

Karlind T. Moller, Ph.D.
Narrator

Lauren E. Klaffke
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

Karлинд Moller was born on May 25, 1942 in Stillwater, MN and grew up in Chisago and St. Paul, MN. Dr. Moller attended the University of Minnesota and majored in Speech Pathology and Audiology. He then pursued graduate work at the University in the Speech Science Pathology and Audiology (later the Department of Communication Disorders). He earned his doctorate in 1970 and then completed a three-year fellowship with the National Institute for Dental Research. He returned to the University as a member of the faculty in 1973 and became director of the Cleft Palate Clinic in 1977. He became director of the Cleft Palate Clinic in 1977. Dr. Moller served the school and the clinic for over thirty years, until his retirement in 2003.

Interview Abstract

Karлинд Moller begins his interview with a reflection on his upbringing and early education. He then discusses how he came to the field of speech pathology and particularly, speech pathology in relation to the cleft palate, relating his experiences in the Cleft Palate Clinic and at the National Institute for Dental Research. He emphasizes the interdisciplinary nature of the Cleft Palate Clinic. He also discusses his experiences publishing with the University of Minnesota Press, his committee work, particularly his work on the Admissions Committee and Minority Student Committee, his work with out-of-state patients, the work of the Cleft Palate Clinic in consulting on treatment, and the completion of the building of the Dental School facilities in the 1970s. Dr. Moller then reflects on his cleft palate work in Guatemala, funding for the Cleft Palate Clinic, the relationship between the Dental School and the Department of Communication Disorders, the Cleft Palate Clinic team, and issues with the state legislature and speech pathologist licensing. He also discusses his teaching, work with dental hygienists, the culture of the Dental School, Dr. Erwin Schaeffer's tenure as dean, the relationship of the Cleft Palate Clinic with other schools in the AHC, the tenures of Dr. Richard Oliver and Richard Elzay as deans, the threatened closure of the Dental School in 1988, retrenchment, work with the state legislature and the insurance industry over cleft palate correction, the vice presidents for the AHC in the 1990s, and the tenure of Dr. Michael Till as dean. He concludes by discussing additional figures of importance in the Dental School's history.

Interview with Doctor Karlind T. Moller

Interviewed by Lauren Klaffke

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

Interviewed in Diehl Hall, University of Minnesota Campus

Interviewed on April 26, 2013

Karlind Moller - KM
Lauren Klaffke - LK

LK: This is Lauren Klaffke. It's April 26 [2013] and I'm in Diehl Hall with Doctor Karlind Moller.

Thank you for meeting with me today.

KM: You're so welcome. It's nice to be here, Lauren.

LK: I wanted to get started asking you a little bit about your background, where you born and raised and your early education.

KM: Going all the way back there?

LK: Yes. [chuckles]

KM: I was born on May 25, 1942 in Stillwater, Minnesota. Actually, that's not my hometown. I consider my hometown Chisago City, Minnesota, about thirty miles north of Saint Paul. The reason I was born in Stillwater was my mother's sister was a nurse there, so they brought me there to deliver me. I lived in Chisago for the first eleven years.

Then, we moved down to the east side of Saint Paul and I attended Farnsworth Elementary School, Cleveland Junior High, and Johnson Senior High, graduating in 1960.

Then, I came out here to the University. Actually, I wasn't planning to come to the University because I thought it was just going to be too big and not enough one-on-one instruction and so many people were out there. But my mother was diagnosed with cancer in my senior year of high school, so going out of town was not an option. I was thinking about going to Dartmouth. So I stayed here and I had a job here at Food Town Supermarkets, which was a great job in high school, and it paid my way through college.

LK: Oh, wow.

KM: I started in the fall of 1960. It was a wonderful year to start. Minnesota had excellent football teams.

LK: [chuckles]

KM: But I really didn't have a clue as to what I was going to major in and pursue as a career. I was in SLA at that time, Science, Literature, and the Arts. It's been changed to CLA [College of Liberal Arts]. About the end of my sophomore year and into my junior year, my undergraduate advisor said, "You've got to make a decision about what you're going to major in here." I started out in some speech communication courses, theater courses, political science, and business. That was really because I was working in a business. I was on the student council, so political science seemed kind of interesting. So political science, business, and speech communication.

But in one of my speech courses, there was a person that was majoring in speech therapy, which I didn't know anything about. As I was talking to her, it sounded like that might be an interesting thing to major in. So I explored it a little bit. But I did have in the back of my mind that maybe becoming a dentist might be kind of nice. With the last name of Moller, I thought that would be perfect for me.

LK: [laughter] Yes.

KM: They would surely let me in, right? I took some chemistry courses, which were prerequisites and I just didn't enjoy chemistry at all. So I decided, No. No. This is not it. So I focused on speech pathology. It was called Speech Science Pathology and Audiology. That was the curriculum in 1963, 1964. That was my undergraduate major. Then, I just segued right into graduate school in that program of Speech Science Pathology and Audiology. It ultimately changed its name to the Department of Communication Disorders. It was part of the Speech Communication Department, a division of, but then they established their own department of Communication Disorders in about 1967. I started graduate school in the winter of 1965.

I became particularly interested in the speech of children who were born with cleft lip and palate. I remember having in my undergraduate program, since it was run through the College of Education, a teaching internship, or practicum, in Wayzata, and there was a little boy who had a cleft lip and palate and couldn't say certain sounds. It just

fascinated me why he couldn't say those sounds. I really didn't have a course in cleft palate at that time.

LK: Hmmm.

KM: So as I was working with him, I was trying to figure out what were his limitations physically, orally to produce that sound. I kind of figured it out. He was losing air through his nose. We worked on speech sounds and tongue placement and things like that, and he finally was able to do it, which was really an ah-ha revelation for me and for little Billy. I'll never forget that incident. So maybe that was part of the reason I focused on cleft lip and palates.

Then, my mentor and my advisor in my graduate program, Clark [D.] Starr, who was a dear, dear mentor of mine, invited me over to the School of Dentistry to observe the Cleft Palate Clinic. Actually, he had just come to the School of Dentistry from the Sister Kenny [Institute, Minneapolis, Minnesota], where a team met there. But they decided to establish a new Cleft Palate Clinic in the School of Dentistry in about 1964. I noticed on the timeline of the School of Dentistry, they list the Cleft Palate Clinic in 1957, starting in the School of Dentistry. Actually, that's not right.

LK: Okay.

KM: Actually, it was 1964 that it came over to the School of Dentistry, but a team had been meeting at Sister Kenny before that time.

What I saw there was a group of people, medical doctors, surgeons, dental specialists, and speech pathologists seeing, diagnosing, and evaluating patients, but, then, coming together and discussing their findings and making recommendations for what they thought would be the best treatment for each individual patient. Wow! I just saw a mutual respect for each other as a discipline and for each other personally. Nobody was trying to take over the discussion saying, "I'm a surgeon. We should do surgery. We should do it now." Or the dentist saying, "No, no. We should do this as a dental procedure." It was just a real nice example of people together for the good of the patient. Boy, that really got me excited. So on my master's program and my doctoral program, that was my focus: cleft lip and palate.

After I got my doctorate degree in 1970, or a little bit before that, I had the opportunity to apply to the National Institute of Dental Research for a special research fellowship to encourage speech language pathologists to come into school of dentistry settings as faculty, perhaps potentially as faculty, to see how a speech pathologists might contribute to the dental school, educational curriculum, research, and clinical service. That was what I wanted to do, so I was fortunate to get it. That was a three-year program, and I finished up in December 1972.

At that time, Dean Erwin [M.] Schaffer had to make decision as to whether or not it was worthwhile keeping this guy around on the faculty of the School of Dentistry.

[laughter]

KM: He was the kind of guy that instead of going vertically within Dentistry said, “You know, we should be broader, stretch horizontally, and bring people on the faculty that don’t necessarily have a dental background or a dental degree, but who can contribute to dentistry.” So, fortunately, he thought I was one of those people who could. I was hired. I started on the tenure track, assistant professorship in the School of Dentistry kind of feeling my way around, you know thinking about how I could help educate dentists about something else that goes on in the mouth besides chewing and swallowing. [chuckles]

LK: Yes.

KM: And that’s speech...and how dental relationships, malocclusions, and cleft lip and palate can affect what goes on there to produce speech.

It was a special research fellowship, so I did a lot of research in those first three years while I was on the grant. Then, afterward, I continued the research.

Along the way, about 1973, 1974, 1975, 1976, I found myself coming down to the Cleft Palate Clinic every week when they had their team meetings and saw patients. So I decided really that was my first love, the clinical service component; although, research certainly was important and teaching was important. But I really wanted to see the patients, and I wanted to work with families.

Ralph B. Kersten was the director of the Clinic in those years, and he died suddenly in 1977. He was an important person in my getting started in this area, as well. He was a dentist who practiced actively in Minneapolis. He contracted polio in 1952. I don’t know if you’ve read about that. That was really an interesting history. While he was on rehabilitation at Sister Kenny, he thought, what am I going to do? I can’t practice dentistry. He was paralyzed from the shoulder to his wrist. So he thought the team approach to cleft lip and palate would be good. So that’s what he did. He was director from about 1964 to 1977.

Then, when he died, of course I really wanted to continue his work. So I applied for the position as director of the Clinic. Erwin Schaffer was still dean. They had a search as they need to do. But I was appointed as interim director of the Cleft Palate Clinic in 1977 and as director in 1978.

One of the first things that I wanted to do—in fact, Ralph Kersten...we were kind of working on that the time he died—was to put a film together about how the Cleft Palate Clinic operated. We got some monies to do that. We worked with Media Resources here at the University, so a film was made showing how the Clinic functioned. We continued to meet as a team of medical, dental, and speech and hearing professionals.

Then, in 1980, we felt there was really a need for a separate clinic that sees patients with more major facial problems, craniofacial problems, craniofacial asymmetries, syndromes, and the like. Of course, Bob [Robert] Gorlin was walking the halls, and he thought that would be a good idea. Again...again a team concept pulling together all the necessary...appropriate is a better word, appropriate specialists to address the range of problems and concerns they had. We knew in Cleft Lip and Palate it was certainly the surgeon, the otolaryngologist, and speech pathologist, the dentist, the prosthodontist, the orthodontist, the audiologist, so it was a pretty good-sized team for Cleft Lip and Palate. But, now, we need a neurosurgeon for the craniofacial issues, and we need an ophthalmologist, and we need a neuropsychologist, and we need a geneticist—Bob Gorlin was instrumental in that—a larger team to address the range of concerns that those children and adults had. So we established that clinic in 1980. It was officially sanctioned in the AHC as the Center for Craniofacial Anomalies and Skull-Base Surgery. John Westerman, I think, was the hospital administrator. Honestly, Lauren, I can't recall who the faculty... It might have been Lyle French. He was provost, vice provost?

LK: I have Lyle French from 1971 to 1982.

KM: See then, he would have been the person that sent a letter to me as co-director of the Center for Craniofacial Anomalies and Skull-Base Surgery. The other co-director was Larry [Lawrence J.] Marentette. Larry Marentette was in the Department of Otolaryngology. That was another important medical treatment component. Larry Marentette, in Ear, Nose, and Throat, Otolaryngology, and Shelley Chou, who was a neurosurgeon and Bob [Robert D.] Letson in Ophthalmology, all were interested, dedicated, and committed to that team. Shelley Chou then retired and continued with some administrative responsibilities. Then, Steve [Stephen J.] Haines came to the clinic as our neurosurgeon. Then, Larry Marentette left for Detroit by 1990 maybe, or a little bit later. Then, Sam [Samuel C.] Levine, who was in Otolaryngology, and I were co-directors of the Craniofacial Clinic. We had the Cleft Palate Clinic, which was ongoing all through the years, and then, added the Craniofacial Clinic in 1980. Those two clinics still continue to this day.

LK: Did they ever merge or were they always separate?

KM: They were separate. They were always in the School of Dentistry on the sixth floor [of Moos Tower].

When we saw craniofacial patients, it was a larger group of people that we needed to involve. Cleft Palate was a smaller group. The Cleft Palate Clinic met every week and Craniofacial Clinic met once a month. There were less patients that had those issues.

LK: Okay.

KM: Like I say, they continue to work today. I enjoy going over and visiting with Gary [C.] Anderson, who is the new director after I retired and Anna [K.] Thurmes, who is the

new coordinator. I know the Craniofacial Clinic now is meeting across the [Mississippi] River. That's fine. The Cleft Palate Clinic continues to meet in the School of Dentistry.

Along the way, in addition to being director and coordinator of the Cleft Palate Clinic and the Craniofacial Clinic... I don't know if you want any of this material, but I brought a brochure of the Craniofacial Clinic when it first came out about 1990. It was sent to all pediatricians and dental specialists so they knew that we existed.

LK: Yes, that would be great.

KM: I'd be happy to do that. This is the brochure of our Cleft Palate Clinic.

[pause]

LK: Is this one of the earlier...?

KM: Actually, this one preceded that one.

LK: Okay.

KM: We had the film of the Cleft Palate Clinic. The Craniofacial Clinic talks about two components, the Craniofacial Anomalies of which I was director and then the Skull-Base Surgery Clinic with Larry Marentette and Steve Haines. That will become more clear.

LK: Okay, great.

KM: That's me there and Larry Marentette.

We worked back and forth. If I would get a telephone call from a pediatrician in Wisconsin who had a child just born with a syndrome or severe facial asymmetry, I might call Larry right away and say, "You should see this patient and see if there are any major issues right now." Once he gets established in our system, then we'll see him in the total team clinic and make recommendations and the actual treatment can be carried out in the Medical School. Here was the thing that really excited me about my work is the interdisciplinary possibilities and opportunities.

LK: Yes.

KM: Here we were crossing between the Dental School and the Medical School. Not everybody did that, unfortunately.

[chuckles]

KM: We were all in the healthcare business...speech pathology, dentistry, all the medical specialists, and dental specialists. I enjoyed that right from the get-go. That

bridge was there. I know it isn't for everybody or wasn't. I think it's much more travelable now.

LK: It seems that that kind of interdisciplinary approach would make the work continually interesting, because you're always kind of getting involved in another subject and learning new things.

KM: Oh, it really was an educational journey as well as a clinical service journey. If you bring together a group of people and put them in a room, all the specialists, that does not a functioning team make. What you have to have is the mutual respect of each person for each other and for each discipline in a cooperative, collaborative effort. I was fortunate that I had people who were like that. We didn't have any dictators or people who thought they could do everything by themselves. No. Everybody had their input. We all discussed the possibilities and decided as a consensus, team consensus, what is the best thing to recommend for this patient at this particular stage of their facial and dental growth and development. There are things to do at certain times and things not to do at certain times. You don't want to interfere with growth and development and, then, to follow their psychosocial, neuropsychological, speech, hearing, along the way, too...all very important.

LK: Yes.

KM: It was that interdisciplinary fervor and possibilities here at the University that were really exciting. I know now and I've heard it said by others that... People talk now about teams and interdisciplinary care, and how important that is, and we should do that. Heck, we started that back in the 1960s. [chuckles] That's not to say we were a template for anybody, but that's just the way it should be. That's the way it was and that's the way it operated. I was fortunate to be a part of that.

LK: Do you think that was part of the environment that Doctor Schaffer fostered?

KM: Yes.

LK: I want to say it was 1970 when the AHC [Academic Health Center] was formed. Do you think that helped facilitate any of that collaboration, as well?

KM: [pause] That's a good question. I guess I can't say that because the AHC was established at that time that that made really any difference, not that that wasn't needed and important, but it was already going on.

LK: All right.

KM: People were here that were cooperative and collaborative without that all coming together. I remember when that happened. I was just getting started. I had just finished my Ph.D. in 1970 and was just coming to the School of Dentistry. I guess I had seen that already, that folks from the Medical School, Public Health, or Pharmacy were already

willing to work together. It's really a good question to think about. But, I guess, administration put its seal of approval on this sort of activity.

LK: Yes. [chuckles]

KM: Yes.

I should mention, before I forget, that I hold here in my hand a videotape of the twenty-fifth anniversary of the AHC.

LK: Oh, wow!

KM: I don't know if you have that.

LK: I don't know. I'd have to ask my graduate advisor.

KM: This was at the [Minnesota] State Fair.

LK: Oh, really?

KM: We put it together for the State Fair in...well, it would have been 1995, the twenty-fifth anniversary. So they played it continually. I asked for a copy of that because our Craniofacial Clinic was featured in there.

LK: Oh, okay.

KM: I'm certainly happy to will this to anybody that wants it from a history standpoint.

LK: Yes, I'd be interested.

KM: Get it into a DVD?

LK: Yes. If the Archives can do it for a pretty low price, like ten or fifteen dollars. It would be cool to try and include on our website, as well.

KM: Yes. Right.

LK: I'll look into that. Thank you.

KM: Okay.

LK: I can send it back to you, too.

KM: I guess I'd like a DVD of it.

LK: Okay.

KM: So if they make one...if you make one, it doesn't take much to make another.

LK: Yes, okay.

KM: I would like that.

LK: Okay. Great.

KM: I served for thirty years plus as director and coordinator of the Cleft Palate Clinic and Craniofacial Clinic. But along the way, I was teaching, mentoring speech pathology students. I had a joint appointment—they don't call it that. I can't think of the term. It used to be called a joint appoint with another department.

LK: Right.

KM: I was in the Department of Communication Disorders and the School of Dentistry. So I kept that relationship, which was very valuable to me. I taught for them, and I taught classes in the School of Dentistry, and I mentored residents in medicine and dentistry all interdisciplinary again and very exciting. I continued that through the years.

Then, I also published with Clark Starr [and Sylvia Johnson], *A Parent's Guide to Cleft Lip and Palate* in 1990...

LK: Hmmm.

KM: ...which was very well received nationally and literally internationally.

LK: Was it a book?

KM: It was a book...University of Minnesota Press... I can give you some history on that.

LK: Okay.

KM: Jack...Jack [John E. Ervin, Junior, director] was editor...no, president, publisher, of University Press for a number of years. He decided that it would be good to have a series of books for parents on common birth defects. So there was spina bifida and cleft lip and palate. There was hearing loss. There was cerebral palsy. There was congenital heart—James [H.] Moller. We're not related at all. I used to get his Campus Club bills. He wrote the one on heart. Clark Starr and I wrote *The Parent's Guide to Cleft Lip and Palate*. The general editor was Bob Gorlin. That came out in about 1990. That was kind of fun to put that together, and again I say it was very well received. It's still used today by families.

We had another person that helped us with the language, so it was very parent friendly. That was a children's author, Sylvia Johnson.

LK: Oh.

KM: She really did a marvelous job. I really thought that I could write so the parents...because I'd counseled parents over the years, but she did such a beautiful job that...gee, I wish I would have said it that way. It was just that kind of color that she added that was very valuable.

Then, Clark and I published an edited text in 1993, *Cleft Palate: Interdisciplinary Issues and Treatment*, where we had contributors from the various specialties. But the focus really was on speech and it was a text for speech pathology students mainly, but it was a valuable text, we felt, for dental specialists and medical specialists. We were thinking about teams. Then, Clark died in, I want to say, 1999 [Doctor Starr died March 24, 1999] and Leslie [E.] Glaze joined me to do a second edition of *Cleft Lip and Palate: Interdisciplinary Issues and Treatment*, which came out in 2008. That was a broader text. It included more disciplines. That was the last of the books. [chuckles] It was fun doing it. I'm glad that they're done.

I retired in June 2008 officially as a full time faculty member, but I stayed on for another year during the transition. Patrick Lloyd was dean. I still am available for any questions. If I can provide any input and be helpful to anybody over there, I'm happy to do that. It was a wonderful journey, Lauren, over a sustained period of time.

LK: Yes.

KM: It was very, very rewarding and satisfying to me.

I served on some other committees for the AHC. I was chair of Promotion and Tenure in two instances. I can't remember the specific years. Certainly when Frank Cerra was here, I chaired the All University AHC Promotion and Tenure Committee. If you want, you could make a copy of the committees for the AHC or All University or I could just read them to you...whatever.

LK: If you want to look at your CV [curriculum vitae] and maybe comment on any of the ones that you played a big role in.

KM: Sure. Good idea. This is my big history.

[chuckles]

KM: That's my last annual report.

LK: Thanks for bringing so many resources with you.

KM: I had to take notes. I might say something about other things that are special to me, too.

LK: Yes.

KM: I started out as assistant professor and went through the ranks. The degrees, you know about. I had an appointment in the graduate school. These were professional organizations, editorial reviewers for journals and things.

[pause as Doctor Moller reviews his CV]

Oh, one of the things that I really enjoyed once I got into dentistry as a full time faculty member, is I was asked if I would be chair of the Minority Student Committee.

LK: Oh.

KM: So I did that for a number of years, bringing people of minority backgrounds into the University School of Dentistry. Women were a minority in Dentistry at that time, a minority. When I started on the Admissions Committee in, like, 1973, there were one or two women.

LK: Yes.

KM: Now, it's over fifty percent.

LK: Yes.

KM: I served on the Admissions Committee for several years and by the time, I stopped, I think it was up to thirty-five percent, which was nice to see—not that I made all that difference. Things changed so nicely in the 1970s, and it was so appropriate.

LK: Can you comment at all on the recruitment activities that you all did to try to change...

KM: For minority students?

LK: For minority students and women, yes.

KM: Well, you know what? I don't recall any active recruitment for women. Maybe it was more the Admissions. Maybe women applied but for whatever reason, they weren't accepted, but not because they were women. I hope not.

We did, actually... [Anthony] Tony DiAngelis and I... I don't know if that name had come up. He's now director of Dental Services at the Hennepin County Medical Center. He would be a good person to be interviewed.

LK: Okay.

KM: He goes way back. Tony and I did a video. I don't have any of that. I don't know who does, maybe somebody in Dentistry. It was made to show people that dentistry was a wonderful career and here are the opportunities. I think we actually focused on women, too...what a wonderful profession this would be for women as well as men, the part time possibilities if they had children. I believe that's true. Yes, I just now thought of that.

For minorities, that was a more active...not more important, but difficult in a way, too.

LK: Yes.

KM: There was an Academic Health Center person... Richard Jenkins is the name that I recall who was in the Academic Health Center, and when I was chair of the Minority Student Committee, I worked with him. They had some materials and things to bring minority students into the health sciences, so we used some of that. I attended some symposia and worked actively identifying students. At that time, you know, it was primarily African Americans, American Indians, and Hispanics. They were not well represented in Dentistry at that time.

LK: Right.

KM: That was interesting for me, and I enjoyed doing that. Now, they have almost a full time person in Dentistry who works in that Office of Admissions on minority student recruitment. But, in the early years, it was beating the bushes to let them know that this was a possibility for them.

LK: Another part of Admissions... I know there was a push in, I want to say, the 1970s, the first time I saw it, to try and address shortages of dentists in rural areas. Was that ever a consideration in your time working with Admissions at all, trying to let in people who were from rural areas so they could go back to those areas?

KM: That's a really good question, Lauren. I think it was like we had almost enough people from Minnesota, from the outstate areas, that we hoped were sufficiently qualified to get into dentistry and then would go back to their communities. I don't remember that there was a feeling of a real shortage of dentists in the outstate areas, because there were enough applicants. We didn't end up, as I recall, with a pool of metropolitan applicants who were so much better than the folks from outstate. I don't remember the ratios of outstate and metro to out-of-state. We brought in a number of folks from Wisconsin, North and South Dakota, and Montana, from the five-state region, purposely and, then, from outside of that region, too. But the bulk of the admitted students were from Minnesota. That percentage, I can't remember.

LK: Okay.

KM: Like I say, I don't remember any programs that pushed for outstate students.

LK: I know there was a lot of work between, I guess, the different regional states because the Minnesota Dental School serves this larger region.

KM: We were the only dental school.

LK: Right, right.

I think that's still on one of the signs down in the tunnel of Moos Tower: "It's the only dental school from here to Seattle."

KM: That's correct. Yes, west of the Mississippi [River]. Marquette, of course, is in Wisconsin, but it's private.

LK: You had mentioned earlier that you were working with a pediatrician in Wisconsin to treat a patient with a cleft palate. So did you do a lot of work with patients from out-of-state as well?

KM: Yes, certainly western Wisconsin. We wanted to make our team clinic, our disciplinary clinic for Cleft Lip and Palate and Craniofacial Anomalies visible to primary care and pediatricians, pediatric folks in western Wisconsin because instead of traveling all the way to Madison [Wisconsin], where they did have a clinic, or elsewhere. Hey, we were here. We'd be happy to see patients from Wisconsin and that was true of the Dakotas. They really didn't have large enough teams, I guess I want to say, that we represented all the specialists, so making ourselves more visible, we got more referrals from out-of-state. Sure. Subsequently, because we did that—I guess I gave that as an example—pediatricians from Wisconsin would call and say, "I just delivered a baby with some issues." Then, of course, we'd put him or her in contact with whoever was the most appropriate initially. Maybe we'd see them in our Clinic. Or a speech language pathologist in North Dakota was aware of our Clinic and was working with a patient and felt this patient had a really limited structure to produce adequate speech. He knew of our Clinic and he could refer to our Clinic and we would evaluate and make recommendations for treatment.

Now, it's important to understand that our Clinic was not necessarily—at least the Cleft Palate Clinic—we weren't the clinic to do treatment. We were the clinic to diagnose, evaluate, and *recommend* treatment.

LK: Ohhh.

KM: Then we shared that...I shared that with the family so they understood what we were recommending and why. Then, they could make the decision as to who would do it. It could be somebody here. We were an open door as far as being available. But, you know, their hometown orthodontist, their hometown dentist, their primary care physician can do a lot of this as long as they see the plan and how they can contribute to that plan.

So we tried to coordinate the treatment as much as possible in their local communities and, then, they would come back to see us every year, and we'd reevaluate and see how things were going. The name of the game was following these patients until their facial growth and development was complete. That's about when they graduate from high school. Hopefully, the final surgery directly related to cleft lip and palate is complete and they've had appropriate speech therapy, the surgical procedures, the dental care so that when they walk down the aisle at graduation, you know, the job is finished, and they can reach their vocational, educational, and social potentials.

I'm still enjoying that to this day where I get cards from patients and families when they're having babies now or high school graduations. I mean I've been lucky when you think about it.

LK: Yes.

KM: I see these families and they become friends over the years. I get invited to high school graduations and the weddings and I hear from them at Christmas time...pictures of their kids. Anyway, I'm getting nostalgic on you here. That was such a beautiful part...that *is* such a beautiful part.

LK: Yes. I was going to say that's got to be really rewarding to be able to see the kids grow up like that.

KM: Yes. It really is.

In terms of AHC activity... Yes, chair of the Academic Health Center All University Promotion and Tenure Committee, a couple of stints with that. Then I was—this was during the transition after I retired—in 2008 to 2009, on the Academic Health Center Task Force on Benefits and Appointments for Non-Stipend Personnel. Frank Cerra, we reported to him directly on that.

Cherie Perlmutter...oh, my goodness. I knew *of* her when I started in the School of Dentistry, but, then, when I was on the Promotion and Tenure Committee and chair of that in the School of Dentistry—that's separate from the Academic Health Center, all University—she was so helpful with guidelines and being a resource. She was *Miss* Promotion and Tenure in the Medical School and the all University Health Center, too, so she was kind of an important person. I just had the opportunity to see her again when Richard [C.] Oliver received his University Alumni [Outstanding Achievement] Award.

LK: Oh. Was that recently?

KM: That's recently.

LK: Was he in town? Ohhh. He's living in Arizona, right?

KM: Yes, he is.

LK: I didn't realize he was going to be in town.

KM: Oh, really?

LK: Yes.

KM: When was that? Last year.

LK: Oh, okay. I wasn't on this project yet.

KM: It was fall [July 19, 2012]. He got the University Alumni honor. Cherie was there, as well as faculty people that were here when Dick Oliver was dean.

So I've seen all the deans starting with Erwin Schaffer all the way up to the present one [Leon A. Assael], who I've met, but I don't know him as well. They all have their wonderful points. They're all wonderful people. Each time a new dean came in, they would look at our Clinic and say, "What do you do?" They didn't quite understand how we worked. We were kind of an independent shop for all these years. We were never a division or a department. We were always a special program as part of a division or a department.

When I first came into dentistry in 1970 on the special research fellowship... I've got to mention these names. Carl [J.] Witkop came from the National Institute of Dental Research to Minnesota and headed up the Division of Human Genetics. I was kind of appointed in his division. He was really helpful in getting me that special research fellowship, too, as well as Clark Starr and Erwin Schaffer. I worked in that division on the sixteenth floor of Moos Tower.

Of course, I was here for the building of the building. Man! I had just gotten my Ph.D. on this special research fellowship, and they're asking me what do I need? What kinds of equipment? What spaces do you need? So I was really on the ground floor of designing based on the sixth floor for the Cleft Lip and Palate Clinic as well as the speech research area on the sixteenth floor. So he [Carl Witkop] was an important person.

LK: Just a comment on that. I saw that moving into Moos Tower, you had soundproof rooms. The video equipment was updated for you guys.

KM: Yes. I remember Mel [Mellor] Holland was chair of that whole committee. I was sitting down with him. He would say, "What do you need to do your research?" Well, it would be nice to have motion X-rays of the patient while we're talking. Video fluoroscopy would be terrific. It was about a quarter of a million dollars for that unit. It was part of the fixed equipment for the school. God! I remember my blue-sky list of things that I would love—that was one of them—and they virtually were all approved. Maybe they really weren't as critical as they should have been. What I want to say is that that was all wonderful and I was able to do the speech research that I wanted to do.

Burton Shapiro is another name...

LK: I interviewed him.

KM: Did you? Good!

LK: Yes, yes.

KM: I was going to suggest if you hadn't that I hoped you could. Oh, absolutely.

I want to say when I first came into the School of Dentistry, I had a chance to sit in on courses in the Medical School as well as the Dental School.

LK: Oh, okay.

KM: A.B. Baker in neurology. Oh, my goodness. I really enjoyed his class. He was a stalwart in neurology teaching in Minnesota for many, many years.

Mike [Michael M.] Paperella and Jack [Arndt J. "Jack"] Duvall [III] in Ear, Nose, and Throat. Mike was the chair of Ear, Nose, and Throat. He's still active, I think, and has the Minnesota Head and Neck Clinic across the way, but still has an appointment here.

I remember the person from the architects [Architectural Collaborative, Cerny and Associates, Hammel Green, & Abrahamson, Setter Leach and Lindstrom] in Boston who designed this building. His name was Duane [Blanchard]. He would come here every so often and get the people together on part of the sixth floor designing rooms and everything.

Richard [L.] Christiansen was important to me, because when I was planning my dissertation research, I needed a special way to measure the movement of the soft palate during speech. What I was interested in doing, if we could do that, then we could teach the patient to raise their soft palate higher, which would, then, result in better speech. Now, you couldn't do that with motion X-rays, because you'd burn the patient out with radiation. Richard Christiansen was an orthodontist here on a Ph.D. program with Maurice Visscher in Physiology.

LK: I know that name.

KM: I took my problem to Dick Christiansen who just really got excited about it. He designed a transducer system, a little wire with a loop on the back of the soft palate. When you'd talk, you got these squiggly little lines on a recorder...

LK: Hmmm!

KM: ...an ink jet recorder. We were able to demonstrate that this was a reliable tool to follow soft palate movement during speech and could be used as a teaching device for kids. When you raise your palate, you have no idea that you're doing that, what comes out of your mouth as non-nasal speech. They don't know how to change it. But if you can show them that when they raise their palate a little that's what you want to do. So I worked with that a lot in my dental research fellowship.

LK: That technology came out of your work on your dissertation? So your dissertation focused on the soft palate?

KM: That's right. That was my dissertation: "The Use of Displacement Transducers to Alter Soft Palate Movement."

Then, Dick Christiansen subsequently went to NIH [National Institutes of Health] and became director...

LK: Oh, wow.

KM: ...of the National Institute of Dental Research. Then, he became dean of the School of Dentistry in [University of] Michigan. He's retired now, but we hear from him every Christmas. You know, the friends you make... Here again, interdisciplinary. I knew what I wanted, but I couldn't do it. There were no speech pathologists in Shevlin Hall that could do it. So you look at who's around and what they do and you talk with them.

Another example is Phil [Philippe] L'Heureux in Radiology. When we got our video fluoroscopic unit, I wasn't the one that could shoot X-rays. So I talked to a person in Radiology. But I got his name through the head of Radiology. I had his name on the tip of my tongue. Well, I can't remember that. [Later remembered, Eugene Gedgaudas.]

LK: It wasn't Kurt Amplatz, was it?

KM: No. I heard of him around that time.

LK: Yes.

KM: He was the guru in Radiology.

LK: I don't know who came after him.

KM: I don't know if he was *head* of Diagnostic Radiology.

LK: Oh. Okay.

KM: Maybe a division of Radiology. The head of Diagnostic Radiology... I could look back.

Anyway, Phil L'Heureux was a member of the faculty. He got excited about... He had never really been trained in how the soft palate worked during speech. That wasn't part of his curriculum. But I told him, "This is what you can see from X-rays of the side of the head, how this little structure needs to move." So he really helped us in getting motion radiography started, working with us in getting that diagnostic service. Again, like I say, it's that interdisciplinary activity that was so available. Opportunities were there, and I guess you had to go and find them, but people were available.

Ralph Kersten, I mentioned. Carl Witkop. John Salk. Has that name come up?

LK: No.

KM: S-a-l-k. He was working with Carl Witkop a number of years while I was on the faculty of the School of Dentistry.

LK: Is he still around?

KM: He went to Johns Hopkins.

LK: Okay.

KM: He probably is retired now.

Another thing that I had the distinct pleasure of doing was an opportunity to give back. I went with a surgical team to Guatemala for many years.

LK: Ohhh.

KM: This was a surgeon who was a member of our team. [The surgeon was Warren Schubert.] I served as a speech language pathologist, but, also, as an advocate for team care. It was so enlightening—shocking, in fact—in Guatemala because I could diagnose and evaluate, identify the problems, but surgery doesn't answer everything. Where is the speech-language pathologist that I could recruit? There weren't any. I guess there were in Guatemala City. We were out in the rural areas of Guatemala. But they couldn't afford to come in for treatment. The cost of surgery down there was so prohibitive. That's why we went. But we didn't just want to be a "helicopter" team who came in and repaired things and then left and had no follow up. So we went back for several years in a row. I brought an audiologist with me, so we could identify the speech *and* hearing issues. Education, I guess is what I want to say, that it was such a pleasure to be involved in teaching the haves, the ones who were making money, about team care and being shocked to think they had no idea... Team care? They thought team care was two or more surgeons in the operating room at the same time. No. No, this is pre-surgical diagnosing and evaluation for treatment. *Planning*. It takes time, but it's the right thing to do. I've had an opportunity to teach people here about that as well. That was really important to me.

LK: Was the work in Guatemala all connected with cleft palate?

KM: Cleft palate and then, of course, we'd identify some syndromes that hadn't been identified before. We just tried to point out available resources to help as much as we could without actually being there.

LK: In terms of being in Guatemala, did you speak Spanish? Does a speech pathologist have to be able to speak the language?

KM: Yes, very, very good question. Here's what I've told people that have asked me that question many times. They'd say, "You don't speak Spanish, right? How do you know that they have a problem?" I say, "I listen for air." When they're speaking in any language, if the air is lost someplace, usually through the nose, there's a problem with the physical mechanism. So I don't need to understand the language. It was nice to have an interpreter with me, which I did most of the time, just to establish rapport with the family and the patient and for them to understand what it is I'm trying to do. I want to look in their mouth, so I had to have an interpreter for that. I didn't know Spanish. In Guatemala, basic Spanish won't help you totally either. There are sixteen different dialects, but Spanish will get you by. I had good people doing that for me.

LK: Okay.

KM: I listened for air pressure.

LK: How was your work there funded?

KM: Totally paid by the people who went. It wasn't like an Operation Smile, or Smile Train who pay your way. This was a Minnesota group that went. It involved Children's [Hospital] in Saint Paul, the University, Children's [Hospital] in Minneapolis, surgeons at Regions [Hospital]. Naomi Quillopa was kind of the coordinator of it. She was the wife of Warren Schubert, who was a plastic surgeon. But many people were involved year after year and new people each year. We just paid for our way down there. It was cheap living down there. That wasn't an issue. How rewarding was it? My goodness. We just wish we could have done more, had the facility to do more.

LK: Yes.

KM: We set up things so we could do surgery, and I could teach. I taught with a white sheet and my slide projector that I brought along with me...

LK: Oh, wow.

KM: ...and an interpreter. I needed the interpreter for that, for sure. The people there would come to hear me, the interpreter would translate. Yes, there we were with a white sheet.

I was invited to Guatemala City to talk to the ear, nose, and throat specialists in Guatemala City. Oh, my goodness. I had my University of Minnesota sweatshirt on—that's the best I had—and my projector and the carousel of slides. They had all up-to-date cutting edge sound equipment...

LK: Oh, wow.

KM: ...and everything in their rooms. So I didn't have to use a sheet that I used up in Chimaltenango.

LK: [chuckles]

KM: So I had an opportunity to talk to those folks, too, on occasion.

LK: When you were doing you teaching, were you training the parents to work with the kids, too? Was that part of it?

KM: That was limited, working with the parents and what they could do. You wanted to encourage them talking with their children to get them speaking in the early years. But most of the education I did was with people that came from Minnesota, to teach them about team care, and the natives, the providers in Guatemala either in the local communities or in Guatemala City about team care, about cleft lip and palate and the various facets of that, surgery, the dental, speech, hearing, genetics. Oh, we had some real adventures down there. I don't think you need to hear all of those.

LK: [chuckles]

KM: Like I say, bottom line, it was so rewarding and a chance to give back.

LK: Yes.

KM: It was really what was important to do, I felt.

LK: How was the Cleft Palate Clinic itself funded? Was that through the Dental School?

KM: Yes. When Erwin Schaffer made the decision to establish it in the School of Dentistry in 1964, there were costs associated with that, certainly the director, Ralph Kersten at that time. Then, we did pay the consultants, team members who were coming in from the outside. We wanted to do that. Community people were participating in a University clinic. I believe, Lauren, that in the 1960s, Ralph was paying them like thirty-five dollars per time. Now, that involved the entire morning away from their practice. They could make more, obviously, if they stayed in their practice. These were people that *wanted* to do this. When I took over as director of the clinic until I retired in 2008, they were still getting thirty-five dollars.

LK: Really! [laughter]

KM: It came to the point where they said, “I don’t want any more money.” When it comes to tax time, it’s an issue. They could probably deduct travel and things. It ended up just being, kind of being, everybody came for nothing.

LK: Okay.

KM: We didn’t have huge amounts of money. We operated on a dime, not a lot of money.

Again, it was supported by Erwin Schaffer and, then, through the years, it became part of a division or a department and had some administrative costs, secretarial work, etc.

LK: I want to talk a little bit more about Ralph Kersten. He became interested in the cleft palate as a result of his time in the Sister Kenny Clinic?

KM: Yes. He was actually in rehabilitation at Sister Kenny for his polio and thinking about what it is he could possibly do. He couldn’t practice dentistry with his physical limitations. He talked about the team clinic. This is interesting. He identified people that he knew, friends of his. Wally [Walter] Warpeha; there’s a very important name. Ted [Theodore] Morstad was the head of Prosthodontics at that time in the school. The pediatric surgeons at Children’s Hospital...a wonderful group of people that did cleft lip and palate repair and a couple of plastic surgeons in the area that did cleft lip and palate surgery. Now, there are bushels of plastic surgeons compared to those days. He identified them, brought them together. And Mildred [A.] Norval [Indritz], she was the head of what we called Crippled Children’s Services of Minnesota.

The Crippled Children’s Services was a federal program that would give money to the states to help evaluate and treat crippled children. Well, back in the 1930s, there was an orthodontist in Pennsylvania who made a trip to Washington [D.C.]. The Crippled Children’s program was established before that. He made a plea to Congress saying, “You know, patients with cleft lip and palate are facially crippled.” Usually, it’s just orthopedic issues more than anything else. He convinced them that was true.

So monies were provide to states for children with cleft lip and palate by the Crippled Children’s Service, and Mildred Norval was the head of that. She was very passionate about those patients. So at Sister Kenny, she provided, I think, some monies and support for the clinic to start there. Then, when the clinic moved to the University, I think she was less enamored about giving money to the University, in a sense. But she was still always—I think she’s still alive—a person that really wanted the best care for patients with cleft lip and palate. She would invite me when I was student, I remember. She would bring some speaker in, some noted cleft palate surgeon from Chicago or something. She would always send me an invitation. I really learned that way, and I was really grateful to her for doing that. Crippled Children’s Services changed its name to Services for Children with Handicaps, which was a better name. Services for Children

with Special Needs is the more recent term. They sponsored team clinics in Minnesota, too—not ours because we were doing our own thing. They went up in Duluth once a month. Mayo [Clinic in Rochester, Minnesota] had a team, too, that was smaller than ours. So she continued to fund team clinics, but that's been eliminated now.

LK: Okay.

KM: I don't know if they still have a team in Duluth or not. They may.

I got off track here.

LK: Oh, no, it's okay. I think it's really admirable of Doctor Kersten to take what happened to him and turn it into something...

KM: Yes, yes. He was such a dear person.

I wanted to say, too, that back in the 1930s when team clinics were first being identified nationally, the first one was at Lancaster Cleft Palate Clinic in Lancaster, Pennsylvania. It was the orthodontist on that team that went to Washington to plead for money.

LK: Who was that? Do you know?

KM: Sure I do. I just can't think of his name right off hand. It's in our book. In my chapter on team clinics, I have the history on that. [Dr. Herbert K. Cooper]

LK: Okay, I'll look it up.

KM: If you can't find it, let me know.

In Minnesota, there was a guy by the name of Carl Waldron, C-a-r-l W-a-l-d-r-o-n. He was a dentist and a surgeon. One of the things he was very interested in doing was doing cleft lip and palate surgery, but he had a dental background, too. He knew how important it was for these kids to have good dental care and, ultimately, braces. That wasn't a luxury for these kids. That was an integral part of their treatment.

LK: Right.

KM: This is what Ralph Kersten told me. He applied to the State of Minnesota for fifty dollars to get a part time secretary to help keep track of some records when patients were seen. Well, it was denied.

LK: Ohhh.

KM: But had it been approved, it would have been the first team clinic in the nation.

LK: Oh!

KM: Isn't that cool?

LK: Yes.

KM: Carl Waldron kept his records on patients in a little blue book. He died about 1975. His son was a pediatric surgeon, John Waldron. He was one of the people on our team.

LK: Oh, wow.

KM: When Carl died, John didn't know what to do with all his records. I said, "Give them to me. We'll take them in our Clinic. We'll just keep them here." To this day, when everybody wants to clean house and everything... "Don't you dare touch that box." So, today, it's sitting over in the University of Minnesota warehouse in the health sciences area...with all of his records. Of course, I've been going through some of that. I may do something with that some day, write about it. He made home visits to these families. "Saw Johnny today. The repair I did last week looks good."

LK: I wonder if the University Archives would take those.

KM: You know, I did ask that question. I wanted to make sure they were still there about a year ago. I went over there and found the box. I took a couple of records to look at home to see what I wanted to do with them. I did, I think...I thought I did call somebody about that. I don't remember for sure. But they're there. I talked to somebody about it. Like you said, I wonder if the University Archives would be interested.

LK: Did he work at the University?

KM: John Waldron?

LK: Carl. These are his papers, right?

KM: Yes, he did. He had a private practice in downtown Minneapolis, but he had some University affiliation, in surgery probably. Whether he was called a pediatric dentist or just a surgeon, a pediatric surgeon at the University of Minnesota... But, like I say, he also had his dental degree. He knew then that the team approach was the way to go. It had just started hitting the national scene and he applies for a grant for fifty dollars. Of course, I know fifty dollars was not the same then as it is now.

LK: Yes.

KM: Gosh, we would have had the distinction of being the first *team clinic*.

LK: Right.

Was it with the move of the Cleft Palate Clinic to the University of Minnesota that the Dental School became interested in communication disorders or did that sort of affiliation precede the clinic?

KM: Yes. Clark Starr, my mentor, graduated from Northwestern in speech pathology about 1956. He came here as director of the Speech and Hearing Clinic in Shevlin Hall on this campus. That program was called Speech Pathology and Audiology and was part of the Department of Speech Communication in Folwell Hall. But he did his dissertation on cleft lip and palate at Northwestern.

LK: Oh.

KM: So when he came here, he had that interest. When Ralph Kersten was trying to identify people that might be interested in coming together, apparently he knew about Clark, because Clark went down and was part of those early meetings at the clinic at Sister Kenny. I remember when Clark was my mentor, my advisor on the undergraduate program, he'd say, "I won't be here Wednesday mornings." He goes down to Sister Kenny. It was after it moved here that he told me, "It's now over in the School of Dentistry. We're not meeting at Sister Kenny any more on Wednesday mornings we're meeting at the University of Minnesota School of Dentistry on the second floor of Owre Hall." Ralph Kersten had a little office there. There was a conference room.

The table in that conference room in Owre Hall, Ralph and I brought over from the old Owre Hall and it's sitting on the sixth floor of Cleft Lip and Palate Clinic.

LK: Oh! That's cool.

KM: Yes, yes. It has the metal conduit. Greenfield, it's called. The table was wired with plug-ins all the way around the table. Of course, we just cut off the conduit and it was hanging on the floor until 2008 when I retired. I went to get a hacksaw and cut it off, so that was kind of a right of passage.

LK: [chuckles] Yes.

KM: It would be interesting as people were sitting around the table. Some people knew it wasn't wired but people that didn't know it wasn't would take a paperclip and put it in...

[chuckles]

KM: That table came from Owre Hall, the conference table.

Clark Starr...the Department of Speech Pathology and Audiology that he was a part of, when it came to the School of Dentistry, they already knew Clark existed. So that relationship was there. Then, Clark got me excited about the whole thing. Then, there were two people really excited. That relationship was established before it actually

moved to the school. But Erwin Schaffer was well aware of Clark and Wally Warpeha and Ralph Kersten, the people that actually made it happen.

LK: Okay.

When you began your master's program, did you know you wanted to do cleft palate? You had said that you saw a patient who was having trouble speaking and that's kind of when it...

KM: No, I didn't. It was when I started my master's program and the Clinic had moved here to the School of Dentistry from Sister Kenny that Clark said, "Why don't you come over to the School of Dentistry and see the Clinic in action?" That was early in my master's program that I did that.

LK: Okay.

KM: Then, I ended up taking the course in cleft palate from Clark who taught it at the time. Then I was really the focused on cleft palate ever since.

LK: Was he your advisor coming in?

KM: Yes. He was my advisor on my master's program, on my thesis, and on the committee for my Ph.D. But he was more in administration at that time, so Richard Martin was my dissertation advisor, who really knew little about cleft lip and palate. But he knew a lot about rigorous research.

LK: Okay. [chuckles]

KM: So that was good.

[pause]

LK: You also said that you had geneticists working on your team. What kind of a role did they play?

KM: Really good question. Early on, this would have been in the 1960s, when we were on the second floor of Owre Hall, Bob Gorlin was just down the hall. Bob is an extraordinary person in genetics.

He had a student by the name of Mike [M. Michael] Cohen [Junior], who was in the Oral Pathology Program that Bob was heading and he became interested in cleft lip and palate from a genetic standpoint. So on all the, new families that came into the clinic, Mike would do a family pedigree, sit down with them, and do the lines and the children and who had what disorder. He did that for a number of years. It turns out Mike Cohen turned out to be a very well known publisher in genetics and craniofacial anomalies and

co-authored the *Syndromes of the Head and Neck (Oxford Monographs of Medical Genetics)* with Bob Gorlin. He got his start in that clinic.

Then, we started the Craniofacial Clinic. We understood the genetics of clefting, but you had to see the patient to evaluate the patient totally before you were able to give genetic counseling to the families. That was a part of our Clinic service.

LK: Genetic counseling in terms of if they have additional children...?

KM: Yes [whispered]. Because, you know, Lauren, some people came into the clinic and I would meet with the families initially and I knew that some families felt so guilty that they had a child with cleft lip and palate.

LK: Mmmm.

KM: It was something that they did.

LK: Yes.

KM: That's not true. So Jaroslav Cervenka was in the Department of Oral Pathology. He came to us from Czechoslovakia in about 1968 and never went back. He was an important person, a genetic counselor in our clinic. He would meet with the families and, of course, allay all those fears.

Here's an example, Lauren. I remember like a twenty-some-year-old from Wisconsin came to our Clinic to be evaluated and thought this would be a good thing for him to hear how he could benefit from our treatment recommendations. We didn't push treatment down anybody's throat. We'd say, "Here's why we think this treatment might be helpful to you if you're interested or of benefit to you." He said, "My mother and father both have clefts. I have a cleft. My brother doesn't have a cleft." His reasoning was that if he got married and had children, there would be a seventy-five percent chance of him having a child with a cleft. That's what he carried with him. He would never marry because of that.

LK: Wow.

KM: He found out that, no, oh no, much less than seventy-five percent through genetic counseling. So that just changed his life. I don't know if he ever got married. It's interesting what people think, and they don't really get the facts. So we provided that for him.

LK: That's great.

KM: Another thing is we may see a patient that looks like they just have a common ordinary cleft of the lip and palate but they also have little indentations in their lower lip. If they didn't have the indentations in their lower lip but they just had what appears to be

an ordinary cleft, the genetic counselor, Doctor Cervenka, would probably tell them—and no history of clefting in the family—“There’s about a two or three percent chance that your next child will have a cleft.” He doesn’t say, “Isn’t that low?” They have to make that decision.

LK: Right.

KM: But if they have little indentations in their lower lip, the risk increases to fifty percent.

LK: Wow!

KM: Is it important to know these other little things that might go along with clefting? You bet. Then, it’s a syndrome called lip pit syndrome that we know about. [Formally, Van der Woude Syndrome.] Families may never have paid any attention to it. Maybe they had these repaired and nobody ever knew the significance of it. That’s why it’s important to be seen by a geneticist, to receive genetic counseling, so they get the correct information.

LK: Right.

KM: Are you learning anything? [laughter]

LK: A lot. As you were speaking, I kept touching my bottom lip. [laughter]

KM: As far as I can see you don’t have cleft lip.

LK: Oh, yes, yes.

[laughter]

LK: It’s that sort of thing when you start reading about different diseases and, all of a sudden, you self diagnose with...

KM: The medical student syndrome.

LK: I was wondering when you entered graduate school, did you enter graduate school with the intention of wanting to do speech therapy and kind of advance your education down that road?

KM: Yes. Basically, that’s right, not necessarily cleft lip and palate, but to get a master’s degree in speech pathology. Ultimately, now, to get licensed in the State of Minnesota as a speech language pathologist, you have to have a master’s degree. That was sort of being talked about in those days. So I thought I could go out and be a speech therapist in the public school system with a B.A., but I knew that was eventually coming

and I was fortunate. Those were the days when there was money available. They paid for my education. So why not?

LK: Yes.

KM: But, then, I didn't stop there.

[chuckles]

KM: But that's when I was really focused on cleft lip and palate, so I really wanted to get the doctorate degree and do research in that area.

LK: You must have been involved in the professional organizations in the state. Was there a push to increase the requirements to become a speech pathologist during this period?

KM: Yes. The Minnesota Speech, Language, and Hearing Association started pushing for a master's and licensure in the early 1970s. I served as president of the Minnesota Speech, Language, and Hearing Association. I was on many committees, the Licensure Committee being one. It finally happened not too many years ago. [chuckles]

LK: Oh, really?

KM: In 2000. It was a long haul and an amazing process.

LK: Was that tension with universities or with the state or...?

KM: With the state, boy there were so many issues involved, Lauren. I think they thought that speech language pathologists weren't of any danger to anybody.

LK: Oh, okay.

KM: Well, you know what, not physical danger but, you know, just felt that it required a master's degree and to be licensed to protect the public from some people. Yes, so it was a good thing.

Then, I was involved very actively in the American Cleft Palate [-Craniofacial] Association.

LK: The national?

KM: That's the national one, yes. I was so fortunate to receive the Honors of the Association in 2009, just a few years ago. I never thought that was remotely possible. It was a wonderful honor.

LK: Yes. You didn't think it was remotely possible because...?

KM: I just didn't think that I had done things that would be worthy of that. Bob Gorlin received the Honors of the Association. He was the person I would think you had to become to get that. I wasn't of that ilk, but, you know, obviously, I'd published, and we had a Clinic that was second to nobody in the country.

LK: Yes.

KM: Nice of people to recognize that.

LK: Yes. Congratulations.

KM: Thank you.

LK: You said initially that you didn't teach courses in the Dental School but you did eventually?

KM: Yes. You ask good questions. When I got into the school, I was trying to figure out how I could fit. I knew it was going to be in the area of education and clinical service and research. But did I want to have a freestanding course for the Dental School students that they were required to take? It probably wouldn't be likely that it would be required as part of the dental curriculum. It's not drilling and filling. It's an extra-added attraction. So I thought instead of having a course people could sign up for it electively, I would be willing to go into courses already in existence, appropriate courses, and give some lectures about speech pathology. That's what I chose to do, because they were required courses. Then, I could just make sure that they got *some* information. I'm not trying to make speech pathologists out of them, but I wanted them to understand there is other stuff that goes on in the mouth, like speech. So I had the opportunity to do that in a number of courses throughout the years.

LK: What kind of courses would that be put into?

KM: There was a human genetics course. It was taught by Burt Shapiro. It wasn't a human genetics course, no. What in the world was it called? It had another name, but it was offered as part of human genetics, and it was in that course that I gave a series of lectures. This was true in dental hygiene, too. I came in and gave some lectures in speech and cleft lip and palate.

LK: Did you work with dental hygienists as much as you worked with dentists?

KM: Other than the lectures, I didn't work closely with dental hygiene, as close as with the dental students. Most of my work was with the residents in dentistry, oral surgery, orthodontics, prosthodontics, pediatric dentistry, and medical residents. But dental hygiene...at one point, I felt it would really be helpful to have a dental hygienist come to our team clinics. If there ever was any compromise in optimal treatment, it almost always went back to just poor dental health. So, sure, the pediatric dentists on our team

and all the other dental consultants might say, “Gee whiz, you’ve got to do a better job of brushing.” We would have a dental hygienist or a person that was a student in dental hygiene working with a dental hygienist in the program come in and really do a thorough exam and give them instructions. I can’t remember, Lauren, what year we started that, but it’s still an important part of the Clinic. Each kid gets a good scrutiny and education by a dental hygienist. I think that only can help. Like I say, it’s just a more optimal end result for their own teeth.

LK: I don’t know if you would have any comment on this in particular, but I’ve read a little bit about student unrest in the Dental School. There was an incident where students protested an exam. I didn’t know if you had any comment on student behavior in the Dental School. This was the 1970s.

KM: Another good question, because it does ring a bell. Yes, I remember the students were a volatile group. When I was sitting in on some of the courses, I sat in on anatomy. I won’t tell you who the instructor was—I’m not sure I know the name. But the dental students were very rude. .

LK: Really.

KM: I mean, they got up and walked out of a lecture that I was in. I was just a quiet mouse in the back of the room observing. But that has really, really changed. But I thought, good Lord, when I lecture to these kids—these kids? They were about my age—are they all going to walk out? Are they going to say, “Speech? What do we need to know about that for?” But I really got a good reception. Maybe it was because it was something that was a little different and not too much of it, just a taste of it. I never had that issue, but I know that it did exist. I do remember giving a lecture once to a dental class where one of the questions at the end kind of implied, “Why do we have to know this?” I don’t remember exactly what I commented on. No, you don’t have to know this. For you to be a dentist working with a family and a patient, to be aware of this, that there are resources available to you as a practicing provider that you can help by pointing out resources... You should know now that speech language pathologists are present in every school district in the State of Minnesota. So if you’ve got some questions about the child’s speech or the mother says, “I have concerns about my child’s speech” and you’re the dental provider, then you can steer them in the right direction. Now, what’s so bad about that?

LK: Right.

KM: I didn’t expect them to diagnose a particular articulation. So it was fine after that.

LK: Practical skills.

KM: Yes. It’s interesting. I do remember some of that.

LK: I was surprised. When I was going through the University Archives, they had some newspaper articles about students acting up in classes from, like, the [*Minneapolis*] *Star Tribune*.

KM: The dental students, specifically?

LK: Yes, specifically dental students. It was surprising. People I've talked to have mostly talked about the 1960s, 1970s activism but it...

KM: That was part of it, though, Lauren. I do remember—of course, you've heard about it, too—from 1968 to 1972, it was not a fun time on the campus. We had dental students that took leadership roles, and I think some faculty didn't like that. Then, it almost got worse. Yes, that was tough times.

LK: There were also comments on student appearance, a lot of contests with authority.

KM: Yes, yes.

LK: We've talked about Dean Schaffer. I didn't know if you had any more comments on different changes he made within the Dental School, aside from bringing in the Cleft Palate Clinic, which was essential to you and the Dental School. But any comments on his leadership or changes in the culture that he made with the Dental School?

KM: As I mentioned earlier, one thing he did is bring in people with non-dental backgrounds into the school to contribute. I was a recipient of that. He was such an even-tempered visionary for the School of Dentistry...I mean Health Ecology. I think we were the one of the first programs in the country that had something like that. We were realizing dentists are going to be out in the community. They should know something about how communities work. Larry [Lawrence H.] Meskin was the head of Health Ecology. That name had to come up at some point.

LK: Yes.

KM: Then, he brought in Les [Leslie] Martens and John [M.] Proshek, Mike Loupe, Dave Born. Have those name come up?

LK: I haven't heard that one.

KM: Joanna [G.] Samuels...these are non-dentists, sociologists, behavioral specialists, educators, educational psychologists into the Health Ecology program, an avant-garde program in dentistry for many years. [Also, John Geier, Jean Frazier, Muriel Bebeau, and Q. T. Smith.]

LK: Yes.

KM: Erwin...one thing I remember more hearing about than actually seeing is how he could really pick your pockets.

LK: In terms of getting donations?

KM: Fundraising. He started the Century Club. I think it's the first. Subsequently other colleges did it. They called it the Century Club where dentists all over, alumni contribute one hundred dollars a year, a century, to belong to the Century Club. You'd get your name listed and all those good things. Then, ultimately, deduct a little bit, but it was called the Century Club. The Century Club had a program that was the Century Club Professor of the Year. Our pictures are down there and I was fortunate to receive that in 1997. He started those kinds of programs. Really, he was fundamental in getting the money to build.

LK: Yes.

KM: He did it not through boisterous speeches or anything. Somehow, he just was able to do it. He was a tremendous person. He was proud, very proud, I might say, of the Cleft Palate Clinic, something that he started, and it grew and became, frankly I believe, great.

I remember him coming down and observing one day in the Craniofacial Clinic. When he saw neurosurgeons in the School of Dentistry, and plastic surgeons, and ophthalmologists, he was really impressed.

LK: Yes. It's exciting to have that come together.

KM: Yes, something that he started. He gave us a wonderful, wonderful donation to the Clinic, part of his estate, before he died. His legacy lives on.

LK: Yes.

Do you know why he stepped down in 1977? I know he stayed on in Periodontics for a while.

KM: He was professor emeritus. Yes, goodness gracious, he stayed on well into the 2000s, right?

LK: I didn't know he stayed on that long. [According to his obituary, Erwin Schaffer officially retired in 1992 but continued teaching and his private practice until 2006]

KM: Oh, I think so.

LK: When did he die?

KM: Two thousand and seven? [December 25, 2007]

LK: It's really a shame because this project seems to have started right when many of the key figures passed on.

KM: Yes, I wish you could talk to him.

LK: Yes.

KM: I wish you could talk to Mel Holland and Jim Jensen.

LK: Yes, and Robert Gorlin and Carl Witkop.

KM: Oh, my goodness, yes. Yes.

You just asked a question that I didn't answer.

LK: Do you know why he stepped down in 1977?

KM: I really don't. Did other people have a thought about that?

LK: Ummm... I think the general answer is just that he was done the administrative work. He'd been doing it since 1964.

KM: That's right. He was drafted into that position. You know that.

LK: Yes.

KM: They probably didn't have a search committee.

LK: Yes.

KM: They probably said, "Come on, Erv. Step up."

[chuckles]

KM: And he did it and did it well.

I remember one comment he made when Robert Isaacson was head of Orthodontics. He resigned and was going to San Francisco to be head of a multidiscipline program, ortho, pediatric dentistry, and some others. I remember him saying, "You know, I wish time would stand still. I wish time could stand still for me." This was, like, in 1977 right around the time...so maybe this is some clue. Things were changing so fast and that's why he said that, I think. Now, everything seemed to be in place for him. I wish time could stand still. I'd rather keep my same people, but people were moving, moving to different programs, and there were probably lots of other things going on, too—not that he was unhappy.

LK: He got the building put together.

KM: That was a big deal.

LK: Yes.

KM: It should have been called Moller Hall, as in Molar? You *know* that, don't you, Lauren?

LK: Moller Hall. [laughter]

KM: Isn't that a perfect name? But nobody even considered it. Moos was that guy...

[laughter]

KM: It does kind of look like a gigantic third molar.

LK: Yes, it does. It's got an odd shape.

[chuckles]

LK: We talked a little bit about this. You mentioned John Westerman, too, earlier, with the multidisciplinary approach that the Clinic took. Did you have a strong relationship with University Hospitals and other hospitals in the area?

KM: Not really. U Hospitals was here and, of course, some of the people that came to the Clinic...Ear, Nose, and Throat people and, certainly Children's [Hospital] in Minneapolis at that time with the pediatric surgeons. But, like I say, we were kind of an independent operation that had a certain function, but we were in the Dental School. I think a lot of people said, "Why are you in the Dental School? This is a medical condition." Well, yes, it is. So we had medical people, but we were in the School of Dentistry because of Erwin Schaffer.

LK: Yes.

Did you have any other comments on John Westerman? And did you work at all with Ray Amberg?

KM: No, other than the fact that he [John Westerman] was hospital administrator sort of extraordinaire, as I remember. I heard him speak. He seemed to be a really nice person, a good speaker, doing a good job over there. We got a letter from him that he recognized the Craniofacial Clinic. I think I've got the right person and the right year, don't I? Nineteen ninety. Was he still...?

LK: I don't have the years for Amberg and Westerman, unfortunately.

KM: I just remember him rather favorably and Lyle French, too.

LK: We've talked a little bit about the AHC. Did you have any idea of how the dentists felt about being included in the AHC or what the general impression was of the creation of this collaborative organization?

KM: Like I say, it didn't really change our behavior. We were already doing some of that...other than saying, "Amen. This is good."

LK: Yes. Okay.

KM: Another thing I could mention, too... Pharmacy and Nursing... Under my watch, we brought Pharm-D students when they started that program through our clinic on observation basis. They were with us for a quarter. How helpful they were. Some of the kids we were seeing had different medications for learning issues. They could be a part of that and see how a team really functioned. That was really good. Nursing... We had a nurse in our Clinic.

LK: In the Clinic?

KM: Yes. Kathy Conway was actually coordinator of the Cleft Palate Clinic at Children's and, then, she decided to go back to nursing here at the University for her master's degree. While she was here in school—I knew Kathy when she was at Children's, just an excellent person—we were able to fund her part time to work in our Clinic. After she graduated, we were able to fund her full time for a few years. The funding was an issue, but she went on to other things.

Then, Wendy [Sue] Looman from the School of Nursing came over to the School of Dentistry to participate in the Craniofacial and Cleft Palate Clinic.

LK: Was Wendy Looman a dentist?

KM: No, she was a nurse in the School of Nursing...

LK: Okay.

KM: ...and really so great. She helped us a lot. If she doesn't participate, another person from Nursing does.

So now, we've got Pharmacy, Nursing, Medical. Public Health? I guess we didn't have somebody from Public Health sit in on every team meeting. Who probably knows?

LK: [chuckles]

KM: Of course, if we needed to espouse some position, we knew folks over there who could help us with things.

LK: Those relationships have been more naturally rather than because of the umbrella that was created?

KM: I think that's right.

LK: Okay.

After Dean Schaffer stepped down, Doctor Oliver came in. I was wondering if you played any role in his appointment. Nineteen seventy-seven was the same year that you took over the Clinic, correct?

KM: That's right. I was appointed by Dean Schaffer and the Search Committee, as director of the clinic.

Then, shortly thereafter, Dick Oliver came in. Like I say, each new dean wanted everybody to defend their program. I felt it was easy for me to do, that we were doing good things. But when financial crunches hit, they look at things...well, do we really need to do this? We were costing some money, for sure...certainly, my salary. But he was really very supportive from the get-go. I remember when he came in, he requested everybody to fill out what they do and why they do it, contributions to the total dental program, which I did.

Dick Oliver recommended that we have an advisory board, which was fine. So he named the people, sitting down with him we could identify people that would be good, Ear, Nose, and Throat, medical people, inside, outside the University. So we had the advisory board for a while.

LK: What was the purpose of that?

KM: He thought the purpose of that would be to provide direction for the Clinic as it grew and developed or help make decisions if I needed consultation. I don't want to say that I probably could do it myself, but people didn't need more meetings to go to.

LK: Yes.

KM: I got the sense that the people on the advisory board were intimately involved in the Clinic anyway. If they had input, they would share it with me. We didn't have to get together and have a dinner. So it sort of, I guess I want to say, fizzled. I hadn't thought about that in a long time.

LK: [chuckles] It lasted a few years?

KM: Yes. I think, officially, it was on the books for his tenure.

Richard Elzay came in after that.

LK: Right. That's when the big budget cuts hit.

KM: Oh, yes, eliminate the School of Dentistry. Yes.

LK: Were you part of that task force to keep it open?

KM: No. What I needed to do is to contact people, interdisciplinary people, from the community and talk about the Cleft Palate Clinic, at least, in the School of Dentistry and how it helped them. This was a clinic in the School of Dentistry and closing the school would eliminate the program and how that might not be a good thing from their perspective. So I solicited letters and would submit them to the administration. Fortunately, they decided not to close the school.

LK: Yes.

KM: It was a quick way to save money.

LK: Were you part of Doctor Elzay's appointment at all? Were you on that search committee?

KM: No, I was not on the search committee. I can't recall if Doctor Bob Gorlin was chair of that committee. I remember going to presentations that people made. We got along fine. Again we had to defend our clinic. And he went till 1996.

LK: Yes.

KM: Then, was it Mike Till?

LK: Yes.

KM: Interim for a bit and, then...

LK: Then official, yes.

KM: Yes. Mike and I were pretty good friends. [chuckles] We had been for a number of years. Mike might even tell you this. We had coffee in the Outside In when the cafeteria was over in Moos Tower for, like, thirty years every morning about seven o'clock...

LK: Oh, wow.

KM: ...until I retired. We still get together for breakfast quite frequently.

[pause]

LK: You had talked a little bit about the admission of women, recruiting of women into the Dental School. I don't have the specific year, but I think it was the 1980s when the Rajender Consent Decree came up. Did you see an impact with that in the Dental School? Or do you have any comments on that?

KM: I think I went off the Admissions Committee in about 1979, so I can't speak directly to that. But I think it probably did. It raised people's awareness that women can do everything men can do just as well and they deserve equal pay. Yes, the Rajender was a big deal here.

LK: Yes.

KM: I was really so pleased with the number of women in dentistry from 1973 to 1979 or so was really moved up.

LK: In terms of budget cuts and the threat of closure to the Dental School, did the Cleft Palate Clinic experience any problems with that? It sounds like the Clinic itself was just people meeting, and it was pretty low budget?

KM: Yes.

LK: Did you experience any cuts or anything?

KM: No, we didn't. But if the Dental School would have closed, it was pffftt! The part that we could play in that whole thing was to get information to the powers that be that special clinics like this, not just us, but in the School of Dentistry, are important to the community and to the state. That we did actively.

LK: Did you do any work with the State Legislature in terms of getting funding for the clinic or for the Dental School?

KM: I'm glad you brought that up. Not directly getting more money for the Dental School.

But, about 1987, 1988, 1989, and through my work with the American Cleft Palate Association... At the American Cleft Palate Association, we were talking about patients that could not get their orthodontic treatment covered by insurance. So that seemed to be kind of a weird thing. "Why not?" Orthodontic treatment for patients with cleft is not a luxury. This is an integral part of their treatment. Oral surgery, bone grafts, orthodontic treatment seemed so reasonable to me and to other people on our team and to Mike Till. He was not dean at that time, but he was head of Pediatric Dentistry. So we got a family that came to our Clinic from outstate Minnesota—we felt that would be helpful to bring in a family in the clinic—and a senator in the Legislature to sponsor a bill saying, "It's mandatory that insurance pay for orthodontic treatment for patients with cleft lip and

palate.” Mike and I went down to the Capitol. I thought we were really prepared—this was a committee meeting—to get this going and to show them why this was really important. Well, we had the family talk first. I’m telling you, Lauren, as that person talked, a very articulate father... His son wasn’t there physically, but he talked about the importance of orthodontic treatment and team care, pulling it all together in the State of Minnesota, no matter where they were, to be seen in a clinic like that. It just buzzed right through the committee. Nobody had any objections. The only one thing the insurance lobby—they were there and present, believe me—wanted to know was how long do have to keep paying for that.

LK: Oh.

KM: So we gave them eighteen years old, which was a little too quick a response, because that’s when facial growth and development is usually almost complete, but some people go beyond that. At least at eighteen. So it was passed.

People in the American Cleft Palate Association said, “How did you do that?” I said, “I don’t know. Here’s what we did.” We are, I think today one of only six states in the country where insurance has to pay for orthodontic treatment.

LK: Wow.

KM: It seems so reasonable.

LK: Yes.

KM: You know insurance has a strong lobby.

Then, a family from Saint Cloud got that act amended to include not just to eighteen years of age, but up to twenty-five years of age if the patient was a dependant of the family.

LK: Wow.

KM: So while they were going to school, they’re still growing and developing. That’s a real nice act.

LK: Did you do any work as president of the American Cleft Palate Association to try and do that at the federal level? That would be a much bigger hurdle.

KM: Yes. Yes. I wasn’t president of the American Cleft Palate Association.

LK: Oh.

KM: I was part of the Committee on the Economics of Team Care in the American Cleft Palate Association and the Structures Committee in the Cleft Palate Foundation. That has been an active committee.

How did we get insurance companies to pay for team activity, diagnosis, evaluation, and treatment planning, stuff we think is so good to get an optimal result? There's no CPT [current procedure terminology] code that's appropriate here. So I thought, well, that's what we've got to get, a new CPT code number that identifies that activity and that insurance will cover. Well, it hasn't happened. But there were several efforts to do that. In fact, Robert Maisel, who was an ENT person who had an appointment here at the University and Hennepin County was on a committee, a medical committee, to sort of start the process for new CPT codes. When he got the notice, he shipped me the information. He said, "Will you please give me some information about why you think this is a good thing?" I did that. But it never got off the ground. To this day, it's not really in the books, but it's beginning to get some attention, the CPT code for that kind of activity. But, you see, the problem with it is so variable from clinic to clinic. Maybe for some clinics, they have three people sitting there. For some clinics, they may have ten people. We don't pay equal amount.

Here's what we did with insurance companies. I invited people from the insurance companies, like Group Health—Group Health is what it was—Health Partners, Blue Cross Blue Shield, UCare, the people that had their insurance, to come to our clinic and see what it is we do. If they felt that it was a beneficial treatment to pay for, maybe they'd be interested in doing that. Don't criticize us or not pay if you're not informed. I remember when Blue Cross Blue Shield came—they were some higher up people that came—they left saying, "Well, if you don't have this kind of meeting and determine what's the best treatment for the patient, we may end up paying more." A child goes into the hospital and needs tubes in the ears for hearing, a cleft palate child, and needs a lip revision, and needs something else, something minor done, one anesthesia, one hospital stay, get it all done versus a child that goes to a surgeon that's not involved in a team and the surgeon has him come back every June and does some surgery. Now they saw the wisdom of it. But the system didn't cooperate too well. What we had to do when we billed from the School of Dentistry to the insurance company with the report was put a little red star on the billing.

[chuckles]

KM: And somebody over at Blue Cross Blue Shield said, "Oh, that's a little red star. It must be the Cleft Palate Clinic." That worked as long as that person was still at the desk.

LK: Yes.

KM: There have been those ups and downs. The bottom line is when people are informed, they see the wisdom of it and should pay something. That was a long answer.

LK: No. It makes perfect sense because you're eliminating redundancy.

KM: Or unnecessary surgery. The insurance company would pay for just like that because it has a CPT code for a surgical lip revision.

LK: It's easy to process.

KM: But not in team evaluation.

LK: Right.

KM: The CPT codes pay for treatment. They don't pay for non-direct treatment, not planning and, yet, that's so critical.

LK: Does Medicaid cover the...

KM: [Doctor Moller shakes his head no]

LK: Okay.

KM: But there are programs, Lauren... Well, for example, Badger Care [Insurance] in Wisconsin. They knew about us because I knew a person in Madison. They came up to see what we did in our Clinic. They kind of rubberstamped evaluations that they brought from Badger Care. They didn't pay a lot, but at least paid for some. MnCare here for folks who really need help. Now, it may change a bit with the new health directives.

LK: Right.

We talked a little bit about Lyle French, but do you have any more comments on Lyle French or Neal Vanselow who came after him? Did you work with either of them?

KM: Not closely. I remember when Lyle French was appointed the first v.p. [vice president] of the health sciences. He was a stately gentleman.

[chuckles]

KM: Everybody liked him. But I never had any direct contact with him, other than I knew he was a neurosurgeon and Steve Haines was working in his department. The neurosurgery was an important part of our Craniofacial Clinic.

Neal Vanselow, I remember him when he came, but, again, no direct contact. Then, another person came, [Robert J.] Anderson.

LK: Yes. Cherie Perlmutter was interim and then Anderson came in.

KM: Right. I didn't work with Cherie when she was in that role as assistant to the vice president. It was more when she retired or sort of retired, and worked in the area of Promotion and Tenure. Then, I got to be involved along with her.

LK: And then...

KM: [William R.] Brody.

LK: Yes, Anderson and, then, Brody.

KM: Anderson...there was political goings on when Anderson was here that affected the school.

LK: Yes, the ALG [Antilymphocyte Globulin].

KM: Right. Then, Dick Elzay, I think, stepped in for a while after Anderson left, for a short period of time.

LK: Oh.

KM: He was kind of interim.

LK: Oh, I didn't know that.

KM: I think so. Then, Dick left in 1996 and Brody came, right?

LK: Yes.

KM: Then, I was involved in Promotion and Tenure, again. That's when I really got to know Cherie Perlmutter. Decisions weren't being made in a timely fashion for certain things and there was sort of...we got to get it done. I was appointed by Brody's office and got to know Sue Jackson and Cherie Perlmutter through that activity. Now, Sue is sitting in the dean's office in the School of Dentistry.

LK: What was your role in Brody's office?

KM: It was to be on the Academic Health Center Promotion and Tenure Committee. I think somebody dropped the ball there. I don't know who it was. I just remember there was kind of a scramble as to who was going to be chair and we've got to evaluate candidates for promotion and tenure, as I remember it. Maybe I'm saying this wrong, but that was a period of time where I had a lot of involvement with P. & T., and, then again, with Frank Cerra.

LK: Did the sale of the University Hospitals to Fairview affect the Clinic at all?

KM: No.

LK: We talked about Michael Till as dean. Did you have any other comments on maybe changes he made as dean?

KM: Mike was just a community-oriented guy. He loved to go around the state and tell people about what was going on in the School of Dentistry, which the dental community really appreciated. Mike started the 2000 x 2000 x 2000 fundraising campaign. He didn't tell you about that?

LK: No.

KM: You know 2000 x 2000 x 2000 was let's get 2,000 people, dentists, to give \$2,000 by the year 2000. It was a very successful campaign. I want to say six to eight million dollars.

LK: Oh, wow!

KM: Yes.

Otherwise, I don't think there were any major changes in the school. But, like I say, his community orientation. The Hibbing Clinic was certainly established under his watch.

LK: Yes, he did talk about that.

KM: He was instrumental in that.

LK: I think that's all of my major questions. Is there anything that I missed?

KM: I'm glad you asked the questions you asked, because I hadn't really noted them, but it did kick off some thoughts.

I'll look over... Oh, Dick [Richard] King. I didn't mention his name. Carl Witkop, Jaroslav Cervenka, Burt Shapiro, Dick King. He was here in the Medical School in genetics. I don't know if he's still coming in anymore or not. He was in the Dental School for a number of years, too.

LK: He worked with the Clinic as a counselor in genetics?

KM: He had a relationship with our clinic, but he was more in the human genetics division than I was in when I first came in dental research.

LK: Okay.

KM: Oh, I want to suggest a name. Yes, Frank Lassman. Has that name come up?

LK: Mmmm... I don't recognize it off hand.

KM: L-a-s-s-m-a-n in Ear, Nose, and Throat, Otolaryngology. Frank is now, I think, ninety-two years old.

LK: Oh, wow!

KM: Does he love this kind of thing! And he's good at it. I hope he's still around. I haven't heard that he's not. He still comes in almost every day.

LK: Wow.

KM: He lives in downtown Minneapolis. We gave him the Outstanding Lifetime Achievement Award from the Minnesota Speech and Hearing Association a couple years ago. Frank was an instructor of mine when I was in Speech Pathology and Audiology. Then, he's been in ENT ever since. He *loves* talking about the Academic Health Center and he's very, very lucid... I'd suggest his name as a person who could give you some real insight way further back than I can and how the AHC umbrella affected things from his standpoint.

LK: Yes, that would be great.

KM: He was head of the resident program for ENT for a number of years. I think he retired three times. But he's still coming in.

LK: [laughter] I talk to a lot of doctors who have that kind of slow retirement.

KM: Yes. I saw on your website that you interviewed John [H.] Kersey.

LK: Yes.

KM: [whispered]

LK: I didn't interview him. My advisor did.

KM: I didn't know him well, but I remember seeing it on there and thinking that he just died [March 10, 2013]

LK: Yes.

We interviewed Robert [K.] Anderson from the Vet [Veterinary] School and he recently passed on [October 11, 2012].

KM: Is there something you're trying to tell me here?

LK: No! [laughter]

KM: These are older people.

LK: Yes. It's not the curse of the AHC interview, I don't think.

Do you have any other names of people you think I should interview? Off hand can you think of anyone?

KM: I'll leave you with that one for sure, and I'm glad you interviewed Burt Shapiro. Mike [T. Michael] Speidel?

LK: That name has been suggested to me, but, yes, I should follow up with that.

KM: He was head of Orthodontics for a period of time. His father was actually head of Orthodontics back in the 1950s.

LK: Is he still at the University?

KM: No, he's retired, but living here. That may be a possibility. If I think of somebody else, I will certainly give you a call.

LK: Okay. That sounds good.

Well, thanks for meeting with me today.

KM: Yes. It's been a pleasure visiting with you. I forget that that thing is on.

LK: [laughter]

KM: I don't think I've said anything that I regret or anything, but just some impressions that I had in response to your questions. I'm happy to share my story with you.

LK: Thank you.

KM: That's basically what it was.

LK: Yes.

[End of the Interview]

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