week, I'll be concentrating on something else.

[break in the interview]

DT: You mentioned Marie Manthey earlier. I saw in the Archives that when you were setting up the Board of Governors and deciding who to appoint, there were questions about adding someone from Nursing and that she was the person who was recommended, but there was some controversy about it. There was a lot of resistance from other nurses, like the Nursing faculty didn't want her appointed. I wonder if you could shed some light on that.

JW: Not too much. When Nursing went through a change, when the Nursing Service Director Florence Julian left, rather than just recruit and fill, we set up a group of senior nurses to recommend what we were filling for.

I remember one anecdote. Someone, I think it was from the Department of Medicine—I can't remember—came to me and said, "We need to have a dress code for nurses." At the time, they were wearing very short skirts and, in the course of their duties, they'd be bending over and it would be disturbing. I said, "To whom would it be disturbing?" "Oh, to our patients." I said, "Okay." I'd never heard of a patient complaint about something like this. Usually, our patients are so sick, the last thing they're going to care about is the length of a nurse's skirt. I said, "Let me see what I can do." I chatted with Nursing and came back and met with the doc and said, "Well, they're open to it, as long as you'll do a dress code for the house staff. They really don't like all those beards and long hair and ponytails. But they're open." "Uhhh, we'll think about it, John."

[laughter]

JW: That was the end of that. The short skirts won.

So the nurses came up with a plan. There was someone there, an administrative assistant, named Donna Nehls. They said, "The administrative duties are really a pain in the neck. Let's split it so that Donna Nehls is director of administration and we'll have the various specialty nurses," or something like that. I said, "Well, you've got to have a nursing council and you vote on what you want. I'm not going to tell you what to do." So they talked some more and came up with this plan. It turned out that Donna Nehls was essentially director of nursing, which, of course, sent shock waves through University circles. So there would be tension, I suppose. You know, the old Australian rule anyone

that gets too high, you chop their head off. I was not too aware of it at that time nor could I answer why. I guess we didn't want to load up the committee with deans ex-officio. That was the good idea. Then, anything the dean said, the committee isn't going to go against academia. So the compromise was only Lyle and the chair of the medical staff Hospital Council, which made sense to the legislative body for the Hospital, and, I think, the chief of staff, so two docs, two clinical physicians, and Lyle. I think that was it. I wasn't aware of the conflict then.

DT: Donna Nehls…it was shocking, because she wasn't a nurse. She was administrative assistant and then a leader?

JW: Yes. That was pretty unusual. I was quite surprised myself. I figured, well, which is the greater good? Letting nurses determine what they want or making sure that an RN [registered nurse] is there?

DT: Florence Julian was director of Nursing Services for a good number of years. I wonder if you can talk at all about the Nursing Services in the Hospital while she was there. I realize this will also go back to when you're the administrative resident at the Hospital. Did you get a sense for how relations were between the Nursing Service and the School of Nursing?

JW: Yes. They were quite good, I thought. The Nursing leadership, Manthey, and others took a real interest in the School, participated in lectures more than they had before. There had been a little nursing service in the School of Nursing and while Isabel [Harris] and Florence got along fine, there wasn't a lot of back and forth. I think there was a real attempt to, but I can't cite as many things as Marie could.

DT: I know that the School of Nursing had changed its curriculum in the early 1960s, and was introducing new graduate programs in the mid 1960s, and that there was a change in orientation of undergraduate nursing education, like less emphasis on bedside care and more emphasis on the science of nursing. I think, as I understand it from what I've read in the Archives, but also from what Marie and some others have said, is that created some potential tension between the clinical nurses that were working in the Hospital and the faculty.

JW: Yes, I suppose that… As they tell the medical students, "Four years after you graduate, most of what you've learned is worthless." That's a natural built-in tension between the faculty trying to impart principles for coping with the world ahead and the day-to-day application of contemporary knowledge.

Also, overlying all of this is—it's worse today—you have a bunch of attorneys ready to pounce on any deviation from clinical practice, anything different from nursing standards. So that doesn't exactly encourage innovation and experimentation.

DT: It is interesting that so much innovation in nursing did happen at Minnesota and the work that Marie did around Station 32. The introduction to primary nursing is one

example of that. I wonder if you could talk about Station 32 from your perspective, what you remember about it.

JW: What I remember most is all the credit goes to Marie Manthey. We were very interested in new approaches in clinical care and working with the schools, the Pharm-D program, the dental, and Hospital clinic. I think we got Public Health involved in our community clinic that we had with [Doctor] Charlie [Charles A.] Branthaver and [Doctor] Ed [Edward] Defoe. CUHC, it was called, Community University Health Center. My memory is we needed to work with the medical staff. There was a young guy in charge of that Station 32 from Internal Medicine, so that they would be supportive of it, so the doctors wouldn't be screaming. All we did was kind of lay the groundwork. Then Marie and her team explained to people what they were trying to do. Really, one of the major goals in addition to improve patient care was to make nursing more of a profession than as a "do as I tell you to do."

DT: Marie credits you with being so open to new ideas and to changing the way that things were done and being so supportive in that regard.

JW: Well, we tried to be that way with all the clinical services…look at new ways to do things. After all, this was the roaring 1960s.

DT: You mentioned Pharmacy. I haven't spoken to anyone from Pharmacy yet. But, as I understand it, Larry Weaver was pushing the clinical pharmacy movement to get pharmacists working more closely in the Hospital…

JW: Right.

DT: …and with the Pharm-D program.

JW: Dean Weaver had them rounding with the medical team. They went on rounds and instituted the Pharm-D program. We were their laboratory.

Larry's got Alzheimer's now.

DT: He passed away a few months ago. [December 21, 2011].

JW: Oh. I was going to say the saddest Christmas letters I get are from Dee [Delores, Mrs. Lawrence Weaver]. Larry looks worse every year. That's probably a blessing, I would think. Life can't be much fun for…

Hugh Westgate—that's not right, Hugh something [correctly Hugh F. Kabat]—used to attend clinical chiefs meetings and had a lot to do with the Pharm-D program.

DT: When the Pharmacy students were rounding with the medical students, that was so that they could… What was the rationale for having the Pharmacy…?

JW: They weren't students. They were advanced students. They were Pharm-D candidates. They served as the drug interpreters, so the residents could ask any questions they wanted and these guys would have the answers. There were lively discussions, because the chief complaint those days was pharmaceuticals were coming online so fast most doctors didn't have a clear understanding of new pharmaceutical developments, except what they read on this disease or that, but they didn't understand the mechanics of why. Then, it soon became clear that multiple drugs for multiple diseases had potential for a *lot* of conflict and that was a big objective of the clinical pharmacists was to say, "This could happen," or "This, this…" Sometimes, you have to go into a world of tradeoffs and not give a drug that's needed because it will have some unintended consequences.

DT: From your recollection, did Weaver encounter any opposition from physicians around this?

JW: I'm sure not at the conceptual level. Remember, Lyle played a pretty key role in this. Lyle would know who to talk to on the faculty to say, "What do you think about this?" and "What are the conditions?" He would advise Larry. I am sure that as it was implemented, some on the house staff would make fun of the pharmacists. That's the nature of the beast, I'm afraid.

DT: It seems to me Tom [Thomas] Jones was mentioned in the Archives a fair amount.

JW: That's correct. He was a resident, my first resident, I think in 1967. He's a pharmacist from Wisconsin. He went through the program, was a resident with us, and we assigned him to work with the school of pharmacy. All of my staff had faculty appointments in the health sciences, so there was one in Dentistry, one in Family Practice, one in Public Health. They were all covered. I said, "If we're part of academia, then we need to be part and participants of it." The deans all agreed and made these appointments.

DT: So you know what happened to Tom Jones, where he went after leaving Minnesota? He's one of the people I'd like to track down and talk to.

JW: Oh, if he's still alive. Yes, he went to Children's Hospital in Miami [Florida], and retired, someone told me, maybe eight years ago. Whether he's still in that area…

DT: Sounds like another trip to Florida. [chuckles]

JW: That's one way to look at it.

DT: That's such a common name, it's impossible to Google and come up with anything specific.

JW: Your better source is the Program in Health Management. They have an alumni directory. I don't have a recent one. That would have Tom's last address in Florida and maybe a new address. I doubt that he moved back to Wisconsin.

DT: One of the things that I saw in the Archives is there were some questions about abortion services at University Hospital during the 1970s. Do you remember any of those discussions?

JW: Uhhh… Some. I'm trying to think of the context. John Sciarra was our chair of OB-GYN [obstetrics and gynecology]. He took over for the old Scotsman, [Doctor John L.] McKelvey.

[laughter]

JW: Sciarra developed a national reputation and was later recruited to the Northwestern University, Chicago OB-GYN Department. Huge. We didn't have a big OB service. John looked at it as a chance to get his first chairmanship and, then, he could move on to bigger things.

I don't recall it being much of a controversy. I know I was part of discussions, that it was pretty much the doctor's decision whether the abortion was medically necessary, not whether to go ahead and do it—that was the woman's decision—and to assign risk factors to it. But we had such a tiny service that I can't believe that it was the focus of an abortion controversy.

I remember I was a candidate for the state convention. What really turned me off is you got up and said who you were. Questions. Pro Life or Choice? Thank you! I thought, is this what the democratic process is about? One factious issue just took over those conventions back then with their selection process.

DT: I've seen in the Archives that the University eliminated the second trimester abortions in 1975 and, then, I think, gradually phased out abortions. The argument was made that other hospitals and clinics provided those services.

JW: Yes. We didn't want to get into the business of being a major abortion provider. I remember that.

DT: Then, he was replaced by Konald Prem and I think there was some discussion or disapproval about his appointment from, I guess it was, Professor Jane Hodgson and University community feminists were upset with his appointment, because he was Pro Life, so they were concerned that that had bearing on the abortion services.

JW: Doctor Prem was a long-time stable member of the department. I think he was a resident under McKelvey. Konald Prem, yes, I remember him well. I didn't remember that when Sciarra left for Northwestern that then Prem took over. Yes, Jane would be concerned. [pause]

What year was that?

DT: Nineteen seventy-six.

JW: Hmmm.

DT: Then, the outpatient abortion clinic closed in 1977. I guess some of the concern expressed was that students weren't getting then sufficient training in abortions if the University Hospital wasn't providing it. But the counterpoint was, "Well, they can get it at other clinics where the volumes are greater." [Hennepin and Ramsey]

JW: Yes. The issue there is whether the private abortion clinics want medical students.

I remember early on, Jim Carey was telling me this story. He was with a group of internists and they said, "Oh, God, it must be nice to have students do that, residents to do that." He said, "Yes. You come over sometime and I'll tell you. [chuckles] You come on rounds with me and all the questions you have to answer… How many patients do you see in the morning? Twelve? Yes, I can see three." [chuckles]

DT: During your tenure, the Metropolitan Council designated University Hospital as an emergency services basic center. Do you recall that process at all?

JW: No, but it sounds…. We never wanted to build up our emergency department, because no one on the faculty wanted to staff it. At that time, we didn't even have a specialty in emergency medicine. I don't think there was a residency created back then. Hennepin and Ramsey would be the logical major trauma centers and they were staffed by us. It was all University doctors there, so the fact we were a basic, I don't recall that being much of a headline maker one way or the other.

DT: I read somewhere it ruffled some feathers that the Hospital wasn't given regional designation, that it was just purely the basic level. That was the rationale given, that, as you say, Hennepin County and Ramsey were the big trauma centers.

JW: Yes. Yes. In our case, it wouldn't make much difference because we could take a referral right into our inpatient service and overfly the emergency screening. They were supposed to be a system of basic emergency and level 2 and level 3, something like that. It didn't make any difference to us. If someone was in deep trouble, they'd fly them into us.

DT: Can you talk about hospital costs? As I understand it, hospital costs were rising like costs generally across the board from the mid 1970s onward. I wonder if you could comment on that at all.

JW: Yes. As I said, in 1966, one of the first things we did was increase our rates, increased them substantially—we didn't have rate commissions then or anything—so

they were at a level with community hospitals in town. In fact, we tried to set them a little higher, a few dollars higher, because of the kinds of services we offered and costs associated with being a tertiary care center.

Then, throughout the 1970s, there was a lot of concern about the creeping cost of healthcare as a percent of GNP [gross national product] as it went up from eight to nine to ten to eleven to twelve, plus the rates. Before I left there, I think about 1975, 1976, we started with a voluntary commission, then had a state commission. I remember filling out forms. We had to justify our increments. But Minnesota didn't have the terrific problems of other states, because of the system we had, hospitals and clinics throughout the state that could take could take care of people. We didn't have a huge transient or illegal immigrant population. To be sure, [Lavand] Syverson at Ramsey and [William] Kreykes [at Ramsey and Hennepin had a challenge in caring for under- and un-insured patients].

Another thing we did [was to create the Minnesota Association of Public Teaching Hospitals]. You said, "What are the things we did right away at the University?" We found that the Medical School departments organized, including Ramsey, Hennepin and the V.A. [Veterans Administration]. But there was absolutely no integration of the hospitals. We didn't know what was going on there and they didn't know what was going on with us. So we created the Minnesota Association of Public Teaching Hospitals, MAPTH. The idea was to be supportive of the educational research enterprise. So we would meet monthly—I forget the chap's name at the V.A., Severson at Ramsey, Kreykes and Bob [Robert] Taylor at Hennepin County—and we would have an agenda. Eventually, we had an executive secretary, Ohnelle Foley. She had that job for about ten, twelve years. The community hospitals were not at all pleased that we had set that up, because they thought we would turn it into a clinical powerhouse and compete with them for private patients, but that was never our intent.

DT: Was that also related to kind of coordinating some of your…you could share expenses in some way?

JW: With the other public hospitals?

DT: Yes.

JW: [pause] I know we would talk about that. Is there a way we could help one another? I can't, at the moment, think of specific expense sharing ventures, but we may well have had some. In fact, I was thinking Hennepin County had this thing—we had it for a while; we didn't want it—that deep-sea divers…

DT: The hyperbaric chamber.

JW: Yes. Whether we supported… Transferring funds between government agencies is a little hard, but by having a system that Ramsey patients and our patients and V.A patients had access to it, they would get compensated by the insurance.

DT: The hyperbaric chamber raises something else I was curious about. There was increasingly new, expensive technology in hospitals. For example, in the 1960s, 1970s, you got kidney dialysis and then you got the new imaging machines, too, like CT [Computed Tomography] scanners and, later, the MRI [Magnetic Resonance Imaging]. I'm wondering what role these new medicine technologies played in hospital costs.

JW: First of all, it was the mission of the health sciences to be first with any new technology whether it be in lab medicine or radiology. The early stages probably cost more than years later when the technology became commoditized. I don't recall many conversations around our CT scan adding costs. In fact, to the contrary, people acquired CT scans to make money. It wasn't long before the for-profit firms were leasing them out to anyone who would contract for them. Not all the contractors knew how to use them fully. Part of the desire was to get ahead of the game and set up a standard of what they could do and what they couldn't do. That could only be done in an academic setting where you have some kind of scientific approach.

DT: It struck me that throughout the 1970s the hospital market became increasingly competitive.

JW: Yes, it did.

DT: What explains that increasing competition between hospitals?

JW: Well… [pause] It used to be that every hospital kind of had its own patch and its own medical staff. There was kind of a gentlemanly accord to not step on other people's territory. The 1970s changed all that, because there was a whole new level of delivery. Multi-hospital systems were all the rage. I remember I was on an AHA committee that was studying that. Academic places were *very* keen on setting up referral networks. Iowa had been at this for thirty, forty years with a very sophisticated referral network throughout the State of Iowa. Because schools, Big Ten schools and other schools, found themselves tied to the campus in a small town, it was not easy…not easy to get patients to Iowa City from Des Moines. So they set up statewide ambulance and air service, lots of good stuff. One of our staff members later on, Ed [R. Edward] Howell, later became CEO at the University of Iowa and participated in that. He's now the president of the University of Virginia Hospital. As the multi-hospital systems and the need for referral network set up, by definition, that set up competition. Then, Mayo Clinic set quite a pattern. When you think Mayo Clinic, Rochester, well, they have about thirty satellites and so does Gundersen Clinic [Gundersen Lutheran Health System, La Crosse, Wisconsin] and La Crosse Clinic and Eau Claire Clinic [Marshfield Clinic in Eau Claire, Wisconsin] and Bismarck Clinic [North Dakota] and Grand Forks Clinic [North Dakota]. As they reached out, this made for more competition, higher quality, and, presumably, no higher costs.

DT: With that greater competition, did that change your approach to how the Hospital would do its business?

JW: Yes, it would, but at Minnesota by 1975, 1976, 1977, Lyle and myself and others were acutely aware of the handcuffs. All those places I mentioned are Mayo Clinic models: salaried staff, group practices, and central appointment and billing. Not [the University of] Minnesota. We were handicapped in that respect.

DT: Can you elaborate then on why that created such a handicap?

JW: Sure. [pause] From a patient's point of view, you're going to a facility, a clinic, an organization and the organization will steer you where you need to go. Obviously, you want to know what the problem is, so there's a diagnostic lab, x-ray, and there's often a family doctor who sorts out areas of exploration of the seven systems or however… Well, you go to Mayo Clinic just a… "Kay, will you go here?" "John, you okay for…?" "Yes." To, to, to, to, to. [whispered] It's done. At Minnesota, call the Department of Medicine. "What do you want?" "Cardiology appointment." "Well, call *Cardiology*!" "All right." You call Cardiology. "No, no, Wednesday afternoon every one is off." "But we've got to do Cardiology, Electrophysiology…" "I don't know about that. I only know about Cardiology." It just doesn't click.

Now, some powerful, smooth, patient-oriented faculty can develop reasonably effective systems. The issue really was one of control. They're understandably concerned about joining a centralized bureaucracy and giving up control over the revenue flow.

DT: The doctors are?

JW: Yes. Departments are dependent on private practice income for a substantial portion of physician income. I remember sitting at the lunch table with Doctors Najarian and French so many times. "John, for the love of God, run that money through the University of Minnesota Foundation. You'll be fine. They won't touch a penny." "Yes, yes, yes, we're thinking about it."

DT: I think this was after you'd left that it seemed that there was an increasing attention to patient satisfaction as a way of kind of marketing the Hospital, focusing more on patient relations.

JW: Yes. We were one of the first universities to hire a director of patient relations, Pat [Patricia] Roberts. She was very good. She was a patient advocate, had just the right personality. She didn't take any crap from the University, and, yet, was smart enough to know when the patients were not totally blameless. She was very good at it. We did everything we could to work around the lack of a cohesive medical staff…appointment system and billing. That was one of them.

DT: So patient relations was kind of a product or a way of trying to deal with the system that was in place that you were stuck with?

JW: Yes. We would have done it anyway even if we'd had a Mayo system… Patient satisfaction. It's just good common sense when running an organization like that.

DT: Now, discussions began, it seems, in the late 1970s to expand the Hospital and then, subsequently, there was the building of the hospital. Can you talk about that process? What led to discussions that the Hospital needs to be expanded?

JW: Replaced is a better term, because I don't think more beds were planned. To the faculty's credit, not only did they go ahead with the Phillips-Wangensteen Building, but supported a sensible planning effort. Clinics, remember, had the lowest priority of any patient care service then in the booming 1960s and 1970s with Mike Paparella in ENT [Ear, Nose & Throat], and John Harris [in ophthalmology, and Dr. Robert Goltz in Dermatology] 'til those places *really* took off, and we set up ambulatory care centers as part of this new building. Now, the reason I bring that up to the faculty's credit is they said, "The Hospital is a mess. It's old. We've done what we can with it. We started with a 1912 structure. Therefore, let's do the clinics first and, then, we'll plan what we want in this new hospital. We want to build it so it will last some time." They were willing to defer that ten years. That's pretty unusual. Most clinical faculties would say, "I want my new beds now. Lab and x-rays and clinics can take care of themselves." Not Minnesota. They went ahead. Not only did they do the outpatient first, but they brought along their health sciences partners and partnered with them in building. Then, they got around to the new University Hospital, which was after my time. When did that open?

DT: In 1986.

JW: I stayed around 1981 to lobby the Legislature for bonding authority, but we never used the bonding authority they gave us. So I was gone by the time this was…

DT: Was the state a little reluctant to give more money to the University?

JW: I don't recall. We wanted bonding authority. We had a lot of money. I think we had over $100-million stashed away. What we wanted to do was borrow the rest, quite usual in those days. But if we had the state authority, we could get it at 100 or 200 basis points less. That's what that was about. So the state said, yes, we could do that.

Then, someone transferred the reserves from the University Hospital and Clinics.

DT: Do you know who did? I don't know anything about that.

JW: The faculty tells me it was the vice president.

DT: Oh, so that's… Oh, yes, the Brodie scenario.

JW: Yes.

DT: Interesting.

How did the community hospitals feel about plans for the University Hospital renewal? The community hospitals, were they concerned at all about the renewal project?

JW: No, not at that time. They were pretty sophisticated. Remember, Fairview had Fairview Southdale. Abbott and Northwestern merged. We had a couple of our faculty set up a nice rural referral system of about eighteen towns and Abbott Northwestern took it over. Najarian thought heart surgery was passé. So our two, three heart surgeons went over to Abbott Northwestern, much to everyone's chagrin, because John thought they were not cutting edge of academic surgery.

DT: Which is funny, given the Surgery Department had been renowned for its cardiac surgeons.

JW: Yes, that's how we built our reputation. [From Doctor Christiaan Banard to Doctor] Richard DeWall, then [Doctor Richard] Varco, [Doctor Aldo] Castañeda, who ended up at Boston Children's [Hospital], C. Walton Lillehei who ended up at Cornell [University Medical Center], Rich Lillehei.

Doctors Robert Goodale and Doctor Demetre Nicoloff carried on in the program until the Department of Surgery seemed to shift emphasis to transplant surgery.

I'm sure you've heard of them before, they went to Abbott Northwestern [Hospital to help develop their heart program].

DT: There were concerns about the shortages of nurses, I think throughout your tenure, but it seemed that they were growing concerns about nursing shortages in the late 1970s, early 1980s.

JW: We were never unduly concerned about it, because of our School of Nursing and our environment. From a nurse's perspective, it's so much nicer working in a place where everybody is salaried, yourself, the doctors you work with. It's just a superior environment. I think the Nursing School was concerned about their undergraduate enrollment, because they'd put so much emphasis on nurse specialty, graduate work, master's and Ph.D.'s. in nursing. So it was not an immediate concern; although, it became a concern in the late 1970s and then that reversed with the economic recession of 1980 to 1982. That threw a bunch of nurses back into the labor force. Yes, I was still there for most of that. I think we had a change of fortunes and, then, of all the places to work, we were very attractive.

DT: Can you tell me about the consortium you set up for university hospitals?

JW: Sure. As I went around the country, the chief complaint of university hospitals and the university was it's very difficult to work through university departments. There was the governance issue. There was limited governance in university hospitals. We thought we could combine the things by setting up a group to study and universities are open for

anything you want to study. Of course, Lyle was supportive. He knew what we were doing, so he said, "Okay." I went around and talked to the eight or nine university hospital councils in the United States, which wasn't hard to do, because you had meetings. There was a general recognition of difficulties university hospitals faced, because of organizational things and there was a recognition that other hospitals were racing ahead. After two years, about twenty hospitals expressed an interest in the project and of the twenty, eight were ready to sign up immediately.

That was a positive reaction and we had meetings with papers outlining more what this would be about and the costs. I said, "Outside of pocket change startup, $25,000 a piece, you won't be charged a thing if our plan goes through." They said, "How could that be?" I said, "Because we're going to move from the study of governance to purchasing [and other money-making activities]. That's where the money is. If we can cut a bigger deal as a group of hospitals than each of us can as a single, there's a *huge* savings, huge."

Out of that group, I asked [University Hospital and Clinics attorney John] Diehl to draw up papers that would form the University Hospital Educational Consortium. He did with the help of Ed Howell and Ron Werft. It turned out we had about twenty really interested, but only eight could sign on. They didn't want to sign to an organization without university approval. The universities generally said, "If there's an ongoing organization, of course you can join." It turned out there were only eight of us, an unlikely group, that were the founders of the University Hospital Educational Consortium. Within *months*, we had twenty-one members. People could then sign on. Today, membership exceeds seventy.

About that time, I left. I got a lot of criticism. The more personal kind was I did that so I could have a job. I said, "The last thing I want to do is serve a bunch of hospital administrators." The AAMC, which had the most to lose, both John Cooper, the president, and Dick Knapp, the COTH [Council of Teaching Hospitals] head, understood what I was doing. As a matter of fact, Cooper had offered me the COTH job years before. They weren't all upset about it. They didn't want to get into the business end of health. That would detract from their central mission.

We soon switched into purchasing, got a few grants for other things. To my knowledge, they never did ask for more dues from the people—or maybe they get dues for working capital, and, then, give a big dividend based on how much you use the services, but it's substantially more than the dues. So it's worked out rather well. The first president was a University Hospital and Clinics grad, Bob Baker. Two years into it, they changed the name to University Hospital Consortium or Council…Corporation, maybe. They invite me back from time to time, mostly to give a farewell address to one of my fellows who is retiring.

[chuckles]

JW: [Robert] Dickler was active in University Hospital Consortium. Then, he went to AAMC-COTH. Ed Howell was also active in University Hospital Consortium. Greg

Hart was both a member and consultant to University Hospital Consortium. So the Minnesota influence stretched a long way.

DT: What kind of things were you purchasing? I know we talked about this on the ride over here, but for the record what kind of things was the Consortium purchasing?

JW: Oh, the Consortium didn't purchase anything. It was the secondary. The Consortium just funded a study of governance. Then, it switched over to the Corporation. But they purchased everything: drugs, laboratory equipment, radiology equipment.

DT: Given that the University Hospital was, obviously, part of the University structure, I'm wondering what influence University Administration had on what you were doing in the Hospital.

JW: Total. Lyle sat in weekly meetings with the President's Council. President Moos had first hand knowledge of health sciences issues. We never did anything with our Hospital Board that the vice president's office or the president of the University wasn't informed about. You're right, there is potential for conflict, but we never had any. A lot of that was due to Lyle.

DT: What led you to step down as Hospital director?

JW: Someone pulled me aside at a meeting and said, "Geez, you're the third most senior tenured guy in the United States." I said, "Well, it was never my ambition to be the youngest appointed director"—which I was at thirty-two—"nor is it my ambition to be the oldest." [laughter]

I just wanted to try something else. I thought it would be kind of fun to go to a teaching hospital and a board where you could play around with a lot of options without the university, without the medical school. It was a fun three years [at Allegheny Health Services Inc.]. I was brought there as Mister Clean, because the chairman of the board had gotten them in trouble by allowing a pharmacy. In Pennsylvania, hospitals can have pharmacies but hospitals can't own them for clinics, something like that. So the board chair got the bright idea that the hospital administrator and someone else would set up a pharmacy as private citizens and own that and, then, of course, run it through the… But he was kind of eased out and, then, he came back. A final thing was he wanted me to hire this guy that had been on the staff when I came. I said, "No. He's a perfectly decent guy and I got him his job in the suburbs but he doesn't fit into what we're trying to do." He didn't like that at all. He got madder and madder and I thought, hmmm. You don't want to get in a fight with your board chairman. All the other guys were great. [Douglas] Danforth at Westinghouse and [W.H. Krome] George at Alcoa and Vin [Vincent] Sarni at PPG [Pittsburgh Plate Glass], Dave [J. David] Barnes at Mellon [Financial], they came to me and said, "Do you want us to get involved?" Then the heart surgeon, [George] McGovern said, "I can get the medical staff organized." I said, "No.

That's a no-win situation." I was ready to move on anyway in five, six years, so what difference does three make? So I resigned.

DT: When you stepped down at Minnesota, did the fact that Lyle French was stepping down around the same time influence your decision as well?

JW: Not really, although there is always the possibility that a new vice president would want to create his own health sciences team.

DT: We've covered an awful lot of ground. I wonder if you have anything else you'd like to share regarding University Hospital and the AHC?

JW: No. If I do, I'll write it up.

DT: Good. Do you have any suggestions for whom I might talk to, particularly on the Nursing side and the Pharmacy side?

JW: [pause] I'm embarrassed… We finally put out these statistical… They used to put this out; it's the annual report. And we put these out.

DT: [laughter]

JW: In this will be the name of the Pharmacy—if I can find it—interns. Hugh Kabat. Maybe I can find some other names. Pharmacy and Therapeutics Committee. Kabat is spelled K-a-b-a-t. I don't recognize any other name from the Pharmacy faculty. But I'm sure if you called them, the CEO could tell you… That's the only name I can come up with at this time.

DT: That's okay. That's a good start. You've given me clue where I might find Tom Jones, so that's good.

JW: Yes, I told you how to get a hold of him.

DT: I'll just go to the alumni directory.

Thank you so much. This has been great.

[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