Robert L. Kane, M.D.
Narrator

Lauren Klaffke
Interviewer

ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT

UNIVERSITY OF MINNESOTA

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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

Robert Kane was born in New York City, where spent the early part of his life. His family then moved to Toronto, Canada, where he attended high school and started college. He returned to New York City to attend Columbia University and completed his undergraduate work in 1961. In 1965, Kane earned his M.D. from Harvard Medical School, specializing in preventive medicine. He completed his internship and residency at the University of Kentucky at Lexington and fulfilled his military service with the Indian Health Service on the Navaho Reservation in New Mexico and at the U.S. Public Health Service in Denver, CO. He began his academic career at the University of Utah, serving as a professor in the Department of Family and Community medicine from 1970 to 1977. From 1977 to 1985, he was a senior research at The RAND Corporation and held a joint appointment at the University of California, Los Angeles in the School of Public Health and the Department of Medicine. He was recruited to serve as dean of the University of Minnesota's School of Public Health in 1985. He stepped down as dean in 1990 but remained a professor in the School. Over the course of his career, his major research has involved geriatric health and long term care, the relationship between acute and chronic care, health outcomes, and managed care. He holds the Minnesota Chair in Long-Term Aging and has served as director of Clinical Outcomes Research since 1993 and director of the Center on Aging since 1994.

Interview Abstract

Dr. Robert Kane begins his interview with a description of his early life and education. He reflects on his medical training, his time with the Indian Health Service, and his efforts to establish a Department of Family and Community Medicine at the University of Utah. Dr. Kane then discusses his move to RAND in Santa Monica, CA, his work on what would become Value-Based Purchasing, his work on the needs for geriatric manpower, his work establishing the Division of Geriatrics at UCLA, and various lines of research that connected to his work at RAND and UCLA. The conversation turns toward Dr. Kane's time at the University of Minnesota. He describes the following topics: his goals in becoming dean of the School of Public Health; his reorganization of the School, including moving and eliminating departments and divisions; funding for the School; his work with the Legislature; shifts in public health research; methods of evaluation he tried to establish in the School; division loyalty within the School; and his reasons for stepping down as dean. Reflecting on the larger contexts of the AHC and the University, Dr. Kane discusses all of the following: financial problems in the AHC; the sale of University Hospital to Fairview; Neal Vanselow and Cherie Perlmutter's leadership in the AHC; and problems with collaboration in the AHC. He describes efforts to admit minority students; the regional importance of the School; deans of the School after he stepped down; Ken Keller's Commitment to Focus plan; William Brody and Frank Cerra's tenures as vice president of the AHC; and the joining of the positions of medical school dean and vice president for the AHC. He concludes with the need for more healthcare delivery research at the University and John Finnegan's tenure as dean of the School.

Interview with Doctor Robert L. Kane

Interviewed by Lauren Klaffke

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

Interviewed in Doctor Kane's Office, Mayo Building University of Minnesota Campus

Interviewed on December 11, 2013

Robert Kane - RK
Lauren Klaffke - LK

LK: This is Lauren Klaffke. I'm here with Doctor Robert Kane. It's December 11, 2013. We are in his office in the Mayo Building.

Thank you for meeting with me today.

RK: Happy to do it.

LK: I wanted to get started and have you tell me a little bit about where you were born and raised and your early education.

RK: Oh, wow. I was born in New York City. I spent the first thirteen years of my life in the suburbs of New York and Long Island. Then, I moved to Toronto, Canada, went to high school there, and started college, started to go into medicine, so I did my pre-meds. In order to do that, I moved to Columbia [University, New York City]. I graduated from Columbia and went to Harvard Medical School.

Do you want me to keep going?

LK: Yes, yes, that would be great.

RK: I did my internship and residency at the University of Kentucky in Lexington, Kentucky. Then, I went to the Indian Reservation to do my two years of military service with the Indian Health Service on the Navaho Reservation.

LK: Oh.

RK: I spent a year at the Navaho Reservation and then a year at the regional office in Denver [Colorado]. Then, I went to the University of Utah and started my academic career there. I left there in 1977 and went to the RAND Corporation and, then, a year later, also had joint appointment with UCLA [University of California, Los Angeles] and, then, came here from there.

LK: Okay.

What prompted your interest in medicine?

RK: That's a good question. I was actually a philosophy major, and I decided it was just too airy-fairy.

LK: [laughter]

RK: I wanted something more tangible. I thought medicine would be a good thing to do. I don't think it was a profound event in my life that told me to do that. I never was really on a track to be a practitioner. I was always an academic rather than a practitioner.

LK: You said you did your residency at the University of Kentucky.

RK: Right.

LK: I saw you were in the Department of Community Medicine. What was your focus?

RK: The reason I went to Kentucky was because they had Department of Community Medicine.

I guess one of my epiphany moments was when I was a second-year medical student, I spent the summer in the Lower East Side of New York at a place called the Gouverneur's Ambulatory Care Center, which was an innovative community health organization that was really trying to integrate medicine and social factors and was very much under the sway of a man named Howard Brown, Jr., who was the director there and later became the first health services administrator for New York City. That sort of pointed me to think about medicine in its larger social context. You can't do everything just by passing pills or cutting people. So I got interested in the whole question about how you integrate medicine into the larger society.

Howard put me on to this program in Kentucky, which was the first of its kind. It really was trying to train medical students in this whole sense of community medicine. How do

you basically put medicine into the context of the community? I officially did an internal medicine, preventive medicine residency, but I was doing it in community medicine.

LK: From research I've done, I've noticed that's a major theme at that time.

RK: This was just when neighborhood health centers were getting started and a number of other phenomena. People were discovering this. I actually went with Howard on the March on Washington [D.C.] in 1963.

LK: Really? That's incredible.

RK: We were very actively involved in what was going on in the community.

LK: Yes, wow.

I know you said you did your military service…

RK: In those days, everybody got drafted, including the doctors.

LK: Right.

RK: I opted to become what we called a Yellow Beret, which was to go into the Indian Health Service in lieu of going to Vietnam. Because I'd had all this training, I was made a service unit director. It was called a service unit, and I was responsible for 25,000 Navahos. I ran a hospital and a community health program.

LK: It seems like that also supported your interests.

RK: Yes. I was sort of way ahead of my colleagues in terms of having learned how to diagnose communities and how to deal with things at a non-one-on-one level.

LK: Is that how you got involved with the U.S. Public Health Service?

RK: I was in the Indian Health Service. I actually got fired from the Indian Health Service.

LK: Ohh!

RK: I did a lot of things they didn't like. The worst thing I did was I doubled my budget by getting a grant without their permission.

LK: Really?

RK: Yes. That's how I got involved with the University of Utah. I went to the University of Utah and worked with the School of Nursing there. We got this big grant to bring nurse midwives down to the reservation. I walked in in a very impetuous naïve

way, put this piece of paper on my boss' desk and said, "If you sign here; I'll double my budget." His answer was, "Like hell I will."

LK: Wow. Was that something like a power thing?

RK: It was a bit of a power thing. I was a pain in his ass.

LK: [chuckles]

RK: I was young and impetuous. I guess being a two-year person, it wasn't like I was building a career in the Indian Health Service.

LK: Right.

RK: Anyway, he agreed, finally, to sign it if I left. So I got reassigned to the regional health office in Denver with the Public Health Service. My official job was assistant to the director. There was no real job to do. I actually spent half of every week commuting over to the University of Utah where I helped to set up a Department of Family and Community Medicine.

LK: Oh, so you helped to set it up.

RK: Then, I eventually took a job there, once I'd finished my public health track.

LK: In setting up that program at Utah, were you seeking to meet particular needs of the state or the local community?

RK: We were just basically trying to develop a training program for family practitioners, which were fairly new—family practice had really only become a specialty in 1969; this was 1970—and also to develop a healthcare research program. Utah was a great place to do research because nobody else was doing it at the time. So you could pretty much do whatever you wanted to do.

LK: What kind of research?

RK: We did a lot of things. We managed the outcomes of family practice care. We set up a number of rural health programs, and I actually wound up back on the Navaho Reservation, on the other side of the reservation, running a program there to deliver care.

The most important thing I did in terms of my career was I started a program to see if we could improve care for nursing home patients. That got me started in long-term care. We did a randomized trial in primary care for nursing home patients. That got me into, basically, looking at this whole question about nursing home care. I got some money from the NIH [National Institutes for Health] to do a study trip to Europe. My wife [Rosalie A. Kane] and I went off, and we wrote a book [*Long-Term Care in Six*

Countries, 1976] about it, so now we were international experts because nobody had written about long-term care internationally.

I came back with the idea that a lot of the things we saw in Europe could be replicated in the United States but weren't being done systematically and set out to develop a program for what we called Outcome-based Reimbursement, which was a little bit ahead of its time. We now call it Value-Based Purchasing. I wrote a grant, got it funded to develop systems for collecting data to predict outcomes of care in nursing home patients. Then, I decided that I really didn't have enough colleagues and technique available in Utah to really pull off something like this. A place like RAND [Santa Monica, California] would be a much better place to do it. So we moved to RAND.

LK: Did RAND approach you or you approached them with your wife or they knew about you?

RK: I think they approached me, originally. I knew the people there. I was active in the health program doing the RAND Health Insurance experiment with a friend of mine.

LK: Who was that?

RK: Bob [Robert H.] Brook.

LK: How did your research evolve at RAND?

RK: We did the project at RAND. That was successful. That project led to another project looking at similar things in rehabilitation. We were starting to develop interventions to try and see how we could improve nursing home care.

After I was there for about a year, I got a call from the head of the Department of Medicine at UCLA, who was a very unique individual named David [H.] Solomon. David said he was going to take a year off for a sabbatical, and he wanted to learn how to do research, particularly around aging. I was still a young whippersnapper. He said I was the only one who seemed to know anything about aging around there. He arranged to come to RAND for a year. He brought one of his former colleagues and friend, John Beck. We put together a team at RAND with an economist [Emmett B. Keeler] and my wife. They went off and got some from the Kaiser Foundation to support all of this. Then, the five of us wrote a book about projections for the need for geriatric manpower in the United States [*Geriatrics in the United States: Manpower Projections and Training Considerations*]. While we were doing that, we also wrote a number of grants to set up what was to become the Division of Geriatrics at UCLA. We got that funded and, then, I basically worked half time at UCLA in the Division of Geriatrics and half time at RAND.

LK: How common was a division of geriatrics?

RK: At that time, we were certainly toward the cutting edge. I don't know if we were the only game in town by any means, but we were certainly early in there. It was an open field then, and we could write grants and sort of just print money.

LK: [laughter]

RK: You'd write the same grants with a little bit of change and get it from three different sources.

LK: Wow.

RK: Those were the halcyon days for that kind of stuff. So we got a big jump, and UCLA has emerged as one of the premier geriatric programs in the country.

LK: Was this becoming a particularly important topic at the time because of the number of health interventions that had come out?

RK: I think people were sort of beginning to glom onto the fact that the population was aging. In the early 1980s, people began to see that there was a need for doing this kind of thing. So it became a topic of conversation in a relatively circumscribed area. But, yes.

LK: From my understanding, healthcare delivery was a big topic of conversation, as well.

RK: Yes, healthcare delivery in general. There were, at that time, a number of social experiments going on trying to find different ways to do it. RAND was right in the middle of this very large randomized trial called the RAND Health Insurance Study, which I was only peripherally involved in. It was trying to look at different types of payment and co-payment that basically affect people's use of healthcare services and their health status.

[pause]

LK: Does that relate to your work on the relationship between acute and chronic…?

RK: Yes. If you start out from the very beginning of the story I was telling you about, the adventures in Utah, we were delivering acute care in a chronic disease environment. Right? Acute and chronic have different meanings. There is medical chronic disease and the disability that's involved with long-term care. Yes, we got involved in that.

This all gets a little bit blurred, but sometime about that time, as I said, we did a study looking at what was happening in rehabilitation. We parlayed that into a large study, which I brought here, which was called The Post Acute Care Study, which actually tracked about 1200 people from three different cities [in three states] who were being discharged from the hospital with one of a set of diagnoses that was associated with the high use of post-hospital care. So we actually ran a prospective study that looked at the

outcomes and the factors that accounted for their outcomes. That was a major study. We also were, when I moved here, doing a lot of research studies around nurse practitioners and their role in long-term care, and I brought those studies with me when I came here in 1985.

LK: Before coming to Minnesota, it sounds like you would have had a strong relationship with people in public health, as well?

RK: My primary appointment was in medicine, but I also had an appointment in the School of Public Health.

LK: At UCLA?

RK: At UCLA.

LK: Okay.

RK: It turned out for the health services research component in public health at least, the medical school had all the talent. So we were actually doing most of the teaching at the School of Public Health. At that point, I came to the conclusion that medicine wasn't going to change much.

[laughter]

RK: I had this idea that maybe there would be a better opportunity to make changes from the public health side. In a sense, community medicine was really a kissing cousin of public health anyway. It was also coming around full circle.

As a result, I began to look around for other opportunities, particularly looking for deanships in schools of public health. I looked at a couple of which this was one. Then, they offered me the job.

LK: Were you recruited at all? By Neal Vanselow?

RK: Yes, by Neal Vanselow.

LK: In coming to the School of Public Health, what were your goals in coming here? Were there particular issues that…?

RK: It was pretty clear that this school had some very real strengths, particularly in epidemiology.

LK: Right, right.

RK: And it had some very big problems. It had basically been run by a dean who was not academic. The faculty, I would say, was mixed in terms of their academic credibility.

So my goal was to transform this place into a place that really had high academic standards and, hopefully, get rid of a lot of the deadwood. I came here at the time when they were just implementing the results of what was then called the Rajender decision, which you may have come across.

LK: Yes.

RK: She said there had been a prejudice against people who had non-tenured track appointments. So they were trying to fix this thing up by deciding which people who were on the non-tenured track should be on the tenured track. So we got involved in a number of programs with people… Some of them I tried to counsel out and suggested they really weren't tenure track material, but you don't make a lot of friends doing that.

LK: Yes. [chuckles] I don't imagine you would…

When you say you wanted to create a stronger academic program, are you specifically referring to research?

RK: My sense was that anybody on the faculty had to be involved in active scholarship. You don't have to be a researcher. You could do systematic reviews. You needed to look at something in a critical way and improve the thinking about it. There were an awful lot of people who were just teaching the same rote course every year and weren't doing anything very creative. To me, that wasn't really the expectation of a faculty member.

LK: Did you create the Center on Aging here in 1994?

RK: Well, I didn't create it. There had been, when we came here, an organization, which was an affiliation across the whole University. It was called the All-University Council on Aging. People would get together periodically and talk to each other, but it wasn't very academic. It wasn't really doing anything of any great value. They did have a gerontology minor going in which people could take for coursework. But it really was sort of a commiseration society where people would come together and support each other.

I had gone out and tried to raise money in the late 1980s. There was a big campaign for getting endowed chairs. So I'd gone out to raise money for a chair in Long-term Care and Aging hoping to recruit somebody with real stature to come here. We were successful in raising the money, but we were unsuccessful in recruiting anybody of real stature. So it was suggested that maybe I would take that chair. Essentially, in 1990, partly to convince me to stop being the dean… I wasn't a very popular dean.

LK: And stop being the dean.

RK: Stop being the dean. So that's what happened.

Then, a couple years after that, we converted this other organization into the Center on Aging with the avowed purpose of trying to increase research and teaching in aging.

LK: I believe it was during your tenure as dean that Public Health Nursing moved [to the School of Nursing]…

RK: Ah, yes. You're actually sitting in the Public Health Nursing office.

LK: Really?

RK: One of those great ironies.

As I said, I was trying to improve the academic quality of what was going. Public Health Nursing was all about teaching about leadership and sort of doing good things, but it had no academic strength to it. It really was questionable whether it belonged in the Public Health School. It had public health in its title, but in most schools, it was in the nursing school rather than the public health school.

LK: Right.

RK: As part of the Rajender decision, there were a number of nurses in that program whom I was trying to counsel out of going for a tenure track position. Ultimately, we entered into a series of negotiations in which we transferred the faculty. The Public Health nurses were not happy about that.

LK: They wanted to stay?

RK: They wanted to stay here.

LK: Hmmm.

RK: I just thought it was using up a lot of money and a lot of space without necessarily bringing a profit.

There's an old joke by Will Rogers about the Oakies that when they moved from Oklahoma to California, they raised the IQ of both states.

LK: [chuckles]

RK: I had the same sense about the Public Health nurses.

LK: Okay. [chuckles] Did you run into…

RK: I ran into terrible trouble. I got letters. Vanselow was upset.

LK: Oh, really?

RK: The Nursing Association is a very powerful lobby, and they got *roused* by this. The nurses called me all sorts of names. No, I was not a particularly popular person for doing that. It's a particular irony that I inherited their space.

LK: [laughter] Yes.

The other big move that I found in the history that I believe happened under your tenure as dean was the movement of the Division of Hospital and Healthcare.

RK: Two things happened.

Maternal and Child Health [MCH] was a division, and, basically again, a very weak division. It subsisted on a grant from the Federal Division of Maternal and Child Health, doing a lot of teaching but not any real research. It was too small to really operate as an autonomous division. We had within the school, at that time, perhaps six or eight different little divisions. (a) The school really was a series of fiefdoms. Each division saw itself as autonomous. There was no School of Public Health recognition. Everything was at the divisional level. (b) A lot of these divisions were just too weak and they couldn't really survive on their own. They fed each other. If you had a bunch of people, they would support each other for the level of mediocrity they represented. So my idea was to try and put them into other orbits where the standards were higher. I moved Maternal and Child Health into the Division of Epidemiology, and it became a combined division. I was trying to push that. It's now been almost totally incorporated into Epidemiology. I'm not sure you can even find it anymore. Epidemiology is a separate division. But it took a long time. There were a couple of people…some of them were tenured and there was nothing you could do about it, but some of them were not. A couple of them were public health nurses.

LK: Oh.

RK: So it went both ways.

LK: Did you run into similar difficulties?

RK: Some, but not as many. Yes, people were on both sides of the fence about that one. There was great concern that Epidemiology was by far the largest division and the most powerful, and we were just making it stronger; and if they voted as a block, they could do anything wanted to in the school. There was some real concern about that. They were right. It was a risk, but I didn't see a better way to do it. So that was one.

The other one was the Department of Health Administration. Health Administration was another program that had a very strong nationally ranked educational program, a Master of Health Administration, but virtually no research going on at all. It seemed to make sense to combine it with what was then called the Center for Health Services Research. We had a Center for Health Services Research, which had been funded largely by a

special allotment from the State Legislature to do studies for the State of Minnesota. I challenged the Center to play in the major leagues and start working on a national level. They came up with some intriguing ideas including, basically, applying to be a national policy center for CMS [Centers for Medicare & Medicaid Services]—and they actually got it! Now, they've emerged as the strongest division in the school and have grown enormously.

Part of that was bringing together these two programs, again very different cultures, with the hope that at least some of one might rub off on the other. That merger now, after a long time, has been very successful. In the interim, the Health Administration Program decamped over to the School of Business for a while and discovered that life wasn't nearly as comfortable over there as they thought it was going to be.

LK: [chuckles]

RK: They got all their salaries raised and, then, they came back.

LK: You've been talking a little bit about budgets, too. I didn't know what kind of retrenchment or budget issues…

RK: Well, we had this interesting phenomenon. The School of Public Health was the most efficient program on the whole campus.

LK: Oh, wow!

RK: If you looked at it in terms of return on investment for what the state gave us, which was damn little—only fifteen percent of our budget came from the state—we basically did a four to one return on investment, which was *unparalleled* any place else. The next biggest return on investment was in the Medical School. It was always hard with them because they have clinical income, and we never knew quite how to account for that in terms of the money.

We went through a number of periods of retrenchment, but it didn't really hurt us. It was never *good* for us, but since we were basically a virtually autonomous program… We had the great advantage that we were an entrepreneurial program generating a great deal of external money, bringing money in, I mean literally bringing money in to the University because the indirect costs went into the University. At that time, it wasn't every tub on its own bottom. The money went back to the central University treasury. We were bringing in more money to the University than they were paying us, a very strange kind of relationship.

LK: Right.

RK: But we still had to deal with all the University bureaucracy. We were out competing for grants and needed ways to be efficient in hiring people and firing people. We were just University employees subject to all of the University regulations. This

created a great deal of inefficiency in terms of what we did. But we persevered despite the limitations.

At that point, we had this very large grant in Epidemiology called the Minnesota Heart Health Program, which was a multimillion-dollar grant. Those were the days when millions were important.

LK: [chuckles]

RK: It was one of three in the country and just provided all sorts of opportunities for research and hiring good people.

Then, we had some big projects out of the Department of Biostatistics. We ran randomized trials. We had a Department of Environmental Health that was never very productive in terms of research. The Health Services Research people who were just making the transition to this… We had the Health Administration program, which was not a research program at all, the MCH program and Public Health Nursing. There were a lot of programs that were not very academic. So we kept trying by mergers or by various things to crank up the firepower.

LK: It's interesting that you say that you're bringing in so much money and the Legislature is providing so little, but you're still so vulnerable to the University bureaucracy.

You made the comment that the Legislature was upset about the move of Public Health Nursing into the School of Nursing. Since they don't supply a large part of your budget, was that much of a threat?

RK: I don't recall they threatened us with any punitive or any monetary penalties.

LK: Okay.

RK: You never want to get a letter from a legislator saying, "Why are you doing something bad?"

LK: Did you have any other interactions with the Legislature?

RK: We would go over to testify and try and raise money. We had a state special that was funding Health Services Research, and we'd have to go and testify trying to defend that. We would, periodically, try and just hold briefing sessions for the Legislature to sort of give them updates on what was going on in health care in general in the state.

LK: I was wondering if you could also comment on what I've read about as shift in public health from prevention to a research focus on healthcare delivery in the 1970s.

RK: Yes, I suppose it's a shift in relative terms. Public health has been a very eclectic profession for a long time, so it runs the gamut from classic prevention, sanitation, all that stuff to looking at healthcare delivery and trying to reach underserved population. A number of schools of public health, certainly back in the 1980s when I was doing it, were pretty severely divided into the group that really were academic in the full sense of the word, i.e. having a research and teaching mission. We were a relatively small teaching program. There was no incentive to teach. We didn't get the revenue from teaching.

LK: Right.

RK: You could presumably improve your prestige nationally by having more graduates, but the money was all in research. So I went after the money.

LK: [chuckles]

RK: There was a group of programs that basically had active research programs, and we were the first or second public university in terms of research in a school of public health across the country. A lot of that was going on. We were flying the flag of public health and pushing programs for underserved populations, pushing prevention programs both at what we called the primary prevention level of getting people immunized, getting them to change health behaviors. In Epidemiology, the Heart Health Program was really a primary care research program. It was trying to change fundamental behaviors in terms of eating and exercise and smoking to reduce heart disease. Research and prevention weren't distinct. We could actually do both.

LK: I had read somewhere that you established an improved evaluation system. It didn't have details about what exactly that was evaluating. I don't know if it was for the divisions or...

RK: I don't know what that means either.

One of the things I did was I tried to put into place clearer criteria for promotion for faculty that basically pushed this idea of scholarship in some way or another. At various times, I proposed, literally, a point score, which never got off the ground.

LK: [chuckles]

RK: There were a number of things I tried to do. One of the things I tried to do early when I came here… I was impressed with the way RAND operated. RAND operated on a matrix model system, where you had what you would think of as divisions, like economics, and statistics, and social science down one axis and, then, you had programmatic areas like health, and defense, and natural resources, and justice on the other axis. The idea would be that you would, basically, put together teams of people from these various relative disciplines and have them work on topical programs. I thought that was what we ought to be doing in the School of Public Health. We were in this strange situation where we had statisticians in several different divisions. We had

nurses in different divisions. We had behavioral sciences in different divisions. It just didn't make an awful lot of sense. I thought that was a great idea. But, I've never seen, it turns out, any educational institution able to pull it off.

LK: Hmmm.

RK: And I wasn't able to pull it off either.

LK: It is something about the politics of tenure?

RK: Well, part of it is the politics of tenure. The School of Public Health at the University is all one department, so the tenure is in the school not in the division.

LK: Okay.

RK: It's partly the politics. As I say, way before I got there and ever since I've been here, the first line of loyalty is to the division not to the school.

LK: Hmmm.

RK: There have been repeated efforts to try and do school-wide programs. I tried to start several school-wide initiatives. At that time AIDS [Acquired Immune Deficiency Syndrome] was big, and we tried to start a school-wide AIDS program. People were used to dealing with things at the divisional level, and the division heads obviously like it that way. It gave them a lot of control over resources.

LK: Would you say that division loyalty is sustained to the present?

RK: Yes, I think it is. It may have gotten a little bit better.

One of the things I did was I pulled a lot of the resources back into the dean's office, which didn't endear me to the division heads, as you might guess.

LK: [chuckles]

RK: But it was the only way we could get any kind of real power or incentives to try and make changes. So there was a constant battle between me and the division head in terms of who was in charge. I probably didn't handle that in as politically savvy way as I should have. I think that tension is still maintained.

The current dean has pulled a huge number of resources and centralized a lot more stuff than we had back when I was dean.

LK: Is that John [R.] Finnegan?

RK: John Finnegan.

LK: Do you think that division loyalty has to do with personalities or do you think it's just…

RK: No, I don't think it's personality. People are, basically, hired by the division. They associate with the division.

LK: Yes, just the culture.

RK: That's their home.

LK: Yes.

RK: We see ourselves as different from people in the other divisions. Now, in some cases, we do some of the same stuff. My standard joke is that epidemiologists talk about why $y = bx + a$ and economists talk about $y = ax + b$.

LK: [chuckles]

RK: It's the same regression model. It's just that we use different terms for it. We don't spend enough time to recognize that we're actually saying the same thing.

LK: Right.

RK: There are a few people… I would say I'm one, because I basically have training in epidemiology and health services research and walk back and forth and do some translation. There are other people now. We have a couple epidemiologists on our faculty in Health Services Research. It's possible to look across these two. There are conflicts and, in some cases, competition for the same grant dollars.

LK: When you stepped down as dean were you tired of dealing with the politics or was it kind of difficult to…?

RK: It was two things. Number one, I never stopped doing research. One of the things that drove people crazy was that I was publishing more papers as a dean than two thirds of the faculty.

LK: Oh. [chuckles]

RK: Deans don't do that.

LK: Right.

RK: Their argument was I wasn't spending enough time doing my deanly duties. I thought I was. I just continued and expanded what I had been doing before, when I stepped down. I felt that I had done a pretty poor job as a dean. They sent me off to

training school to learn how to talk to people better and deal with things like that, because I wasn't very politic. My sense was, in the end, that everybody is a middle manager. My standing joke was if I had to come home and tell my kids what I did today, and the answer was, "I put out two brush fires for people who were complaining about something," that wasn't a great big day. I came into the job wanting to really make change and made some change, some of which lasted and some of which didn't. At a certain point, I basically had incurred a lot of opposition, I wasn't making any more change, for sure, and it wasn't fun.

LK: In this first year…?

RK: In the last several years, it just stopped being fun.

You didn't ask me about what was going on in the rest of the Academic Health Center [AHC]. You're going to do that later?

LK: Yes, yes.

RK: It's all about what's happening in these different areas so they all come together.

LK: We can certainly talk about that. So Neal Vanselow…

RK: He was the vice president.

LK: ….while you were… Did you do a lot of work with him?

RK: We met with him a lot. He was involved in some of the strategic decisions that we made, and he kept trying to fix me…

LK: [laughter]

RK: …make me more politic.

What was happening in the Academic Health Center at the time was it was like *Animal Farm*, all animals are equal but some are more equal than others. At that time, we had our own Hospital. It was the Hospital and the Medical School and then the other programs. It was very clear that the Academic Health Center was fixated on the Hospital and the Medical School who were having big problems.

LK: Yes.

RK: We had just built a new hospital and it was a very difficult time in terms of doing that. They were spending a lot of money. They were deeply in debt. My school was the only school that was actually doing well economically.

LK: Right.

RK: Most of the other schools were scraping by. The Medical School was in bad shape and the Hospital was eating up money left and right. We would have meetings where all the deans would come together to meet with Vanselow, but we never talked about big-ticket issues in the Academic Health Center. We talked about the Hospital.

LK: Ohhh, okay.

RK: I would periodically get up and say, "Look, this is not necessarily in the best interest of society: how do you make more money for the Hospital. I'm in the School of Public Health. We're interested in the good of the people. This isn't necessarily good for people." But I was told the major concern was that we had to keep this system going.

LK: How did the other deans react?

RK: I think most of them just basically were much more political so they kept their mouths shut. As long as they could protect their turf that was basically their job.

LK: You have said that you ran into a lot of problems for not being political, but it seems like in a situation like that where you're representing the school…

RK: Again, representing the school or representing what the school represents… I could represent the school by basically making Vanselow feel like he was always right and, then, getting him to like us better and presumably doing better things for us. But the other side was you wanted to do what was actually *right*.

LK: Right.

RK: So I wasn't in one sense representing the school. If my political objectives were the power of the school, then I probably wouldn't raise all those objections.

LK: Right. I know when Vanselow leaves, the Hospital continues to be in financial straits until its sale to Fairview [Health Services] is my understanding.

RK: Again, the sale to Fairview was unique in the lore of University Hospitals in that we didn't get any money!

LK: Oh, really? I didn't realize that.

RK: It wasn't a sale. It was a give away! Basically, Fairview absorbed the debt of the Hospital but didn't give us any money. Most other programs in Health Services Research, in fact, blossomed when they sold the "University Hospital," because they got a big chunk of the proceeds. That was part of the deal.

LK: Ohhh.

RK: There was no sale price. As I said, they basically absorbed debt. So there was no transfer of resources, as such.

A lot of the deals that were signed and that I got in that much later… One of them was the agreement that Frank Cerra cut with regard to how to finance training in the University Hospital. It turned out to be a *horrible* deal, which gave all sorts of money to Fairview. Ultimately, the then chairman of Medicine, Jonathan [I.] Ravdin looked into this and saw what a terrible deal it was. It wasn't anything like what he had seen when he was at Cleveland [Case Western Reserve University/Cleveland VA Medical Center]. He recruited me to do a study to actually look at the real cost of education. Of course, we came up with a set of numbers that were *dramatically* different from what they were assuming it would cost to do this stuff. We're talking, I think it was, $16 million a year, which is, again, a reasonable amount of money. Cerra was not a strong negotiator anyway. The Fairview people after they looked at our findings and tried to refute it and couldn't basically said, "It would be unseemly to argue over this. Let's just forget about it and just keep things they way they are."

LK: Is that why you say he's a poor negotiator?

RK: Oh, yes. He was the one who sold the Hospital.

LK: When you stepped down as dean, it sounds like you continued to have a prominent role within the Academic Health Center Administration.

RK: No. I had nothing to do with the Academic Health Center Administration.

LK: Okay, okay, but you did this study as part of…

RK: I would do periodic things, but I was not involved in administration at all.

LK: Okay.

Then, did you work at all with Cherie Perlmutter when she was vice president?

RK: Yes. Cherie really ran the program from day to day.

LK: How did you perceive her leadership to be different than Vanselow's?

RK: Well… Ummm. Cherie was very pragmatic and sort of down to earth. Neal was sort of a little bit up in the sky. He tended to preach a lot.

LK: [chuckles]

RK: [pause] He certainly was not a visionary. He had some very conservative ideas, particularly about the role of women.

LK: Oh, really?

RK: I remember when he came to recruit me, he came out to Los Angeles and met with Rosalie and me…my wife, who was an academic social worker. Basically, he didn't understand why my wife would want to work.

LK: Really?

RK: Not only did she want to work, she wanted to be hired on the basis of her own accomplishments, not as a spouse. Neal just didn't get it. It was just so contrary to the way he thought about the world. He tried very hard to do what he thought was best for the Academic Health Center, but he had no great sense of vision about what to do there.

LK: Do you sense that that outlook…I don't know if you'd want to call it conservative, but…

RK: Yes, I'd call it conservative!

LK: [chuckles] That conservative outlook. Do you think that negatively impacted his leadership?

RK: I think he trusted a lot in the dean of the Medical School and the director of the Hospital. Their needs came first, and they would demand what needed to be done.

LK: I guess that gets to the core of what this project is looking at in how the Academic Health Center creates a collaborative environment, but it doesn't sound like that…

RK: The Academic Health Center has *never* been a collaborative environment. That was one of the great problems and, even now, we have this huge national award for interdisciplinary training, and we don't do any in the Academic Health Center. We're presumably teaching it to everybody else, but we don't do it ourselves.

LK: Right.

RK: The same person that runs that program took away all the funding for the AHEC.

LK: The AHEC?

RK: The Area Health Education Center.

The most collaborative discipline we have is probably geriatrics. We've never developed a geriatric presence in the Academic Health Center at all. I shouldn't say that. We had a start on one. At one point the Division of Family Practice actually had a number of geriatricians but it withered on the vine.

LK: Why do you think that is?

RK: There wasn't a lot of support for it, and geriatrics is never a moneymaker. They didn't do well competing for research funds. They were more of a clinical program, training program.

LK: Okay.

RK: But Family Practice didn't do well for research funds, in general. So they weren't any worse than their colleagues in Family Practice.

LK: When you were dean of the school, did you seek to set up relationships with any of the other schools in the Academic Health Center?

RK: Oh, yes! We would try to develop all sorts of relationships with people, more at the individual faculty level than in some sort of formal collaborative level. We worked with them. We would go in on grants together and do things in that sense, yes.

LK: [pause] Do you have any comments about the culture of the School in the 1980s? We've talked about the Rajender Consent Decree…

RK: When you said the school, do you mean the Medical School?

LK: The School of Public Health. Their efforts to admit more minority students or women to the program…

RK: I think women were coming in anyway. I don't think women were a hardship. Minorities were a big problem. Yes, we set out as a goal to try an increase minority hires, but they were few and far between.

LK: Right.

RK: We did not do too terribly well in going after them. But, yes, that was certainly a priority to try and do that.

LK: Did you do any work with other universities in the area, like South Dakota, North Dakota, Wyoming, and…?

RK: We did some collective things. One of the programs that we started was the Minnesota Area Geriatric Education Center. There, we tried to build relationships with a number of other programs in the area and in the Dakotas. But I would say no, we really didn't have a very active sharing across the schools in the area. On the other hand, we were the only school of public health between here and Colorado. Even Colorado didn't have a school of public health.

LK: Oh, wow, I didn't realize that.

When you stepped down as dean, I know they brought in Stephen Joseph, and he had a short tenure as dean.

RK: Yes.

LK: Do you have any comments on his leadership style and what happened?

RK: Stephen came in from the Department of Public Health in New York City. He basically was not an academic. I think he found it an uncomfortable place. People who come out of government programs are used to a much more hierarchical approach to the way things are done.

LK: Hmmm.

RK: I've seen a number of people who have tried to make this transition from government to academics. Academics is much more egalitarian, and people don't typically simply do things because you tell them to do it. There's a lot more pushback. I think Steve came in with a mindset that had been built on being head of the public health program in New York City, which was a different kind of hierarchical experience than what he was used to here.

LK: Did he try to make many changes?

RK: I'm trying to remember. Yes, he did. He tried to reorganize the divisions, I remember. But if you ask me the details, I can't remember what they were.

LK: Okay.

RK: He did make some changes there. He didn't last terribly long, as you say. He was replaced by a more politic statistician, Mark Becker.

LK: Was that Edith Leyasmayer?

RK: No. Edith had always been the associate dean. She was my associate dean. Edith stayed on. At one point, we gave Edith an academy award, because she'd been acting the most of anybody.

LK: [laughter]

What was it like to work with Edith Leyasmayer? She was your associate dean and she…

RK: I had two associate deans. I had Edith and Jim Bowen. Jim was a statistician. Edith was a very, very straight person. I mean she thought about what things were right. She was very politic, would never say anything about anything, would never raise a word of question. But she was, I think, very loyal and tried to support what I was doing. I

would say she was the person that most of the division heads went to to complain about things. She tried to deal with them as best she could. She ultimately became the dean.

LK: Right.

RK: Her tenure was one of good solid administration, but no real development.

LK: Okay.

I couldn't actually find who was dean… I found that she became full dean in 1996. He [Mark Becker] must have had quite a short tenure, as well.

RK: He had a fairly short tenure. He went off to be a vice president at, I think, South Carolina.

LK: Did he leave because he was running into…?

RK: I think he left because he was ambitious.

LK: Do you know who was dean between Edith Leyasmayer and John Finnegan? I had a break there.

RK: There was nobody.

LK: Nobody. Oh!

RK: John was the acting dean for a while. When Edith left, John was the acting dean and, then, became the dean.

LK: Okay.

Ken [Kenneth] Keller's Commitment to Focus plan was implemented…

RK: It was never implemented.

LK: Oh. [chuckles] It was introduced when you…

RK: I think it was about the second or third year of my deanship. I thought Ken was the best thing that ever happened to the University. He was incredibly bright. He was trying to be farseeing.

The plan, which never really got anywhere, was designed to try and build on the strengths of the University and put more resources into your strengths and cut loose some of the things. It never came off for a whole bunch of reasons. One is that Ken, basically, incurred the wrath of a number of people. You probably know the story of the president's house [Eastcliff] and the picket fence and the kitchen.

LK: I don't.

RK: You don't know that?

LK: No.

RK: People were trying to undercut Ken, so they got him on two things, and they were both trivial. One was that he raised money—he had a fund that he used—to renovate the president's house and sort of turn it into a place that you could use to host events. So he built this great big catering kitchen. This was obviously not for him. Nobody in their right mind would want a kitchen like that. So, he put a lot of money into spiffing up the whole place and making it look better. People sort of took him to task for spending University money on his own house—which it wasn't. It wasn't his house. It was the University's house. Then, the second thing he did is he bought a big fancy desk. That was probably a stupid thing to do. But somebody got a hold of that and they found out the price of the desk. I don't know what it was…whatever it was $6,000, $10,000, which at that time was a lot of money for a desk, and probably still is.

Those things occupied much more attention than what he was trying to do in terms of actually doing this. He was out to gore oxen. He wanted to actually change this University and make it more competitive, bring it into the twenty-first century, and did not succeed.

One of the things that they had proposed, which certainly alienated the school, was to close the School of Dentistry.

LK: Right. I saw that.

RK: He was very much supported by Rudy Perpich, who was the governor and trained as a dentist.

A lot of the battles were around the Dental School; certainly for the Academic Health Center, that was the big battle. Ultimately, depending on which side you're on, Keller lost that battle.

LK: In discussing Commitment to Focus in AHC meetings after the threat of the closure, that totally alienates the health sciences?

RK: Yes. One person who saw Commitment to Focus as being good was me.

LK: [chuckles] Okay. It seems in line with your philosophy.

RK: But also with what we were doing. We were productive…. I used to go to briefings of deans councils and go to the people and show them if we were just running a business, you couldn't make a better investment than the School of Public Health. Leave aside

whether we turned up any good research findings or educated any students, just in terms of bringing in money to a… If you were running a business and you could get four dollars back for every dollar you spend, that's a pretty good business. I had all these charts about productivity per faculty member. We brought in a lot of money, and we had a small faculty, so if you did it by faculty member, it was even much higher. Anything that was going to basically build off of putting money into places that were strong was bound to help us.

LK: Right.

RK: We were strong. But, again, clearly, you couldn't be too vocal about supporting Commitment to Focus when they were trying to do in one of your colleagues.

LK: Cherie Perlmutter took over the interim vice presidency from 1989 to 1992. Then, they brought in Robert Anderson. I didn't know if you had any interaction with Robert Anderson. He was here only about a year.

RK: Anderson, I don't remember. The guy that came after him was a radiologist from [Johns] Hopkins.

LK: William Brody, yes.

RK: Brody, yes.

LK: Did you work with Brody at all?

RK: Yes. Brody was another one who came in and was going to make tremendous changes. If I was impolitic, he would get an award for being impolitic. One of his first suggestions was do away with tenure.

LK: Oh, wow!

RK: So he did not necessarily win a lot of friends on the basis of doing that. Again, it didn't hurt his career. He went back to Hopkins as the president of Hopkins.

LK: Right. My understanding is that Brody began the sale, or the debt exchange as you put it, to Fairview. [chuckles] Then, Frank Cerra carried it through.

RK: Yes.

LK: Did you work with Frank Cerra?

RK: I worked a lot with Frank Cerra.

LK: How would you compare his leadership style to the other vice presidents you worked with?

RK: I think Frank actually tried to have a lot of vision. But, as I say, he was not a strong negotiator. He was incredibly politic. He said yes to everybody and, then, didn't follow through, of course. We used to talk about new words like *cerrandipity*…

LK: [chuckles]

RK: …which was a chance that anything would actually happen that Cerra said was going to happen.

[Telephone rings – break in the interview]

RK: Then, there were what we called *cerrabucks*.

LK: Funds that never came. [laughter]

RK: I was one of the more productive faculty in the Academic Health Center. So I was part of that thing on the wall for the academic research

Frank tried to do those things to promote people who weren't getting recognition on a nationally competitive level.

I already told you about calculating the training costs. A group of us went to Frank and said, "Look, we are way behind the rest of the schools in terms of not having a geriatrics program. It's really going to hurt us." So Frank said, "Okay. Put together a proposal and let's do something." So we put together a group of people from all the different schools and we prepared some ideas. We talked to a number of other schools about what they had done. We actually got Frank to go on a site visit with us to the University of Michigan. He was very impressed with what he saw there and what they were doing. Then, he said, "What is this going to cost?" So we told him, "It will probably take a minimum of five faculty and probably cost over a million dollars." He said, "We don't have the money!" So we spent a year putting all this together, and he killed it in a day. That was a very bad thing.

LK: Right.

RK: Frank's goal was to try and build up the school's reputation in basic science. Vanselow had started it, and Frank was very keen to want to get a Howard Hughes Foundation Award for the basic science.

LK: Okay.

RK: I kept telling Frank that we were coming into the game much too late. At that point, what we ought to do because we had all this stuff going on in the Twin Cities was demonstrate how to do good chronic disease care. My argument was that's the name of

the game for the future. I could never convince him that it was worth doing that. So we never went anywhere. I just was so frustrated with Frank.

Frank was good at glad-handing people. He was good at backslapping in politics. I think he tried quite sincerely to do some things to strengthen the Academic Health Center, again largely fixated on the Medical School.

LK: It was under Frank Cerra's tenure when the vice president of the Academic Health Center became the Medical School dean.

RK: Yes.

LK: Do you have any reflections on how that changed the…?

K: It didn't change anything.

LK: You don't think so?

RK: No. Basically, I guess, it was an acknowledgment of the fact that it was primus inter pares. It was always the Medical School. As I say, it used to be the Hospital, too, but, then, we didn't have the Hospital any more. It was just the Medical School. This is not the only place where the medical school basically drove the rest of the academic health center. If you talk to almost any academic health center, the other schools wind up being tapped to support the medical school.

What we never did is we never developed a primary care program…

LK: Here at the University?

RK: …other than the Family Practice program, which was, basically, outside the University. We never really engaged in a partnership way with the other programs in the area who were in many ways way ahead of us in terms of doing innovative things for care delivery.

LK: What other programs?

RK: Health Partners, Medica, Park Nicollet.

LK: Okay.

RK: They were all doing interesting things that were trying to push the envelope for finding better ways to deliver health care. We never really got into delivering health care. We were always a tertiary or quaternary specialty organization doing highly sub specialized stuff. Historically, this Medical School has always been dominated by surgeons going back to the [C. Walton] Lillehei days.

LK: Right, right.

RK: That doesn't lend itself to primary care thinking.

LK: That's what I think is the interesting point of… Considering this is a land grant institution with this mission to serve the people of the state, it's interesting that a primary care program wasn't developed…

RK: Yes.

LK: …as well as a geriatric program.

RK: Although, obviously, training these people would be important, but developing better ways of delivering those services, even if you did it as primary care research and innovation… We just never did it.

LK: To serve Minnesota as a particularly rural…

RK: Yes. Then, you have the rural part of it. That would be another part of it. Most of our population is urban, like most rural states. However you want to look at it, we just didn't do it!

LK: Do you have any comments on John Finnegan's leadership style as dean?

RK: John's done, basically, a good job of trying to pull things together. He certainly has grown the school enormously. Our faculty has doubled in size.

LK: Oh, wow!

RK: I think he's been successful, perhaps too successful in pulling resources into the dean's office and away from the divisions but, at least our division is doing quite well so we can afford it.

Part of the role of the dean, as I always thought, was to try and act as a clearinghouse, to serve almost as an insurance company for the school. So if you had divisions, you needed to support the divisions through the lean times in order to get them back on their feet so they could do a better job again. So there's a certain redistribution of resources. There are sort of two flows of money. One flow is into the dean's office to run things centrally. We have more than I think we should have in terms of central things that are not run well. Then, we have the redistribution efforts where you're trying to take some money and, kind of like any insurance program, redistribute it around.

LK: Did you do any work with the Regents or I don't know how much you may have worked with Ken Keller, specifically, or any of the other presidents.

RK: No. I really didn't spend a lot of time with them.

LK: That kind of covers my questions. I didn't know if there were any topics that you had wanted to talk about that I didn't address.

RK: I don't think so. I can't think of any.

LK: Okay. Thank you so much for meeting with me.

RK: Good!

LK: This has been really great.

[End of the Interview]

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