

John Diehl, J.D.

Narrator

Dominique A. Tobbell, Ph.D.

Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

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

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

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

Biographical Sketch

John Diehl was born in Des Moines, Iowa on December 18, 1941. He earned his bachelor's degree and his law degree from the University of Iowa in 1964 and 1969, respectively. He moved to Minnesota for his first job, special assistant to the then Attorney General of Minnesota, Doug Head. He left public service to work for the Minneapolis law firm Howard, LeFevre, Lefler, Hamilton & Pearson. Mr. Diehl was then appointed as Chief of the Department of Health HMO in 1973. In 1975, Mr. Diehl became General Counsel to University of Minnesota University Hospital. He served as general counsel until 1983, when he left the University to pursue broader applications for new approaches to health law at the law firm Larkin Hoffman. He has served on many associations and committees related to health law and health administration and founded the National Association of HMO Regulators in 1974 and the Minnesota Society of Hospital Attorneys in 1976.

Interview Abstract

John Diehl begins his interview with a brief reflection on where he was born and raised, his education, and his first job as special assistant to the attorney general of Minnesota. He then discusses changes in health plans and his work as the chief of the Department of Health HMO, focusing on the development of a regulatory framework for health plans. He details the process of introducing the Health Maintenance Organization (HMO) Act of 1973 and developing a grant-making function to develop and regulate HMOs. As part of this discussion, Mr. Diehl reflects on federal legislation regarding HMOs and the influence of professional organizations. Because of his work on HMO legislation, Diehl developed a close relationship with John Westerman and was invited to be general counsel to University Hospital. Mr. Diehl discusses all of the following in relation to his time as general counsel: changes in the governance of University Hospital with the establishment of the Board of Governors; the mentorship of John Westerman; Joel Tierney as University Attorney; the medical-legal protocol for minor donors in kidney donation; his responsibilities as the University Hospital general counsel; the end of sovereign immunity; the Hospital's abortion policy; labor and student employment issues; the medical school's private practice arrangement and patient rights; the hospital marketplace; certificate of need law; the University's designation as a basic center for emergency services; and hospital consortium and regional health systems. He then reviews his experiences with Medicare and Medicaid over the course of his career and the rising costs of healthcare. Mr. Diehl also discusses Hospital's expansion, the Hospital bonding bill and the deal's failure, poor University publicity, and the set-up and dismantling of Regional Co-ops. He concluded with the development of the Committee on Thanatology and various legal matters concerning death and dying.

Interview with John Diehl

Interviewed by Dominique Tobbell, Oral Historian

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

Interviewed at Wells Fargo Plaza, Bloomington, Minnesota

Interviewed on February 9, 2012

John Diehl - JD
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with John Diehl. It's February 9, 2012, and we're at Wells Fargo Plaza in Bloomington [Minnesota].

Thank you for meeting with me today.

To get us started, can you just tell me a little about where you were born and raised and what your educational background is?

JD: I was born and raised in Des Moines, Iowa. I was born December 18, 1941, eleven days after Pearl Harbor. I was educated in the Des Moines public schools and the University of Iowa. I have a bachelor's degree from the University of Iowa, 1964, in the business school. I have my law degree from the University of Iowa, 1969.

DT: What led you then to join the State of Minnesota? Was that your first job, as special assistant to the attorney general at Minnesota?

JD: Right.

Through my travels, I experienced virtually all the cities in America and I just liked Minneapolis.

So I was looking for a job here and such a job became available with Attorney General Doug Head.

DT: What were your responsibilities there then?

JD: I wanted to be a trial lawyer, so they assigned me to the Highway Department where we were doing land condemnation work for the interstate highway system. In 1969, that had sort of run its course, but there was still plenty of work, kind of loose-end type work. You could get trial experience doing land condemnation. So I did that.

I think I served the state reasonably well, but, regardless, my personal objectives were achieved; by the time I'd been a lawyer for one year, I'd had several administrative cases and two jury trials. We were not admitted to practice law until October, but I started in June, because I needed the money. Thank God for Doug Head.

[chuckles]

JD: By the following June, I'd been on the job for a year, even though I'd only been admitted since the previous October.

About that time the attorney general asked me to be the attorney for the Insurance Department, which was in a transitional phase from separate departments for insurance, securities, and banking into what is now the Department of Commerce, which encompasses all of that. So I became the Insurance Department's lawyer in, it must have been, roughly the summer of 1970 and continued in that job for a couple more years. So that's what I did with them.

DT: What led you, then, to shift focus to healthcare. You were appointed as chief of the Department of Health HMO [Health Maintenance Organization] unit in 1972, 1973?

JD: Nineteen seventy-three.

It actually relates back to my work in the Insurance Department. This is an awful lot about me. Of course, I'm happy to talk about me. I'm very interesting and charming.

DT: [chuckles]

JD: When I moved over to the Insurance Department, that agency was recovering from *horrible* scandals in Minnesota. I do not think the dimensions of that were known for another maybe ten or fifteen years. In the later 1960s, there was an automobile insurance company called American Allied that had come into the state. It had, as they say in the insurance industry, burned its way into the market with absurdly low rates and, then, went broke leaving all of the people recovering from auto accidents, some of whom were horribly injured and needed this for medical expenses, high and dry. So there was a lot of reform in the insurance regulation incidental to that. I became involved in the tail end of that, and that work, and the acute awareness of the public harm that is occasioned when an important financing system fails, led to my work in health care.

In those days, that is until we changed it in 1971, health plans such as Blue Cross, Blue Shield, and Delta Dental, were separate; they were regulated under separate statutes. Blue Cross was a hospital service plan. Blue Shield was a medical, that is physician, service plan. Delta Dental was a separate dental service plan. They each had their own

statutes that governed their service. It was considered a service arrangement, not an insurance mechanism. Each one was required to limit their services to the discipline that the law related to: hospital, medical, dental. And, these plans were regulated, not by the Insurance Department, but by the Attorney General, and that function was delegated to the attorney for the Insurance Department

In this context, in 1970 it was discovered that Blue Shield—I'm not quite sure how it came to the attention of the state—was insolvent. At that point, my guess is, there were probably—not 500 people in Minnesota who knew that Blue Shield went broke. I am not sure that even the whole legislature knew about it although they passed the law necessary for the “bail out” (but I am getting ahead of myself). It was decided that it would be better to arrange some kind of recovery without destroying the confidence in that system. I had no part in that decision, but I arrived on the job as the attorney for the Insurance Department and this was a part of my assignment.

The insurance commissioner, Tom Hunt, had just announced his resignation to go into the private practice of law. In those days, we only had legislative sessions every other year. So in 1970, we were approaching an election and about a year away from the next legislative session. Reform of insurance regulation was still on the agenda. Figuring out a bailout for Blue Shield was on the agenda and the commissioner was leaving.

The person who was the acting commissioner—his name was Al—people called him Andy—Anderson. He was the head of financial oversight for insurance companies and he agreed to be the acting commissioner. But, as I remember it anyway, he did not want to be involved with the Legislature. Some of these things, thinking back, I don't really know how they happened, but they happened. I gather that the attorney general, then, perhaps, was consulted. At any rate, it was understood that he would be the acting commissioner but I would handle the whole legislative package. There were eighteen Department bills including some insurance reform, the Insurance Holding Company Act, regulation regarding claims, practices, the regulation of claims adjustors, and other matters.

Among them, then, was a new law to regulate all of these health plans, which became my responsibility to draft and to, then, get passed, which I did. Blue Cross was the main player and, of course, I worked very closely with their lawyers in developing this new regulatory system.

There's an interesting story, at least I think it's interesting. There was a fellow that was the Blue Cross vice president for public affairs and marketing named Jim Regnier. Jim was a great old-style lobbyist. Of course, Blue Cross had a contract with the state to provide benefits for state employees, including legislators. His form of lobbying, among other things, was to stay in close touch with the legislators if they had any problems with their claims. Everybody loved him. He was really a pleasant guy. He knew the business and he knew what he was doing in politics. So he became my mentor to pass this bill.

The president of Blue Cross at that time was a guy named Dick [Richard] Crist, who was a CPA [certified public accountant] who sort of, at least to the outside world—well, at

least to me—fit the perfect stereotype of a CPA. He was serious and he was focused on making sure that Blue Cross was financially sound.

So one day, Jim Regnier called and said that Dick Crist is getting worried about this bailout of Blue Shield and he said he needed to talk to the attorney general. At that point, Doug Head had run for governor against the man who much later would be my law partner, Wendy [Wendell] Anderson, and had lost. In that election, Warren Spannaus was elected attorney general, so I called Warren and we arranged to have a meeting. We gathered in Warren's office and Jim Regnier said, "Dick Crist is getting kind of concerned."

It's interesting, the intersection of all kinds of things prominent and not so prominent. Ross Perot, a name that most Americans would recognize as the head of a huge computer services company and, later, a presidential candidate, had, maybe within the previous ten years, started his company. Then, that company had a contract with Minnesota Blue Shield to try to figure out their finances. It was a computer company. Ross Perot's operation couldn't even figure out how far underwater Blue Shield was—at least that was my understanding and impression.

So Dick Crist said, "We don't even know how deep this hole is. Do we have to do this? Should we do it?" So we had this meeting to put that question. My memory of that meeting—it was deadly serious to all those people—to me, in hindsight, it was very amusing. Warren said, "Of course, you don't have to do this if you don't want to. We'll just have a press conference and announce to the State of Minnesota that Blue Shield is insolvent and, then, all you'll have to do is try to explain that Blue Cross is different than Blue Shield." Regnier said, "Okay, I get it."

[chuckles]

JD: So we proceeded with that bill. Certainly, those people who were carrying that bill... I can't remember now who my authors were except John Tracy Anderson in the Senate and, maybe, Cal Larson or Ernie [Ernest] Lindstrom in the House. Anyway, we passed that bill consolidating the oversight of these so-called health service plans into a single law and, then, putting that under the Insurance Department.

I might add... I may have gotten tapped for that not only because that's where this regulatory system was going, but, also, under the old scheme, those plans were subject to regulation by the attorney general. That was limited to simply reviewing contracts, the contracts they issue to the public to assure that they conformed to the law. The laws had certain rudimentary requirements of what had to be in the contracts, so the attorney general reviewed those contracts. By custom, the attorney general would always assign that duty to the guy that was the Insurance Department lawyer. Our bill expanded the regulatory scope to include financial solvency regulation and all of that was, then, moved over into the Department of Insurance, which all occurred in the 1971 legislative session.

Keeping in mind that your question was how did I get involved in healthcare...? You thought I'd forgotten. [chuckles]

DT: No, no, no. I could see you coming back. [chuckles]

JD: Unbeknownst to me, and probably to most people, in 1971, and maybe for two years, probably two years, prior to that, a group of the Minnesota Fortune 500 companies' vice presidents of human resources had been meeting under the auspices of a charitable planning organization, the Upper Midwest... I don't know. It was an interstate regional planning agency. I believe it was a private charity. This organization looked at a broad array of research and planning initiatives and the human resources executives had a section on healthcare that was run by a guy named Warren Eustis, who was a lawyer that had been in Rochester [Minnesota]. I think he relocated to the Twin Cities to take this job. He was working with a consulting group called InterStudy, the principals of which were Walter McClure and Paul [M.] Ellwood [Junior]. Walter is a Ph.D. physicist and Paul is an M.D. who had been involved in patient care through, I think primarily, the Sister Kenny Institute working on polio. They had formed this healthcare think tank. It's amazing how many people are alumni of that operation and how long the thing persisted.

At that time, they were looking at prepaid health services as a public policy strategy to shape the healthcare system to be responsive to market pressures. I think that the old timers in prepaid healthcare always sort of resented their declaration that this was a new idea, because prepaid group practice dated back to the 1920s. There were plans in Los Angeles [Oakland, California], the Kaiser Permanente. There was Group Health [Cooperative] of Puget Sound [Washington]. As of the mid 1950s or later 1950s, in Minnesota, there was Group Health. But, basically—I'm not sure that the leaders of those organizations thought of their plans this way, but Interstudy did. These men studied that model and looked at it not as just an alternative or, as it was at the time, as sort of a strange, out-of-the-mainstream, socialistic idea. Certainly organized medicine and fee-for-service doctors, whether they were organized or not, were always willing to offer some negative comment about it. But, InterStudy was looking at this as a strategy and a financing/service delivery strategy.

They had coined the term Health Maintenance Organization, the idea being that if you give an organized and integrated system a certain amount of money on a prepaid basis, they have a financial incentive to maintain health. They can get the money and, then, they don't have to spend it if they keep the people well. This idea had been under consideration by this group operating under the auspices of the Upper Midwest Regional...whatever it was.

These were high-powered people. As I say, I think they were mainly the human resources people. It was the vice president of General Mills and 3M, Pillsbury, etcetera, who were not only self-interested, but they were great civic leaders. They had decided that they wanted to try this. Park Nicollet Clinic and, of course, there was already Group Health, were kind of off to the side from those guys' radar, because these were high-powered international business executives and Group Health was a little deal run out of the tradition of the co-op movement, which probably couldn't be much further away from corporate America. Anyway, there was Group Health and there was a health plan like

that in Two Harbors [Minnesota]. These corporate leaders, thinking of public policy and strategy, decided that it was something they wanted to try.

Park Nicollet Clinic, which had come into being through the common vision and leadership of a core of docs who wanted, as I've always understood it, to have a multi-specialty group practice, the way I think of it anyway, modeled on the Mayo Clinic [Rochester, Minnesota]. They wanted to try this and, perhaps, others did as well. The Aetna Life Insurance Company, I remember them because they were my client later, and Metropolitan Life, I think, they were all in the health insurance business in those days, and all of them, I think, had these big corporations as customers, because they had nationwide operations with employees everywhere. So these big insurance companies sold them their health insurance and, then, provided coverage nationwide or internationally. These big insurance companies were interested and they were standing by to work with medical groups like Park Nicollet to develop an integrated model. If you've been following the healthcare reform discussion of the last couple years, you'll notice that nothing's changed—[laughter]—except to make it work.

Late in the 1971 legislative session probably Warren Eustis approached the then Senate minority leader, Nick Coleman, and asked him if he would float a bill to authorize "health maintenance organizations." This was at the end of the session. In those days, it was biennial sessions, so nothing was going to happen then and nothing was going to happen until 1973, but they asked Nick to introduce a bill to get this idea in writing and on the political/legislative agenda. He was willing to do it. Nick Coleman, from my perspective, was a very engaged and charming leader who was open minded about new ideas. I'm not sure that made him any different than anybody else, but, at that time, the Senate was controlled, as it had been since Statehood, by the Republicans and, for some reason... I'm pretty sure, as sure as I can be, that Warren Eustis was, as they say, a DFL [Democrat Farmer Labor] "activist", so he may have gone to Nick just because he knew him from the DFL. Anyway, they went to Nick and not to the majority, but it didn't make too much difference. The bill was going nowhere. This was like in late April, let's just say. The session ends in May. I don't recall that Nick was involved in that Blue Cross legislation, I mean directly, but he called me up and asked me if I would draft this bill.

So I worked with a fellow that was an employee at InterStudy who had come out of, I think, the Prudential Insurance Company. We wrote the first HMO law in America in 1971, and it was introduced to the Minnesota Legislature. It's an interesting thing in that there's a feature that has become a part of that law and most laws ever since, which comes from the fellow who succeeded Andy Anderson as the financial regulator in the Insurance Department, named Jay Koleski. When Blue Shield went broke, Jay just shook his head, because, in his mind, this was the physicians' financing plan. Most doctors wanted their patients—this isn't unique to doctors—to have a mechanism to pay their fees, and, you know, sometimes, when you get real sick, those can be huge. Doctors wanted a mechanism for financing their services and they set up Blue Shield to do that. It was controlled by medicine. But, then, they sort of became resentful of the utilization controls and coverage limits that they had to have in order to make the product viable in the marketplace. I don't think the doctors always viewed it as their plan. They

sometimes viewed it as an adversarial arrangement. But, at any rate, Koleski viewed it as their plan, and he said that if the doctors had simply written off a certain portion of what Blue Shield supposedly owed them, it would have made Blue Shield solvent. He was, from a public policy perspective, upset that they wouldn't bailout their plan. It was their plan; they should bail it out.

So we wrote into that HMO Act, I believe in 1971—it certainly became a part of the act in 1973—that the providers that get involved, and, of course, they don't have to be involved, have to accept what the plan pays to them as payment in full, and if the plan doesn't pay them, that's their problem not the consumer's.

Anyway, we put together this law in 1971 and, then, I left the public service and joined the law firm in Minneapolis: Howard, LeFevre, Lefler, Hamilton & Pearson. That was my opportunity to fight crime. They were a municipal law firm. I found out after I left that they had wanted me to become a municipal bond lawyer, which I think is rather dry but it would have been very lucrative. I never made it to that part of their operation, because they represented a bunch of cities and I did their criminal prosecution.

But, I was, also, engaged by Aetna Life to represent it in the 1973 legislative session, to represent their interest in what was, obviously, going to be an attempt to pass an HMO authorizing and regulatory law. I did. There was a guy named Larry Fredrickson who had been a staff person in the Minnesota Senate. The Minnesota Senate has a renowned legal services arrangement, what they call Senate Counsel, a system where a cadre of lawyers that were put in place by the legendary Gordon Rosenmeier from Little Falls who, so the legend goes, felt that there should be a continuity of legal advice and high quality legal service to the Senate. So the Senate Counsel Office, certainly by 1973, had become a tradition, and Larry worked for them. Larry and I and, then, of course, other interest groups weighed in, drafted the HMO Act of 1973. It, basically, had the elements of the 1971 bill that I drafted.

The most controversial part of this effort was whether or not for-profit companies could be involved as HMOs. I still am probably rather naïve; I certainly was naïve then, and I didn't fully appreciate the real issue. In Minnesota, Blue Cross is a non-profit corporation. It's not even a mutual insurance company. So they were opposed to this, opposed to it being for-profit. There were the labor groups and, I think, the co-op movement all adamantly opposed to allowing for-profit companies be HMOs maybe because they were supportive of Group Health's position. I remember Group Health's lobbyist belittling the idea of having an Orange Julius HMO. [laughter]

There are actually some good jurisprudential reasons for the non-profit limitation, but I was not conceding that at that time in my life. [chuckles] The scope of the regulation, the terms of the regulation, the empowerment, the authorization, a central feature being to override the corporate practice of medicine prohibition, all of that was pretty much agreed to by everybody and the political fight was over whether an HMO could be for-profit or had to be non-profit. That was ultimately resolved by restricting HMOs to be non-profit corporations.

The policy reason supporting this restriction is that a for-profit company has an absolute primary legal duty to maximize profit for its shareholders. A medical service organization reflecting the ethics of doctors, which under this law must be preserved, has an absolute primary duty to act in the best interest of the patient. On a philosophical level that's an irreconcilable conflict. A non-profit corporation, on the other hand, has a legal duty to effectively pursue and fulfill its mission. If the mission is to provide medical service then the ethics of medicine and the interest of the patients and the purpose of the corporation all line up.

Anyway, I'm kind of glad we lost that fight. Just as a footnote, as it was becoming obvious that there was going to be the non-profit restriction, we resolved that by going back into the bill and allowing all the non-medical functions to be outsourced so that these insurance companies, if they wanted to be involved in providing claims service, essentially—in quote—banking services, marketing, all that, could be involved. My clients were the insurance companies.

For some reason that never happened, but that legal structure [that allowed a non-profit HMO to outsource massive parts of its operation] became the legal path that led to the creation of United Health Care. As the HMO movement evolved, fee-for-service doctors decided they needed their own plan to retain market share, if you will, and not have to go through an HMO to get their patients. So they developed Physicians Health Plan, which is now Medica. Shortly after they started that, that entity spun off, if you will, United Health Care as a means of raising capital.

Sort of the naïve part of society... Maybe I should limit this to myself.

DT: [chuckles]

JD: People who are not in business don't often think about, okay, how do you raise needed capital? If you've got plenty of it, that's not a big deal. Of course, Blue Cross had plenty. Group Health Plan, by that time, had a lot of capital. But if you were starting up a new plan, this was a big problem. Physicians' Health Plan set up United Health Care as an entity that could issue securities, raise capital by selling securities, which they did on the basis of a revenue stream from Physicians Health Plan under a long-term service agreement. So, then, based on this revenue stream, they sold stock.

That model was possible because of the way we reconciled the involvement of the insurance industry by allowing non-profit HMOs to outsource. Anyway, we passed the law.

About that time, I left that firm, because the Health Department was inviting me to head up the new regulatory/grant-making function to develop and regulate HMOs.

That, by the way, creates a schizophrenic governmental role that has, in my opinion, become a problem, at least in Minnesota. I think the state is managing the problem reasonably well, but we were not only the regulator, we were the cheering squad, the whole thing, and we were giving away money to help them start up. It was not a lot of

money; I think the whole appropriation was \$250,000. By 1973, that allowed us to give five or six or seven grants that were sufficient to get plans off the ground.

I was invited by Doctor Ellen Fifer, who was deputy commissioner of Health—Warren Lawson was the commissioner of Health—to take this on. I think she'd actually invited Larry Fredrickson and he wanted to stay with the Senate. I was happy to be second choice.

At that time, the Department of Health, the statewide public health service, was operated under the governance of a Board of Health. These members of this Board of Health were appointed by the governor and they picked the commissioner. The commissioner, therefore, was sort of a career position.

This is kind of key to my future—[chuckles]—in that Ellen also hired a guy named Kent Peterson, who was a pharmacist and he had a master's in public health. She hired him as sort of my sidekick. Theoretically, I think I was his supervisor, but we were partners. He had the public health perspective, and I knew the law, and my background was insurance. So our job became the development of HMO regulations and the setting up of a grant application mechanism and evaluation of those applications, awarding of grants, monitoring grant performance and, once we got the regulations done, inspecting and licensing HMOs, etcetera. We did this over the span of, oh, like from September of 1973 or something like that, August, maybe, to December of 1975. It was quite a project.

As all of this relates to the University of Minnesota Health Sciences, this Board of Health had representatives of various constituencies. The governor would pick people who were thought to be representative of hospitals and doctors, nurses, and so forth. In the early 1970s, there was a big push to involve lay people in all these things, so-called consumer representatives, and there were several of those people. So there was a Board of Health of maybe, just to take a wild guess, twenty people. John Westerman—at that time, his title was General Director of the University of Minnesota Hospitals and Clinics—was the chairman of the Board of Health.

Public health, of course, is critically important to the health of Americans. Our Department of Health has been, I think, an exemplary agency in that regard. But I wouldn't argue if someone advanced the notion that, from a governance perspective, a lot of public health activity just sort of takes care of itself. There are programs to get children vaccinated. The Department kept death records and birth records. [The agency needs oversight, of course, but unless there is an epidemic—an outbreak of communicable disease—there are very few items that require policy-level oversight or that attract public attention. It is at least my bias that the other work of the Department, although very important, did not require much Board of Health attention. The HMO program, on the other hand, was busy and somewhat controversial. This was a first-in-the-nation effort to realign the financing and delivery of health care in America, and it is the model for everything that has occurred since, including the ACO concept under PPACA.] Accordingly, I worked with the Board a lot.

We got the rules written. We got the grant criteria established. We received applications. We awarded money. Ultimately, we licensed everybody that wanted to be an HMO at the time, and we deliberately picked a bunch of different models: hospital-based, medical-based, community-based. We had, I think, two rural, one in the Arrowhead Region out of Virginia or Hibbing and, of course, the established plans in Two Harbors and Group Health. I think we started something in Saint Cloud. We tried to get something going in Rochester, but Mayo Clinic demonstrated very little interest. Olmsted Medical Group said they were interested but their business plan was to coexist with the Mayo Clinic, so they did not want to disrupt that so they stayed out. Then, there was the Ramsey Health Plan based at the Saint Paul Ramsey Medical Center in Saint Paul. There was S.H.A.R.E., which was the old Great Northern Railroad Good Samaritan Hospital based plan, which created Aspen Medical Group for purposes of this effort. There was Park Nicollet that developed the Med-Center's Health Plan. The Eitel Hospital, which, at that time, was on the east side of Loring Park—you can now buy a condo and live there if you want—had a model that was neighborhood-based. It was a hospital-based neighborhood-oriented plan where people that lived in that little area would prepay for their healthcare and come there to get it. There were all kinds of different models. Actually, at that time, the Nicollet Clinic and the Saint Louis Park Clinic were separate entities and, I suppose, competitors. The Nicollet Clinic had a start up HMO. Saint Louis Park did. The Nicollet Clinic was another multi-specialty group, but at least my memory of it is that it was smaller than Saint Louis Park. I don't know whether this was a part of this movement, but soon enough, the Saint Louis Park Clinic and the Nicollet Clinic merged to form Park Nicollet, and they merged their HMOs to form Med Centers. Anyway, we got a lot of action going.

All this time, I was in front of the Board of Health with all these rules and decisions regarding grants, and what's going on with licenses, and what's going on with the socialization of medicine.

[laughter]

JD: I don't know what drove this, except that I was, if you will, working closely with John Westerman and his board.

At some point, as all this was getting wound up, actually, Warren Lawson came to me and suggested that I go to the University and get a master's in public health with the idea of becoming the commissioner of health. I had not a lot of interest in that. I didn't see a future in public health for me.

As all of this stuff was coming together, maybe as that job was done... Warren and John, I think, were reasonably close, at least as Board chair/commissioner. I don't know whether they engineered this. But, anyway, Westerman invited me to come over and be general counsel to the University Hospital. So I left the Health Department and went to the University.

I think the hospital had, maybe, five objectives in engaging in-house legal counsel: to support their new governance system; to help in the accommodation of hospital

Accreditation standards, that, in part, drove the governance changes; to help address the University's new exposure to tort liability; to help address the increasing regulation of health care; and to simply have legal input in management and operations.

DT: I'm actually curious... What was the relationship between the HMO legislation that you were working on in Minnesota and the federal legislation that was moving forward at the same time?

JD: Well, we finished first.

DT: Yes, we did.

JD: It pleases me greatly, because we can say that not only did we make this first effort at reflecting these ideas in law, but we actually *did* it first. Paul Ellwood...and I hasten to always mention Walter McClure, because I think Walter was the real strategic genius behind describing prepaid group practice as a health services delivery/financing strategy from a public perspective. So Paul and Walter were out hustling people in Washington, too. I'm sure...well, I don't know, but the way I believe things worked is that this little group that Warren Eustis chaired or coalesced, represented these huge companies, gave them standing to approach the Federal Government and Congress. So the relationship was that the same guys, who were studying this and advocating it, were out there, too. They had airplane tickets. I remember them talking about selling the [President Richard M.] Nixon Administration on this as a strategy and, then, convincing Ted [Edward] Kennedy that it was a good idea. I think people, from time to time, comment on that, that that whole thing was a Nixon/Kennedy deal. Anyway, it was the same group of people. The laws were similar. I like to think that—I have enough of a connection with reality not to let it get too big in my head—the framework of that federal law came from the work that I did here. Anyway, the same forces, a different legislative body, then, came together. They were unable to finish their work as soon as we were.

DT: [laughter] Another Minnesota first.

JD: Yes, right.

And, of course, they had a lot more money, but they had a lot more strings attached. That was the relationship.

DT: You mentioned earlier about the attitudes of organized medicine and some reluctance to this kind of thing. Was the Minnesota State Medical Association [MMA] lobbying at all in opposition to the HMO legislation?

JD: You know, I don't remember. There were doctors who showed up. I have a good friend—[chuckles]—Dr. Bob Geist—we still see each other at all kinds of stuff. He's been against this from the beginning. There were a lot of individuals who made it their business to be opposed to this. Actually, there are reasons to be concerned. When you move services like healthcare into systems, they become more and more and more

bureaucratic, and more and more and more expensive. That is a fact. That is a reality that we need to come to grips with, because, ultimately, it compromises tons of good work. We talk about red tape and bureaucracy and Catch-22. These things are not just annoyances we complain about; they are real problems. I think that probably deep down inside, doctors didn't want to discount their fees, but, also, they didn't want to have these bureaucratic burdens become a part of taking care of patients. I don't recall what MMA's position was. I wouldn't be surprised if they were opposed. This bill was a done deal. [chuckles] I don't remember what their position was.

DT: You had a lot of powerful support for it.

JD: It just seemed like an idea for which the time had come, you know. Plus, I'm a terrific lobbyist. Let's get to the bottom of this.

[laughter]

JD: You were asking about the federal legislation.

DT: Yes.

JD: One more footnote about that. I founded an organization called—I thought it was so clever—the Association of HMO Regulators. The acronym of AHMOR was *amour*. Apropos of my comments a moment ago about bureaucracy, all these old-line prepaid plans and all the new start-ups who recognized that the government was trying to help them get going, always said that we were “loving them to death.” Amour.

DT: [laughter]

JD: Help us out but don't tell us what to do. Well, that's not the way that worked. I thought it was extremely clever to name this association of HMO regulators AHMOR. After I left that organization, when I left public service, they actually changed the name for some reason. Perhaps, they didn't like the idea that that joke was in there—or maybe they never got the joke.

That was born of a real need. When Kent Peterson and I went around to license these HMOs, we'd come up with kind of a protocol. We looked at their articles of incorporation. Everybody has articles of incorporation. What that has to do with anything is beyond me. But, we'd come up with sort of a two-, three-page thing of stuff we were going to look for. Their medical records system, was it laid out according to standards of practice? It became real clear that we had serious limitations in terms of evaluating in a real way whether an HMO could provide good service and be financially sound.

Another digression... Although an overstatement, I would note that actually, nobody cared whether they were financially sound. This was a bold strategy and a part of that was that the regulation of HMOs was placed in the Department of Health, not the Department of Insurance, because we, that is, the advocates for the law and the political

leaders in the Legislature, did not want any particular financial requirements. The HMOs had to have enough doctors to take care of the defined population. That was an absolute, they had to have capacity. But, to get that capacity, they had to sign a contract, and the contract had to say that the providers would provide service and accept whatever they were paid; they'd accept that as payment in full. So there was really no consumer risk of insolvency. We knew, especially with the non-profit limitation, that there was no way that these plans could raise the capital to actually get into existence. So, the financial side involved a lot of prayer. Anyway, Kent and I would go around trying to decide whether these plans were qualified to have a license, and it became clear to me that a lawyer and a public health pharmacist didn't constitute... I mean, forget the CPA. [chuckles]

I formed this national thing, because I thought that if we started talking to people... By this time, other states were passing these laws. The Federal Government was involved. The Department of Health and Human Services had a staff. I thought that if we could get together a couple times a year, we could actually come up with regulatory techniques that would be intelligent and work. So that was the idea. Paul Ellwood and InterStudy tried to co-opt that from the very beginning, and I think it depended a lot on funding from the Federal Government. Many years later, I was invited back as the founder at some meeting they had. I would be shocked if it still exists. I thought it was very appropriate. I don't know what other people thought about it. You know, the role of government as a regulator is a serious role, and people have to be competent at it. Yet, you have to assemble that competence in the context of limited public budgets. So I think collaboration is just an obvious way to get it done good and cheap. Digression.

DT: No, that's all good.

JD: So, now, Westerman has hired me to be the attorney for the Hospitals.

DT: Yes. Actually, before we get to that. I know the University was trying to establish an HMO in the early 1970s. Do you have any information about that?

JD: They weren't trying very hard.

DT: Oh, they weren't?

JD: No. Let me look into this. Turn that off a second.

DT: Yes.

[break in the interview]

JD: Well, you may know more about that than I do, whether the University wanted to start an HMO. I would have thought that had they been serious about it, I would have been involved since I was their employee, and I'd had that background.

DT: This was before you were at the Hospital. The information I've seen in the Archives suggested that they were trying to develop it in 1971, 1972.

JD: Oh, really? In the earliest days.

DT: Yes.

JD: It's interesting. Group Health was founded by University faculty. The University is where new ideas start, hopefully. Actually UCare, I think, was created by the University Family Practice Department.

DT: Yes.

JD: So, in that sense, they did that. But as a broader strategy, I was never involved in anything like that.

DT: That's where I've seen most of the information, in the Department of Family Practice records.

JD: I think that happened in the later 1970s.

DT: Yes. They started talking about it in the early 1970s, but there was a lot of opposition from even Minnesota Academy of General Practice.

JD: The Department of Family Practice didn't even come into being until, I thought, I got there.

DT: No. It was established in 1968 as a division and in 1969 as a department.

JD: Oh, really?

DT: Yes.

JD: Okay. All right.

DT: Anyway, you were general counsel of University of Minnesota Hospitals and Clinics. What were your responsibilities there?

JD: Well, I was general counsel.

[chuckles]

DT: What does a general counsel do?

JD: If you have a legal problem, you call the general counsel, and he'll figure out what to do. Actually, there were certain motivating factors and related "front end" goals, which I will address in a moment.

To put this in some sort of context, there were changes in the governance of the hospitals which, I believe were initiated by John Westerman. Among other things, the University Hospital was accredited by the Joint Commission, and those accreditation standards required board involvement in physician credentialing and quality assurance. I believe that John felt that they needed a separate hospital board to be involved in this way. And, it worked. By the way, some years later, John became an AHA designated member of the Joint Commission board. Lyle French was the vice president of the health sciences, who, in my opinion, was a great doctor and a great leader. John Westerman...as general director of the Hospital...was his subordinate but John was in charge of the hospitals. The vice president, I think, really provided the leadership for the Hospital, especially in matters that would involve the Regents, which certainly would include governance changes. A footnote... Each department ran its own clinical operation through a private practice entity. So the vice president was limited on that side. I don't know whether that's changed, but that has been a very mixed blessing in that whole operation, in that whole structure, in my opinion. Anyway, the vice present of health sciences was the boss—in quotes—of the general director and the general director I suppose did nothing that the vice president didn't think was okay.

John was a wonderful man. To be personal about it, he's the only guy that I've ever considered to be a mentor. I have found myself in situations where I was always kind of out in front and there was nobody experienced or ahead of me that could give me advice. But Westerman liked to think of himself as a thoughtful leader, and I think he was. And working for and representing him was a very positive experience.

Someone else can tell you... You should ask someone, "What were the motivating factors that led to the reorganization of the University Hospital?"

My perspective was that there was a realization that it had no real governance and that the element of governance was important, and they needed to do something to establish governance. This may have been as simple or as sort of mechanical as the Joint Commission for Accreditation of Hospitals putting a new emphasis on governance. I don't know. I believe that John Westerman thought they needed better governance. The Board of Regents simply was not geared up to fulfill that role. I mean, they cared about the hospital in that they wanted a hospital and they wanted it to be run okay. They didn't want it to lose money or be a source of problems, but under the accreditation standards for hospitals, the governing board is supposed to credential physicians. They're supposed to have oversight over patient care. They're supposed to do a lot of things that the Board of Regents really *never* did and, so far as I know, was probably poorly situated to assume those duties.

So I believe under Westerman's leadership, and Lyle French's consent and support, the University Hospital had undertaken this effort to establish a separate subordinate Board of Governors. They hired John Harty out of Pittsburgh to put together the bylaws and advise them on the structure.

[break in the interview as John Diehl answers a phone call]

JD: Horty had been engaged to describe a structure. As I soon enough became aware of hospital law, what he did was not that unusual, but the trick at the University Hospital then, and probably now, was to integrate the clinical chiefs into the governance structure, the organizational structure and governance of the hospital. I guess it's important to say both the organizational structure and the governance. The chiefs had operated their academic departments and their private practice groups seeing patients in, you know, the spaces within the health sciences area as sort of on their own. They had a bunch of residents. They had a bunch of research they wanted to do. It was their job to find money and to take care of patients and do all this stuff. At least the popular notion was that they didn't much interact with one another and they certainly, except for using the hospital as a place to do a lot of this stuff, weren't so much involved with the hospital. So the establishment of an improved governance system was intended to provide actual governance oversight of hospital operations and structure, specifically patient care oversight and physician credentialing and that sort of thing. Governance is not management; it is an important factor in any organization, but especially a big organization, overseeing finance and patient care and the medical staff...

The bylaws reflected what I think is called the American model, which is to have a corporate entity—that's the hospital—run by a board of, in that case, governors that has all the responsibility for everything, including patient care, but, then, with a strategy of requiring doctors practicing in the hospital to organize themselves into an organized medical staff and, then, delegating to that organized medical staff certain functions in patient care, primarily quality oversight and credentialing. So all that stuff that was in those bylaws was the American model.

This had come into being, I think maybe, weeks or months before I started. The structure was on paper, but it was brand new. The board that was appointed by the Regents was a very good board. It was geographically diverse. It was demographically diverse and, then, had some really talented, dedicated people. They set them up, you know, organizing and putting in place a governing system for this otherwise sort of wild and crazy animal. So my job, a big reason for my job, was to provide legal counsel to this body and this entity as it was going forward in this new model. I don't know whether Horty actually added anything to it, but he got the job done. Horty was a famous healthcare lawyer. In 1975, there were about four of them in the country.

The trick was to integrate the chiefs with one another and into the rest of the structure and operations. Frankly, in anticipation of meeting with you, I was trying to remember how that ultimately worked and I can't remember. I could look at the bylaws, I suppose. It created a Council of Clinical Chiefs and that was the central thing. It met every Tuesday at noon for lunch. I think it worked. [chuckles] They'd all come in and have a hot dish of whatever the hospital was serving that day. There was business. It was always sort of routine business. Then, Westerman would read articles from the *New York Times* and other publications which was intended to put the University Hospitals in the big picture context. He'd always talk about the triple threat of teaching, research, and service. It was his way to get all these guys in the room and sort of preach at them a little bit. I thought, at the time, it was good. Looking back and having a better perspective, it was as much as you could ever do with guys who had a seventy-year history of being

autonomous, oftentimes indifferent to one another, medical giants, and try to put them into some semblance of an organization. I think the chiefs were advisory to the general director. Do you know?

DT: That's what I had thought from what I've seen in the Archives, yes.

JD: Yes. They had no delegated functions from the Board. Actually, probably the creation of the organized medical staff occurred with this structure. They may not have ever had an organized medical staff before. Now, that I think about this, *that* may have been the huge change. There was an elected chief of staff and the related structure of the medical staff to which the board of governors delegated the oversight of medical care standards. In any complex, large medical organization, the American model contemplates clinical departments within the medical staff. I don't remember there ever being any issue, so it was handled okay. That probably was a delicate arrangement in integrating the purview or the province of the chiefs with the clinical department structure of the organized medical staff. So that was there.

I remember once in my whole tenure a credentialing dispute. In terms of my role, physician credentialing is a very legally intense process in health law or in healthcare. Some health lawyers, that's all they do. I assume that the realization that that was probable is one of the reasons they wanted to have a lawyer.

DT: They didn't have a lawyer before they hired you?

JD: Yes, that's correct. Well, that's not entirely correct. There was a wonderful guy named Joel Tierney.

DT: You were telling me about Joel Tierney.

JD: Joel, his title was "University Attorney". He was actually hired by the University, as I remember *him* telling it, as a real estate manager. Joel is a little older than I. I gather he started at the University, perhaps, as a younger guy. I don't know what real estate manager meant, but if you have a lot of real estate dealings, it's nice to have a lawyer. So here he was; he was a lawyer, and he was situated in Morrill Hall, so when people had legal questions, they'd go see him. [chuckles] His role sort of evolved from being a real estate manager, to being the lawyer in Morrill Hall, to being the University attorney. He always seemed to lack the title that, perhaps, he needed to validate his authority. At any rate, he was in the job and the University turned to him. I mean the Hospital people would turn to him. He had another fellow. There were different guys over time. When I got there, there was a fellow named Jeff Lalla who was the assistant University attorney. Jeff and I became friendly and we've been friends ever since. He's now—I don't know what his title is—the general counsel to the Saint Paul Public Schools, so he stayed on the education side. That was it. He had Joel and Jeff and maybe some law students who would come in and out of there or something and, you know, that's a vast operation. The Hospital had explained to me that when they'd call him about something, he wouldn't give them advice. He'd ask them what they wanted to do. Basically, I think the way he dealt with the fact that he had way too much to do in *way* too many areas, each of which

probably required a great deal of expertise that he may or may not have had, is he would ask the client what they wanted to do and, then, he would make an evaluation from a legal perspective, given the judgment that lawyers have, whether it was a good idea or not a good idea. I know that the people in the Hospital wanted more legal input on a strategic basis. They felt that his approach was not giving them the guidance that they wanted, I think is fair to say. At any rate, the University had a University attorney. Joel was involved in health sciences.

Joel and I think John Najarian. Yes, it was John Najarian. They started doing kidney transplants with minor sibling donors. Joel was certainly up to that task. I think he and Najarian, but certainly Joel, developed sort of a medical-legal protocol. When you have a minor donor, obviously, that person is not competent legally to make a decision of donating a kidney. In those days, for kidney donations—today as well—you had to have a tissue match. A sibling is a likely donor. A minor sibling can't decide. The parent, who has a love relationship with both children but a desperate life and death situation with the one, Joel felt had a conflict of interest in consenting for their donor child. He and John Najarian came up with a system to secure sort of supervision of that decision-making process by the court. I did it many, many times, but they had it all lined up. Joel had it all lined up with the legal pleadings, etcetera.

There was a protocol. They would have a psychiatrist, a child psychiatrist, interview the donor for two reasons. One—we didn't ever tell others this—was to see whether the child seemed to be under duress, overt or otherwise, and whether they truly kind of appreciated what they were doing and, even though they're not legally competent, whether they wanted to do it. The psychiatrist would say to this child, "I know that this"—if the child was aware that this was life and death for the sibling—"is a very hard thing and if you don't want to do this, you tell me and I will tell them that I'm not going to let you do this." So it was sort of a fail-safe. The court knew about this. So we'd go to court.

At any rate, that was Joel. They had that, but they wanted a lawyer who could devote more time to hospital issues.

DT: I started out by asking what your responsibilities were and, then, we got sidetracked onto why they didn't have a lawyer before.

JD: The governance issues, which had to do with drafting resolutions and things like that for the Board... I attended Board meetings with the other second level managers, maybe even third level. It was a huge crowd at every Board meeting. That was relatively minor. I was involved with physician credentialing, and I was involved in medical malpractice risk management...

There was another environmental phenomena going on at the same time and that is the state had, historically, been immune from liability due to sovereign immunity. In a case where the Highway Department was thought to have been negligent in the design of, I think, actually I-94 [Interstate-94], leading to a head-on collision at freeway speeds, they

were sued and defended on a basis of sovereign immunity. The Minnesota Supreme Court decided that the time had come to abolish sovereign immunity.

Well, the University Hospital had been protected by that doctrine. I think individual physicians were exposed to liability and they had the insurance and insurance companies always responded if there were claims. The Hospital itself, we had a standing relationship with Geraghty, O'Loughlin & Kenney. Jim Geraghty, if we got sued, would—this was a relationship that Joel Tierney had established that I maintained—go to court and move for dismissal based on sovereign immunity. [chuckles]

In the case of *Nieting v. Blondell* [1975], the court declared that on a *prospective* basis that they were going to abolish sovereign immunity, meaning that the University Hospital be exposed as a separate defendant.

So that was another function. I set up a risk management system, and incident reporting system, and claims management. I'm not sure when, but soon enough, we became self-insured for medical malpractice liability and I related to that process. I set up an arrangement where we would if we could catch a claim and settle a claim...the way we would get paid from our own self-insured fund. So that was a part of it.

Because of my involvement at the Legislature historically, there were some odds and ends. I was involved in writing the state Tort Claims Act, which was necessary as a result of that Supreme Court decision. I was not the principal draftsman or advocate in it, but I was at the table for the University Hospital

When you're an in-house lawyer, it's a different life than being a private practicing lawyer in that you're brought in to provide your perspective and judgment on just almost everything that happens. Law touches every part of human endeavor. So there you are.

[laughter]

Of course, at this point in time, I'd been a land condemnation lawyer. I'd been a criminal prosecutor. I'd worked with the Legislature, and I'd developed this HMO program. These are relatively narrow things. I feel like I had a terrific legal education, and I always try to pay attention. It's amazing how much you can learn if you just show up and stay awake.

[chuckles]

JD: I remember—in 1973 was *Roe v. Wade*—one of the early issues that I was only observing, but it was a big political embarrassment, I thought. Whoever appoints department chairs—I think it was the vice president—was considering Konnie [Konald] Prem as chairman of OB-GYN [obstetrics and gynecology] and Konnie was prolife. There was all this politics of whether you wanted a prolife chair for OB-GYN. He was a gynecological cancer surgeon. There was a lot of nonsense around that. And, of course, as a governmental entity, we certainly couldn't interfere with individuals' rights. I'm not sure of the date, but one of my first assignments was to write an opinion on what the

University Hospital, as a governmental entity, had to do, couldn't do, should do relative to patients that wanted an abortion. So, then, I had the occasion to advise on matters like that. That was a momentous type of issue.

I saved my opinions, formal opinions, that I rendered from that era, and I can tell you I think at least four times I was asked to give legal advice on whether you can sterilize and reuse disposable tubes, which, of course, is permissible if you want to be sued. They're disposable, you know.

[laughter]

JD: I made it a practice of writing... Most of my advice was rendered in written form setting forth the facts, setting forth the question, and rendering an opinion. I'd think, you know, these opinions are floating around here. Why are you asking me this again? It came to a point where I was just reciting my earlier opinion as authority for my new opinion.

DT: [chuckles]

JD: I suppose there was a lot to do with risk management and potential liability. There was stuff to do with governance. The only time I ever remember governance being a high profile, major consequence of error issue was when one of our Board members was *thought* to have a conflict of interest, and I had to help him sort through that, and, then, credentialing and an occasional legislative issue. On the ministerial side, I had to set up an office. I bought an amazing amount of law books.

[laughter]

JD: I developed a staff. Ultimately, I had an assistant, a lawyer that followed up on the risk management matters and did legal research, and we got a secretary. So there was a little bit of office development and support development in terms of research materials and so on. Today, that function would be in deciding which computerized research tools you'd buy.

DT: I've got some follow up questions.

JD: Yes. Okay. Go.

DT: The sovereign immunity issue was one of the main things I wanted to ask you about. I hadn't realized the kind of ending of sovereign immunity in, I think it was, August 1, 1976, which I saw in the Board of Governors minutes...I hadn't realized that that came from an issue completely unrelated to healthcare, that it was this highway issue. It looked like from the records I saw that the Hospital was engaged in some kind of debate for a couple of years trying to say that it should still have sovereign immunity. Was that a protracted debate?

JD: Well, there was a protracted sovereign immunity court case, a very unfortunate case. The first case that arose after the abolishment of sovereign immunity was a psychiatric patient who was injured in the psych [psychiatric] unit.

This patient was a young man who was at least abusing drugs, which caused a psychotic state and he was brought to the psych ward. [pause] At one point, I thought I would never forget the plaintiff's name.

DT: Was it Nathan Stein?

JD: Yes. He was in the stereotypical padded room, and he was running from one side of the room to the other bashing himself against the padded walls. People were terrified he was going to hurt himself. The standard of care is to approach a psych patient in that state with a "show of force" to create, I think—this is my own deduction—the impression that the patient's cooperation is his best option. So they did that. We had psych aides, many of whom were students working part time at the Hospital. The aide that this patient then ran at turned out to have been a wrestler. The patient attacked this aide. You shouldn't rely on this; this is probably more my imagination than actual memory. But as I remember it or as I imagine it must have been, the aide, given his sport, sort of intuitively reacted, and got him in a "full nelson" wrestling hold. Then, the patient pitched forward and landed on his head. Well, he broke his neck, making him a quadriplegic. So we got sued over that as you might imagine. Frankly, we were prepared to go to trial to defend that on a rationale that the aide acted reasonably under the circumstances, i.e., that we had to intervene and the approach was consistent with the standard of practice in the community; we intervened in a way that's not unreasonable. It was the patient's own action that caused the accident. Anyway, I don't know whether that would have been a successful defense, but that was where we were headed with that.

Our defense counsel, Jim Kenney, as it turned out, had a career-ending heart attack about three months before trial.

First of all, we were preparing for trial. We were arguing that... If you've seen things where the question of immunity was involved in that Stein case... My recollection is, piecing it together from what I recall, the Supreme Court abolished sovereign immunity prospectively, and the accident in the Stein case occurred before that decision took effect. The question may have been whether this occurred after the decision but before the prospective effective date of that. I vaguely remember that that was a legal point that was in play. When did you think that that case came down?

DT: The Stein case was 1978.

JD: I mean *Nieting v. Blondell*...

DT: Oh. Sovereign immunity was not allowed after August 1, 1976.

JD: Okay. I became general counsel in December 1975. As noted, above, I think part of the motivation to get a lawyer was that decision.

Looking back, I think there were three issues in the case. First, whether sovereign immunity should have ever been applied to the University Hospitals because, arguably, it was a “proprietary” function (and, therefore, not immune). Second, even if the hospital were not deemed to be “proprietary,” whether it was exposed to liability under the *Nieting v. Blondell* decision. And, third, whether the hospital staff acted with reasonable due care under the circumstances.

DT: In the Stein case, did the Hospital settle?

JD: Yes. What ultimately happened was our lawyer had a heart attack and became permanently disabled and the court wouldn’t grant us more time to have his partner, Terry O’Loughlin, prepare for the defense. So we were looking at a brand new lawyer. I’ve resented that of our court and the judges who were involved ever since. It was not a fair decision. Now, they may have looked at all of this and said, “There’s no way in hell the University is going to win, so why don’t we just get it over with?” [chuckles] But that wasn’t my point of view.

DT: I was just wondering what happened with the case.

JD: We were forced to go to trial without time for our new counsel to prepare and that provided the additional motivation we needed to settle it.

DT: Yes.

You mentioned the Hospital setup its own insurance company.

JD: We established a self-insurance program with the help of Alexander & Alexander, insurance brokers and consultants.

DT: Okay.

JD: This was a segregated fund, an account, funded by the hospital, from which claims costs were paid.

DT: Can you explain that in a bit more detail. I saw a little bit of it mentioned in the Board of Governors’ minutes, but it’s a bit foreign to me.

JD: Obviously, legal accountability is a reality in any organization, especially a large, highly visible organization. If you get sideways with your legal duties to individuals or the public or whatever, there’s lots of ways that you can be held accountable. Part of it is if you cause damage that can be quantified in money, you have to pay money damages. So, then, prudent governance and management requires you to have a means to meet that obligation. Insurance is only one of many ways to do it. It’s the way most people do it because they don’t have the resources to do anything else. Other mechanisms are to form your own insurance company and, typically in America, that’s done by creating a “captive” company (often in one of several Caribbean countries that make that an

industry) or you can just set up a fund. There's an awful lot of tax law overlay to all that, because insurance premiums are a deductible business expense. The IRS [Internal Revenue Service] has set up standards governing self-insured plans that determine when you can treat a set-aside as a deductible premium. For a governmental entity that doesn't pay any taxes anyway, you know, it really doesn't make much difference, but the point is that this is a recognized technique used to manage risk.

The University had the means at the time. I can't remember the size of the operation, but the University Hospital has always been among the biggest, highest dollar volume hospitals in the state. There were adequate funds, so we just set up an account. The Central [Administration] University Department of Finance vice president of finance, Don [Donald] Brown was the vice president of Finance. That person, in consultation with John Westerman and our financial people, Cliff Fearing, and the Hospital Governing Board finance committee, decided it was a good strategy. We set that up, and I know we engaged the brokerage firm of Alexander & Alexander to administer it. Once in place, I kind of related to those people in how we financed liability.

DT: That was set up in Bermuda, as I understand it.

JD: I don't think so.

DT: Oh? Really?

JD: Maybe. I remember it as a... I defer to your research. I thought it was just a separate fund.

DT: No. I saw that the Captive Insurance Company was set up in Bermuda.

JD: Oh, all right.

DT: Yes.

JD: I'd forgotten that. Obviously, I was not among those that had to go to meetings in Bermuda.

[laughter]

DT: I've been rereading the Board of Governors' minutes.

JD: Then, all my comments about one's own fund, I believe you can do that, but, apparently, we didn't.

DT: It was all new information to me, so I'm just glad to have more explanation of what the issues are.

Can we talk more now about the abortion issue? That was another question that I had. The University Hospitals eliminated second trimester abortions in December 1975 and,

then, Konnel Prem was appointed head of OB-GYN in 1976. Then, there was this backlash. Can you give any more detail about what the rationale had been about eliminating abortion services? It seems like that was right at the time that you joined the Hospital.

JD: Yes. I don't think I ever knew that they had limited their service to first trimester. Maybe I did. I don't remember that. If that was an action that was taken in December 1975, all the play preceded my engagement. State your question again. This is news to me. I remember the Konnie Prem piece.

DT: I just wondered if you had more information about that whole debate about the abortion services. I know that the Hospital closed its outpatient abortion clinic in 1977.

JD: I don't know. I don't remember that it happened, so I certainly don't know why.

DT: [chuckles]

JD: In spite of all that people were trying to say about Konnie, I don't think that it was a moral issue. I think that it was more a matter of, first of all, whether there was anybody that wanted to do it, and I don't think there was. There was a lot of pressure on the University as a teaching institution to teach doctors how to do abortions and there was a lot of pressure...or there were many people that held the point of view that, as a public entity, you ought to be able to go there to get an abortion because, as a taxpayer, it's your hospital, that kind of mentality, I guess. But in order to have a clinically competent, safe abortion, you have to have a clinically competent doctor. [chuckles] And that requires, in America, where we seem to frown on indentured servitude, a person who wants to do it. My memory was that, while there were doctors who were willing to do it, nobody particularly was into it. OB-GYN at the U had a lot to do with fertility. Those guys thought it was contrary to their scientific mission in life, which was trying to create pregnancies. There were lots of female cancer treatments in that department. I just don't think anybody saw it as a part of what they wanted to do. Well, if that's where you're going to be oriented...

One thing I've learned about healthcare is once you have a competent provider, whether it's a tech or doctor, whoever it is, that's only a good beginning. You have to have a support system. You have to have a follow up milieu that makes their, hopefully, good work stick, so to speak. This was a tertiary care research center. This was not an abortion clinic. Planned Parenthood operated an abortion clinic in what had been a restaurant on Ford Parkway [in Saint Paul]. You don't need the University of Minnesota Hospital to do abortions, especially if you're doing first trimester. Then, if you were moving into a higher risk—this is all hindsight speculation—category like second trimester, then you have to start diverting high tech, high cost hospital resources for a set of services that basically not very many people wanted to do.

DT: What I read that's consistent with what you're saying is that one of the arguments that was made was that, well, the University Hospital doesn't need to do it because there are all these other hospitals and clinics in the Twin Cities that are providing abortion

services, so it's not a case that people can't get access. We're just saying that that's not what we're doing here.

JD: Yes, right.

DT: That tertiary care argument actually makes a lot of sense.

JD: And, of course the teaching programs are integrated. Some are more autonomous than others, but they're all integrated, so the Department of OB-GYN could take comfort in knowing that, for example, at Saint Paul Ramsey Medical Center, they had a *huge* abortion operation. A resident could rotate through there and learn everything he or she needed to know. I don't remember what was going on at Hennepin County, but, yes, in terms of teaching people, the University had it covered and, in terms of patient access, there was access.

The opinion that I wrote, which I have revisited from time to time... [chuckles] It was a big deal because it had to be right, and I hadn't been doing that kind of work for a few years. It really addressed the ways in which the government could manage the delivery of healthcare services vis-à-vis *Roe v. Wade*. I thought it was a very well done opinion. I'm a prolife guy, but I was bound and determined not to have that color my point of view and it didn't.

Prolife people don't seem to appreciate what *Roe v. Wade* does. I mean, probably few of them have ever read the opinion. It really has to do with individual constitutional rights vis-à-vis the role of government more than... It's a limitation on the power of government. It does not assure the availability of abortion on demand. That may be one thing that flows from that. [chuckles] But the Supreme Court did not say that.

Our court system being organized as it is, we're the Eighth Circuit and the Eighth Circuit includes Missouri. In fact, it sits in Saint Louis. So it had some rather conservative abortion decisions, and we used that for guidance, and we established an approach based on my opinion. I knew there were people trying to rip apart my advice, but they never surfaced. [chuckles] So I concluded that they figured out that I was right.

DT: [chuckles]

JD: Anyway, that was my first big issue after I became general counsel.

DT: Another thing that seemed to come up a lot in the minutes of the Board of Governors is the contract negotiations between University Hospital and its various employees. I saw that there was debate about which union was going to represent Hospital employees. Would it be AFSCME [Association of State, County, and Municipal Employees] or the Teamsters? Were you as general counsel involved in any of that or was that someone else's responsibility?

JD: No. That was outsourced. It went out through the Central [Administration] Human Resources office. We had a firm, at least the University did relative to the Hospital, that

for years and years, had been central to health care labor law in Minnesota. Then, they had a falling out and the University engaged a different lawyer. I don't remember now who it was. The first firm was a Saint Paul firm and, then, they moved to a Minneapolis firm. I didn't even know about that *history*.

I got involved in one labor issue in my tenure. In fact, I engaged that old Saint Paul firm to advise me, which made everybody angry. Well, it didn't make everybody... It made the people whose authority I had usurped angry. They were trying to actually recognize a union that had abandoned their claim of representation. I don't know whether they'd even had a vote. At any rate, it was a union that had sort of been around but over five or six years had never actually undertaken the representation of the employee unit. Then, something surfaced and the University wanted to recognize these people and start bargaining with them. I got involved on that issue and had advice from this outside firm. It turns out, if a union does not follow up on their selection as a bargaining representative after a reasonable period of time, they lose their status, which is only logical. [laughter] That's the only union deal I ever was involved with.

DT: What about the question about whether residents were regular employees or students?

JD: Students are employees for income tax purposes?

DT: Yes.

JD: Well, that was an issue that was ongoing. Joel Tierney had started the legal involvement on that, and he had engaged a lawyer in Saint Paul to represent the University's interest in that...Ronald Patrick Smith. Ultimately, I hired a lawyer to assist me. Her husband is a premier pediatric cardiac surgeon, John Meyer. This was Chris Meyer

She was a terrific lawyer, smart as a whip. At some point, she kind of got into this. I think she, actually after she left the University, still represented residents in those cases.

Do you know the issue? It's still being litigated.

DT: Oh, really?

JD: Mayo Clinic is fighting with the government. [chuckles]

DT: All I know is do they get taxed or not taxed and, then, can they be part of the National Labor Board or be members of that Board?

JD: Do you mean governed by the labor laws?

DT: Yes, exactly, that's it.

JD: The tax question is whether they are “employees” for purposes of payroll taxes and income tax. The labor law issue, I’d forgotten about that issue.

At the University—I’ve come to understand that it’s different from one department to the next—at the time, I thought it was common among all the departments. The Department of Surgery, which is where much of the legal action was, treats residents as students. I have the vague impression that you couldn’t be in just a regular residency program in surgery. Now, maybe that’s not true, or maybe it was true and it’s no longer true. The model anyway was if you were a surgery resident, it was a seven-year program that led to a Ph.D. You were, of course, getting clinical training, but there was a research lab year or two and it was an academic undertaking. You had to write a dissertation, etcetera. If there were other departments where that was not necessarily true, my memory is that the University sort of bled that image over into them. Do you know whether all residents had to enroll in the University?

DT: They used to have to, certainly in the Department of Medicine, Surgery. I’m not so clear on some of the other departments. Surgery was the model, as you say. Then, sometime in the late 1970s—I think it stopped in the 1970s sometime—that was eliminated. It was reformed as a regular residency as they do other institutions.

JD: Yes. Anyway, as a student that had a support stipend, the University took the position that that was not compensation for employment; therefore, it wasn’t subject to the income tax or anything else, you know, payroll tax or whatever. The IRS, surprise, surprise, had a different point of view. That was ongoing. I think that the initial issue was income tax and I think more recently Mayo’s been litigating payroll tax with Social Security and those things. It’s an issue that doesn’t seem to want to go away. That was the academic side. The University Hospital and every other hospital that’s a part of the teaching site network pay—I think they all do anyway—money to the University to support education. So far as I know, that was in a technical sense all the University Hospital did. They paid their share, paid way more than anybody else, probably. These people, if they were employees of anyone, it wasn’t the Hospital. So it was a legal issue that was playing out while I was there, but it was not my deal.

In a similar vein, another pervasive “system,” but one that was not within my job description, was the medical school faculty’s “private practice” arrangement. No history would be complete without a full exploration of that. This is a problem in terms of internal governance and management and in terms of external relationships. There is a perception that the state is funding the medical school, while, as a matter of fact, no matter how much money they are pouring in over there, basically, the faculty is funding the whole operation [Mr. Diehl pounds the table twice.] And people think they are on the public dole. They have to bring in money from patient care and research grants so they can teach. The patient care part of this is all managed under the so-called private practice policy, which is a political compromise that dates back 90 years. It is a disaster-waiting-to-happen kind of system. As an example, long after the time frame of my tenure, the University and Dr. Najarian had the embarrassing ALG issues, which I know very little about, other than that which was reported in the popular press, which, in spite of my ignorance of most of the facts, I think was a direct consequence of the way all of this is

funded and the pressures that that creates. I think that would be an interesting part of this history.

DT: It seemed like there was increasing focus on the patient, emphasis on the patient's bill of rights that was introduced in the early 1970s.

JD: Yes.

DT: And, then, the establishment of a Patient Relations Department. It just seemed that there was a lot of emphasis on making the patient happy and making sure that their needs were met beyond just clinically. Can you talk about that, why this renewed emphasis on patient satisfaction and patient rights?

JD: Well... [chuckles] I can talk about anything.

[laughter]

JD: How long do you *want* me to talk?

No one has asked me to comment on that in a long time. A lot of this is just informed guesswork. I don't think that was unique to the University of Minnesota Hospital. I think it was a movement, a nationwide movement, or at least a statewide movement. I remember being involved. The law firm that I was with prior to going to the Health Department represented the Minnesota Hospital Association, primarily doing labor law work. That was not one of those firms that I was referring to earlier. I remember when the Legislature first established a patient bill of rights. I think I was involved on behalf of the Hospital Association through that firm in developing that law. My recollection—now you're bringing this back—is that it was kind of a grassroots political idea, a consumerism model, if you will, that applied to hospitals. I do remember, now that you make me think about it, that this was originally kind of a statement of concepts supposedly that had no legal bearing. Of course, if you believe that, you're right there with Santa Claus and the Easter Rabbit. But that was the start. It was attempts by consumer activists in the Legislature.

Keep in mind that in that era, in 1975, the big flip in Minnesota is the elections of 1974. Before that, they'd had biennial sessions. So there's that 1973 session. The next election was in 1974. I think it was in 1975 that we went to annual sessions. I think that it was in the 1974 election, and starting in 1975 was the first time the Democrats controlled the State Senate. It was all that tremendous Vietnam strife in our country. A lot of the people that came into the Legislature in that era were intent on reform in every way, empowerment of more people to be involved and to have their positions respected.

I feel that that patient rights initiative was simply one manifestation of that nationwide movement applied in our Hospital.

JD: Kathy Countryman was the first patient relations person, and Nancy Green was her associate after a couple years. Ms. Countryman was the first University Hospital patient

representative, or whatever we called her. That became a common thing in hospitals generally.

I remember having a dispute with the Health Department because the statement of rights includes both rights of hospital patients and nursing home residents. They very mindlessly required that you post all of them. My point of view was that hospitals needn't post nursing home rights. We had a dustup over that. In fact, that involved one of the most delightful members of the Medical School faculty, Dr. Paul Quie, who was the chief of staff at the time. I mounted a legal challenge to assert my point of view on the scope of the posting requirements in hospitals, and he was my expert witness. He actually testified against my position. I couldn't believe it. [chuckles] I said, "Now, Doctor Quie, it says here that a person has a *right* to wear their street clothes. That does not apply in a hospital, does it?" He says, "Oh, yes, I think it does." I thought, "Why did I bring you?" Looking back, I suppose that was his way of letting me know that the University had better things to do than to fight with the Health Department over the wording of this notice in a hospital.

More seriously, the management issues in patient relations are interesting. If you have patient relations "specialists," it raises a question of how you deal with patients from a management perspective. I have a client today that deliberately does not have a patient relations staff, because they feel that patient satisfaction is the primary duty of every employee of the hospital. This client thinks that if you have a separate patient relations staff, it sends a message to your employees that it's not a part of their job; it's somebody else's job.

Patient relations issues presented a lot of busy work. From a legal perspective, I was involved in patient issues a lot, but I think it was primarily because those employees needed somebody to serve as a sounding board. Should we take this person seriously or not? So I was the sounding board.

DT: I am very aware of the kind of national patient consumerism that happened at the same time as this that foregrounded this patient bill of rights and the focus on the patient. But, at the same time, it also seemed that hospitals were adopting an increasingly market orientation through the 1970s and there was a lot more competition in the hospital marketplace. So I wondered if it was also that somehow the focus on the patient was related to that increasing market orientation.

JD: I don't know if I would have said that at the time, but I think you're absolutely right, that this is when hospitals were thinking more in terms of marketing. There was a huge consolidation going on, at least on the hospital side, probably all of healthcare, but certainly on the hospital side and, then, competition for market share.

Certificate of need was a big issue.

DT: Can you explain that? I think I understand what a certificate of need is, but...

JD: Actually, let's try to finish on market orientation.

DT: Sure.

JD: I can finish from my perspective saying I don't know much about that as it relates to the University Hospital in the late 1970s. It was a phenomenon. I'm not sure that market awareness, attempts to influence the market, and attempts to position the hospital in the market were motivating forces in operations. I can't remember much where that was a day-to-day part of managing that place, or at least providing legal service to the managers.

These other phenomena relate to health planning. Minnesota, under the leadership of the Minnesota Hospital Association, was the first state in the nation, as I've always understood it, to adopt a certificate of need law. It may very well be that this tied to this marketing phenomenon in the sense that if you have redundancy in the system...there is increased competition, and with increased competition one must devote resources to influencing the choices made by patients and referral sources. If everybody has a particular service or technology, a provider has to reach out to the public and influence people to pick *my* particular version of that service or technology. That is marketing. [chuckles] In Minnesota, the hospitals have *always* had an orientation to public service, a public health perspective, at least that's something I've been told. And, I've sort of observed it. I've been told that it was because of the philosophy taught at the University of Minnesota School of Public Health Hospital Administration Program, which, for most of the last sixty years, was one of the preeminent programs in that field in the country. They taught hospital administration from a public health perspective as opposed to a business perspective. Whatever the roots, that was the orientation of our hospital system.

I think really, this all has to do with managing technology. If all you're doing is providing a big building with a bed and a battered up old stand next to it with a pitcher of water on it, who cares? [chuckles] But when you're starting to invest millions of dollars in this piece of equipment and that piece of equipment and you have to have technical support for each medical discipline, then, it becomes a public issue of whether everybody installs the complete array of what anybody would need and, then, fight it out as to who is going to get the patients to support it.

The concept of a certificate of need is based on the fact that the government cares about redundancy. Remembering that we have a cost-based reimbursement system that was started by Blue Cross—this is my interpretation of the history of health services financing—Blue Cross established a model where they paid hospitals based on a cost-based formula. When Medicare and Medicaid were established in 1965, they adopted that system. So if you are, essentially, reimbursing based on a formula that's underpinned with costs, if everybody incurs unnecessary costs, then, those systems are going to pay for it whether you needed to expend that or not. So there was no business downside to *not* acquiring technology. Society was paying for redundancy that was not needed for anything. So, in Minnesota and, then, soon enough the Federal Government and, then, virtually every state in the union adopted a regulatory mechanism where the state would determine whether a particular service was needed in the geographic area or for that population. So, that's what certificate of need is. As I say, it started in

Minnesota as a police power regulation. It became a part of Medicare as a part of federal; spending power regulation in the early 1980s. Then, Minnesota was the first state in the union to repeal certificate of need. For many years, we had to sort of manage the overlap of a continuing Medicare certificate of need concept. I don't know...it is a research question, but I'll bet half the states today still have a certificate of need process, but Minnesota does not. In any event, that's what it was.

I was only slightly involved in that on behalf of the University. The decisions were made in the metro area by the Metropolitan Council, which was a designated health service-planning agency under a federal... At the same time they passed the HMO Act, the Federal Government, they passed the health planning law, whatever it was, in 1973. Under that law a network of planning agencies was established that did planning and, then, ultimately, approved the changes in the system based on the plan. In the metro area, the Metropolitan Council was that agency. The University had good rapport with them. I think the only time we ever lost a certificate of need effort was in our Emergency Services [EMS]. The ultimate decider—to borrow the [President] George [W.] Bush term—was the Department of Health, and we had good rapport there, so we never had legal fights. If the University wanted something... This is kind of conceited. If we're going to try something new, if there's going to be some fancy technology, if any place should have it, it should be the University. There's a lot of lawyers in America that made their whole career fighting over certificates of need. I was involved, but that was not a big deal for us.

DT: I'm glad you brought up the Emergency Services because I saw that there was some discontent when the Met Council only designated the University a basic center for EMS and the University Hospitals were arguing that actually it should be a regional designation.

JD: Yes.

DT: Do you have any insights on why the Hospital was only designated "basic" and what the Met Council's rationale was for that?

JD: Not really. It was just a process we went through. I was never asked to be involved. I don't know whether that was a personality thing. The people that handled that internally were Tom Jones and, later, Bob [Robert] Dickler and whether they felt involving a lawyer was interfering with their prerogatives, I don't know. But, I was almost never involved beyond just being aware. I do remember when we lost that, but since I hadn't prepared it or argued it, I don't know what they did wrong. I can say *now* that if you think about it... I remember Bob Dickler coming back after the meeting when they lost the vote and somebody had said that because of the traffic around the University, its E.R. was not easily accessible by ambulances. [chuckles] It's funny how you remember certain things. He said, "That's why they have sirens."

[laughter]

JD: Apparently, the Metropolitan Council didn't fully appreciate the value of a siren.

If you think about it, there are two problems...or maybe three. The location of the University, especially the University Hospital and the access to the emergency room especially then, off of Church Street... It was hard to imagine a high volume of ambulance traffic with traumatic injuries and so on happening there. It's likewise hard to imagine that with medical crises, people having to wend their way through 40,000 students to get to the emergency room. So that's a factor. Number two: the University is not thought of as providing such service. It was a referral center for difficult cases. To have such an intense clinical program as a trauma center, maybe—this is just John Diehl guessing about something that happened forty years ago—intuitively the Metropolitan Council sensed that the University really wasn't geared up for this, and that they wanted it as a matter of institutional ego but they really weren't prepared to follow up. I think that was a part of it, plus they had other very well situated facilities that were accessible. You didn't have to thread your way through the University of Minnesota. They were oriented to freeways, and they were geared up and located where there's a lot of business being generated, i.e., the city core. Then, of course, North [Memorial Hospital] made it their business strategy. You had these two topnotch emergency medical centers so why screw around with it?

DT: So that's HCMC [Hennepin County Medical Center] and...

JD: Regions or, at that time, Saint Paul Ramsey Medical Center.

DT: Something that seems to relate a little bit maybe to planning, maybe not... I saw that there were plans and, perhaps, they did the form Hospital Consortium in 1977 as a way of coordinating some of the supplies or services.

JD: Oh, yes.

DT: Can you talk about that?

JD: Yes, I set that up. I didn't have much to do with it thereafter. Is that the University Hospital Consortium?

DT: Yes.

JD: The one that was ultimately based in Chicago?

DT: I didn't really have a... Wasn't it between the University Hospital, Hennepin, Ramsey County, and the V.A. [Veteran's Administration]?

JD: There were different consortia.

[laughter]

JD: John Westerman never saw a consortium he didn't like.

[chuckles]

JD: In fact, that he didn't love.

No issues that I know of were ever seriously presented, but I became familiar with the antitrust law because we needed to be sure we were not entering anti-competitive arrangements. My memory is that we set up a Teaching Hospital Consortium within the Twin Cities, that is the teaching hospitals that provided teaching sites to the University Medical School. That was one. My memory is that a University Hospital administrator named Janelle Foley ultimately...I don't know if she left the employment of University, but her duties... She either became an employee of this consortium or she remained an employee of the University Hospital, but her whole job was sort of staffing this consortium. That, if I remember it right, focused on coordinating educational activities.

I think, quite frankly, it was a way that John Westerman thought that we could maintain rapport—I'm trying to be discreet here—with these other hospitals, perhaps, remembering that there was a time, before my time but not that long before my time, when Hennepin wanted to sever its residency program from the University Medical School. There was a movement in Saint Paul to establish a separate medical school. Keep your friends close and your enemies closer. I don't believe anybody ever viewed any of those places as enemies. You know, it's a very positive tool. Apparently, those relationships had been ignored, taken for granted perhaps, which gave rise to people saying, "We're going to do our own thing." So this was a technique to stay in touch and to, you know, put up a positive light and it was intended in a positive light. Residents compensation, all those kinds of things, I suppose...maybe hours of work, all those things were the subject matter of discussions. The University is great for having meetings. Have you ever noticed that? That was that consortium

The other was a nationwide consortium that became a purchasing group. You can save bazillions of dollars and, for that matter, make a lot of money as the purchasing group entity doing direct purchasing for hospitals. John viewed university-based teaching hospitals as a peer group that, in his mind, should work together. I think that's how these systems have historically operated, and I think that's kind of how they operate today.

A very interesting philosophical issue or, perhaps, management theory—I don't know what discipline is involved—is whether consolidation should occur within hospital peer groups or vertical systems. The alternative to peer groupings would be to have these tertiary-care university-based teaching hospitals somehow function as part of a tiered system. The antitrust laws would probably prohibit a combination of more than one tertiary care hospital in a particular geographic area, so maybe one could do both a horizontal consortium and a vertical integration. At the time, we apparently thought that one would either be in a nationwide peer group like that, or you think of yourself at the top of a regional system. This consortium definitely fostered the peer strategy, so we did it. I set it up. I think it's a Minnesota corporation. I do believe Bob Miller, who had been assistant director, left the University of Minnesota Hospital to run it. I think he spent his whole career doing that. I assume that it worked very well. There are things

that those hospitals have in common that other people don't care about or understand, so they need that.

DT: My understanding about healthcare history is that there was an effort to institute regionalism in health planning in the mid to late 1960s and it, basically, fell flat. It didn't take off here but was most successful overseas.

JD: Well, regional health planning in the 1960s, to the extent that it happened, related, I think, to the construction of hospitals under the Hill-Burton [Act] law into which certificates of need played and, then, ultimately, was taken to the next level with the National Planning Act of 1973 that I mentioned. I think it worked, in my opinion. It was certainly alive and very vigorous throughout the 1970s. I think it started undoing itself in the early 1980s. Who knows? I don't think that the street level, the actual doers in America, evolved their operations into that model at that time because of that law. I think there was a lot of resistance. Probably human nature...you can't tell me what to do. But as soon as they quit telling them what to do, they did it, because, now, we have regional health systems. Whether the law worked or not, I think that our delivery system has become regionalized.

DT: That's interesting.

I'm curious... Medicare and Medicaid you've mentioned several times. Obviously, they're both huge structural factors in the way that healthcare delivery is done. I'm not really sure how to formulate the question, but could you talk a bit about Medicare and Medicaid reimbursements and how those reimbursements changed during your tenure at the Hospital, or how that affected the governance and the operations at the hospital?

JD: [sigh] I was not consciously aware of the impact of those payment systems on our operation—they started in 1965—but I would add, I do know about them from my work more generally. What I might have to say about it isn't related to what I was doing at the University.

DT: Okay.

JD: As a personal bias, it's just irritating to me to equate service with money, to talk about health financing, the financing mechanisms we use to pay for service, as healthcare. You can have a roomful of money, and that is not healthcare. Of course, on the other hand, it's stupid to think that you would have very much healthcare if you don't have money.

Anyway, the systems to fund healthcare services for poor people, at least in Minnesota and probably nationwide, probably internationally, were local. It was a county-based system historically. In Minnesota—when I'm not sure; I think before 1965—we had moved that to some state support in what Minnesota called the Medical Assistance Program. I think that that was just using logic. It was probably a method of cost shifting from one geographic part of the state to another, perhaps, from places with means to

places without means, to have a fair distribution of resources to support medical services for poor people.

Medicaid is a federally described state-based program that provides financing for health services for indigent people who are not only indigent but categorically eligible. Elderly, disabled, and families with children are the categories. So you have to be poor, and you have to fit into one of those categories. In Minnesota, the reason I think our system sort of predated Medicaid is that we've always had what we called general assistance medical care that provided when Medicaid came online anyway, or maybe this came after Medicaid—the same level of coverage for people who were indigent but *not* categorically eligible, mainly adults without children who were poor.

The federal Medicaid program described a set of coverage of eligibility criteria and a set of benefits, which a state had to offer. A state had to cover certain minimum of categories of people and offer a minimum of benefits. If the state did this, your program, your state-based Medicaid program, qualified and you would, then, get federal financial participation. Federal financial participation is from, I believe, fifty percent to eighty percent federal money matched to the fifty to twenty percent state money, with the percentage varying dependent upon the economy of the state as measured by government criteria. Because our economy is strong, Minnesota never had more than fifty percent federal financial participation.

Based on my assumptions about the history of these programs—I think I'm right, but I really have not researched it—you had counties taking care of their poor people, moving to a state support system of some kind and, then, essentially, ratcheting it up to a federal level simply because the states couldn't afford it, or they wanted to not afford it, or the federal government decided to foster this type of help for the poor. The Federal Government then, in our case, pays half of the cost. Simply, if you have a qualified program and you spend money on it, you document that and the Federal Government will match it. So then, Medicare, just to complete the groundwork, is an insurance mechanism for people age sixty-five and over or disabled people. Medicaid was and still is a cost-based system. In Minnesota in the 1980s or maybe early 1990s, Medicaid evolved that into kind of a per-case payment, but it's still cost based. The payment you get is based on the average length of stay for a particular type of case based on your costs. So it's just a way of how you calculate the check. It's still a cost-based system.

Medicare started out as a cost plus three percent arrangement. The three percent dropped off real quick. But it was a cost-based system. This, by the way to me, is...well. This borrowed from the Blue Cross reimbursement strategy and, therefore, that Blue Cross cost-based reimbursement approach, whatever the root is, it creates a huge perversion in healthcare economics. I don't know how to sort it out. I have many acquaintances and clients and friends in healthcare, they don't know how to sort it out. We all just know that it's ridiculous. It drives the absurd bills for a five hundred dollar Band-Aid, for example.

When you have a cost-based system, then the government accountants and private accountants collaborate to determine how you measure those costs. Of course, you

allocate, within whatever accounting rules you have, costs to those things that get paid for. [chuckles] If they're allocated with something that *isn't* paid for, television sets or something, then all those costs go unreimbursed. So you may have an artificial allocation of costs to where the money is coming from, not to where it's actually being spent. Anyway, that's our system.

It has affected healthcare because that's how we think of everything. The way you measure cost, then, is you report your costs every year to the government. You, also, report your charges. The government, or anybody actually, takes those two sets of data, charges and costs, and they say, "Well, you charged \$100 million and according to the cost data, your costs were \$80 million, so your cost-to-charge ratio is eighty percent, so we assume your costs are eighty percent of everything you ever charged." Even that cost number is invalid. It's an arithmetic derivative of what you're charging. How has this affected healthcare? Number one: it has made healthcare that much more accessible to the extent that people who couldn't pay for things, now they can. People are going. I mean, there's a certain human nature, you don't want to ask for a handout, I believe—at least in Minnesota—so if there is a payment mechanism in place, people will go to get the help that they need. So it's a huge benefit. It has allowed us to finance the development of a very, very high-tech system. I mean, the amount of money that flows through healthcare is, of course, now, a national scandal. These reimbursement programs have made that possible and I believe it's made a huge difference.

When I first became involved when I worked for the Department of Health, there was a school of thought, at least among the public health people, that personal healthcare services really didn't affect health of a population—it is public health: clean water, vaccinations, things like that—that actually change life expectancies, the health of a population. I think that's changed. I think the personal health services, stents, for example, things like that, that are individual personal interventions have measurably improved health, quality of life, etcetera. I think all of that's possible because of all the money that came into the system through Medicare and Medicaid. I don't know how this addresses your question.

In terms of my job at the University, I advised on these matters occasionally, but payment issues were not central to that position.

We, from time to time, had Medicare cost reimbursement disputes. In our case, through the Teaching Hospital Consortium—which were Ramsey and the V.A., the V.A., of course, had separate funding, Hennepin and so had similar reimbursement issues—we hired McDermott, Will, & Emery out of Chicago to handle those cases. So we did have some of those cases.

Incidentally, while on the subject of payment for health care services, the University Hospitals also had a special program that we called, "County Papers," that I think the counties called "University Papers." This was a state law supported by a small annual appropriation, that allowed any county to "certify" a resident for care at the University, and the services, then, were paid from that state fund. I believe that that program ended

long ago, perhaps even during my tenure. It is, however, an interesting footnote on the ways in which we have provided payment for needed care.

DT: What about the concerns from the mid 1970s onwards about the rising hospital costs and the federal calls and cost containment movement in hospitals? As general counsel, did you see any of that or what was your experience?

JD: To me, trying to put myself back to that era, our point of view about cost containment was certificate of need and health planning regulations like that. It seemed to be on a system wide basis, not on an individual institution basis. So that's my impression. The Board was constantly aware of financial operations and interested in it. We recognized certificate of need and things like that as efforts to contain costs. I don't remember us thinking of it as something that went beyond that, that we had to do something more than just participate in those systems. The leaders on the University Hospital Board of Governors, and the first Board Chair, Harry Atwood, in particular, were very involved in regional strategies for hospital consolidation as a means of reducing redundancy and, therefore, system costs.

DT: I did see that President [Jimmy] Carter or his administration had, I think in the late 1970s, called for hospitals to voluntarily limit their price increases. I guess it was a volunteer thing. If the hospital already thought it was doing what it needed to do with cost containment, then, that wouldn't have made much difference, I guess.

JD: I didn't remember that President Carter did that. I have a rather low opinion of President Carter as a political leader.

[laughter]

DT: You're probably not the only one.

JD: By then, prices were irrelevant. Prices are irrelevant today. That's the whole point.

One thing that HMOs brought about was negotiated rates. I don't know. Maybe there's someplace in America where hospitals were setting prices and somebody was paying those prices. It wasn't happening in Minnesota. Blue Cross was everywhere. So before HMOs, Blue Cross decided how much each hospital would get for their services. Once you had HMOs involved and competing with Blue Cross for financing business, they were negotiating rates, deals, a per diem, a per case, whatever. The price you set had nothing to do with it, and the price you set has even less to do with it today.

Now, someone else may recall that we were worried about price increases, but I do not remember it that way.

In Minnesota, do you know—I was on the board of the Hospital Association when we agreed to this—the attorney general, Mike Hatch, has asserted himself in hospital billing and collection practices? Are you aware of that?

DT: No.

JD: He did. The only thing that's shameful about it is that he had to do it. Hospitals should have done it on their own. In Minnesota, all the hospitals, by happenstance, not by law, are either governmental entities or non-profit charities, in other words, all charities in a sense. Therefore, they're all subject to the authority of the attorney general representing the public interest vis-à-vis charities. He found, in some investigations that he did, that some hospitals were not behaving in a very charitable manner. There's a whole hospital politics side to this, but without getting into it, every hospital in Minnesota entered a consent order with the attorney general that they would charge uninsured people no more than their most common managed care rate. So stated prices in Minnesota are just something you have just to have a starting point or a base.

There are some third-party payment contracts today that are a percentage of price, so if you have agreed with a particular health plan to settle for eighty percent of your billed charges, for example, then, you raise your prices, you raise that eighty percent number. That type of arrangement is unusual, and that is the extent of the significance of "prices." I remember a lot of attention to healthcare economics, but I don't remember much attention to pricing, because I don't know that it affected much.

DT: I think that's a very important insight into the way the healthcare system is in this country, that the patients don't see what the prices are.

JD: Right.

DT: It's all the degree of negotiation between third party payers and the providers, as you say.

JD: Right.

DT: I think that's really important to have that recognized.

JD: Today—just as an aside—the government is not paying its fair share for what they've promised citizens who rely on the government for financing. Medicaid is systematically below cost by about forty percent. So that is having a dramatic impact on what people who, either by private coverage or payout of their pocket, have to pay. That's a modern phenomenon. Before 2000, that was not really a big factor.

DT: I only have a couple more questions.

You left the University Hospital in 1983. Is that right?

JD: I left in 1982, but I continued to serve as their general counsel for a year while they were searching for, my successor, Jan Halvorson.

DT: You were still there when discussions began about the Hospital renewal, to expand the hospital buildings?

JD: Yes, absolutely.

DT: It seemed that that was controversial and there were some newspaper articles that questioned whether the Hospital really needed to expand. I wonder if you could talk about that for a moment.

JD: Sure, but I would show you these photographs. The top one was the original University Hospital. There's probably a date on that.

DT: Nineteen eleven.

JD: Yes, there you go. It was a long drive out to Washington Avenue. That's still in use today. [chuckles] It's hard to find it, but it's still part of the Hospital. Then, the so-called Mayo Building that was built, presumably, with some funding from the Mayo Clinic—naming rights—...

[chuckles]

JD: ...in 1954. By 1980, we were dealing with a thirty-year-old building and a technological explosion. So we were starting to talk. We were still taking care of a lot of... If I remember right, the transplant service was in this oldest building, at least their clinic offices. So we were looking at the need for a new building. We were talking about certificate of need. We were talking about funding mechanisms.

Remind me... I want to talk a little bit about my legislative activities on behalf of the University and others during the late 1970s.

Sure, we were working on getting a new building. My status at the University was as a faculty member.

What that meant was, the practical thing for me, was that I was allowed or I had the right to have an outside law practice of up to twenty percent of my time. I joined this law firm when my twenty percent was bringing in more money than my eighty percent.

During that time, I continued to have some clients that had interests in the Legislature, so I was over there. I don't know if I want to be on the record for posterity, but it was a lot of fun. When you're engaged with policymakers, as in the legislature, and have some rapport, which I did because of all of my work from a public interest perspective, you can get a lot done. If they know you and trust you and there you are, you can help legislators accomplish things.

So one such deal, where I just sort of got pulled into duty because I had these relationships at the Capitol, was to get authorization for the University to issue, I believe, \$220 million in bonds to build a new hospital. A bonding bill has to have a super majority, which I believe is sixty percent. It's hard to get a super majority for anything. I remember working on that bill. It passed by one vote. I think it passed by *just* what it

needed. One vote would have killed it. Of course, everybody that delivered any vote then took credit for the whole thing, including me.

[laughter]

JD: I don't remember whose vote I delivered.

That was a wonderful experience working with Lyle French. What a great man. We'd be over at the Capitol, and I knew some places where you could make a private phone call. I get emotional when I talk about this. He was a neurosurgeon and in his younger days, doctors from all around the state would call. He told me once—I don't know why this is so moving—he got a call from a colleague in the operating room in Saint Cloud. The surgeon found a mess. The patient's skull was open and the surgeon needed help. Lyle got in his car and drove to Saint Cloud and helped this guy out. So here we were trying to get votes. Lyle calls his colleague in Saint Cloud and says to me, "I need the Saint Cloud legislator's phone [number]." So he was calling in these chips. We put it together.

Then, the University killed the deal. I think most people think it was unfortunate that they did. I guess history will tell. I think people thought that it was too much money. Of course, \$220 million today is... Regions is a billion dollars a year. The University is a billion dollars a year. Hennepin is a billion...Abbott. The delay in the project probably cost more than the savings. But anyway, that was quite an effort.

DT: I know that through the reorganization and expansion of the health sciences that have been ongoing since the late 1960s, it seemed that there were some members of the Legislature—I won't remember their names now—that were starting to... Was it John Milton, maybe...

JD: Yes.

DT: ...started to get really frustrated with how much money the University was getting? I wondered if the...

JD: He, later, went to work for North Memorial. He wasn't upset with how much money *they* were getting.

DT: [laughter] Very interesting.

I didn't know if there was just this general malaise with how much money the University got from the state. Then, Joe Riegert, I guess, was the journalist who was writing the pieces in the [*Minneapolis*] *Tribune* criticizing how much money the University was getting.

JD: Well, I know John. He's now an author.

You're correct in observing that. That was going on. It's a legitimate issue. It's a legitimate issue as it relates not only to the University Hospital but the whole system.

I think the best is yet to come. I see a lot of energy and talent devoted to making the system more efficient and, therefore, the per case cost is going down even though units of cost seem to go up like everything else.

John Milton was just the guy at the moment, and I don't think he was the only one. Joe Riegert? I don't know what his deal was. He bugged me. I thought he was exploiting a kind of bogus issue just to sell newspapers or, even more than that, just to make himself a big deal, and I don't think he was a big deal. When you are in a position like the University or any important institution, I think part of the territory is that small people realize that they can achieve momentary attention by attacking important institutions. I think that's probably a constructive phenomenon, because if you're running one of these places, you should be aware of that. [chuckles] That keeps the edge sharp. That's how I view Riegert. John Milton was a sincere politician who was trying to... He picked healthcare. He's not the only politician that's picked healthcare as a field of interest. I don't recall that either of them changed the course of events. Do you think they did?

DT: Nooo...

JD: Have you found something that would suggest they did?

DT: No. I think the questions that John Milton was asking did... I don't know about the cause and effect, but it did seem like, then, the Academic Health Center, Lyle French had to justify better why...

[break in the interview]

DT: The University still needed money to build a new building for, I think it was, the Pharmacy and Nursing Schools in particular, in the late 1970s when they'd already received X amount of money. I think it forced the University to have to justify...

JD: Yes, maybe. Of course, Pharmacy and Nursing are not in the Hospital. They are very important parts of the health sciences. I don't know. It would be interesting to see what other people think. The University has some strong supporters in the Legislature and they always have some detractors. All you need is a couple detractors and you have to jump through the paces to get what you need over there. I don't mean to demean or belittle or minimize the role of John Milton or the other John Miltons. Even if they're for something, they would be derelict if they didn't put your feet to the fire. Everybody wants to get the job done with the least effort.

[chuckles]

JD: Right? At least I know that's me, so it probably includes Lyle French and everybody else. If you don't make them justify it, why do it? That's how I think. It's a process that should demand accountability. I don't think it reflects a lack of support or respect.

DT: What I've heard universally is that Lyle French was a fantastic advocate for the health sciences, and everybody loved him in the Legislature, and he and others who were going before the Legislature had a lot of support in general.

JD: I think so; I do. People like people who earn their stripes, and I think he earned them.

DT: Can you talk more about your legislative activities?

JD: There were a couple other deals. In that era—actually some of this happened after I left there—there was one effort, let's say that. We had a physician; his name was Steve Zuckerman, who came back from the public health service on the Island of Truk, which is a place which I think is pretty small. It's an island in the South Pacific.

Coincidentally, I have a law partner who was appointed attorney general of Truk, which was kind of like a legal aid job, at the same time and, years and years later, found out that he and Steve Zuckerman were there at the same time.

Zuckerman showed up at the Council of Clinical Chiefs meeting with all these woven baskets with seashells woven into them. He was displaying all of this stuff. There he was. Slightly strange.

Somehow, he had developed a professional relationship with the person that ran the hospital up in Onamia, Minnesota, which is a little town on the south end of Lake Mille Lacs. Zuckerman had this idea that the University faculty, and maybe residents, should reach out and provide clinical services to little hospitals like that.

Before that—your research could prove me wrong—I think the only outreach the University ever did was the CUHC Clinic and sort of an amorphous support kind of planning thing up in the northwest quadrant of the Twin Cities that was a condition of the certificate of need for, I think, the Phillips Wangenstein Building. Maybe some individual departments had done stuff, but I don't think they had.

So Zuckerman had this idea of allowing these little teeny clinics and hospitals to outsource specialty care and staff education. It was his idea that this should be set up on a co-op model. I'm not sure that anybody authorized me to do this. [chuckles] In fact, I'm pretty sure nobody did. Zuckerman and I... There were lots, like maybe ten, hospital people involved in setting this up. We went throughout the State of Minnesota and set up what we called Regional Co-ops. We would go to a market center town like Alexandria and I don't recall what was north of there, maybe Detroit Lakes or something like that. Certainly, we went to the southwest region around Montevideo and that area. I think, ultimately, there were maybe five Regional Co-ops. We would look at a map and see a cluster of hospitals and we would try to organize them.

By the way, the Minnesota hospital system is very well developed, partly through health planning and the Hill-Burton funding program and then some other things, accidents of

nature of hospitals succeeding and failing. So we have a nice system of hospitals statewide.

You can look at an area and say, “Okay, these people sort of relate to each other and to this town.” You can move over and you can see a similar grouping and so on. We created non-profit corporations that related to each region and they were governed by representatives of the involved hospitals. Then, they would get together and determine what they needed in terms of specialty services and staff education. Then, the University would send, often by airplane, trainers, teachers to those areas and they’d do in-service training for nurses or techs, whatever, and the doctor would hold a clinic. I went to the Legislature, and I got money for these things. [chuckles] I think for several years, we got like \$200,000 per biennium to fund these networks. We had this outreach statewide.

As this developed, the clinical phenomenon was that we were leap-frogging the regional centers like Fergus Falls, Brainerd, places like that. Of course, these doctors wouldn’t have driven twenty miles to see a patient at Cottonwood or someplace, but it was bugging them that their patients could get top-notch specialty care without coming to them.

When Doctor [Neal] Vanselow became vice president—I don’t know this at all, but I just assume—he received complaints from these regional centers and killed this whole thing.

Now, there’s still a rural-based group-purchasing program out of Alexandria that is the remnant of that thing. Down in southwest Minnesota, there’s a huge consortium that still does the same thing, group purchasing, training, and specialty care, that is the remnant of that effort, although they no longer relate to the University for outreach clinical service.

This gets to that tier of peers versus a network. Long after I left, the University decided they needed to have a statewide system, but, I would respectfully submit, their effort was too little too late. They picked up Red Wing and Hibbing and that’s hardly a statewide system.

That was kind of a fun part of... That was one I threw in on the side over at the Legislature.

[chuckles]

DT: That sounds like a really important... Especially in the late 1960s, one of the reasons the Department of Family Practice was set up is because there was a shortage of rural physicians, rural family care physicians.

JD: Sure.

DT: Obviously, this is specialty care that you’re talking about, but there was consistently concern throughout the state that there weren’t enough healthcare providers outstate. So this seems like an important function that the University would be doing.

JD: Yes, right. I don't know that this idea was a great idea, but the reality is that there are several different components to geographically accessible healthcare. First, you have to have a place to go. These little hospitals, and some of them are real little, serve that.

Then, you have to have a doctor there, or at least somebody that's qualified to take care of patients. There's a huge conglomeration of programs aimed at that. There are two or three federal programs, including immigration service and so on, that make that staffing possible. The educational piece is trying to train people to be primary care doctors. I have some opinions on that. So that's a part of it.

To me, the other part is that the local people have to decide they want to go there. Members of the public need service available for certain things, but to have a local hospital be viable, they have to go there for more than urgent problems. The artery bleeding out, of course, you're going to go to the nearest place then. But what happens if you have an infection? Are you going to go there or are you going to go to Mayo or Owatonna? They have to respect the doctor's ability. To me, a part of that—of course, depends on the doctor—is having an awareness or a feeling that everybody knows that not every doctor can do everything. You have to know that if you go to this guy, you're not going to put him or her in a position of doing things they're not competent to do. So having this specialty support, having this be a place to go where you can get more than just your primary care doctor's best guess, to me, creates respect or confidence in that local delivery place. So, in that sense, it may not be the most efficient way or the best way of delivering specialty care, but it does support the business viability of that local enterprise. That's as important an ingredient as having it there. It was one effort. It lasted a few years, five years maybe, maybe more.

Doctor Zuckerman now is with the Aspen Medical Group.

DT: What led you to leave the Hospital?

JD: Well, I told you my twenty percent was doing better than my eighty. But, also, I was finding solutions to legal problems—this is my own impression—that were sort of complicated. I find this work very interesting because it is so complicated. Once I had solved a problem for that client, first of all, that's what they thought they were hiring me for, and I was underappreciated. Also, it occurred to me that if I solved a problem, I could sell that again to three other places or twenty or a hundred, but at the University, I didn't have any other "customers." So I thought I could probably do better; I could get more out of the creative part of my work, if I could find more outlets. So it was sort of a combination of things. As it turned out, there were transitions afoot. I'm sure I would have enjoyed it longer. John Westerman left. There was really no link there, but he was a wonderful guy. So that was a transition. Lyle left. So it was time to move on.

DT: That makes sense.

We've covered a tremendous amount of ground and I have learned a lot. Is there anything else that you feel would be important to share about your time at the Hospital?

JD: Ummm... I really appreciate your tolerance. This has been great fun.

DT: This is like the ideal interview. I have questions and, then, I get lots of information back. So this is ideal.

JD: The other area that I became involved in, and am active in in certain circles I guess, was the whole issue of death and dying. I don't know that the University could be considered a pioneer in the thinking of what is today the beginning of a modern thinking about that. I think that started, actually, in our area at the Hennepin County Medical Center, but the University was quick to pick up on it. Doctor Shelley Chou, who later became the dean, who succeeded Lyle as the head of Neurosurgery, became chairman of a thing called the Committee on Thanatology.

DT: I saw that in the records. I had to look up what thanatology was.

JD: Really. What does it mean?

[chuckles]

JD: What does it mean? Death and dying, right...the study of?

So I worked with him on that committee. Basically, it was trying to develop an understanding of individual rights and to develop healthcare setting-based systems to deal with patient's rights to decide about care and about dying. That would never have been a part of my life had I not been at that place.

There's a lot of stuff that happens in healthcare law, and perhaps every field of law, where if you're in a private practice people don't call you. They get those things through their trade associations. I don't know how else. But they just don't feel that they should pay fee-for-service lawyers to look up some of this stuff and help them think things through. As a result, if you are in a private practice you are much less likely to have these kinds of very rich, intellectually-challenging experiences. So that was a terrific opportunity. That's one example.

I was on the national speaking circuit on termination of treatment and death and dying. Of course, the New Jersey Superior Court, or whatever it was called, decided that Karen Ann Quinlan Case and Massachusetts decided the Saikewicz Case based on the *Roe v. Wade* principles of privacy and determined that individuals have a right to decide whether or not to have healthcare service and that incompetent individuals can themselves make those decisions through a surrogate. Saikewicz involved a person [Joseph Saikewicz], a never-competent adult, and the litigants and the court figured out how a person who had never been competent could decide something through somebody else. It was a lot of interesting legal analytical constitutional law work, so I got on top of it, and we developed our systems and forms within the University and, then, I kind of went national with that, ever so briefly. That was an interesting experience in my own practice.

After I established my private practice, I was hired by a hospital to help address these issues. They had a situation in which there was a dying patient, and nobody knew what to do. I'd given talks about this. I'd written papers about this. I'd developed a guide of all the analytical models that you use. I can tell you, all of that's worth about nothing when you're sitting in a room like this with four or five family members and their loved one is dying in the next room, and you tell them that you have a right to let him die. What would he want? It's a different situation.

DT: Yes.

JD: That was a big part of that. It wouldn't have happened if I hadn't been in-house.

I, also, got pressed into duty on... I wrote a lot of wills for people that thought they were going to die or that maybe were about to die, not sophisticated estate planning. [chuckles] There were all kinds of these little side things that came up because there you were.

I remember one woman from Wisconsin, who had no relatives and tons of animals. She was in the Neurosurgery Department to have some kind of brain operation the next day. She had a modest estate, and she had a cat and a dog and a horse, and a bunch of animals. She'd never talked to anybody about who was going to take care of these animals. She had several different people in mind. So we wrote a will that bequeathed the horse to Mary if Mary agrees to take care of the horse. If Mary agrees, then, she gets \$1,000 or whatever. If Mary doesn't, then we go through each person... Then, we go to the dog and Mary goes through each person and, then, the cat. This will was about the size of a phonebook. So we got it, and I'm in my office and no staff is there, right? I'm typing all this stuff myself. We get it all done. She signs it and the next morning, she discharged herself. [laughter] I've always said that I thought that she probably came in to have Medicare pay for her will.

[laughter]

DT: That's funny.

JD: It was a wonderful experience and to be associated with the incredible talent that was there and the stuff that they were doing—of course, I had very little to do with it—this transplant stuff and the system that Joel Tierney worked out with Najarian that I, then, went to court with many times... I'm slipping on some of the... The head of Pediatrics was a pioneer in bone marrow transplants...

DT: Oh, yes,

Bill...Krivit?

JD: Yes! Yes!

DT: [chuckles]

JD: Exactly. Najarian at the Council of Clinical Chiefs chided him that he was collecting bone marrow in a coffee can. I mean, it's like the old stories about Owen Wangersteen, who was a legendary academic leader, going into surgery and his idea of a sterile approach was to hold his necktie over his mouth as he looked into the patient's open gut.

Don Hastings, the head of Psychiatry, he was a wonderful man. I think he was the chief of staff when I got there. His family now...I think only his daughter is left among the people I'm acquainted with, lifelong friends. It's quite an institution.

I think that the leadership there has missed the boat. The public doesn't have the feel for this fabric. If they did, they would adore the place. It's not that it's institutionally aloof, in my opinion, but, somehow, the public doesn't have that feeling that so many people do. My wife, Karyn, for many years after I left, stayed involved in the University Hospital Auxiliary. That was largely a faculty wives' thing, which is, I suppose, understandable. But the level of devotion of, in that case, those women, I've never seen anything like it. It's a treasure. We probably should find ways to make it better appreciated.

DT: Hopefully, this history project will help remind people what the institution has done.

JD: I'm probably going to cry again, but I want to tell one more story and it ties this all together. It relates to a passage that my son has embraced and that my father wrote in the Big Book: "Humility is teachability."

I used to get—I think it happened maybe two years in a row—I wish I could find these letters—a letter from a retired minister from someplace. You pick it; Koochiching County, or somewhere. He would, on the anniversary of his son's death—the letters would come to me—relay once again the story of his son's demise at the hands of the doctors at the University of Minnesota Hospital where he had come with renal failure, I think cancer in a kidney. The doctors at the University of Minnesota, protected by sovereign immunity, removed his good kidney and, thus, killed him. This father reported that his son went home and slowly died. He talked about how his son believed in God and faced death with the comfort that he was going to a better place.

[pause]

I don't know that I ever really did much with those letters, but I felt that every medical student should read those letters. They ought to be set out on a plaque on the wall someplace and everybody should be required to read them, because the consequence of error in that kind of operation is so unbelievable. This fellow talked about trying to get a kidney donor from a prisoner at Stillwater [State Prison], reflecting the fact that transplants were being done, but they were in the earliest experimental stages. That story depicts the evolution of science and how much good it does for us. It also points out the vulnerability of our patients. Obviously, nobody was trying to kill this kid, so the need for diligence and for respect of all these people that come here expecting the best has to

be driven by more than good intentions. I think sometimes in our failures, we are best able to find our strengths.

DT: Yes. [whispered]

Well, thank you. This has just been wonderful.

JD: Thank you very much.

DT: Yes. Great.

[End of the Interview]

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