Public Health Is People

Elisabeth Emerson

A History of the
Minnesota Department of Health
from 1949 to 1999

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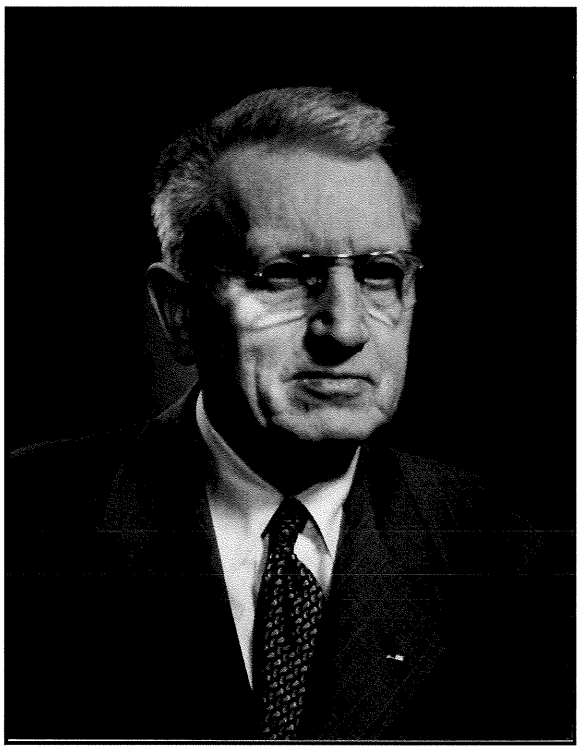
Chapter 1

The Health of Minnesota – 1949 to 1955



"Dean of Health Officers"
Dr. Albert J. Chesley
Secretary and Executive Officer of State Board of Health

Often carrying an overstuffed briefcase, Dr. Albert J. Chesley, secretary and executive officer of the Minnesota State Board of Health in 1949, was a common figure in the halls of the Health Department. Usually one of the first to arrive in the morning and the last to leave at night, he worked weekends and holidays, seldom taking a vacation. He often returned to the department after his evening meal, sometimes working until midnight. During these times, employees who were also working late might hear this usually quiet man talk about two of his favorite topics: the Spanish-American War and World War I. He might even show and discuss some of the many maps he collected and studied.

Dr. Chesley was a man of integrity, but he once told a lie. At the start of the Spanish-American War he added a year to his age so he could enlist as a private in the medical corps of the U. S. Army. He worked in the Philippines, treating the wounded. Returning

to his native Minnesota in 1901 following the war, he began his public health career as a clerk for the Health Department.[1] The minutes of the Board of Health indicated the employment of this young university student – this new office boy – at 75 cents a day was only a temporary arrangement. The "temporary" position extended into other positions for a total of 54 years of service at the department, 34 as its chief.

While attending the University of Minnesota, Dr. Chesley worked part time as a laboratory assistant at the department.[2] In 1907, after graduating from medical school, he became an assistant bacteriologist at the department and later became director of the communicable disease division.

During World War I, Dr. Chesley temporarily left the department to work in Poland with the American Red Cross. On a train from Paris to Warsaw, he met another American, Dr. Placida Gardner.[3] Dr. Gardner was laboratory chief for the public health unit of which Dr. Chesley was commissioned. Years later, in the department newsletter, their courtship was described:

> Their romance, an old-fashioned courtship, was one of the most carefully guarded secrets of World War I, and even Dr. Chesley's roommate was unaware of it. Dr. Chesley was often out in the field, but when he returned to headquarters, the two of them strolled through the streets of Paris at night hand in hand. They chose streets where they would be least apt to encounter other military personnel.[4]

In 1920, a small part of a church in Warsaw, Poland, was briefly declared American territory, so the two could marry.[5] Dr. Chesley's best man was Dr. Harold S. Diehl, long-time medical school dean at the University of Minnesota.

The Chesleys returned to Minnesota in 1920, and Dr. Chesley resumed his position at the Health Department. One year later, on May 13, 1921, he was appointed secretary and executive officer of the board and became, with 34 years, one of the longest-serving health officers in the nation.

Dr. Chesley was a self-effacing man who liked to refer to himself as the board's "office boy." His weather-beaten desk of cherry wood was one he had salvaged from the old state capitol building. His filing boxes, marked with brief labels, such as "TB Stuff," were stacked near the desk for easy reach. Attending the board meetings, Dr. Chesley usually sat at the side absorbed in his briefcase of papers, but always attentive to the board's actions.

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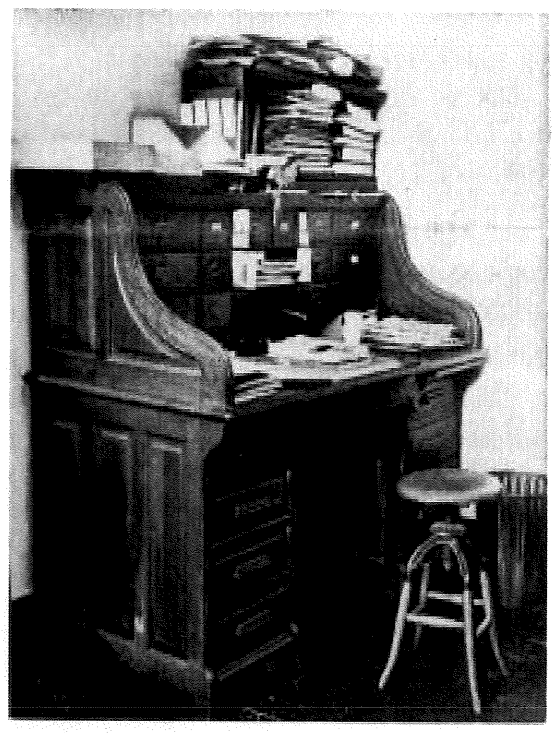
[1] Minnesota Department of Health (hereafter MDH), *Minnesota's Health*, Vol. 9, No. 9, November 1955, p. 1.
[2] Minnesota Civil Service Department, *The Minnesota Career Man,* July-August-September 1954, p. 11.
[3] Harold S. Diehl, "Public Health in Minnesota: An Overview of the Past and a Glance Toward the Future," *Minnesota Medicine*, Volume 42, January 1959, pp. 31-37.
[4] MDH, *Minnesota's Health,* Vol. 20, No. 4, April 1966, p. 2.
[5] *Minneapolis Star,* "Town Toppers Here's a Quick Look at Dr. Albert Chesley," January 6, 1953, p. 8.

Department employees were like family to Dr. Chesley. He referred to them as "my gang."[6] With his box camera, he would frequently gather employees and visitors together and take photographs.

Dr. Chesley led many crusades. He almost single-handedly persuaded Congress to transfer Indian health and medical care from the Bureau of Indian Affairs to the U.S. Public Health Service. His field-training course for health officers was a forerunner to the public health school that he helped establish at the University of Minnesota. He had deep concern for the health of children and advocated maternal and child health programs. He personally invested, not only his time, but also his financial resources in public health. When the governor once vetoed funds for a venereal disease laboratory, Dr. Chesley forfeited three months of his own salary to contribute to the operation of the lab. He held a strict non-commercial code, refusing to accept payments for endorsing any products.[7]



PUBLIC HEALTH HISTORY was made at this weathered cherry desk where Dr. Chesley spent countless hours reading reports, writing letters and memorandums in longhand, and otherwise guiding public health in the state for 34 years.

Dr. Chesley traveled to all areas of Minnesota, working the front line of public health. He drove throughout the state, visiting doctors in their offices. He kept a slip of paper with the names of typhoid carriers in his pocket. If he was in the town where one of them lived, he stopped and visited.[8] If he received a notice that a drug store had distributed an anti-toxin, he was known to visit the patient to check for diphtheria.[9]

Dr. Chesley believed it very important to work closely with the medical profession and the University of Minnesota Medical School. A unique and supportive relationship was maintained. He consulted with and gained the support of the Minnesota Medical Association and the University of Minnesota School of Public Health for public health initiatives. A strong and united public health front was presented. Dr. Chesley thought it equally important to work with the population, stressing an individual's responsibility

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[6] *Minneapolis Star,* "Dr. Chesley, State Health Chief, Dies," October 17, 1955, p. 1.
[7] Ibid.
[8] MDH, *Minnesota's Health,* Vol. 9, No. 9, November 1955, pp. 1-6.
[9] *Minneapolis Star,* October 17, 1955, p. 1.

for his or her good health.[10] He encouraged and inspired others, and gained cooperation through suggestion rather than direction.[11]

Dr. Chesley's Filing Boxes

One of the outcomes of Dr. Chesley's excellent relationship with the medical profession was the unusually good reporting of vital statistics, a foundation of good public health practice. After the 1950 census, the National Office of Vital Statistics determined 99.9 percent of the births in Minnesota were registered. Minnesota tied for second place with Rhode Island. The only state with a better record was Connecticut with a 100 percent registration record.[12]

Dr. Chesley's Teachers: The First Public Health Greats

Dr. Chesley knew and admired the public health greats of Minnesota. One of them was Dr. Charles Hewitt, a man of boundless energy, whose efforts created the State Board of Health in Minnesota in 1872. Just behind California and Massachusetts, Minnesota was the third state in the nation to have a health board, establishing an early pattern of being in the forefront in public health. Dr. Hewitt's foresight was a determining factor in the state's later successes in all areas. Though not always recognized by legislators

[10] Diehl, "Public Health in Minnesota," p. 37.
[11] Ibid, p. 36.
[12] MDH, *Minnesota's Health,* Vol. 12, No. 10, December 1958, pp. 1-6.

and the public, public health interventions saved resources in one area, freeing them for use somewhere else.

Dr. Hewitt was secretary and executive officer from 1872 to 1897, and his accomplishments were many. In his own laboratory in Red Wing, Minnesota, in 1890, he began making smallpox vaccine for health officers and doctors.[13] He began examinations of the diphtheria culture in 1894.[14] He fought for improved sanitation and advocated for the delivery of health services at the local level. He established a system to collect health statistics. Minnesotans of today, used to a high level of public health services, owe much to Dr. Hewitt's early efforts. Dr. Chesley liked to refer to a statement made by Dr. Hewitt in 1872:

> ***"The true policy in Minnesota is to begin immediately, to start right, and to hasten slowly."*** [15]
>
> **Dr. Charles Hewitt, 1872**

Dr. Chesley worked with Dr. Henry M. Bracken who was secretary and executive officer of the board from 1898 to 1919. Dr. Chesley also worked closely with other public health pioneers, including Dr. Hibbert Hill, reportedly the first person in the United States to have the title of "epidemiologist," and Dr. Frank F. Wesbrook, head of the department's laboratories and later a professor at the University of Minnesota.

Dramatic Changes in People's Health

Working in the department from the beginning of the century, Dr. Chesley observed, first hand, many significant accomplishments in public health. When he first started working at the department in 1901, Minnesota life expectancy was 49 years. Due to improved sanitation, vaccination and immunization, development of antibiotics and drugs, blood replacement, better health facilities and improved medical and nursing education and care, life expectancy for persons born in Minnesota had increased to 67 years by 1949.[16] In 1900, only 22 percent of deaths in Minnesota were in individuals aged 65 and over. By 1950, 61 percent of the deaths occurred in people aged 65 or older. [17] The days when at least one child in every family was expected to die had disappeared.

Changes in the state's health status are readily noted by comparing the leading causes of death in Minnesota in 1910 with those of 1949. The leading cause of death was no longer an infectious disease.

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[13] Philip Jordan, *The People's Health,* St. Paul, 1953, pp. 53-54.
[14] Ibid., p. 80.
[15] MDH, *Minnesota's Health*, Vol. 9, No. 9, November 1955, p. 2.
[16] MDH, *Minnesota's Health,* Vol. II, No. 10, October 1948, p. 3.
[17] MDH, *Minnesota's Health,* Vol. 11, No. 1, January 1957, p. 3.

Leading Causes of Death in 1910[18] and 1949

1910	1949
1. Tuberculosis	1. Heart disease
2. Heart disease	2. Cancer
3. Pneumonia	3. Intracranial lesions of vascular origin
4. External causes	4. Accidental deaths
5. Cancer	5. Pneumonia
6. Diarrheal diseases of children	6. Diabetes
7. Nephritis	7. Nephritis
	8. Arteriosclerosis
	9. Premature birth
	10. Congenital malformations

Pregnancy and birth were no longer as great dangers for mothers and infants in 1949 as they had been. Dramatic gains had been made in the areas of infant and maternal mortality. In 1943 and 1946, Minnesota had the lowest maternal mortality rate in the country. The rate continued to decline, with 48 maternal deaths in 1948 when the state's total population was 2,940,000.[19] The improvements were credited to early prenatal care, use of antibiotics, better-equipped and better-staffed hospitals. Nearly all babies were now born in hospitals.

Deaths Per 1,000 Live Births in Minnesota

	1910	1948
Infant deaths per 1,000 live births	96.6	26.6
Maternal deaths per 1,000 live births	5.6	0.66
Stillbirths per 1,000 live births	31.1	17.6[20]

[18] Minnesota State Planning Board, "Report of the Committee on Public Health of the Minnesota State Planning Board," December 1936, p. 10.
[19] MDH, *Minnesota's Health,* Vol. III, No. 3, April 1949, pp. 2-3.
[20] MDH, *Minnesota's Health*, Vol. IV, No. 1, January 1950.

In the beginning of 1949, the board agreed that the state of health in Minnesota was excellent. Dr. Thomas B. Magath, chief of clinical pathology at the Mayo Clinic and president of the State Board of Health said, "1948 was one of the best years we have ever had."[21] The department's newsletter referred to 1948 as "a banner health year."[22]

It was a hopeful time. There were fewer reported typhoid cases than there had ever been. From 1947 to 1948, syphilis cases dropped 40 percent, from 431 to 177.[23] For the first time since 1943 there had been no smallpox cases in the state, and malaria cases were decreasing. While tuberculosis cases had increased, there was a decrease in the number of deaths from tuberculosis. At 503, the number of deaths from tuberculosis was at an all-time low.

Advances occurred with other diseases and conditions. Deaths from appendicitis, as high as 416 in 1930, were reduced to 69 in 1949 as a result of antibiotics.[24] A new low level of pneumonia deaths was reached, with 1,009 reported deaths.[25] Influenza deaths in 1948 were also the smallest number on record and half the 1947 number.[26] Diphtheria cases were markedly reduced. Polio cases and deaths occurred, but they were far below the numbers experienced during the epidemic of 1946. The state's death rate of 9.5 per 100,000 was the lowest recorded.[27] Minnesota's sewage disposal system, had better showing than any other state, no doubt due in large part to the early efforts of Dr. Hewitt and Dr. Bracken.

Cases and Deaths for Nine Selected Communicable Diseases as Reported to Minnesota Department of Health for Years 1910, 1920, 1930, 1940, and for 1946 to 1950 Inclusive

		1910	1920	1930	1940	1946	1947	1948	1949	1950
Diphtheria	Cases	5012	3616	768	122	443	326	131	113	99
	Deaths	566	243	32	6	43	20	15	12	8
Measles	Cases		7673	6196	5245	1462	9411	9574	3359	4073
	Deaths	263	159	89	6	10	17	11	2	10
Poliomyelitis	Cases	481	80	479	258	2881	201	1387	1715	502
	Deaths	201	18	37	26	226	13	110	110	21
Scarlet Fever	Cases	4117	3329	4030	3410	1866	1994	1637	1574	724
	Deaths	284	117	38	14	4	3	3	1	0
Smallpox	Cases	1262	6333	332	416	5	1	0	0	0
	Deaths	7	15	0	0	0	0	0	0	0
Tuberculosis	Cases	1440	4841	3305	2749	2622	2869	3966	2778	2700
	Deaths	2270	2157	1248	762	596	587	502	405	331
Typhoid	Cases	3204	684	217	57	26	23	28	21	12
	Deaths	688	71	25	6	3	1	4	1	1
Whooping Cough	Cases		2081	1863	3764	511	2712	781	181	1377
	Deaths	172	297	60	34	15	31	14	6	14
Brucellosis	Cases			62	137	403	378	295	349	281
	Deaths			0	3	1	0	1	0	0

[21] Minnesota State Board of Health Meeting Minutes (hereafter BOH, *Minutes*), January 20, 1949.
[22] MDH, *Minnesota's Health,* Vol. III, No. 2, February 1949, p. 1.
[23] Ibid., p. 4.
[24] MDH, *Minnesota's Health,* Vol. IV, No. 2, February 1950, p. 4.
[25] MDH, *Minnesota's Health,* Vol. III, No. 2, February 1949, p. 1.
[26] Ibid.
[27] Ibid., p. 2.

Reflecting on the successes and hard work to get there, the board president said:

> ***"We think it is barely remotely possible that after 30 years maybe our program has been effective."*** [28]
>
> **Dr. Thomas Magath, 1949**

In 1949 public health had, according to Dr. William Shepard, president of the American Public Health Association, "come of age." Public health schools were accredited, specialty boards in public health had been established, and health practice indices were being used to measure the effectiveness of public health programs.

The September 1951 issue of *Minnesota's Health* included a letter from Dr. McGandy, board chairman of the Hennepin County Medical Society. He extolled the virtues of Dr. Chesley and public health in Minnesota noting that the pattern of accomplishments was followed by other states: "The public health record of the State of Minnesota is an eloquent and lasting monument that speaks volumes for the accomplishments of the Minnesota Department of Health under the guiding stimulus of Doctor Chesley." [29]

Board of Health

The nine-member board appointed Dr. Chesley to the position of executive officer. The governor appointed or reappointed members to the board for three-year terms. Since terms overlapped, a governor often worked with board members he had not appointed. This arrangement ensured consistency when parties changed. This was especially important at a time when the governor's term of office in Minnesota was two years.

Board members typically served for more than a decade. They were unpaid, dedicated and contributed many hours of their time to the management of the department, while holding other leadership positions in the community. In 1949, the nine members had a total of 67 years of experience on the board. Contrasting that with the last Board of Health in 1977, the total number of years of experience as board members was 42, even though the number of members had increased to 15.

Led by President Thomas B. Magath, M.D., the board in 1949 was strong, powerful and respected. Dr. Magath, a member of the staff at Mayo Clinic since 1919, had been a board member since 1939. He served in the U.S. Navy from 1941 to 1946 inspecting medical installations all over the world and advising on matters of sanitation and tropical medicine. His work on the Interdepartmental Quarantine Commission had resulted in new quarantine measures throughout the world. Dr. Magath was the public health officer in Rochester from 1937 to 1941, succeeding Dr. Charles H. Mayo. Dr. Magath spent his career primarily in laboratory aspects of public health.[30]

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[28] BOH, *Minutes*, January 20, 1949.
[29] MDH, *Minnesota's Health,* Vol. V, No. 9, September 1951, p. 3.
[30] MDH, *Minnesota's Health,* Vol. IV, No. 2, February 1950, p. 4.

Board of Health Members in 1949

Thomas B. Magath, M.D., Joined 1939
Chief of Clinical Pathology, Mayo Clinic, Rochester

Ruth Boynton, M.D., Joined 1939
Director, University Student Health Service, Minneapolis

Frederick W. Behmler, M.D., Joined 1940
Senior Member of Morris Clinic, Morris

Leo Thompson, Embalmer, Joined 1940
Owner of Shelley-Thompson Mortuary, Little Falls

Theodore Sweetser, M.D., Joined 1948
Minneapolis

Charles V. Netz, PhmD., Joined 1947
Professor in College of Pharmacy, University of Minnesota, Minneapolis

Frederic H. Bass, C.E., Joined 1931
Professor of Civil Engineering, University of Minnesota, Minneapolis

W. Lester Webb, D.D.S., Joined 1944
Fairmont

(Note: Appendix D lists all board members from 1949 through 1977.)

Three long-serving board members who completed their terms between 1949 and 1955 were Prof. Frederic Bass, Dr. Frederick Behmler and Dr. Theodore Sweetser. Prof. Frederic H. Bass resigned from the board on February 7, 1952, after serving almost 21 years. He had attended 114 meetings, was board vice president from 1933 to 1935 and president from 1936 to 1938. Board meeting minutes indicate "Dr. Sweetser proposed a toast to Prof. Bass's future health and welfare, which was drunk in water."[31]

During his career, Prof. Bass supervised the installation of some 40 municipal water and sewage plants in Minnesota, led a drive to clean up Minneapolis' water supply, and was active in creating a metropolitan sanitary district.[32] Following his death on May 25, 1953, the board wrote a letter to Mrs. Bass, and it contained the following excerpt:

> The Metropolitan Drainage Commission is a lasting tribute to his professional ability combined with his tact and pleasing personality and persistence in carrying through what he knew to be the right thing for the public health and welfare of the Twin Cities. It is an example of exceptional merit in sanitary engineering achievement for Minnesota and for the whole United States to admire."[33]

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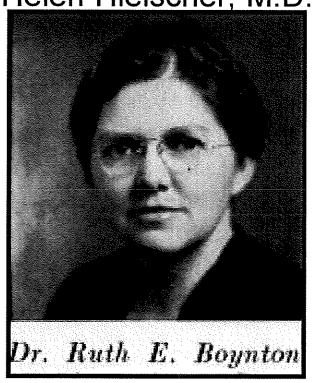
[31] BOH, *Minutes*, February 5, 1952.
[32] *St. Paul Pioneer Dispatch*, May 13, 1953, p. 26.
[33] BOH, *Minutes*, May 21, 1953.

Professor Herbert Bosch, recently returned from work in Geneva for the World Health Organization, succeeded Prof. Bass.

Frederick W. Behmler, M.D., from Morris, Minnesota, served as board vice president from 1950 to 1951 and president from 1952 to 1954. He had been a member of the board since 1940 but had to resign when he was elected to the state senate in 1954. Born in Jordan, Minnesota, Dr. Behmler graduated from the University of Minnesota Medical School. He served as health officer every place he practiced: Lafayette, Appleton and Morris. Active in many organizations, he was the first vice president of the Minnesota Medical Association and past president of the Minnesota State Public Health Conference. At its April 1955 meeting, the board passed a resolution honoring Dr. Behmler for his service.[34]

Theodore Sweetser, M.D., left the board in 1954, serving his last two years as vice president. He had been a member since 1948. Later, in 1967, his son, Horatio B. Sweetser, M.D.; was appointed to the board.

By 1955, 23 Minnesota governors had appointed a total of 98 persons to the board. Helen Hielscher, M.D., had the honor of being the first woman. Appointed in 1932, she died in 1935 while still a member. The second woman to be appointed to the board was Ruth Boynton, M.D.[35] Appointed in 1939 she eventually served for 22 years. The third female was Inez Madsen, embalmer, appointed in 1953.


Dr. Ruth E. Boynton

Board topics varied. Some of the subjects discussed during 1949 meetings were: quarantine signs, recalcitrant tuberculosis patients, new plan for numbering birth certificates, shortage of skilled personnel, adopting new embalming regulations, prohibiting the use of BB guns, pasteurization of milk, rodent control, licensing of plumbers, low salaries, possibility of establishing a rheumatic fever registry, providing gamma globulin for measles and hepatitis contacts and expansion of hospitals. Diseases that were frequently discussed included, brucellosis, influenza, syphilis, diphtheria, polio, whooping cough, rabies, psittacosis, ringworm, typhoid, scarlet fever, and hepatitis.

Although it hadn't always been this way, the board was not advisory, but decision-making. It made the hard policy decisions, working closely with the Minnesota Medical Association, the University of Minnesota School of Public Health, advisory groups and other members of the public health community. The relationship with the Minnesota Medical Association was very close.

The board depended on advisory groups who would study and analyze the decisions that needed to be made and make recommendations. Advisory groups that were in existence in 1949 were:

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[34] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1955, p. 4.
[35] Ibid.

Board of Health Advisory Groups in 1949

Advisory Council for the Hospital Survey and Construction Program
Advisory Board on Registration of Superintendents and Administrative Heads of Hospitals
Advisory Board on Hospital Licensing Law
Advisory Committee on Certification of Water and Sewage Plant Operators
Advisory Committee on Mental Health
Advisory Committee on Milk Sanitation

The board also worked with the Minnesota Public Health Conference, the precursor of the Minnesota Public Health Association. The department established the conference on January 30, 1947.[36] It was created out of the former Minnesota State Sanitary Conference which limited membership to health officers. The new organization was open to all persons involved in public health, and in its early years it operated as a professional association, rather than a policy-making body. The Minnesota Public Health Conference accepted and supported policies established by the department.

Together, the key public health organizations and persons in Minnesota presented a strong, unified group that worked together for the betterment of the people's health. At most board meetings a reference was made to the basis for all decisions: Will it improve the health of the people of Minnesota?

Health Challenges for Minnesota in 1949

Part of Dr. Chesley's genius and success in his work was his ability to adapt to the incredible changes that occurred during his lifetime. He didn't have a favorite disease or condition or method of working that he promoted. He had a singular focus: doing what was necessary at the time to improve the health of all people. Thus, though he experienced a broad spectrum of public health issues throughout his career, his actions in 1949 were as timely then as they had been 20 or 30 years earlier.

The health of Minnesotans was much better, but many problems still existed. In the beginning of 1949, legislation requiring pasteurization of milk did not exist. Brucellosis cases continued to increase. While cases of polio had dropped, the threat of an epidemic was ever present, and no means existed to prevent it. Polio created fear in the population, and the board often needed to respond to the public's fear with little information and few means. Rabies was of a concern equal to or greater than polio. Minnesota's accident figures approached the top in the nation. [37] In 1948 there were more deaths from accidents than from pneumonia, tuberculosis, polio, diphtheria, measles, scarlet fever, and whooping cough combined.

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[36] MDH, *Minnesota's Health,* Vol. III, No. 9, September 1949, p. 4.
[37] BOH, *Minutes*, July 14, 1949.

Like polio, some of the challenges facing the board presented many unknowns and were difficult to address. Magath commented:

> ***"We have worked ourselves out of a job in certain phases only to find ourselves confronted with new tasks that seem much more complicated and much more difficult than those others."***[38]
>
> **Dr. Thomas Magath, 1949**

A statewide conference on youth, in 1948, identified the most important health issues for the state as the prevention, detection and treatment of emotional and mental illness; medical supervision of children from birth to adulthood through periodic health appraisals and treatment; an adequate public health nursing service in communities; sanitary environment including safe water, milk and food supplies; and adequate housing facilities. In 1950, the 2,000 attendees at the same conference recommended the establishment of local health departments as the main health need. Other recommendations for 1950 included: more psychological and psychiatric services for families; courses in sex education in the schools; tests of physical and emotional health for pre-school children; annual examinations of all school employees; complete survey of environmental conditions in schools; campaigns for improving problems identified in environment of school; and more extensive use of school for recreational purposes.[39]

The need for a better local health system had been long recognized. Despite legislation to promote coordination and consolidation of local health units, many distinct and separate governing units remained in operation. Local units resisted consolidating. This made outreach efforts by the department all the more challenging, having to contact many different people and places. Work towards an improved, coordinated and effective local health system continued into the 1970s.

The 1949 Board of Health was beginning to deal with conditions in state nursing homes. In 1952, Dr. Barr commented on this growing concern:

> ***"Our biggest problem in the future is the problem of the older person and the chronically ill. I don't think we can avoid that. In Washington at the session on nursing, the thinking was that public health nursing was going to have to change its thinking and spend less time on some of the fields like communicable disease control, maternal and child health, and spend more time on the question of ensuring services for persons with degenerative diseases, bedside nursing care, etc. It isn't going to be done easily and overnight. People who have been working in a given field will resist changes."***[40]
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> **Dr. Robert Barr, 1952**

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[38] BOH, *Minutes*, January 20, 1949.
[39] MDH, *Minnesota's Health,* Vol. IV, No. 4, April 1950, pp. 3-4.
[40] BOH, *Minutes*, June 3, 1952.

The board faced a shortage of hospital beds, incorrigible tuberculosis cases, and sanitation problems. The survey results of an unidentified Minnesota town in 1952 indicated some of the public health challenges:

> There is faulty plumbing in both A high school and B (parochial) school....The county is not a Bangs' accredited county, nor is there a local ordinance on milk control or a local milk inspector in the city....There is no local ordinance or inspector regulating sanitation in eating and drinking establishments. The city council issues no permits to operate such establishments nor are there any educational courses held for managers and employees of taverns and cafes....Domestic sewage is discharged into the river....The river has little or no flow during the hot dry summer and fall months, and consequently objectionable conditions exist in the river during this period each year....Garbage is either collected by non-licensed private scavengers or hauled by property owners themselves and disposed of in a city dump.....No local ordinance controls the collection and disposal of the garbage and rubbish....There were numerous flies in and around the dump....It is possible for the dump to be a source of pollution to the lake, especially after heavy rainfall.[41]

When the department received news that the 1951-53 biennial request to the Legislature should ask only for funds needed to continue the present operation plus any special needs incidental to the defense program, the board decided to submit a separate statement of needs. It identified what would be necessary to "establish and operate an adequate public health program" at this time. The projects listed were: alcoholics rehabilitation program; a survey of allergies to study the extent and what can be done to eliminate causative factors; and expansion of the cyanosis study because of an increased interest in "blue babies."[42]

Internal issues at the department during this period included low salaries, problems with the civil service system, personnel shortages, interagency relationships, and lack of centralization of data. The staff were overcrowded in their building on the University of Minnesota campus, and in 1947 the board had submitted a request to the Legislature for a new building. Changes in reorganization, imposed from outside the department, threatened. Some changes, such as moving the responsibility for milk supply to another agency, irked a department that had pioneered the control of milk in its early days.

The Department's Organization and Functions

The board had been established with its chief work the control of communicable disease. By the 1940s, health needs were shifting to better control of chronic disease and accidents, more and better hospitals, adequate provisions for the elderly, and more rehabilitation programs. Some of the resulting organizational changes needed were addressed by the governor's Efficiency in Government Commission, established in 1950. This commission, better known as the "Little Hoover Commission," was evaluating all state agencies, with the intent of improving efficiency and effectiveness.

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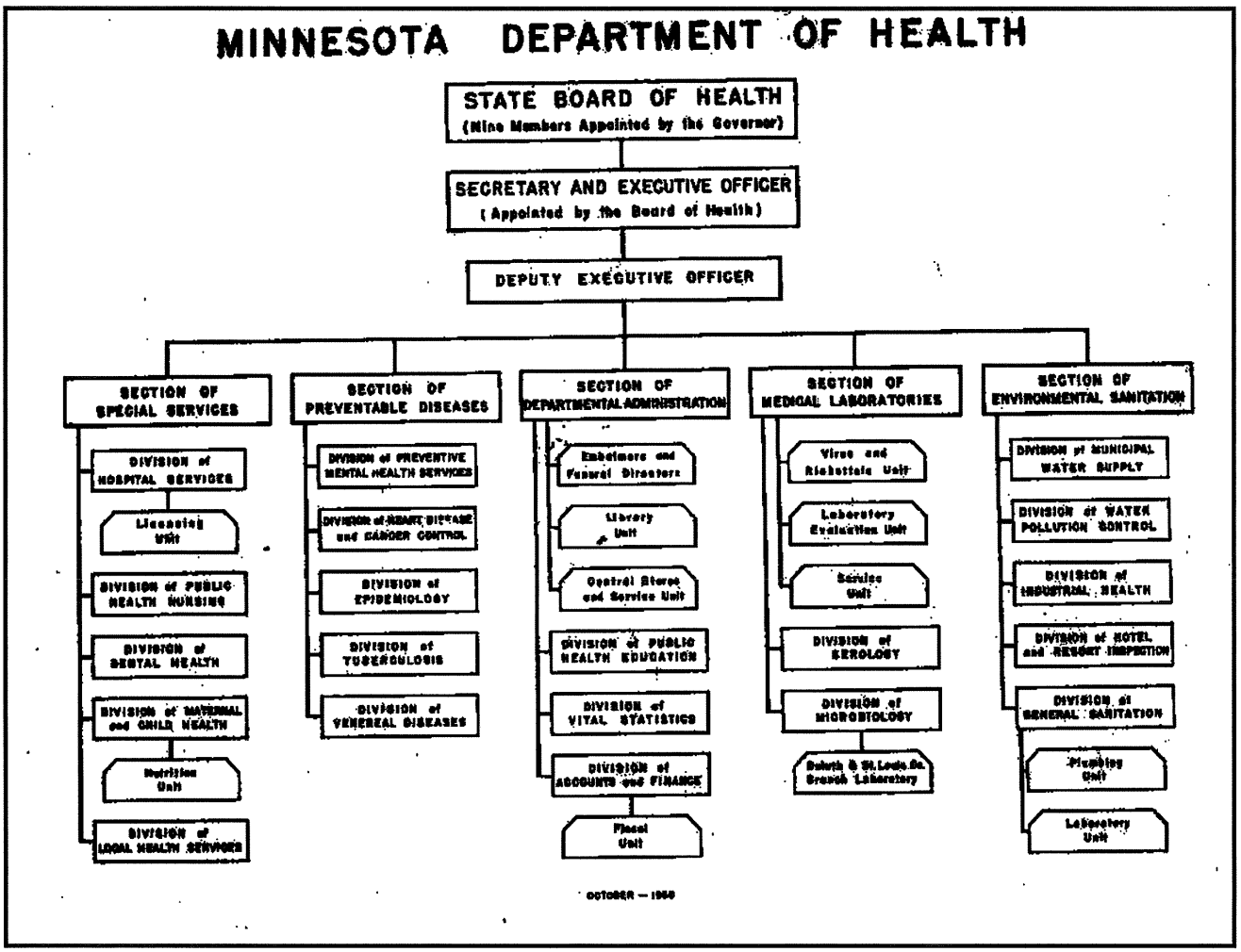
[41] MDH, *Minnesota's Health,* Vol. VI, No. 4, April 1952, p. 4.
[42] BOH, *Minutes*, August 1, 1950.

The “Little Hoover” report produced by the commission noted that the department’s structure was backwards. The main branches of the organization were called “sections,” and subdivisions were titled “divisions.” This wasn’t consistent with other agencies and was confusing, if not misleading. A survey found only two states, Minnesota and Wisconsin, used the term “section” to identify major segments of an organization’s structure. While department employees didn’t strongly oppose the proposed name



Minnesota Department of Health Organizational Chart, 1949

change, there was some resistance. Mr. Jerome Brower, chief of the departmental administration section, commented on the proposed change, “I don’t see where we can benefit by anything of the kind.”

Board members seemed less resistant to the proposed change:

> Dr. Frederick Behmler: "We could go along with them on that and if it makes them feel any better that would be all right."
>
> Brower: "We would have to change our letterhead."
>
> Herbert Bosch: "Couldn't you make this change effective the first of the year, or something so you could use up your stationery? There is something to be said for this change. You might as well bow gracefully to the things that aren't so important and scrap out the things that are important."[43]

Eventually, the change in terminology was made. Sections officially became divisions and vice versa.

The "Little Hoover" commission recommended that the preventable and chronic disease division be renamed disease prevention and control. While the change was not made immediately, the division was renamed several years later.

A new organizational plan reflecting all changes went into effect on January 1, 1953. The new organizational chart created a local health administration section.

Employees

The persons who surrounded Dr. Chesley at the department were a stable, cohesive group. Dr. Robert N. Barr, who became the first deputy executive officer in 1949, had worked with Dr. Chesley for more than 20 years. Jerome W. Brower, chief of the departmental administration section, began work at the department in 1933 as an antitoxin record clerk. Other section (later to become division) leaders in 1949 were:

Dean Fleming, M.D., M.P.H., preventable diseases
Herbert M. Bosch, M.P.H., chief of environmental sanitation
Robert N. Barr, M.D., M.P.H., special services
Paul Kabler, Ph.D., M.D., M.P.H., medical laboratories

Other department unit or section heads in 1949 were:

William Griffiths, M.A., director of public health education
Charles A. Amann, supervisor of embalmers and funeral directors unit
B. J. Estlund, supervisor of fiscal unit
F. Michaelsen, supervisor of central stores and service unit
Eleanor Barthelemy, B.A., B.S. in L.S., librarian
William Griffiths, M.A., acting supervisor of mental health unit
N. O. Pearce, M.D., acting director of cancer control
C. B. Nelson, M.D., M.P.H., director of epidemiology
Hilbert Mark, M.D., M.P.H., director of tuberculosis
H.G. Irvine, M.D., acting director of venereal diseases

[43] BOH, *Minutes*, February 5, 1952.

Marion Cooney, B.A., supervisor of virus and rickettsia unit
Henry Bauer, M.A., supervisor of laboratory evaluation unit
Albert Anderson, supervisor of services unit
Anne Kimball, Ph.D., director of serology
Mary Giblin, M.S., director of microbiology
H. E. Hoff, M.P.H., bacteriologist at Duluth and St. Louis County laboratory
O. E. Brownell, C. E., director of municipal water supply
Harvey G. Rogers, director of water pollution control
Frank L. Woodward, B. E., director of general sanitation
Dean M. Taylor, B.Ch.E., public health engineer in charge of laboratory unit
W. J. Cannon, supervisor of plumbing unit
George S. Michaelsen, M.S., acting director of industrial health
Harold S. Adams, B.S., director of hotel and resort inspection
Arnold B. Rosenfield, M.D., M.P.H., acting director of maternal and child health
Irene Netz, B.S., supervisor of nutrition unit
Helen L. Knudsen, M. D., M.P.H., director of hospital services
Ethel McClure, R. N., M.P.H., supervisor of hospital licensing unit
Ann S. Nyquist, R. N., director of public health nursing
W. A. Jordan, D. D. S., M.P.H., director of dental health
Percy T. Watson, M.D., M.P.H., director of local health services

During the 1940s and 1950s the salary of department employees was low. Renowned and respected Dr. Chesley received an annual salary of $8,000 in 1950. According to the Consumer Price Index, the buying power of Dr. Chesley's salary was equivalent to $55,302.90 in 1999.

Dr. Chesley was underpaid in comparison to other state health officers. In 1950 Montana had just employed a health officer at $12,000 with an annual increase of $1,000. North Dakota paid its health officer $15,000. Wisconsin paid $10,000.[44] In 1950 the governor's annual salary was $12,000; the attorney general received $11,000; the mental health commissioner was paid $12,500; the commissioner of agriculture received $8,500; the head of highways received $9,500, and the state auditor was paid $8,000.

Dr. Chesley's salary was set by legislation. The board made numerous attempts to increase it, and in 1951, the Legislature approved an increase to $11,000.[45]

The board was often frustrated in its attempts to try to increase the salary of department employees to make them more competitive. While salaries were low, however, there were other benefits for employees. One was the opportunity to advance their educations. Every year several employees earned graduate degrees through state financing of tuition, monthly stipends up to three-fourths of their salary and travel expenses. Some education was sponsored through federal sources. Unfortunately, this benefit sometimes resulted in the loss of employees. It was frustrating when a recently educated employee did not return to the department but accepted a higher-paying position somewhere else. One time when it happened, Dr. Chesley said:

[44] BOH, *Minutes*, August 1, 1950, MHS, pp. 434-436.
[45] BOH, *Minutes*, January 25, 1951, MHS, p. 82.

> We spent $3,000 on his stipends and travel when he got his MPH at Chapel Hill. He was under no obligation to return to Minnesota, but it was quite a disappointment because we had made this arrangement. Sometimes I feel that the attitude of Civil Service is simply giving us the permission to give people special training and then they go somewhere else. They keep down ratings and salaries to such an extent that they can find better pay and better conditions and, of course, they go.[46]

Still, when the Legislature opposed the financing of employees' educations, the board fought back. Though it was frustrating to lose recently educated employees, the board strongly believed a good public health system needs well-trained staff. The issue was discussed at a board meeting in 1952:

> Jerome Brower: "They (legislators) have advanced through hard work and they don't see the picture as we are inclined to see it. They can't see why the people with a bachelor's degree or even a master's degree have to be sent away for further training, and our problem is explaining that by giving them additional training they can render better service to the people."
>
> Prof. Herbert Bosch: "I think there is another thing involved. Maybe we are paying too much. Three-fourths of their salary may be too much. Without income tax we are paying his complete salary. I have a feeling that a person should contribute something of his own to his training. I don't think it is obligatory, or even good, for the Board to send a person to school and pay his complete training. In the long run it accrues to the individual's good to go to school."
>
> Dr. Theodore Sweetser: "And he will appreciate it more."
>
> Bosch: "And I agree with Jerry that you shouldn't send every Tom, Dick and Harry. They should be carefully selected."
>
> Charles Netz, PhmD: "If you reduce the stipend maybe they will say, 'To heck with it. I'll keep on with my job.' "
>
> Dr. Ruth Boynton: "If he feels that way, then he shouldn't get it."[47]

The board discussed increasing the training budget. Mr. Brower felt the legislators would not accept such a change.

> Brower: "How do you get the money to train people when you haven't enough money for operations?"
>
> Dr. Robert Barr: "Our answer to that is, if we hadn't trained people we wouldn't have any staff at all."[48]

They agreed it would be difficult to gain legislators' support:

> Brower: "When a man who has no education himself finds that the Department is setting aside $20,000 for training people that already are University graduates..."
>
> Sweetser: "If we had somebody to talk to him and told him, 'We can't keep your people healthy if we haven't got the personnel...'"

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[46] BOH, *Minutes*, February 5, 1952.
[47] BOH, *Minutes*, June 3, 1952.
[48] Ibid.

Brower: "You can't win much in the way of appropriations with that technique."[49]

The board hoped to find funds for increased training somewhere in the budget. Amid other suggestions, Dr. Fleming mentioned the possibility of discontinuing the mobile x-ray units for finding tuberculosis cases.

Brower: "I am sure the legislature would like taking the units out of service and putting the money into training."

Barr: "Maybe we ought to give them the units and tell them to operate them." [50]

By 1952, the department had financed the training of 393 people. This included 31 physicians, 25 dentists, 56 engineers, 240 nurses, 11 public health educators and 30 general people.

The board thought employees at all levels were underpaid as a result of the limitations of civil service rankings. At the July 1953 board meeting the issue was raised again, and there was special concern over the switchboard operator:

Chesley: "Specifically, I am going to speak about one case and that is Avis Nott, our telephone girl over there. I have never seen anyone who compares with her for efficiency and courteous service. She knows how to get everybody. She has had two jobs elsewhere and she came to me the other day and said her classification here is such that she feels she will have to make a change. What has been your experience on requesting classification for this position?"

Brower: "I don't think we have anything in writing on this particular job. The thing is, there is only one Switchboard Operator 2 in the state service and that is the Chief Operator at the Capitol. Everyone else is a 1. I don't see why they can't reclassify it. There is a difference of $25 a month in the two jobs.

Chesley: "Do you think she should remain a 1?"

Brower: "I see no reason why she shouldn't be a II, but Civil Service doesn't understand. I pointed out that, and they say they will come over and survey the job. They say the operator in Public Welfare does comparable work and she is on the same level."[51]

Dissatisfaction with the civil service board and its failure to reclassify employees to adequately compensate them was discussed at the September 1953 board meeting:

Barr: "I said I thought that was right, and there was too much politics mixed with the Director. Civil Service has a board, and the Director of Civil Service is definitely tied in with the Department of Administration. It is not a Civil Service Board but a director who is carrying out the wishes of the Department of Administration."[52]

Prof. Bosch advocated taking professional employees out of classified service or at least studying the possibility of doing so. Dr. Boynton didn't necessarily agree:

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[49] BOH, *Minutes*, June 3, 1952.
[50] Ibid.
[51] BOH, *Minutes*, July 1, 1953, MHS p. 46.
[52] BOH, *Minutes*, September 23, 1953.

> Boynton: "Rather than get all professional people out of classified service, would it be better to get the people up to the salaries where they belong."[53]

A unique feature of many of department employees of the 1940s and 1950s was the experience they had had overseas either with the armed forces, the World Health Organization or in other capacities of international work. In the early 1950s several persons left the department to work overseas. Mr. Harold R. Shipman, acting director of the hotel and resort inspection division, served as sanitary officer of a civil assistance command team in Korea for the American Red Cross.[54] Dr. Anne Kimball, director of the serology division, traveled to Rangoon, Burma, where she worked with the World Health Organization at the Pasteur Institute on congenital syphilis.[55] Mr. Herbert Bosch, head of environmental services, accepted a position with the World Health Organization in Geneva, Switzerland, as its first head of environmental services. [56]

During this period, 1949 to 1955, there were few women in leadership positions in the department. Married women, especially those with children, tended to remain at home. This was reflected in an interchange between one board member and Dr. Henry Bauer, director of the public health laboratories, in 1950:

> Dr. Lester Webb: "Are you maintaining your personnel pretty well?"
>
> Bauer: "The greatest loss in personnel is girls going off and getting married and raising families. I threaten to hire men. When they get married they are stuck."[57]

A few months later Dr. Bauer acknowledged a new challenge when men were needed for the Korean War. Dr. Fleming, director of the preventable disease division, and several other employees were called away. Medical officers in the Navy were at risk for being called out at any time. This resulted in the following conversation at the board meeting:

> Bauer: "Incidentally, you probably have heard me lamenting about all the women in our Section getting married and leaving me to raise families. So I put in men and now look what happens. The Army is going to take them."
>
> Boynton: "That just goes to show, what happens when you start to discriminate."[58]

Finances

The department's budget for the biennium 1949-1950 totaled $1,751,775.48.[59] The expenditures were broken down as follows:

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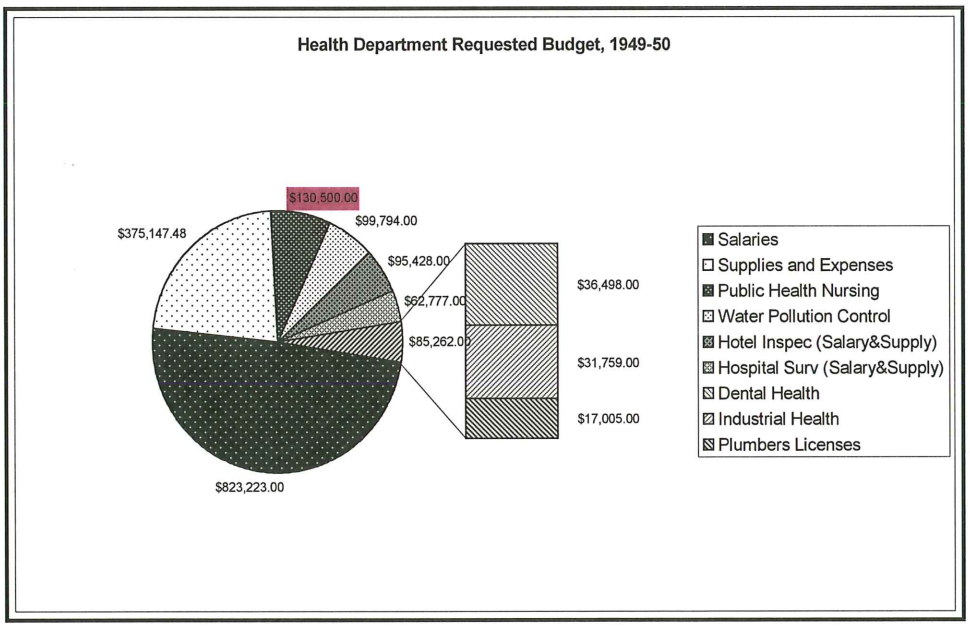
[53] BOH, *Minutes*, September 23, 1953, MHS, p. 45.
[54] BOH, *Minutes*, October 16, 1951, MHS, p. 35-36.
[55] MDH, *Minnesota's Health,* Vol. V, No. 2, February 1951.
[56] BOH, *Minutes*, April 25, 1950, MHS, pp. 102-103.
[57] Ibid.
[58] BOH, *Minutes*, August 1, 1950.
[59] BOH, *Minutes*, January 20, 1949, MHS, pp. 5-6.

Health Department Expenditures, 1949-50

Title of Account	Budget for 1949-50
Salaries	$ 823,223
Supplies and Expenses	375,147
Water Pollution Control	99,794
Hotel Inspection, Salaries	59,970
Hotel Inspection, Supplies & Expenses	35,458
Embalmers licenses	12,010
Plumbers licenses	17,005
Registration of Hospital Sanitarium Heads	2,330
Hospital Survey, Salaries	53,307
Hospital Survey, Supplies & Expenses	9,470
Public Health Nursing	130,500
Dental Health	36,498
Industrial Health	31,759
Federal Aid, Maternity and Infancy Protection	37,518
Federal Aid, Public Health	20,786
W. K. Kellogg Foundation, Field Training	7,000



The most significant change to funding during this period was the increase from the federal government. In 1948 the federal government provided funding for slightly more than 10 percent of the department's expenditures. These expenditures included tuberculosis control, venereal disease and education, protection for maternity and

infancy, emergency maternity and infant care and public health work.[60] The smallest amount was $439.15 for tuberculosis control, and the largest was $111,556.05 for emergency maternity and infant care.

In 1949, the federal government provided $70,536.67 to the department for hospital survey and planning, as part of the Hill-Burton Act. The following year, 1950, the amount was increased to $1,252,866.54, becoming the department's single largest expenditure. Expenditures of the department doubled from 1949 to 1950, with the federal government now providing nearly 50 percent of the funds.[61] Annual payments from the Hill-Burton program ranged from $613,170.69 to $3,955,997.07 over the five-year period ending in 1956.[62] Federal funding for a large percentage of department programs has continued through the present.

In the 1950s, board members weren't certain if they liked this new trend of federal funding. They recognized some of the potential problems. One was the failure to provide continued funding once a program was implemented. At the April 1951 board meeting one member expressed his concern:

> Netz: "...the Federal government has done that in other fields. They start the things, and then let the State hold the bag."[63]

At the July 1951 board meeting, when some expected federal funds were cut, Dr. Sweetser made it clear he didn't think it was a problem:

> Sweetser: "I'm all in favor of people getting along without any Federal money at all, so it is all right with me."[64]

A Multitude of Activities

Based on identified and perceived needs, the department initiated many activities, all designed to improve the health of the population.

One public health activity that was unique to this time, were preparations for dealing with the casualties and health problems created by an atomic attack. The threat of an atomic attack was felt throughout the nation, and federal civil defense programs were implemented. The board had the main responsibility for planning and preparing emergency medical services that would be needed in the event of such a catastrophe. Facilities to handle casualties were identified, a blood bank was organized, equipment was stockpiled throughout the state, and professionals and laypersons were educated about radiation and its effects.

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[60] *Report of Public Examiner on the Financial Affairs of Department of Health, Years Ended June 30, 1948, 1949, 1950 and 1951.*
[61] Ibid., p. 5.
[62] *Report of Public Examiner on the Financial Affairs of Department of Health, Five Years Ended June 30, 1956, p. 4.*
[63] BOH, *Minutes*, April 30, 1951, MHS, p. 86.
[64] BOH, *Minutes*, July 23, 1951, MHS, p. 226.

Board members were ever mindful of the need to be prepared for an atomic attack. At one meeting Dr. Sweetser commented on the location of the hospitals:

> As I understand it, that Hennepin County Central Medical Center is all going to be built down around where St. Barnabas and Swedish Hospital are now. You all saw the Sunday's paper and the question of whether we are a target for atom bombs or not, and I couldn't help but think that here are the flour mills and here is the center where these hospitals are going to be built, and what is the use of building your hospital center in the area that is going to be hit...The Federal government and everyone else is worried about hospitals in case of attack and then they put them right where they would be the most liable to get hit.[65]

(Note: Chapter 4 describes the department's civil defense program in greater detail.)

A large activity of the department's was the administration of federal grants for new hospitals or remodeling of hospitals. The board was the designated agency for handling federal Hill-Burton funds. The department created a plan that identified priority areas. For the next 25 years, under the capable leadership of Dr. Helen Knudsen and Dr. Robert Barr, the board would play a pivotal role in determining which areas of the state would receive funding for health facilities.

(Note: Chapter 6 describes the department's role in the Hill-Burton program in greater detail.)

In the 1940s and 1950s, the department began activities in the areas of heart disease and cancer control. Heart disease and cancer had become the leading causes of death among Minnesotans. A cancer control program directed by Dr. N. O. Pearce was begun in 1947. Grants from the U.S. Public Health Service made the creation of the division (later named "section") of heart disease and cancer control possible in 1949. This division worked closely with the Minnesota division of the American Cancer Society and the Minnesota Heart Association. The division coordinated information opportunities for health professionals, and began a study of rheumatic fever, which was one of the leading causes of death and disability among children. Control was difficult, as the exact cause of the disease was not known, and symptoms resembled less serious conditions.[66] The tuberculosis mass-screening program was utilized, to conduct a pilot study of case finding for cancer and heart disease in two counties.

The department tried to develop more programs in mental health, alcoholism and the misuse of drugs. The governor, popular Luther Youngdahl, showed strong interest and support in these areas, particularly mental health. Funding for state programs was appropriated, but most of the programs were placed in other agencies.

While chronic diseases were beginning to attract more attention, several communicable diseases were not yet under control. Of particular concern at this time was polio, and the department played a significant role in the development of polio vaccine.

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[65] BOH, *Minutes*, September 26, 1950.
[66] MDH, *Minnesota's Health,* Vol. III, No. 9, September 1949, pp.1-2.

(Note: Chapter 2 describes the department's role in typhoid, brucellosis, tuberculosis and other communicable diseases in greater detail.)

(Note: Chapter 3 describes the department's role in polio in greater detail.)

Careful records of health statistics were kept, and the collection of data for public health measurements was enhanced in 1949 when all babies born in Minnesota, as in every other state, were given birth numbers. The first number, "1," indicated the United States, the second number, "22", indicated Minnesota, the next two digits indicated the year, and the next six indicated the order of birth in the county where the baby was born. Each county was assigned a block of numbers. The number on the birth certificate of the first child born in Minneapolis through this new national plan was 122-49-000001. [67]

The president of the board described it:

> Magath: "The Federal government has undertaken to give each person in the United States a number. It isn't quite the same number you get when you go to prison, but a similar number." [68]

Getting the Message Out

Television was relatively new in 1949, and the department recognized it as a useful medium to spread the public health message. The first live television broadcast in the department's history occurred January 3, 1949.[69] KSTP-TV in Minneapolis-St. Paul showed a film on the care of premature babies, and this was followed by an interview with a department consultant on community health. The topic was the state's programs on maternal and child health. Regular weekly programs of films, sometimes followed by interviews, continued on Monday evenings.

The department began its first regular radio broadcast in its history on February 14, 1949.[70] Every Monday morning at 11:15 a.m. on station KUOM, Dr. Robert Barr would speak to listeners about public health legislation, mental health, vital statistics, epidemiology, health days, health councils, and a host of other topics.

Dr. Barr's radio program was expanded in 1950 through the availability of funds from the mental health project. Prior to Dr. Barr's weekly broadcast, Dr. Roger W. Hwell,

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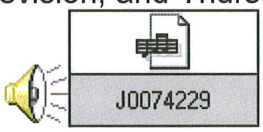
[67] MDH, *Minnesota's Health,* Vol. III, No. 3, March 1949, p. 1.
[68] BOH, *Minutes*, January 20, 1949.
[69] MDH, *Minnesota's Health,* Vol. III, No. 1, January 1949, pp. 3-4.
[70] MDH, *Minnesota's Health,* Vol. III, No. 2, February 1949, p. 2.

associate professor of psychiatry at the University of Minnesota, talked about mental health.[71]

A new radio series, beginning March 9, 1955, was titled "Public Health Is People." A feature of Bee Baxtur's program, the KSTP broadcasts were seen and heard Wednesdays on television, and Thursdays on radio. The programs from March through June 1, 1955 were: 

What Public Health Is and What the Health Department Does – Robert Barr, M.D.

Hospitals for Today and Tomorrow - Helen L. Knudsen, M.D.

Finding Disease with Microscope and Test Tube - Henry Bauer, PhD

How We Control Communicable Disease Today - Dean S. Fleming, PhD

A Day in the Life of a Public Health Nurse - Alberta Wilson, R.N., Dorothy Hagland, R.N.

The Story of Public Health in Minnesota - Albert Chesley, M.D.

Meeting Public Health Problems in Urban Areas - Karl Lundeberg, M.D.

Saving the Lives of Mothers and Infants - A. B. Rosenfield, M.D.

At the same time, "Health – Wanted," a series sponsored by a Twin Cities health education group, was shown on WTCN-TV on Saturdays.[72]

Outreach to professionals and the public didn't stop with radio and TV. Beginning in 1947, monthly newsletters were sent to 10,000 physicians, dentists, sanitary engineers, public health nurses, school personnel, libraries, health and welfare associations, members of the state Legislature and other groups. [73] Within its four pages, the newsletter, *Minnesota's Health,* contained photographs and graphs and updated readers on public health activities in Minnesota. First edited by Netta W. Wilson, the bulletin contained information on how the recipient could be involved in promoting and maintaining good health in each person's community.[74] When Ms. Wilson left the department to take a position in health education in Oregon, Marie Ford became editor.[75] Together, the two women left a legacy that well documented the department's history for several decades.

Another newsletter, *School Health News*, was published jointly by the departments of Health and Education. Begun in 1947 and continuing through the 1960s, *School*

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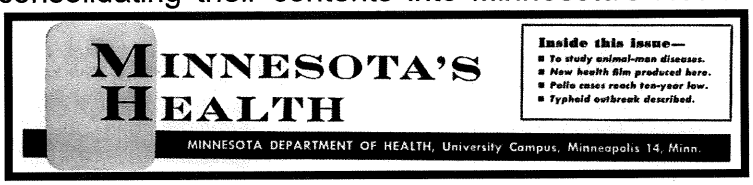
[71] MDH, *Minnesota's Health,* Vol. IV, No. 2, February 1950, p. 4.
[72] MDH, *Minnesota's Health,* Vol. 9, No. 3, March 1955, p. 4.
[73] MDH, *Minnesota's Health*, Vol. 1, No. 1, January 1947, p. 3.
[74] Ibid.
[75] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1955, p. 4.

Health News was distributed to all school health directors to keep them informed of resources, as well as to exchange ideas and information. This newsletter was published three times a year in October, January and April.

Three nursing newsletters were published for several years until the department decided to reduce duplication by consolidating their contents into *Minnesota's Health* and the newsletter of the Minnesota Association of Nursing Homes. *What's Going On*, produced by the department's public health nursing section, and *Nursing Home News*, produced by the department's hospital licensing unit, were distributed from 1948 to 1952.[76] [77] *Nursing in Industry* was produced until 1952.[78]


MINNESOTA'S HEALTH

Inside this issue—
- To study animal-man diseases.
- New health film produced here.
- Polio cases reach ten-year low.
- Typhoid outbreak described.

MINNESOTA DEPARTMENT OF HEALTH, University Campus, Minneapolis 14, Minn.

The emphasis on distributing information matched that of Dr. Hewitt, the department's first health officer in 1872. Dr. Hewitt, a strong supporter of outreach and education, wrote:

> ***"Our library ought to be representative of all that is valuable in the practical departments of public health...It has been collected chiefly to serve the purposes of our office and laboratory, and is a fair working collection. The literature of hygiene, both as a science and an art, is growing very rapidly, and we hope to be enabled to keep our library fairly abreast of current knowledge. We have such books of reference as are needed by health officers, and are glad to assist them in this way..."***
>
> **Dr. Charles Hewitt**

Like Hewitt, department leaders in the 1940s and 1950s encouraged people to contact the department. One newsletter invited professionals and lay persons to ask for help at the library:

> A nursing advisory committee studying rheumatic fever, a physician needing articles on trichinosis, a mother desiring material to assist in training a child with spastic paralysis, a school boy writing a theme on smallpox vaccination – these turn to a public health department for assistance.[79]

The department played a strong role as educator, such as distributing guidelines to persons who had booths at county and state fairs, providing information on fly control, distributing handouts on recommended industrial practices, and providing information on the status of health facilities.[80]

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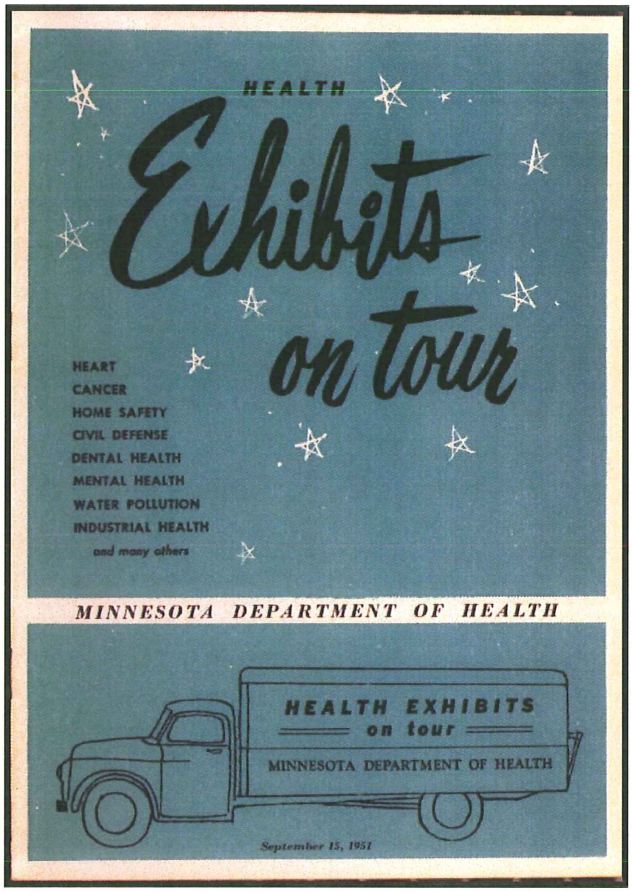
[76] MDH, *What's Going On*, March 1952, PHN-479.2.
[77] MDH, *Nursing Home News,* Volume III, No. 4, October, November and December 1951, p. 1.
[78] MDH, *Nursing in Industry,* Vol. 1, No. 1, October 10, 1944, PHN-95-1, p. 1.
[79] MDH, *Minnesota's Health,* Vol. II, No. 8, August 1948, p. 2.
[80] BOH, *Minutes*, August 1, 1950.



In addition to using radio, TV and the newsletter, the department traveled directly to the people with "Exhibits on Tour." A health caravan with displays on heart disease, cancer and several other public health problems visited all parts of the state. Special attention was given to communities with populations of 2,000 or less who may not have easy access to the information.

In 1948 the department began holding "health days" to bring together persons interested in improving the health of a particular community. These continued and focused on an exhibits-on-tour program. The first health day was held in Worthington on February 23, 1948. The counties that helped with the planning were Nobles, Jackson, Cottonwood, Murray, Rock and Pipestone. The day included three panel discussions and an evening meeting addressed by Gov. Luther W. Youngdahl. Panel discussions were led by Dr. Gaylord W. Anderson, director of the School of Public Health at the University of Minnesota; Dr. Robert Barr; and Dr. Dale B. Harris, acting director of the Institute of Child Welfare at the University of Minnesota. The topics for the first event at Worthington were community health problems, farm and home safety and mental health.[81] In 1952, rural health days were held in Rosemount, Winthrop, Arlington, Shakopee, Pine Island and Wabasha.[82]

Success with health days led the department to focus on a particular topic. The first mental health day was held in Albert Lea on September 23, 1949 and was attended by both professionals and lay persons. Gov. Youngdahl spoke at the event and described the state's mental health program, which had begun July 1, 1949.[83] The following year, Gov. Youngdahl signed a proclamation naming April 23-29 as "Mental Health Week." A series of events were held all over the state.[84]

Further outreach to professionals was offered through a unique postgraduate professional education program. For two evenings a week over an eight-week period, seminars on heart disease, cancer and psychosomatic medicine were held in communities. The educational programs were jointly sponsored by the department,

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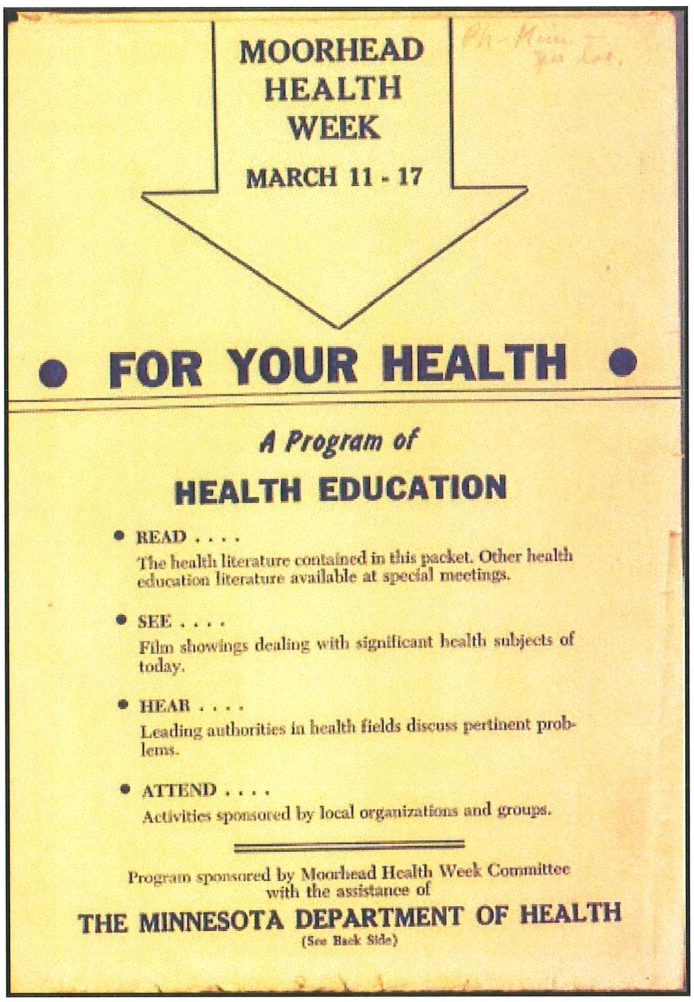
[81] MDH, *Minnesota's Health,* Vol. II, No. 2, February 1948, p. 1

[83] MDH, *Minnesota's Health,* Vol. III, No. 10, October 1949, p. 1.
[84] MDH, *Minnesota's Health,* April 1950, Vol. IV, No. 4, p. 1.

which financed and organized the program, and the schools of medicine, dentistry, nursing, pharmacy and public health at the University of Minnesota; the state medical, dental, nursing, and pharmaceutical societies; the Minnesota division of the American Cancer Society; the Minnesota Heart Association; and the Minnesota Mental Hygiene Society. Dr. George N. Aagaard, director of postgraduate medical education at the University of Minnesota, organized the speakers.[85] The first seminar was in Bemidji, with the first class held September 27, 1949.[86] By 1951, seminars had been held in Albert Lea, Austin, Bemidji, Crookston, Duluth, Fergus Falls, Mankato, Moorhead, St. Cloud, Slayton, Virginia, Willmar and Winona.[87]

An outgrowth of the eight-week seminars was a series of health weeks for non-professionals, organized by citizen groups. The first health week was held in Virginia, Minnesota, during the week of October 22-28, 1950. The Virginia Health Council sponsored the events that included exhibits on cancer, rheumatic fever, sanitation, accident prevention, tuberculosis, industrial health and mental health. The American Legion auxiliary presented a film on breast cancer self-examination.[88] Like the seminars, the health weeks were successful, and other towns wanted to organize them. Crookston and Willmar had health weeks in the spring of 1951.


MOORHEAD
HEALTH
WEEK
MARCH 11 - 17

FOR YOUR HEALTH

A Program of

HEALTH EDUCATION

- READ . . . .
  The health literature contained in this packet. Other health education literature available at special meetings.
- SEE . . . .
  Film showings dealing with significant health subjects of today.
- HEAR . . . .
  Leading authorities in health fields discuss pertinent problems.
- ATTEND . . . .
  Activities sponsored by local organizations and groups.

Program sponsored by Moorhead Health Week Committee
with the assistance of
THE MINNESOTA DEPARTMENT OF HEALTH
(See Back Side)

At the department's encouragement, more and varied public health events were organized by local organizations. In Morrison County, public health nurse Margaret Momberg organized a mock trial at the county courthouse. Community members were charged with failing to do all they could for public health. The state's star witness was "Mrs. Annie Do-Nothing" who never sent her children to the dentist, didn't have them immunized and never helped promote public health programs. She was pronounced guilty and sentenced to many years of poor health.[89]

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[85] MDH, *Minnesota's Health,* Vol. IV, No. 2, February 1950, pp. 1-2.
[86] MDH, *Minnesota's Health,* Vol. III, No. 10, October 1949, p. 3.
[87] MDH, *Minnesota's Health,* Vol. V, No. 4, April 1951, pp. 3-4.
[88] MDH, *Minnesota's Health,* Vol. IV, No. 11, November 1950, p. 1.
[89] MDH, *Minnesota's Health,* Vol. IV, No. 4, April 1950, p. 3.

Spurred by the success of the seminars for professionals, in 1952 the department joined with the Minnesota Medical Association, the University of Minnesota School of Medicine, the Minnesota Heart Association and the Minnesota Cancer Society to offer a new informal educational program for physicians. Pathological conferences on cancer and heart disease were scheduled as part of regular hospital staff meetings. At each session a guest consultant reviewed case histories of cancer and heart patients and discussed diagnosis and treatments with those in attendance.[90]

Throughout these years, the department regularly exhibited at the State Fair. The theme of the department's 1949 exhibit was mental health, and in 1950 it was environmental sanitation.

Public Health: Challenges in Getting Support

While the department did an outstanding job of promoting public health issues, it wasn't so sure it promoted itself or public health adequately. It sensed a lack of support from legislators who probably didn't understand what the department was doing and trying to do, as indicated at this discussion at a board meeting in 1950:

> Netz: "I think you are getting enough material out (publicity about the Minnesota Department of Health) but people aren't cognizant of who is doing the work. This Department has worked along for years and years quietly and efficiently and never made any fanfare, etc. I think we should give some study to that in the future and see if our Public Health Education Division couldn't some way point up something to emphasize the work of the State Department of Health surreptitiously now an then. I have no suggestions to make, but I feel the Department does not get the credit they deserve from the people of the State."
>
> Barr: "We have gained a great deal of assistance by giving all the credit we could to the group working with us, and we have gotten a great deal more accomplished by doing so."
>
> Netz: "Do we get more money from the legislature?"
>
> Barr: "I don't think so."
>
> Netz: "Your policy is all right. I don't criticize that. But if the individual legislators were more aware of what is being done....They question whether this work is necessary at times or that is necessary. If there was some way of making the people more cognizant of what is being done."[91]

At another meeting the board discussed how it could get its message to the Legislature:

> Boynton: "I think Professor Bass is so right when he says that the Legislature is more interested in people than they are in laboratory figures. The League of Women Voters brought Sen. Shipstead over one day to get him to support the Sheppard-Towner Act. All I did was pull out of the file two or three letters from women who had received some of the material that had been sent out. That was all that was needed. That convinced him more than all the talking anyone

[90] MDH, *Minnesota's Health,* Vol. VI, No. 11, December 1952, p. 6.
[91] BOH, *Minutes*, November 14, 1950, MHS, p. 629.

could do. I think if we can, not only in tuberculosis but as many of our services as possible, make the Legislature see what it means to the people of the state it will have a salutary effect on our appropriation."

Sweetser: "May I move that Mr. Bass be a committee of one to make some pilot studies on this personalization stuff?"

Boynton: "I would like to suggest that our Division of Public Health Education get busy and figure out ideas how this might be presented." [92]

Challenges of Working with Others, Getting Support for Public Health

Interagency working relationships and the politics of state government were a challenge to the board. One example is its effort to keep mental health activities in the department. Against the board's wishes, funds through the federal Mental Health Act of 1946 were given to the Department of Public Institutions. President Thomas Magath told the board he did everything he could to prevent it. Gov. Youngdahl had assured him during the campaign that there would be no withdrawal of funds from the board, but in the end the mental health commissioner was given responsibility for administering, expending and distributing federal funds designated for mental health activities.

At its May 5, 1949, meeting, the board wondered if there was a way to have a joint program with Public Institutions.

Magath: "Well, it would seem to some of us at least that we would probably always be in hot water and it would depend on the personalities involved, if our representative here was a person of disagreeable personality or vice versa. I don't know if it will be possible for two state departments on the same level ever to get together. On this water pollution control situation that was saved not by cooperation between the departments but by setting up a definite commission."[93]

He continued:

Magath: "The Governor, of course, has his troubles and I am sympathetic toward them, just as we have ours, but I think the thing that I find it most difficult to understand is why he didn't call in the only agency in the state who has done anything about mental health for at least an expression of opinion. He was under moral obligation to give the State Board of Health an opportunity to express an opinion as to whether they thought the bill was good, bad or indifferent. He didn't do that, and that is my chief complaint."

Chesley: "You must remember that he was bedeviled from all points of view. If there was any attempt to change it he was afraid he might lose the whole thing."

Magath: "He should have thought of that long before he got himself out on a limb."[94]

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[92] BOH, *Minutes*, November 14, 1950, MHS, pp. 485-489.
[93] BOH, *Minutes*, May 5, 1949.
[94] Ibid.

The board had an opportunity to receive $29,667 for mental health activities, channeled through the commissioner of Mental Health. At a meeting in Duluth on June 13, 1950, board members discussed what they wanted to do:

> Boynton: "The thinking of the Board in times past is that the Board has never been in a position where any other State department has dictated to it what it shall do. I am sure the Board does not want to be in that position and I don't mean to infer that is what it wants to be. But I want some assurance of non-interference and cooperation and my feeling is that Dr. Rossen's reaction is that he wants that type of cooperation. If we were to ask another agency for permission to expend money, that would be intolerable. As to continuity, again I got the impression that the opportunity for cooperation and continuity was good and was there. We must have Board action on accepting these funds and then after that if we should continue the division as such." [95]

Other areas where the board encountered many challenges in working with others were certification and licensing. At the August 1950 meeting the board discussed whether or not tests should be given at times other than the scheduled times. Mr. Woodward, director of environmental sanitation said: "Usually the day after the examination we get a request to license someone. Personally, I think they wait intentionally." [96]

Once the environmental sanitation section received a request from the governor's secretary to test a man who wanted a temporary permit. When the section said it did not give temporary permits, the governor made a special dispensation so it could. A special examination was held. Mr. Woodward gave the results: "The Governor's man got 60, which is not a passing grade. It is rather difficult when we are asked to change a precedent because of a request like that."[97]

The board wrestled with how to get public and legislative support for public health activities, their relationship with other agencies, public apathy to immunizations when a disease seemed controlled, waning interest of the Legislature in a public health problem once a crisis was past, how to get the public health message across similar issues to those that faced public health workers in 1999.

The board recognized its need to coax the public and cautiously sell its public health messages. Referring to sewage disposal systems in municipalities, Dr. Magath explained the approach used:

> The Board has brought about a policy of taking due time about these big things and not trying to push them so fast that you get antagonism and get nothing done. Eventually they will fall into line, whereas if you push them they get their backs up and will do nothing. While the State Board of Health has broad police powers, nobody wants to attempt to assert them and risk a decision that might be very unfavorable and maybe disastrous. It is unthinkable that you can stop the sewage disposal of a municipality even if it is improper. While you have the apparent authority to do so, the actual carrying out of such a plan would be unthinkable. We try to convince the municipality that it should be improved. That is what we have done.[98]

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[95] BOH, *Minutes*, June 13, 1950, MHS, pp. 249-250.
[96] BOH, *Minutes*, August 1, 1950, MHS, pp. 346-347.
[97] Ibid.
[98] BOH, *Minutes*, January 20, 1949.

Occasionally the board made mistakes. In one instance it had to respond to a chiropractor who complained about the department's actions. The chiropractor sent blood from a patient to the Minneapolis Health Department, and the results were sent to the Selective Service. The Selective Service informed the state Health Department of the findings, and the department wrote the patient that he should see someone other than a chiropractor. The chiropractor had already referred his patient to a medical doctor and took exception to the department's action. Dr. Sweetser ended the discussion with his solution to the problem:

> ***"Every once in awhile I think of what an old surgeon said to me in the war. The best way of closing up a communication is to tell them what you have done, that it might be improved upon, and hope that you will not get into any such difficulty again. We have usually felt that that straightened everything out and everyone was happy."***[99]
>
> **Dr. Theodore Sweetser, 1952**
> **State Board of Health Vice President**

Board members did not have an easy task. Their roles and positions were captured in the statement made by Dr. Magath, 84th member and 15th president of the board, when he announced his resignation on December 16, 1949, after serving on the board for 12 years:

> I have always had a philosophy about that kind of thing that after you have held a public job like this for a certain length of time it is better to get out. It is a question of how long you can be of use to an organization. You have to do things that won't please a lot of people because it is your duty, and ultimately you build up enough opposition so that it is better to get out after you have served your term and let some one come in fresh.[100]

End of 34 Years as Health Officer

Dr. Chesley was unusual in that respect. Despite working for the department for more than 50 years, he never seemed to build up opposition. By the time of his death on October 17, 1955, he had received almost every honor that could be received in public health. The last was one of the highest awards in public health, the Sedgwick Memorial, which was awarded to him by the American Public Health Association in 1955.

Dr. Chesley didn't live to receive the Sedgwick Award at the ceremony. Taken ill in October, he entered St. Mary's Hospital in Rochester. Though hospitalized in Rochester, he continued his public health work, writing letters to friends about public health problems the day before he died.

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[99] BOH, *Minutes*, February 5, 1952.
[100] BOH, *Minutes*, December 16, 1949.

Dr. Chesley's last visitor was Dr. Helen Knudsen. She brought him flowers, to which he said, "You bring flowers to dead people. I'm not dead yet."[101]

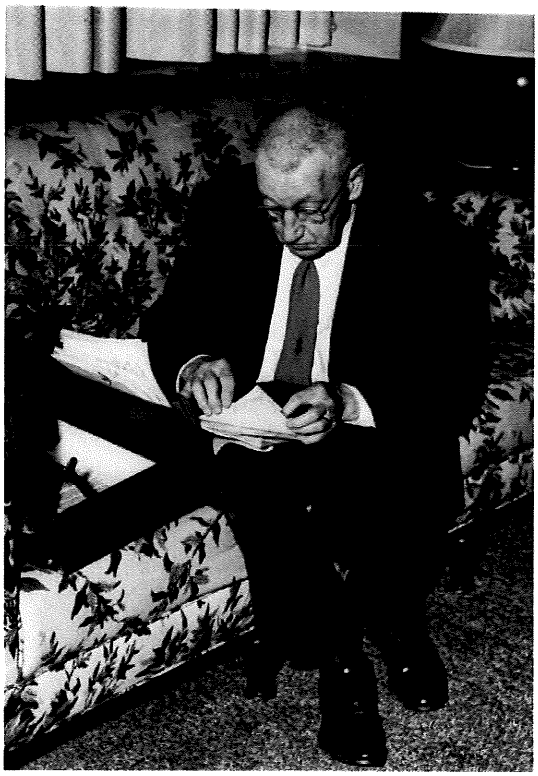
The Sedgwick Award was accepted on behalf of Mrs. Chesley by Dr. Barr in 1955. At the presentation Dr. W. G. Smillie described Dr. Chesley:

> He molded state health policy of this nation through many critical years. The many honors he received, including the presidency of the American Public Health Association in 1930, were accepted with quiet, shy embarrassment. He was the most modest of men. [102]

Referring to his years with the state and Territorial Health Officers Association, Dr. Smillie said:

> He was the Association. He gave wise guidance to a whole generation of young, inexperienced physicians who were catapulted into the great responsibilities of state health officer in one of the various states. Dr. Chesley wrote to them all. Thousands of letters.[103]

At the ceremony, Dr. W. P. Shepard added:



> Perhaps his greatest and least recognized service was to the medical profession of his state and the nation, gradually gaining their support and understanding of the principles of public health, and gradually teaching the public what to expect of their doctor. None can name the thousands living today who owe their lives, quite unknowingly, to Albert Justus Chesley, M.D. They, their children, and their children's children are living proof of the eternal worth of this man's life. [104]

At his death, Dr. Gaylord Anderson of the University of Minnesota School of Public Health, spoke of Chesley:

> To all persons in public health, Dr. Chesley represented and personified the highest ideals of public service. His unselfish and tireless devotion to the cause to which he had dedicated his life set a pattern of public service surpassed by no one. Throughout the nation public health workers will recognize the passing of one of the noblest of all.

To those of us in the School of Public Health, Dr. Chesley represented in a very special way not only an inspiring leader and a dear friend but also one to whom we are all indebted for the establishment of the School. Without his leadership, interest and support, the program in public health at the University could never have been started and developed.[105]

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[101] Interview with Dr. Helen Knudsen, February 1999.
[102] MDH, *Minnesota's Health,* Vol. 9, No. 10, December 1955, p. 1.
[103] Ibid.
[104] Ibid.
[105] MDH, *Minnesota's Health,* Vol. 17, No. 10, December 1963, p. 1.

During the 34 years Dr. Chesley served as secretary and executive officer of the board, he never missed a single board meeting. The first board meeting he missed was the one that was held in the back of the church following his memorial service on October 19, 1955. That short meeting was held to designate Dr. Robert Barr as acting secretary and executive officer.

The Albert J. Chesley Memorial Fund for a lectureship in public health was established at the University of Minnesota.

Albert Justus Chesley Award

Recipients of the Albert Justus Chesley Award, presented at the Minnesota Public Health Association annual meeting, have included:

1961 – Boris L. Levich	1980 – Frances Decker
1962 – Mario Fischer, M.D.	1981 – Donna Anderson
1963 – Ruth Boynton, M.D.	1982 – Robert Hohman
1964 – Frank Krusen, M.D.	1983 – Hal Leppink, M.D.
1965 – Laura Hegstad	1984 – No Award Given
1966 – Viktor Wilson, M.D.	1985 – Paul Schuster
1967 – Myhren Peterson	1986 – No Award Given
1968 – Abraham Rosenfield, M.D.	1987 – No Award Given
1969 – Stewart Thompson, M.D.	1988 – Arvid Houglum, M.D.
1970 – William Jordan, D.D.S.	1989 – Edward Ehlinger, M.D.
1971 – No award given	1990 – Esther Tatley
1973 – Alberta Wilson	1991 – Steven Mosow
1974 – Fannie Kakela/Grace Stolze	1992 – K. C. Spensley
1975 – Robert Hiller/Arlene Lehto	1993 – Gayle Hallin
1976 – Robert Schwanke	1994 – Charles Oberg, M.D.
1977 – Gaylord Anderson	1995 – Lynn Theurer
1978 – Henry Bauer, Ph.D./Katherine Gram	1996 – Malcolm Mitchell
1979 – Warren Lawson, M.D./Richard Bond	1997 – Deborah Plumb
	1998 – Barbara Hughes

The first floor conference room of the Minnesota Department of Health Building at 717 Delaware Street S.E. was dedicated to the memory of Dr. Chesley on Monday, February 3, 1986, and renamed the "Chesley Room."[106] At the dedication, Buddy Ferguson, public information, prepared remarks that were presented by Fred King of vital records:

> Today we are marking a very special occasion here at the Minnesota Department of Health. It is my privilege, today, to announce the renaming – and rededication – of the room in which we are holding this observance.
>
> It is here, in this room, that we conduct some of the most important business of public health in Minnesota.
>
> It is here that some of our state's most distinguished experts, public officials and private citizens have gathered, to discuss issues that affect the health of all people.
>
> In this room, we have addressed many of the major health concerns of our time... from AIDS....to the future of our health care system....and from environmental health problems....to the needs of the local public health agencies in the State.
>
> In this room, we have responded to the State's mass media, whenever events have focused public attention on the Department and its work.
>
> It is only fitting, then, that this room be designated to honor one of the great leaders and true pioneers of public health in Minnesota: Dr. Albert J. Chesley.
>
> Dr. Chesley's career at the Department began in 1902 and ended in 1955, spanning nearly half of our agency's 114-year history. He headed the Department from 1921 onward --- longer by far than anyone else who has held that position.
>
> In many respects, Dr. Chesley's tenure here was a time of transition, which truly brought public health into the modern era. Dr. Chesley presided over many of the dramatic accomplishments – so familiar to us by now – that marked public health during the first half of this century.
>
> When Dr. Chesley first came to the Department, more than four out of every ten children born in Minnesota died before reaching the age of five. By the end of the Chesley era, it was less than three out of every 20. The infant mortality rate dropped even more dramatically during that time, from 120 deaths per thousand live births, to about 20. In the beginning, diseases like influenza, pneumonia and tuberculosis were among the leading causes of death. By the end, deaths from those diseases were rare.
>
> Under Dr. Chesley's leadership, the shape of the Department itself also changed. The agency moved, for the first time, into areas that have since become basic to public health – areas like maternal and child health, occupational health, public health nursing and health education.
>
> Dr. Chesley left us with a much different public health agenda than the one he faced in 1902 – or even 1921. He also left us with a proven record of success, and high expectations of the future. His legacy is still with us, as we proceed with the still formidable task of protecting Minnesota's health. And much of that work will continue to take place right here – in the Chesley Room.[107]

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[106] MDH, *In Common*, Vol. 3, No. 9, February 28, 1986, p. 1.
[107] Ibid., p. 1-3.

Chapter 2

Conquered and Almost-Conquered Diseases

Smallpox
Typhoid
Diphtheria
Whooping Cough
Tuberculosis
Brucellosis
Rabies
Parrot Fever

"If we are to maintain the gains made, we must do more and more immunizing, since it is impossible to completely eradicate these diseases." [108]

Dr. Dean Fleming
1958

Dr. Dean Fleming
Director of Disease Prevention and Control, 1947 to 1975

Minnesota Health Department employee, 1937 to 1975

During the 50-year period from 1949 to 1999, the dramatic decline in deaths from communicable disease continued its downward trend in Minnesota. There were no cases or deaths from smallpox during this period, and by 1999 cases of polio or diphtheria had dropped almost into oblivion. Cases of whooping cough, typhoid fever and measles still occurred but deaths were rare. The last reported death from one of

[108] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 1.

these once common childhood killers was reported in 1980. Through public health measures, cases of brucellosis, rabies and parrot fever were also almost drastically reduced or eliminated.

Dramatic drops in the number of tuberculosis cases occurred in the state during the 1950s but underwent resurgence in the 1980s and 1990s. Similarly, the incidence of sexually transmitted diseases declined but began increasing in the 1960s and 1970s.[109]

This chapter describes some of the major communicable diseases that disappeared or declined substantially in Minnesota between 1949 and 1999.

Smallpox

By 1949, there were no cases of smallpox in Minnesota. More than 50 years earlier the disease was so prevalent in the state that Dr. Hewitt, the first secretary and executive officer of the State Board of Health, felt compelled to travel to the Pasteur Institute in France to learn how to make smallpox vaccine from Dr. Louis Pasteur.[110] In his own laboratory in Red Wing, Minnesota, in 1890, Dr. Hewitt began producing smallpox vaccine that he distributed to health officers and doctors throughout the state.[111] The disease peaked in 1924 with 3,125 cases and 307 deaths, before it began declining.[112]

- The last death from smallpox in Minnesota was in 1941.
- The last case of smallpox in Minnesota was in 1947.[113]
- Early in the 1970s Minnesota children no longer received smallpox vaccine as part of their routine immunizations.
- The last case of smallpox in the world was in Somalia in 1977.

Dr. Hewitt's efforts and those of many other public health people contributed to the eradication of smallpox in Minnesota and worldwide.

Typhoid Fever

In 1949, Minnesota reported only one death from typhoid fever, a disease that was once one of the leading causes of death in the state. Although there was an increase in the number of cases from 1948 to 1949, they resulted from vacationers who brought typhoid back from Mexico.

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[109] Sexually transmitted diseases are covered in Chapter 14.
[110] Philip Jordan, *The People's Health,* St. Paul, 1953, pp. 51-53.
[111] Ibid., pp. 53-54.
[112] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 1
[113] Ibid.

A public health challenge in Minnesota that has been conquered

"The house was dark but upon knocking loudly on the one door of the log cabin a woman's voice asked what was wanted. On my replying that I was a doctor come to care for the smallpox cases, a lamp was lighted and a dirty and bedraggled and woebegone old woman opened the door. A fearful stench came with her from the interior. Putting over my head a cloth in which I had cut openings for my eyes to see through, and protected by my rubber coat, I entered the house. It was cold and dark. There were two or three small sticks of wet wood making an ineffectual effort to burn in the kitchen stove, but they had made small impression upon the cold and damp. The whole house was indescribably filthy. The kitchen had a table covered with a few dirty dishes, and two or three chairs, all the cheapest variety. In the other half of the lower part of the house, about twelve feet square, there was one bed and on the floor a mattress and on the two I found eight persons sick with smallpox and ranging in age from twenty-four years to twelve months. Mrs. Mary Smith, 24; daughter of Mrs. Gillan; James G., 21; Michael, 17, Patricia, 8; Dominick, 6; Bridget, 14; Sarah, 4; the Babe of Mrs. Gillan, 1 year. All except the babe had been ill since the 13th, nine days, and the four older ones have the confluent form of the disease with their faces almost black and so swollen as to have little resemblance to human beings. The younger ones have the appearance of being less advanced and the baby has only the scattered eruption of varioloid, and has the appearance of being starved. As a matter of fact, the child was so starved, it had always been weak, that there was no foundation for the development of a floid (sic) case of variola. Mrs. Smith, the eldest female, whose husband died of smallpox on April 11th, miscarried two days ago being two months pregnant. The older ones complain much of their throats and are unable to swallow solid food. They have had no care since Tuesday, five days, when an old demented man left them, except what the poor old mother could do and she is sick and half crazed. The filth and the stench are fearful and all the air holes are stuffed with rags. The only wood in the house and under cover is in the stove trying hard to keep alive a flickering flame in spite of being water soaked. They have had no wood since Wednesday except what the mother has cut and prepared. There is a small pile of rough scrubwood of various lengths, all too long for the stove, in the yard where it has been exposed to the almost constant rain. They have had nothing to eat but flour gruel and some alcohol. They have some other provisions in the house but the mother has been unable to prepare food so they could eat it. They have been unable to get any milk, partly because they had no one to forage for it and as well because the nearer neighbors would not furnish them."[114]

Excerpt from the Diary of Dr. E. J. Brown, Montgomery, Minnesota, 1882

[114] Unpublished diary of Dr. E. J. Brown, 3027 Pleasant, Minneapolis, 1882. Kept in MDH library.

Typhoid epidemics such as those reported in 1908 and 1935 were no longer occurring, thanks to the aggressive approach that had been taken.[115] Isolation of the carrier to limit transmission of the disease was done through quarantine, confining a patient to his or her home, or placement in an institution for persons similarly infected. Typical isolation involved ill persons, but this was not necessarily the case with typhoid carriers. Carriers of typhoid might not show any outward signs of illness but might infect many others with this fecally transmitted disease. This was a particular concern when a typhoid carrier had contact with food eaten by others. In 1952, seven cases of typhoid occurred following a picnic at which food infected by a known typhoid carrier, seemingly healthy, had been eaten.[116]

In the 1930s the Board of Health tried a new and interesting approach in its attempts to isolate typhoid carriers and prevent transmission of the disease. Typhoid carriers were forbidden to work as milk handlers, cooks or in any other occupation where they had direct contact with the food and drink of others. For some typhoid carriers, their livelihood depended on these jobs. To compensate them for their loss and to encourage carriers not to work, the board offered monthly stipends to those typhoid carriers who had to leave their field of work.

The amount of the stipend varied per recipient. Each case was evaluated as to the loss suffered by being unable to work and the availability of other resources for that person. From time to time the amounts increased when the board granted cost of living raises.

Monthly payments to typhoid carriers were not automatic. Each case was reviewed and approved by the board quarterly. By 1949 the board members who approved payments were not the same board members who had made the initial decision to provide this stipend. While payments to the list of typhoid carriers were usually approved without comment, periodically the board would discuss whether or not the department should continue such a policy. Some members questioned whether such stipends were appropriate.

When President Thomas Magath brought the issue forward for discussion at the December 16, 1949, board meeting, there seven persons in the state were receiving monthly stipends:[117]

> Some time ago I raised the issue on this aid to typhoid carriers and I think we might well review it. I have the idea, and I don't know where I got it, that we are entitled to pay compensation to people forced out of jobs which have to do with food handling. One would question whether Mrs. Jackson, age 88, is a person who could be employed and why we should support her. This would be equally true of one 81 and two 71, and I wonder whether we are justified in paying them compensation because they have been robbed of their job.[118]

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[115] Jordan, *The People's Health,* p. 119.
[116] MDH, *Minnesota's Health,* Vol. VI, No. 9, October 1952, p. 4.
[117] BOH, *Minutes*, December 16, 1949.
[118] Ibid.

Board members noted that this group didn't have much earning power because of their ages and wondered if the original rationale for the aid was still valid. They recognized that the carriers had been prevented from accumulating savings for their old age when they were not able to work, but they wondered if they should now be getting support from an old-age assistance group rather than the Board of Health.

The issue was tabled, but brought forward at the board meeting on February 14, 1950[119]. Dr. Fleming, head of the disease prevention and control section, reported that all carriers had been visited within the last six months and the basis for their grants reviewed. He described one visit to the home of an 81-year-old woman who had been receiving aid since January of 1937. She was well but found it difficult to carry water and coal. It was unknown if she had any additional income besides the $49.00 in aid she received each month as a typhoid carrier.

The board again questioned if it was appropriate to continue to provide financial support to a group who could possibly receive old age pensions instead of the stipends:

> Dr. Ruth Boynton: "I think we might be quite vulnerable on this, giving aid to these people who might be eligible for old age assistance or some other form of assistance. Originally it was to compensate them for loss of income because we refused them the right to pursue the occupation which they formerly pursued before they were known carriers. It is a question of policy of the Board, I think, whether we should consider a person once deprived of a means of earning a living as deprived for the rest of their lives. I have always had a feeling that perhaps we ought to have a little more social service type of investigation on this perhaps once a year."
>
> Mr. Leo Thompson: "People past 60 years of age would be past working age. It would seem that they should get what was actually needed."
>
> Dr. Frederic Bass: "If we are to assume responsibility for this amount, it seems to me we should have an analysis of each case, not only with respect to their necessities for living expenses but their other sources of income, if any. Otherwise we can't act intelligently."
>
> Dr. Albert Chesley, Secretary and Executive Officer: "Do you get reports from each one before you send them their checks?"
>
> Fleming: "Yes."
>
> Chesley: "Couldn't you put something into that letter?....some of these people have been on for a long, long time."
>
> Boynton: "I wonder if we shouldn't ask Dr. Fleming to make a complete and careful investigation of the circumstances of each of these individuals. This could probably be done through public health nurses in the community."
>
> Thompson: "We could get that through the welfare societies."
>
> Fleming: "We have had quite a bit of information from the welfare societies about these people because they are persecuted so much. Most of them have been kept out of a job at one time or another in their life because of their condition and would learn something through that. Many of

[119] BOH, *Minutes*, February 14, 1950, MHS, pp. 10-13.

them are still able bodied and if you don't have something to offer them they are going to do work they shouldn't."

Bass: "Mrs. J., 88 years of age, gets $21.00 a month and Mrs. H., 81, gets $49.00. That is just on the face and that raises the question to me why they differ. What does $21.00 a month do for a woman 81 years old? Not much. I would like to know a little more about them."

Dr. Charles Netz: "They are getting these checks. If we refused them and they applied for old age assistance they might not get it because they might be living with a son or a daughter who can support them. In a case like that the son or daughter is just getting $21.00 a month more. If they have someone to support them, they can't get any old age assistance, I understand."

Dr. Frederick Behmler: "There are a lot of them that could be supported by sons or daughters but aren't."[120]

The issue resurfaced at the April 15, 1952, board meeting as a result of a specific case.[121] This woman had been identified as a carrier in 1936. At that time she was living in Olmsted County where she sold milk. One fatal case and two other cases were traced to her. Initially she received $25.00 a month through the typhoid carrier aid program, and this amount had increased to $49.00 a month by 1952.

The woman was now 84 years old, had cataracts and was almost blind. She had moved to another state to live with her daughter's family. The family had to handle her dishes separately, buy her medicine, and provide for her care. When the department learned she had moved to another state, it notified that state's health officer that she was there and was a typhoid carrier. That health department was now keeping track of her. The department informed the woman that the March 1952 check would be the last, since she was not living in the state. This caused the typhoid carrier great distress, as she had no other source of income. She would have to have five years' residence in the state where she had moved in order to quality for old age assistance.

This led to a discussion on the department's policy in the matter:

Fleming: "...we would have great difficulty in defending our position in paying her aid when she is out of the State. On the other hand, there are some human values there that make it rather difficult to tell people they will get no other money. If we could turn the person over to another agency..."

Dr. Theodore Sweetser: "It used to be that the great majority of people after 60 or 65 became dependent on the next generation. She is living with a daughter now who certainly has some responsibility."

Netz: "It seems to me the fundamental part of the purpose of that act is to protect the people of Minnesota against that carrier. It is not our duty to protect the citizens of Oregon from a typhoid carrier."

Fleming: "The theory of this aid was to reimburse these individuals for the loss of income for the restrictions placed upon them. This payment goes on as long as the person lives, representing a fraction of the income they would have earned."

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[120] BOH, *Minutes*, February 14, 1950.
[121] BOH, *Minutes*, April 15, 1952, MHS, pp. 135-142.

> Boynton: "When this legislation was first passed we had not Old Age Assistance and no means whereby they could get funds available to them. I understand the Social Security Act is considered as a pension and not as charity. I wonder, then, whether this isn't first for the protection of the public health. That was the purpose of the passage of the legislation to compensate these people so that they wouldn't have to engage in food handling work. I wonder if we shouldn't take into consideration the changes that have taken place in the welfare situation I certainly don't see how we can pay aid to these people in another state. I wonder if we are justified in paying these other people of 70 or 75."
>
> Chesley: "Technically I don't think we have any business paying anything to anyone who leaves the State."
>
> Netz: "I feel, too, that we haven't got any defense."
>
> Chesley: "Dr. Fleming sends details to the Health Officer so that they have a complete record of a carrier of this kind. It is up to them to protect their own people."[122]

Payment to the typhoid carrier in question was ended. By September 8, 1955, the number of typhoid carriers was down to four, and the quarterly payment to them totaled $357.[123]

While the board believed it should not be paying to protect the citizens of another state from typhoid, an earlier decision points out the difficulty in determining boundaries in public health matters. The department had supplied Canada with typhoid vaccine it needed. At the April 25, 1950, board meeting the director of disease prevention and control asked what it should charge for the vaccine:[124] "$205.00 worth of typhoid vaccine was sent to Winnipeg. They have asked for a bill. I wonder what the board wishes to do in this situation."[125] Dr. Chesley answered the question with a question: "Where did the water come from?"

The board decided that since the $205.00 for vaccine was expended in the protection of Minnesotans and because of the great movement of people between Winnipeg and Minnesota, the board should not request reimbursement from Winnipeg.

In the interest of reducing the expense of aid for typhoid carriers at the department, the board considered the possibility of transferring some responsibility to another government agency. A suggestion was made that the welfare board handle these cases, and the response gave insights into the difficulties the department might have had in working with other agencies.

> Fleming: "When the welfare board or other agency handles these cases, problems increase because they don't take a very enlightened attitude when supervising carriers. They want to lock these people up in jail practically as soon as they find out they are carriers. As long as they abide by certain restrictions that is not necessary."

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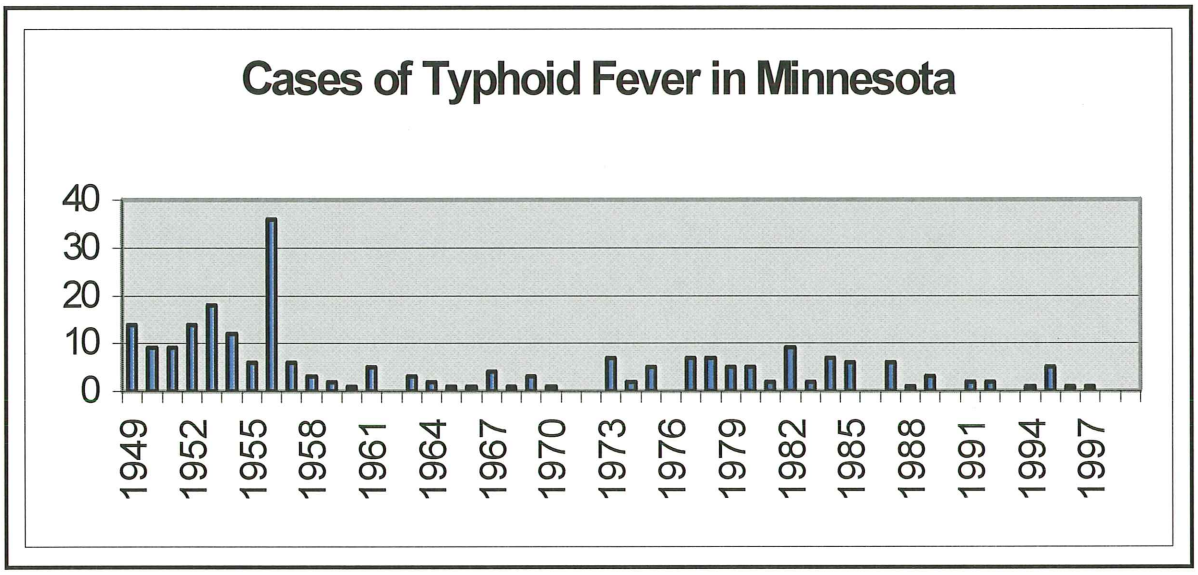
[122] BOH, *Minutes*, April 15, 1952, MHC, p.
[123] BOH, *Minutes*, September 8, 1955, p. 213.
[124] BOH, *Minutes*, June 13, 1950, MHS, p. 253.
[125] Ibid.

> Herbert Bosch: "It seems to me, Mr. President, I don't feel that we should give this consideration primarily as a welfare thing. It was meant originally as a financial help to keep them out of a certain occupation. We are not going to be adding anything more to it. I have a sneaking hunch that if you turn the welfare boards loose on these six or seven people you will probably have as much difficulty as you have now. It amounts to only $200 a month. I just hesitate a little bit to see us turn the county welfare boards loose."[126]

While typhoid was considered under control in the 1940s and 1950s, it remained ready to make an appearance. In 1956 it did. There were 20 cases of typhoid in 12 counties during the first few months of the year. As people were infected with the same type of typhoid organism and many became ill in the middle of January, it was initially believed to have been transmitted during a holiday party.[127] When cases began to occur in March, however, that hypothesis didn't prove true.



The source of the cases was perplexing. No two cases occurred in the same family or among acquaintances. Cases appeared in people living miles apart. No common link was noted. It wasn't the classic outbreak of typhoid traceable to a common factor such as poor sanitation practices or a typhoid carrier. Specialists from the U.S. Public Health Service and Food and Drug Administration were brought in to help, but the source was never discovered.[128]

There have been only six deaths from typhoid in Minnesota from 1949 to 1999. One was in 1949, two were in 1953, two in 1963 and one in 1965. The 1965 death was a non-resident, so the last death of a Minnesota resident was in 1963.[129] The last case of typhoid in the state was recorded in 1997.

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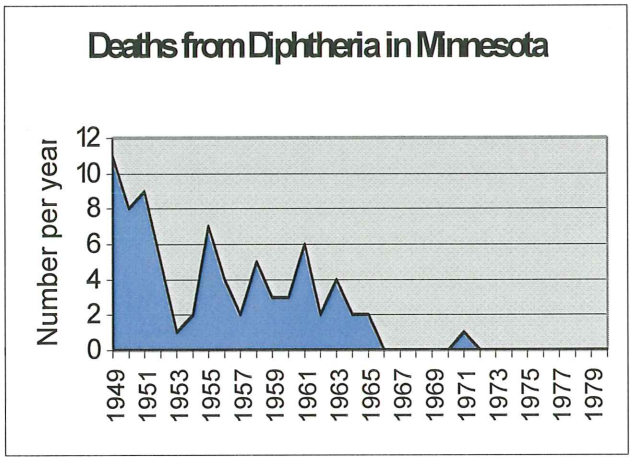
[126] BOH, *Minutes*, April 25, 1952, MHS, p. 140.
[127] MDH, *Minnesota's Health,* Vol. 10, No. 2, February 1956, p. 4.
[128] MDH, *Minnesota's Health,* Vol. 10, No. 9, November 1956, p. 4.
[129] MDH, *Vital Statistics Minnesota, 1963.*

Diphtheria

In 1949, though effective vaccine had been available for about 20 years, diphtheria was not yet fully under control in Minnesota. An average of 222 diphtheria cases and 20 deaths occurred each year between 1946 and 1950.[130] With education and immunization, cases and deaths were dropping, however. In 1950, there were 99 cases of diphtheria in the state.[131] This was the lowest ever recorded to date. By 1953, the number of recorded cases fell to 27.[132] From 1952 to 1960 there were 426 cases of diphtheria and 40 deaths in Minnesota. Cases, most from the northern part of the state, continued to be reported into the 1960s.[133]

A study of students in the fall of 1955, found that in some communities 70 percent of children entering school had not been immunized.[134] As the number of cases declined and the disease became less visible, public health workers began to be concerned about the declining interest in immunizations and the potential for outbreaks.



An outbreak of diphtheria in Bemidji in January 1955 resulted in the death of a 40-year-old man and a six-year-old boy. In July and August of 1958, there were outbreaks at the Cambridge State School and Colony. By the end of the year, 75 cases and five diphtheria deaths had occurred.[135] In 1960, 36 cases of diphtheria occurred, primarily in Becker, Beltrami, Cass, Clearwater, Hubbard, Itasca, Koochiching, Pennington and Polk counties and an area around Bemidji, Deer River, Grand Rapids and extending to Crookston. It followed the same pattern as previous years.[136] In 1961, cases occurred in 11 counties: Becker, Beltrami, Goodhue, Hubbard, Cass, Itasca, Hennepin, Mahnomen, Koochiching, Isanti, and Ramsey. The first nine months of 1961 found only three states – Texas, Louisiana and Florida – with more diphtheria cases than Minnesota.[137] A study of 14 cases and four deaths in 1963 found asymptomatic carriers in 21 counties. The problem was statewide.[138]

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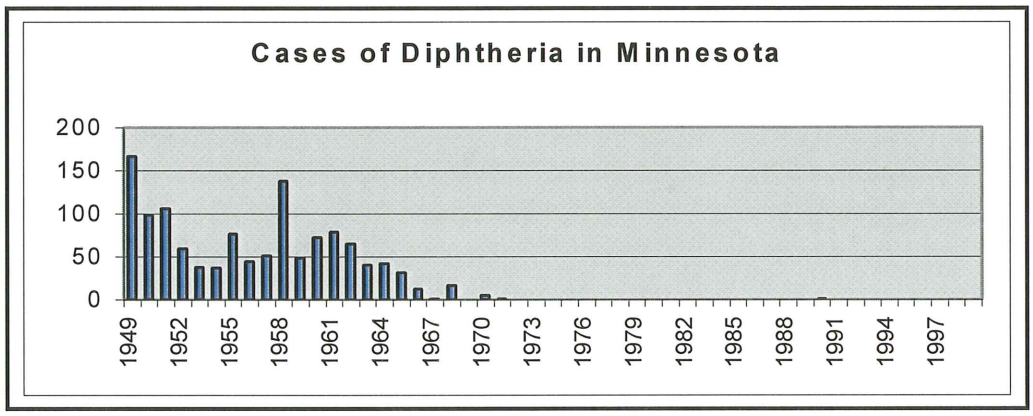
[130] MDH, *Minnesota's Health,* Vol. VI, No. 2, February 1952, pp. 3-4.
[131] BOH, *Minutes*, January 25, 1951, MHS, p. 27.
[132] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 4.
[133] BOH, *Minutes*, October 31, 1961, MHS, pp. 466-467.
[134] MDH, *Minnesota's Health,* Vol. 10, No. 2, February 1956, p. 1.
[135] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 1.
[136] BOH, *Minutes*, December 19, 1960, MHS, p. 420.
[137] BOH, *Minutes*, October 31, 1961, MHS, pp. 466-467.
[138] MDH, *Minnesota's Health,* Vol. 18, No. 10, December 1964, p. 4.

Trying to urge the population to be immunized, a report on diphtheria used civil defense to sell their point: "With the threat of a possible nuclear disaster, it would be prudent to attain a high level of protection against diphtheria and tetanus in our civilian population."[139] The federal government's Vaccination Assistance Act of 1962 was a boon to immunization against diphtheria, as well as smallpox, whooping cough, tetanus, polio and measles. Vaccine was provided free of charge to physicians. They could not charge patients for the vaccine, but they could charge for their services. Assistance was also granted communities for establishing school immunization maintenance programs.[140]



Nineteen sixty-six was the first year in the department's history that no death from diphtheria was reported. There has been only one recorded death since then, occurring in 1971. A disease, once treated by every general practitioner in Minnesota is rarely, if ever, seen by today's health personnel, thanks to the efforts of early public health workers and continued vigilance of the current ones.

Whooping Cough

The state's peak year for whooping cough cases was 1933 with 5,272 reported cases and 77 deaths. The most deaths in a year occurred in 1920 when 297 Minnesotans died of whooping cough. [141]

With the availability of vaccine, whooping cough cases and deaths began to decline but not as fast as expected. While the number of cases and deaths in 1949 had dropped considerably, a large increase occurred the following year. There were 1,373 cases and 12 deaths in 1950, compared to 180 cases and six deaths from whooping cough in 1949.

When discussed at the August 1, 1950, board meeting, the lack of immunization was identified as the contributing factor in the increase.

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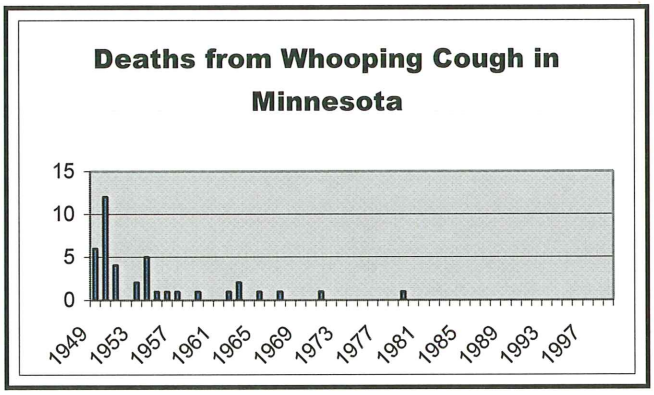
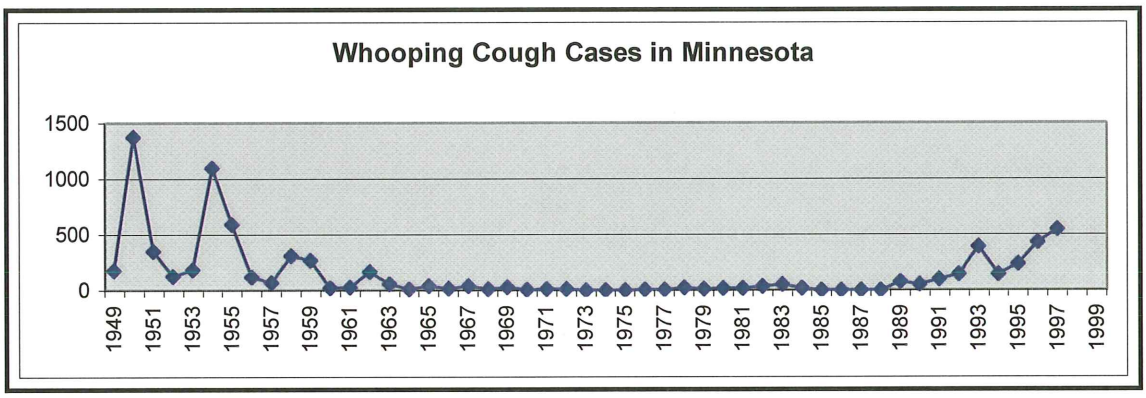
[139] BOH, *Minutes*, October 31, 1961, MHS, pp. 466-467.
[140] MDH, *Minnesota's Health,* Vol. 21, No. 8, October 1967, pp. 2-2.
[141] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 1.

Boynton: "I don't think we are having wide-spread enough immunization in whooping cough to control it."



Chesley: "The trouble is that you have to get them so early that unless there is a death somewhere the people won't come in to get it. The only place we have been able to get them interested is among the Indians. You can't convince the people that they should have that done."

Boynton: "It's really a short time, too, that whooping cough innoculation has been accepted. Of course we provide the immunizing material for the physicians to use."[142]



Cases began decreasing in the 1960s, with an increase in the 1990s. The last death from whooping cough was reported in 1979.

Tuberculosis

According to Dr. J. Arthur Myers, international expert on tuberculosis, Minnesota invited tuberculosis into the state by advertising, in the 1800s, the supposed benefits of its climate. In his book about tuberculosis in Minnesota, "Invited and Conquered," Dr. Myers also recognized the cooperative efforts that led to control of the disease.[143]

The peak year for tuberculosis in the state was 1911 when there were 2,552 deaths, with 119.7 deaths per 100,000 persons. With the introduction of streptomycin and isoniazid, the possibility of eradicating tuberculosis, once the leading cause of death in Minnesota, became a reality.

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[142] BOH, *Minutes*, August 1, 1950, MHS, p. 331.
[143] MDH, *Minnesota's Health,* Vol. III, No. 11, November 1949, pp. 1-2.

By 1949, the tuberculosis death rate had declined to 13.6 deaths per 100,000.[144] Still, it was the most devastating of communicable diseases in the state. Houston County had the lowest death rate in Minnesota between 1946 and 1950, with only one death from tuberculosis during that period.[145] Tuberculosis was still the greatest killer of people aged 15 to 25 in 1950, but the reservoir of infection was in the middle-aged group.[146]

Nineteen-fifty was a red-letter year for tuberculosis. For the first time in the department's history, tuberculosis was no longer one of the ten leading causes of death for Minnesotans. In addition to the availability of drugs for treatment, the reduction in deaths was due to improved methods of treatment, reduced exposure through the isolation of infectious cases in sanitariums, and early case finding. More cases were being treated before they became serious enough to cause death.

Recalcitrant Patients. Like a number of other diseases in the 1940s and 1950s, a method for controlling tuberculosis was the isolation of those infected. Tuberculosis was the only disease, however, which had institutions created specifically for these patients. The first sanitarium for tuberculosis patients in Minnesota was built in 1907 in Walker.

While most persons diagnosed with tuberculosis went to sanitariums willingly, the board was challenged by a number of recalcitrant tuberculosis patients. These patients refused to remain in hospitals and were possibly endangering the health of others. The courts would commit tuberculosis patients, but the facilities weren't able to retain patients against their will. Dr. Hilbert Mark, director of the tuberculosis division of the preventable disease section, reported, "Several cases beat the sheriff home." [147] Guards were needed to insure the patient remained in the hospital. At a cost of $29.00 per day, this was too expensive, so the present legislation was virtually inoperable.[148]

The board was frustrated with this obstacle in its continued fight to reduce tuberculosis, and the issue was discussed at the January 25, 1951, board meeting:

> Dr. Ruth Boynton: "I think our division of Tuberculosis and the Minnesota Public Health Association are interested in seeing whether anything can be done to change the present legislation which will make some institution in the state take these people. We have authority now to put them in an institution but, as I understand it now, none will accept them. The sheriff takes him up there and they walk out."
>
> Dr. Theodore Sweetser: "The State Department of Health has police authority to make somebody take care of them."
>
> Dr. Albert Chesley: "....No sanitarium will take that kind of a case—the big places where you could segregate them. We tried the place at St. Cloud and they said they can't take them there. We ought to be able to classify the person who is of that type so that they could be committed by

[144] MDH, *Minnesota's Health,* Vol. IX, No. 8, November 1955, pp. 2-3.
[145] MDH, *Minnesota's Health,* Vol. V, No. 12, December 1951, p. 4.
[146] MDH, *Minnesota's Health,* Vol. VI, No. 10, November 1952, p. 1.
[147] BOH, *Minutes*, August 1, 1950, MHS, pp 313-314.
[148] Ibid.

the court and they couldn't get out. Some of these people are just plain cussed. As a rule they are that type of individual. Irresponsible and don't give a whoop for anybody or anything. There are only six or eight of them at a time."

Boynton: "I think it might be a good idea if Dr. Wilson sent these two case histories to the legislators."

Mr. Jerome Brower: "There is going to be a meeting on this Monday evening where they will discuss these two big proposals."

Sweetser: "Maybe they could be isolated at St. Peter."

Dr. Robert Barr: "Two possible places were discussed, one was St. Cloud Reformatory and the other was the Anoka State Hospital. We went through that very recently and it would be a difficult thing, although I think if they clapped (sic) one or two of those individuals in a room with some of those other patients he would be awfully glad to behave himself somewhere else. In general it is open wards with a few rooms for disturbed patients. If an individual is just a plain devil—These men are mental cases and also frequently chronic alcoholics plus TB. They are not reasonable individuals and the only thing they understand is force. If the institutions really wanted them, I think they could take care of them."

Sweetser: "Could they be committed as mental cases?"

Barr: " I think it would be a very difficult thing to do. They are maladjusted." [149]

A tuberculosis law (Chapter 314) was passed in 1951. A county board was authorized to commit a person infected with tuberculosis on the basis of the health officer's report of a suspected tuberculosis case.[150] Board members and department staff didn't seem overly optimistic about this law when they discussed it at an April 1951 board meeting:

Dr. Frederick Behmler: "Did the Legislature do anything about control of tuberculosis incorrigibles?"

Dr. Dean Fleming: "Yes. They passed a new bill which is an amendment of the previous bill. It is designed to simplify the application of that law and to clarify which agency is responsible for handling these recalcitrants. In my own mind, the basic thing is setting up a facility where these people will be kept until they are permitted to leave. Both laws, to my mind, won't work so well until that is set up. People are committed under this act or the previous one but escape from the place they are committed to and return home and that is apparently all that can be done about it. These other matters are important also, whether the local county or the State shall pay the cost. The new act is designed to relieve the county somewhat so that the State will assume a larger share of the cost for keeping these people. Many have no legal residence. It does become unfair for a city like Minneapolis which picks up a lot of nonresidents and then has to pay all the costs of those patients in the sanitarium."

Behmler: "What is the procedure on those people now? Just let them run loose?"

Fleming: "They can be picked up and committed under this law and it works very well for those people who will stay in the sanitarium."

Behmler: "What if they leave the State San? Then what happens?"

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[149] BOH, *Minutes*, January 25, 1951, MHS, pp. 54-56.
[150] MDH, *Minnesota's Health,* Vol. V, No. 6, June 1951, p. 3.

Fleming: "That is just what happens. Until there is a suitable facility with lock and bars and a staff to keep the people there neither of these laws is going to work too well. If such a place is set up and these few people know that once they are there they are going to have to stay there... But as long as they know they can get away, they will do it."

Dr. H. Z. Giffin: "How is this new law better than the old one?"

Fleming: "It simplifies the commitment procedure considerably. I don't think it has made any change in the site where they will be kept. The State San didn't work out as a suitable place to lock these patients up. We did hope that the State Mental Hospital at Anoka would be a suitable place to put these people, but their staff is not anxious to take these people. The St. Cloud Reformatory is not suitable."

Giffin: "Why can't the State San do it?"

Fleming: "They don't want to, for one thing. They have difficulties with their staff. The nurses threaten to quit if they have to take care of these patients.

Dr. Viktor Wilson: " We have one here that is already under court order. We have a little game of cat and mouse going on. I am the cat. He walked out of the san and unless we have some place to put him where he can be kept he is just going to ignore the law. So far as I can tell he is a criminal at heart and he is going to stay that way. We have another family where the father in the family about three years ago decided that he was not going to cooperate any longer and he told - that at that time he wouldn't do anything until he was forced by law. He did cooperate for a time to the extent of staying out in his rural place and not mixing with the public. His wife and sons lived there with him. One son now has tuberculosis. He had an x-ray when he was called up for army examination. His wife quit her job in town here and the employees at the place said she was coughing up blood. She won't cooperate to the extent of getting an examination, so we don't really know. This morning one of the local doctors called me to say that one of the neighbors has tuberculosis, positive sputum. Just how much he may have associated with this man, I don't know."

Sweetser: " What about the one who you said was a criminal at heart? Could they send him up to St. Cloud for something else and keep him there for TB?"

Wilson: "No, he is not a criminal, but he has no intention at all of conducting himself so as not to expose other people to tuberculosis."

Fleming: "We have had pretty good cooperation from the county attorneys. They are the assistants to the local health officer in committing these people. In most instances the county attorney is quite willing to go through the rigmarole of these laws, but when the patient comes home after being sentenced to one of those institutions they lose interest."

Wilson: "I could call up the sheriff right now and he would go and pick this guy up if we only had a place to keep him. But if he is going to beat the sheriff back home, what's the use? That actually happened in Dodge County. So far as the State San is concerned, I don't know. I worked up there, as Dr. Chesley said, for two years. I think it is largely a matter of wanting to do it."

Giffin: "Is there any way in which the State San can be required to do it?"

Wilson: "Obviously there are some difficulties in doing it, but I think that could be worked out."

Dr. Netz: "Doesn't the help quit? The personnel doesn't want these patients."

Fleming: The nurses don't like to take care of these people. Some are people that drink a lot and

break things up when they get a chance. Nobody wants to take care of them."

Wilson: "What about the State Prison? They have a hospital at the State Prison and could keep them from leaving."

Fleming: "You recall we had a meeting last October on something like that and at that meeting we had the other State agencies, and under this law we discussed the State mental hospitals and St. Cloud and it seemed there was a wing at Anoka and they were going to use that. But that fell through and there didn't seem to be any particular reason why St. Cloud couldn't be used. The have a dispensary within the walls there. They wouldn't be exposing other prisoners to tuberculosis, which is against the law."

Sweetser: "What about Stillwater? That is what he was asking about. How about having a motion that we approach the Department of Public Institutions asking what they are going to do about it? I think a letter from the State Board of Health might help a little."

Behmler: "Do you want to make that as a motion?"

Sweetser: "Yes."

Netz: "I'll second it."

Barr: "A bill was passed creating a commission composed of one Senator and one Representative and the remaining eight members to be appointed, I believe, by the Governor, to make a survey of the State's tuberculosis facilities. I think that you will find that when this discussion came up before because of all these laws and changes and discussions coming in and all of these groups, they just slackened back. Anoka was asking for enough money to build a separate unit. It is inconvenient to take care of these people and the loss of personnel is not so much due to these people but having difficulty in getting personnel anyway.

Sweetser: "That is their responsibility. I should think that a letter from this Department to the Commissioner would get some results."

Barr: "Or the responsibility of the Department of Social Welfare. I think we should send a copy to the Division of Public Institutions and to the Interim Committee, too, and at least get them on the spot."

Wilson: "The Commission, I suppose, is to report back to the Legislature. That means two years more. We need it now. The doctors and the people and the neighbors don't understand why we can't lock these people up. The people are apparently way ahead of the laws."

Sweetser: "That ought to be a part of the letter."

Wilson: "I wouldn't think there would be much point in sending it to the Commission. I think we should send it to the State agency which has the responsibility."

Fleming: "I think the plan is to centralize them at this new building at Anoka."

Chesley: "Many years ago Dr. Bracken recommended that they have a small hospital inside the walls of the State Prison. When they found that their bluff stuck, they wouldn't need it any more. If the sheriff comes and gets them and brings them back they are going to beat the sheriff home. It is the old, old story and until something of that sort is done I think it will keep on right the way it is. I have circularized the sanitariums from time to time. With Dr. Hilleboe we presented a Joint Resolution to the Senate and the House at one time. In 1935 or something like that. Occasionally one of these fellows will be an alcoholic or use drugs or something of that sort and yet they are not mentally off the beam to the extent where you can commit them to an asylum. The State Board of Control when, we had one, used to have joint

meetings with the State Board of Health. Mrs. LaDu directed the Superintendent of the State Sanitarium to take steps and so on, but it never was done very effectively. The same thing was done in regard to Indians after we got the Indian wing. One fellow got a gentleman who was a county official at one time and quite a high man in his community and got out on habeas corpus. When you get down to brass tacks it is public opinion that has to control it. When you get an Indian woman who calls and says that a child who has been in the State San and has positive sputum has come home and she doesn't want him there. There was another extreme – a postmaster who defied everyone. They got him in for a while and then he moved to one of the other states and he died of tuberculosis. I doubt if there are a dozen cases at any one time in the State that would qualify for any such restraint as that. It does seem a shame that when we get down to 551 deaths a year, and that includes a lot of people in the State institutions, that we can't put the clamps on this thing and bring it down within reason, when a little while ago we had 2700 deaths per year. It is an economic problem anyway. I think this resolution that you propose couldn't do any harm it might cause a little reaction."

Behmler: "Is there any further discussion? We have a motion to be acted on."

Sweetser: "Dr. Fleming might call up the Department of Institutions every week and get in their hair until they do something. I am not joking. Then they might do something in desperation."

Fleming: "The thing that sometimes irritates me is that everyone thinks the State Board of Health is responsible for these people wandering the State. I think someone else should be getting some of the heat."[151]

The state looked for a single secure facility for recalcitrant patients. The attorney general gave power to the public institutions division of Social Welfare to designate an institution as the place for commitment. They chose Anoka State Hospital.

Keeping all recalcitrant tuberculosis patients at one place didn't work either. In 1955, Dr. Fleming and board members discussed the problem:

Boynton: "Nobody wants them."

Fleming: They are a problem to take care of. If it is set up as a jail, these people are still able to tear the doors out of the walls and disappear."

Giffin: "How many do you have in the State?"

Fleming: "Not more than four or five at a time. As long as they know they can break away and get back home before the sheriff, they stir things up." [152]

In 1955, legislation was passed creating a tuberculosis security facility at the Anoka State Hospital. The locked wards in this 30-bed unit made it possible to isolate contagious patients.[153]

TB – Mass Survey. Aggressive case finding was a large contributor to the reduction of tuberculosis in Minnesota. The Legislature provided the department with funds for mobile units, which traveled throughout the state, offering free chest x-rays to all citizens. This massive case-finding effort began in 1947, and Dr. Hilbert Mark, state tuberculosis control officer, was one of the chief organizers of the program.[154]

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[151] BOH, *Minutes*, April 31, 1951, MHS, pp. 95-102.
[152] BOH, *Minutes*, December 21, 1950.
[153] MDH, *Minnesota's Health,* Vol. 9, No. 8, November 1955, pp. 2-3.
[154] MDH, *Minnesota's Health,* Vol. I, No. 1, January 1947, p. 1.

Any abnormality found through mass screenings was reported back to physicians. The county public health nurse followed up to see if the patient was seen by a doctor. If he or she did not come in for a visit, the public health nurse visited the patient's home. Once a case was designated non-tuberculosis, further follow-up was dropped. [155]

Dr. Mark appears in the comics. This Smorgy strip was one of those used by the Minneapolis Tribune to publicize community X-ray surveys.

By 1948, 509,602 persons in the state had received a free x-ray through the mass-screening program for tuberculosis. By 1949, nearly all Minnesotans had had an opportunity to receive a chest x-ray.[156] By the end of 1950, nearly a million people – about a third of the population – had received an x-ray.[157] Out of each 1,000 x-rays, an average of five people would be identified as having positive tuberculosis, two had suspected tuberculosis and eight had other diseases discoverable by x-rays, including heart conditions, tumors and cancer.[158]

The case finding was successful, and tuberculosis deaths and cases began to decrease. Then, to Dr. Chesley's and other's dismay, the Legislature did not fund continued mass screening in 1951. Dr. Chesley and Dr. Mark commented on the situation:

> Dr. Chesley: "Now you got down to 502 deaths (TB) in 1949, so you can see there has been considerable progress made and it is only these last few years that we have had these means of picking out early cases, and certainly this is no time to let down on our TB control program. When you consider the cost for care of these cases....Get them early and then compare that with what it means on the long continued hospitalization and eventual death, as well as spread of infection to others. It seems to me we are getting along fine with it and this is a heck of a time to lose Dr. Mark. I don't know what we are going to do."
>
> Dr. Mark: "...even with the decreasing deaths, Minnesota has been one of the highest states in the number of cases found per death. Last year we found about six per annual death and the year before about seven. We have more beds filled with TB patients than ever before. And there are fewer vacancies, except in the small sanitariums. The larger institutions are running pretty close to capacity. St. Louis County found, during their first survey, that they had to increase their

[155] BOH, *Minutes*, August 1, 1950.
[156] MDH, *Minnesota's Health,* Vol. III, No. 5, May 1949, pp. 5-6.
[157] MDH, *Minnesota's Health,* Vol. VI, No. 5, May 1952, p. 3.
[158] MDH, *Minnesota's Health,* Vol. IV, No. 6, June 1950, p. 3.

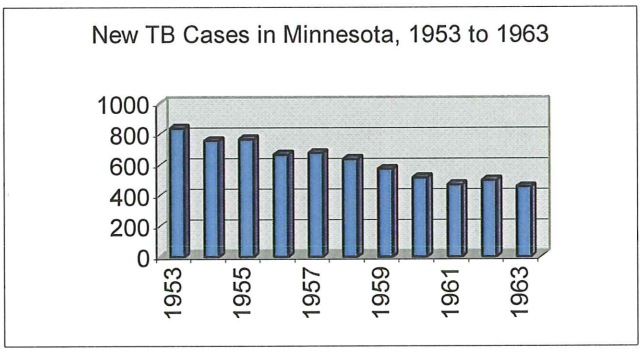
capacity. Now they have about a 35 or 40 bed vacancy. They are now taking over cases on a contract basis from other counties."[159]

Dr. J. Arthur Myers also advocated for continued case finding:

> ***"If we could find all infectious tuberculosis cases existing today, it would still be at least 70 years before the disease could be wiped out. From now on, we need to place emphasis on finding the tubercle bacilli themselves and keep on corralling them."***[160]
>
> **J. Arthur Myers, M.D., 1953**

Dr. David Smith, president of the National Tuberculosis Association and professor of bacteriology at Duke University spoke in St. Paul on April 12, 1954, and expressed his concern about the stoppage of x-ray programs in the states. He thought the decline in death rates was misleading, and the screening programs should continue until there was complete elimination.[161]

When the state's mass-screening program for tuberculosis ended in 1954, the equipment was dispersed. The x-ray equipment went to the Department of Public Welfare for twice-yearly surveys of all inmates in state hospitals and institutions. Another set of equipment was given to the University of Minnesota Student Health Service.[162]



With the loss of its tuberculosis mobile x-ray unit program, the department's role in tuberculosis control evolved into one of coordination and monitoring of patients. Dr. D. S. Fleming, chief of the preventable diseases section said:

> Perhaps the most important function of the Health Department in the control program is to act as a center for receiving information about persons with tuberculosis and for exchanging these reports with other workers and agencies concerned with other aspects of control of the disease. Thus, if the Veteran's Hospital discharges a man with tuberculosis to his home, this information is sent to the Health Department, which in turn notifies the health officer and the public health nurse in the Veteran's Home are, and supervision of the case is continued. This constant interchange of information is the key to successful control and prevention, involving and cutting across the special interests of all workers and agencies. Continuous effort and support from every possible source are needed if eventually we are to eliminate tuberculosis from Minnesota.[163]

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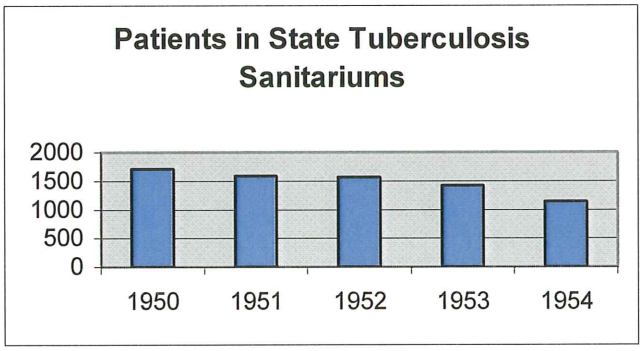
[159] BOH, *Minutes*, November 14, 1950.
[160] MDH, *Minnesota's Health,* Vol. VII, No. 10, November 1953, p. 4.
[161] MDH, *Minnesota's Health,* Vol. 8, No. 5, May 1954, p. 4.
[162] MDH, *Minnesota's Health,* Vol. 8, No. 10, November 1954, p. 3.
[163] MDH, *Minnesota's Health,* Vol. V, No. 11, November 1951, p. 2.

The department encouraged tuberculosis case finding in other ways. It joined with the Minnesota Medical Association and the Minnesota Hospital Association to advocate the use of routine hospital admission chest x-rays for patients. About one-fourth of all hospitals were participating in December 1954. A year later half were giving chest x-rays to all patients being admitted.[164] By 1961, 75 percent of the state's general hospitals provided routine admission chest x-rays for the detection of tuberculosis and chest abnormalities.[165] By January 1, 1964, 82 percent of the state's 188 general hospitals provided admission chest x-ray services.[166] This increased to 92 percent in 1967.[167]

Another method of case finding used was tuberculin tests. More than one million tuberculin tests were given from 1958 to 1962. Of these, slightly over 1.5 percent were positive.[168] Many of these tests were organized and sponsored by communities. For example, during the period from May 10 to May 14, 1954, 6,000 persons in Wright County received skin tests for tuberculosis and histoplasmosis.[169]



A study was undertaken in Polk County and the East Grand Forks area, as part of a U.S. Public Health Service study of tuberculin reactions in the general population. Dr. Carroll Palmer, who was conducting the study, believed that some reactions were due to the Battey strain and did not indicate tuberculosis. The population with the Battey strain was in the southeastern United States, so Minnesota was being used as a control. More than 20,000 Minnesotans were involved in this study in March and April of 1960.[170]

In 1957, the Legislature enacted a law that granted a county sanitarium commission authority to hire tuberculosis control officers.[171] Case finding was to concentrate on targeted groups: migrant workers, low-income groups where the incident was higher, and mental hospitals where the disease was often spread easily. One out of every seven tuberculosis deaths was a patient in a mental hospital in 1949. With no provisions for segregating patients, the disease was easily spread. In 1950, a 252-bed hospital for tuberculosis patients from state mental hospitals was opened in Anoka.[172]

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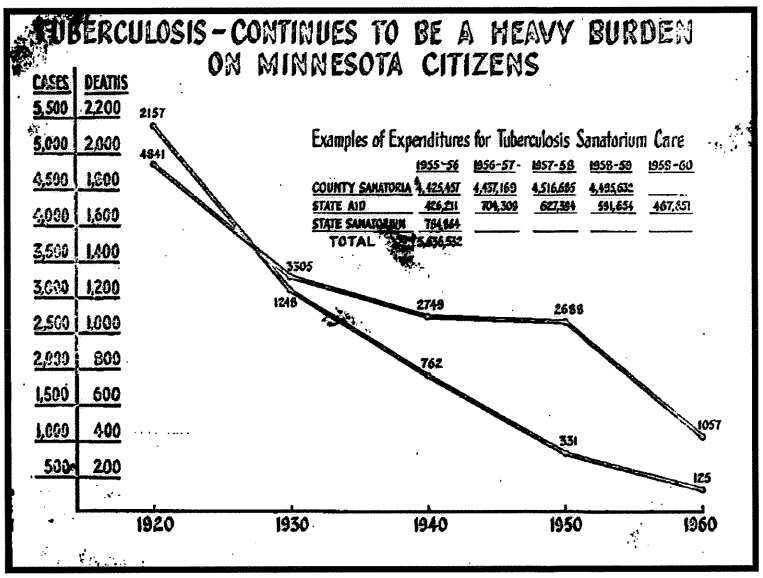
[164] MDH, *Minnesota's Health,* Vol. 10, No. 6, June-July 1956, p. 2.
[165] MDH, *Minnesota's Health,* Vol. 15, No. 5, May 1961, p. 3.
[166] MDH, *Minnesota's Health,* Vol. 18, No. 7, August-September 1964, p. 1.
[167] MDH, *Minnesota's Health,* Vol. 21, No. 9, November 1967, p. 4.
[168] MDH, *Minnesota's Health,* Vol. 17, No. 6, June-July 1963, p. 4.
[169] MDH, *Minnesota's Health,* Vol. 8, No. 6, June 1954, p. 2.
[170] BOH, *Minutes*, January 12, 1960, MHS, p. 9.
[171] BOH, *New Dimensions for Minnesota,* 1976, pp. 21-22.
[172] MDH, *Minnesota's Health,* Vol. V, No. 4, April 1951, pp. 1-2.

TB – Closing of Sanitariums. Because of a decline in cases, in 1949 legislation was passed permitting the closing of small county sanitariums no longer needed for tuberculosis patients. Deerwood Sanitarium, serving Crow Wing and Aitkin counties, was the first to close. It was converted to a nursing home.[173]

There were 15 county TB sanitariums in 1951, and they were reduced to five by 1961. The remaining five were Mineral Springs at Cannon Falls; Nopeming in St. Louis County; Ancker Hospital in Ramsey County; Riverside in Granite Falls and Sunnyrest in Crookston. Cost for care was $27.65 per day at Glen Lake and $25.00 per day at Nopeming in 1960. Tuberculosis patients were also cared for in the Veterans Administration Hospital at Fort Snelling. Sunnyrest Sanitarium at Crookston closed July 1, 1967, after 50 years of continuous treatment of tuberculosis.[174] By 1969, only two county sanitariums remained – Nopeming near Duluth and Mineral Springs at Cannon Falls.[175]

Up until 1962, Ah-Gwah-Ching at Walker had been the state sanitarium, but it was converted to an institution for the care of non-psychotic mental patients. On January 1, 1962, Glen Lake became the state tuberculosis sanitarium.[176] A total of 564 patients remained in sanitariums in 1962.[177] With the closure of TB sanitariums, private physicians began caring for an increasing number of tuberculosis patients. The department's medical laboratory provided them with technical laboratory support.



Graph used to demonstrate to the Legislature the value of tuberculosis preventive efforts

Legislation in 1963 authorized a grants-in-aid program that enabled the board to assist counties in the development of local tuberculosis control programs, especially outpatient clinics. As of March 15, 1964, seven tuberculosis outpatient clinics were operating or approved: The seven facilities served 36 counties. They were: Mineral Springs Sanitarium in Cannon Falls, Nopeming Sanitarium near Duluth, Ramsey County Pavilion in St. Paul, Sunnyrest Sanitarium in Crookston, Hennepin County Chest Clinic in Minneapolis, Riverside Out-Patient Clinic in Granite Falls, and Central Minnesota Out-Patient Clinic in St. Cloud. The local tuberculosis control programs were under the direction of county sanitarium

[173] MDH, *Minnesota's Health,* Vol. V, No. 4, April 1951, pp. 1-2.
[174] MDH, *Minnesota's Health,* Vol. 21, No. 9, November 1967, p. 4.
[175] MDH, *Minnesota's Health,* Vol. 23, No. 8, October 1969, p. 1.
[176] MDH, *Minnesota's Health,* Vol. 15, No. 8, October 1961, p. 1.
[177] BOH, *Minutes*, May 23, 1962, MHS, p. 214.

commissions. The out-patient clinics assisted local physicians with diagnostic problems, served as evaluation centers for known cases, provided consultation with a chest specialist on a referral basis, and focused on case finding.[178] An out-patient clinic was added in Bemidji in 1965.[179]

TB – Cooperative Worldwide Effort. While cases had declined, tuberculosis was considered the most important infectious disease confronting public heath officials in Minnesota in 1962. The previous year, 1961, there had been 97 deaths from tuberculosis. Tuberculosis was expensive for the state. In 1960 an estimated $5 million in public funds was spent for tuberculosis problems. This did not include funds spent for the burns unit at Anoka, the state sanitarium or the cost to take care of American Indians with tuberculosis.[180] Research and studies on tuberculosis were done at the University of Minnesota Medical School, the Mayo Clinic in Rochester and the Minneapolis General Hospital.

Public health workers emphasized Minnesota couldn't operate independently. The department's newsletter stated, "When American servicemen are stationed in countries where TB is rampant, the world problem becomes our problem."[181]

The fight against tuberculosis was a group effort, involving county boards of welfare and county commissioners, public health agencies, voluntary agencies and private practitioners of medicine. A voluntary agency that played an important role in the reduction of tuberculosis in the state was the Minnesota Tuberculosis and Health Association. It had chapters in all 87 counties. This organization gave support and aid, getting funds through the sale of Christmas seals.

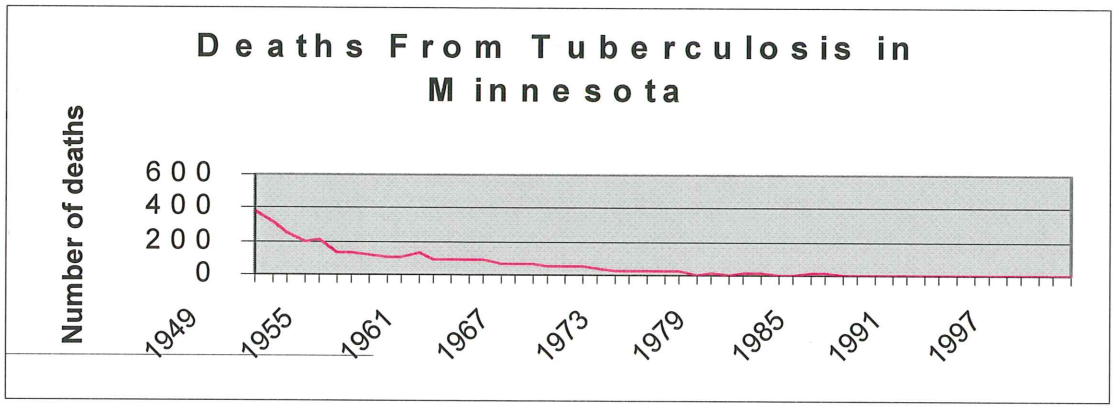
Several state agencies worked together to control tuberculosis: Public Welfare was responsible for the state institutions; Health maintained a case registry of infected persons and conducted follow up activities; Education was responsible for rehabilitating patients; and the Minnesota State Livestock Sanitary Board was responsible for control of tuberculosis in animals.[182] Effective July 1, 1969, Public Welfare's tuberculosis control section was transferred to Health. The department assumed control for tuberculosis control in all state institutions and general administration of the contract with the federal government for the care of tuberculosis patients on land owned by American Indians. Welfare retained responsibility for the direction of the state sanitarium at Glen Lake and assistance to non-residents with tuberculosis. [183]

Minnesota received national kudos for its work on tuberculosis. A representative of the U.S. Public Health Service said:

> No other state has worked more vigorously than Minnesota to banish tuberculosis. Progress in controlling tuberculosis has been achieved here because you have been wise enough to adopt a

[178] MDH, *Minnesota's Health,* Vol. 18, No. 5, May 1964, p. 1.
[179] MDH, *Minnesota's Health,* Vol. 19, No. 5, May 1965, p. 1.
[180] BOH, *Minutes*, December 19, 1960, MHS, p. 421.
[181] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 4.
[182] MDH, *Minnesota's Health,* Vol. 15, No. 8, October 1961, p. 1.
[183] MDH, *Minnesota's Health,* Vol. 23, No. 8, October 1969, p. 1.

coordinated cooperative approach to the problem. It is your working partnership of professional and voluntary organization of public and private institutions that has cut the mortality rate so drastically. Physicians alone can't control tuberculosis. The final responsibility for complete eradication rests with the entire community." [184]



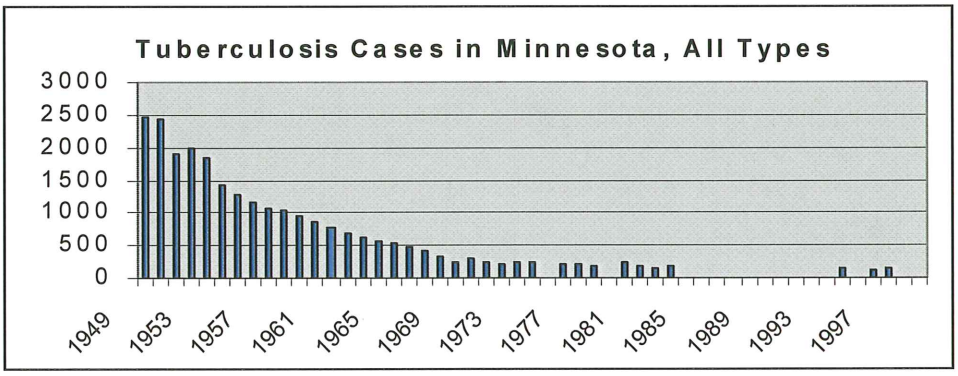
While the control of tuberculosis was a community effort, a number of individuals deserve special recognition. Dr. Mary Ghostley was the director of the Lake Julia Sanitarium at Puposky from 1930 until it closed in December 1952. She promoted school tuberculin tests, chest x-rays of reactors and education.[185] Dr. Walter J. Marcley devoted his life to fighting tuberculosis, beginning as the director of the first state sanitarium in the country at Rutland, Massachusetts in 1897. He was the first superintendent of Minnesota's first state sanitarium at Walker in 1907. In 1941, he began working for the department as a tuberculosis consultant to the Board of Health, the department and physicians and health officers throughout the state.[186] Dr. Ejvund Fenger headed the tuberculosis control program at the Public Welfare and Health departments. He died in 1969, after devoting his life to the field of tuberculosis control.[187]

TB – Resurgence. Tuberculosis reached a historical low of 91 cases (2.2 per 100,000 population) in 1988, but the downward trend reversed itself. In 1999, 201 new cases (4.3 per 100,000 population) were reported in Minnesota. This is the largest number since 1980.[188] Minnesota's upward trend in tuberculosis cases does not match the national trend in which the incidence of tuberculosis has declined since 1993.

The majority of new tuberculosis cases in Minnesota in the 1990s occurred in the seven-county metropolitan area. Data suggested the increase was related to increased immigration to Minnesota, as 67 percent of the new cases from 1995 to 1999 were foreign-born. The percentage of new TB cases that were foreign born increased to 78 percent in 1999.[189] Managing the disease presented cultural challenges. For example, people in the Somalia community believed tuberculosis was incurable and tended to

[184] MDH, *Minnesota's Health,* Vol. V, No. 12, December 1951, p. 3.
[185] MDH, *Minnesota's Health,* Vol. VII, No. 4, April 1953, p. 3.
[186] MDH, *Minnesota's Health,* Vol. 9, No. 4, April 1955, p. 2.
[187] MDH, *Minnesota's Health,* Vol. 23, No. 8, October 1969, p. 1.
[188] MDH, *Disease Control Newsletter,* Volume 28, Number 1, January/February 2000, p. 1.
[189] Ibid.

keep the disease a secret. People from the Vietnamese community, on the other hand, spoke candidly about tuberculosis and readily sought treatment.[190] To address the growing problem of tuberculosis, Commissioner Anne Barry created a special task force on tuberculosis.



A challenge to the control of tuberculosis in the 1990s was one foreseen 30 years earlier in the department. The department's October 1961 newsletter warned:

> ***"If tuberculosis is to be eradicated it must be done before the bacillus produces so many drug resistant mutants that drug therapy is no longer effective."*** [191]
>
> ***Minnesota's Health***
> **October 1961**

Of the TB cases identified in the last five years of the century, 16 percent were resistant to TB drugs.[192]

Animal-to-Man Diseases

In the 1940s and 1950s the department increased its emphasis on the investigation and control of animal-to-man diseases. As director of the department's laboratory, Dr. Henry Bauer was one of the detectives who hunted down the sources of all diseases in Minnesota, including those transmitted through animals. Dr. Bauer pointed out that any disease transmittable to lower animals is potentially a threat to people. Those known to cause disease in humans, existing in Minnesota, included brucellosis, toxoplasmosis, bovine tuberculosis, Q fever, anthrax, trichinosis, tularemia, rabies, salmonella infections and psittacosis.

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[190] American Lung Association of Minnesota, *Breathe Easy,* "TB on Increase in Minnesota," Vol. 1, No. 2, Winter 2000, pp. 1 and 4.
[191] MDH, *Minnesota's Health,* Vol. 15, No. 8, October 1961, p. 1.
[192] MDH, *Disease Control Newsletter,* Volume 28, Number 1, January/February 2000, p. 1.

To help with the challenge of animal–to-man diseases, in the 1950s Dr. Joe R. Held, a veterinarian from the U.S. Public Health Service, was brought in to study the relationship between humans and animal diseases. He worked with the department's divisions of disease prevention and control and medical laboratories, the state Livestock Sanitary Board, Minnesota Livestock Breeder's Association, the University of Minnesota School of Veterinary Medicine, and private practicing veterinarians.[193] Together they focused on the source of disease – be it animal or human – and control.

Minnesota became one of three centers in the Western Hemisphere that participated in a worldwide information and training program on animal-to-human diseases. The department and the University of Minnesota's veterinary medicine and medical schools were chosen by the World Health Organization for this center. The head of the center was Dr. Wesley W. Spink, professor of medicine at the University of Minnesota School of Medicine, and expert on brucellosis. One of the department's main contributions was an extensive collection of epidemiological data on brucellosis.[194]

Brucellosis

By 1949, as a result of antibiotics, there had been no deaths from brucellosis in the Minnesota population since 1944. Brucellosis, an infectious disease sometimes called "Bang's disease" in cattle and "undulant fever" in humans, still caused disability and illness to the 300 and more cases that occurred each year. There were two agreed-upon reasons for the continued existence of the disease: the sale of raw milk in the state and infected cattle herds. These were the two areas the department targeted.

Public health workers had been imploring the public not to drink raw milk for as long as the department existed. In 1873, Dr. William Budd, early authority on typhoid fever said, "Drinking unboiled milk is like eating raw meat and is open to consequences of the same pathological order."[195]

In 1949, unpasteurized milk was still being sold in the state. In addition to brucellosis, it could carry typhoid and paratyphoid fevers, scarlet fever, septic sore throat, food poisoning, diphtheria, dysentery and tuberculosis. Health workers advocated pasteurization – heating the milk to 143 degrees F. for 60 minutes or 160 degrees F. for 30 minutes – to kill the germs.

Not everyone supported the pasteurization of milk. A pamphlet, "The Truth About Pasteurized Milk," circulated in 1949. It decried the loss of nutritional value in pasteurized milk and discredited the work done by the department. The pamphlet was produced by the "National Nutrition League," an agency in Seattle. Health department staff made a phone call and discovered there was no such organization. The address

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[193] *St. Paul Pioneer Press*, "Job for a Team," January 6, 1957.
[194] MDH, *Minnesota's Health,* Vol. V, No. 3, March 1951, pp. 1-2.
[195] MDH, *Minnesota's Health,* Vol. III, No. 2, February 1949, p. 3.

given was that of a stationery store, being used as a front. The U.S. Public Health Service was contacted, and it obtained suspension of the publication and got copies on hand destroyed.[196]

State legislation passed in 1949 required all milk and all fluid milk products sold on or after July 1, 1950, to be pasteurized.[197] Even before the legislation, the number of persons drinking raw, unpasteurized milk had dropped significantly. The estimated number of cases of brucellosis contracted from drinking raw, unpasteurized milk was 85 percent in 1947. In 1949, only 25 percent of all cases were believed to be contracted from raw milk.[198]

As milk was no longer responsible for transmitting most of the cases of brucellosis, in 1950, Dr. Dean Fleming, director of the disease prevention and control division; and Dr. Wesley Spink, University of Minnesota professor and expert on the disease; identified brucellosis as an occupational disease. Infected persons tended to be cattle raisers, packing plant employees and veterinarians.[199] In 1956, 47 of the 63 cases were packinghouse workers or farmers.

At a board meeting in 1950, Dr. Barr said, "The statement was made – I don't know how much truth there is in it – that Gov. Youngdahl wasn't interested in this program until someone told him that a number of the cases in his mental institutions may have been victims of brucellosis." [200] The governor created a committee on brucellosis, comprised of: Mr. Frank B. Astroth, Minnesota Livestock Breeders Association; Dr. W. W. Spink, University of Minnesota; Dr. Gaylord W. Anderson, University of Minnesota; L. D. Peckham U.S. Public Health Service, and Dr. R. N. Barr, Minnesota Department of Health.[201]

Like many others, Dr. Robert Barr, executive officer for the department, believed the only way to eradicate brucellosis in humans was to get rid of Bang's disease in animals. A statewide plan to eliminate brucellosis in cattle had been adopted in 1939, and testing of herds began the same year. Costs were shared by the federal government through the U.S. Department of Agriculture. The program didn't get fully under way, however, until after the war years. By May 1, 1949, 28 counties were "modified accredited disease free areas." A county was declared modified brucellosis free, if the number of reactor animals in the country did not exceed 1.0 percent and the percentage of herds infected did not exceed five.[202] The Minnesota Livestock Sanitary Board recommended that all cattle in the state be tested and those that tested positive be slaughtered.[203]

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[196] BOH, *Minutes*, January 25, 1951, MHS, p. 50.
[197] MDH, *Minnesota's Health,* Volume 11, No. 2, February 1957, p. 3.
[198] MDH, *Minnesota's Health,* Vol. III, No. 10, October 1949, p. 2.
[199] BOH, *Minutes*, August 1, 1950, MHS, p. 326.
[200] Ibid.
[201] Ibid., pp. 324-326.
[202] MDH, *Minnesota's Health,* Volume 11, No. 2, February 1957, p. 2.
[203] MDH, *Minnesota's Health,* Vol. II, No. 8, August 1948, pp. 3-4.

Legislation in 1951 required all cattle over six months old to have certification proving they were free of brucellosis in order to be sold.[204] Minnesota herds were expected to be clean within five years. Other agencies joined the campaign. The theme of the Minnesota Public Health Conference (now the Minnesota Public Health Association) on September 28 and 29, 1951, was brucellosis and the quality of milk.[205]

Like so many aspects of public health, brucellosis was an economic issue, as well as a health issue. Brucellosis was a costly expenditure to the livestock and dairy industry. Unchecked, brucellosis could have disastrous consequences for the dairy industry. Because of it, Minnesota was already unable to sell milk in some states. Dr. Robert N. Barr, chief of the special services section, stated:

> ***"I think it is an accepted recommendation in both the feeders and shippers of dairy cattle and the dairy people that there must be more done in the control of Brucellosis, if Minnesota is going to retain and regain its status as a milk producing state."*** [206]
>
> **Dr. Robert Barr, 1959**

Based on USDA estimates, brucellosis was costing the livestock industry about $4 million annually in Minnesota.[207] The eradication program from 1946 to 1957 cost far less. At a total cost of $9 million for those 12 years, the annual cost was about $831,000 a year – a far cry from $4 million.[208] The gains also included better production. Despite a reduction in infected cattle, milk production increased markedly. There were 3,636,000 cattle in Minnesota in 1946. This compared to 4,018,000 in 1956.[209] Other benefits not measured include person-hours saved, and prevention of human suffering.[210]

The effort to reduce brucellosis was a joint effort, as noted in a 1957 issue of *Minnesota's Health*:

> Success of the eradication and control program is closely associated with the close working relationship and subsequent accomplishments of the Minnesota Live Stock Sanitary Board and the Minnesota State Board of Health. The two agencies also received the far-sighted cooperation of such groups as legislators, physicians, veterinarians, county agents, and the livestock owners through organizations such as the State Livestock Breeders Association, the Minnesota Farm Bureau, and others.[211]

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[204] MDH, *Minnesota's Health,* Vol. V, No. 5, May 1951, p. 4.
[205] BOH, *Minutes*, July 23, 1951, MHS, p. 227.
[206] BOH, *Minutes*, August 1, 1959, MHS, pp. 324-325.
[207] MDH, *Minnesota's Health,* Volume 11, No. 2, February 1957, p. 3.
[208] Ibid.
[209] Ibid.
[210] BOH and Minnesota State Livestock Sanitary Board, "A Milestone Toward the Eradication of Brucellosis in Minnesota," 127.H.12.8F, BOH, *Minutes* attachment, MHS, pp. 181-182.
[211] MDH, *Minnesota's Health,* Volume 11, No. 2, February 1957, p. 2.

In 1957, all 87 counties in Minnesota were certified as modified brucellosis free, and Minnesota became an accredited state. Dr. Henry Bauer, director of the medical laboratories division, described the accomplishment as:

> ***"...a beautiful illustration of what years of work, coordination, good planning and stick-to-itiveness results in."*** [212]
>
> **Henry Bauer, PhD, 1957**

Deaths from and cases of brucellosis steadily declined in the 1950s and 1960s. While there had been 149 cases of brucellosis in humans in 1954, there were only 19 cases in 1961.[213] The last death from human brucellosis was reported in 1963.[214] In 1969, 11 cases were reported.[215]

In 1978, Dr. J. G. Flint, secretary and executive officer of the Minnesota Livestock Sanitary Board, reported that Minnesota had been certified free of bovine brucellosis since July 9, 1970.[216]

Rabies

In 1949, rabies was not a significant health concern. A case of human rabies had not been reported since 1917, and the state was relatively free of animal rabies. There were no cases of animal rabies in 1943, 1945 and 1946. Of the 104 cases reported between 1940 and 1950, all but five were in domestic animals. [217]

The situation began to change early in the 1950s. Dr. Dean Fleming noticed it: "We seem to be sitting on a powder keg so far as this rabies situation in concerned." He questioned whether there should be a program to eradicate skunks, as many of the cases involved skunks.[218] A case in a dog was reported in November 1950, and during the next year cases were discovered in cattle, cats, civet cats, gophers, horse, fox, groundhog, muskrat, raccoon, in addition to skunks and dogs.[219]

While there were five cases of animal rabies in 1948, there were 245 cases in 1951 and 264 in 1952.[220] It had reached epidemic proportions and affected the whole state. Rabies was considered a greater problem than polio. Rabid skunks were reported as attacking people and chasing children.[221] Rabid animals appeared throughout the

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[212] BOH, *Minutes*, July 30, 1957, MHS, p. 124.
[213] MDH, *Vital Statistics Minnesota, 1954* and *1961*.
[214] Ibid., 1963.
[215] Ibid., 1969.
[216] *Duluth News and Tribune,* "St. Paul: Minnesota Certified Free of Brucellosis Since 1970," November 4, 1978, p. 2A.
[217] MDH, *Minnesota's Health,* Vol. 18, No. 2, February 1964, p. 3.
[218] BOH, *Minutes*, December 21, 1950, MHS, pp. 539-542.
[219] BOH, *Minutes*, October 16, 1951, MHS, pp. 313-318.
[220] MDH, *Minnesota's Health,* Vol. VII, No. 2, February 1953, pp. 3-4.
[221] BOH, *Minutes*, July 23, 1951, MHS, pp. 215-217.

state, including metropolitan areas. A skunk was captured at 55th and Colfax in Minneapolis.[222] A rabid cat appeared at 42nd and Pillsbury in Minneapolis.[223]

New rabies regulations became effective January 27, 1953. Regulation 1100 required that the attending physician or health officer determine as soon as possible if the person attacked should receive treatment. The suspected animal was to be observed two weeks and not killed unless it could not be safely secured.[224]

Education of the public was a critical method of intervention with rabies. A pamphlet for distribution was prepared in collaboration with the Twin Cities Veterinary Society and the Livestock Sanitary Board.[225]

Department staff were dismayed when, in the midst of their efforts to protect the public from rabies, Allen Gray, a WCCO radio announcer, read an article on the air which questioned whether rabies existed. The article, "Rabies – Fact or Fancy," was produced by Nature's Path magazine in New York. Veterinarians, representatives of the department and other listeners called to complain. Dr. Dean Fleming, director of the disease prevention and control division, wasn't quite satisfied with the response. He said that Allen Gray "retracted his statements in such a way that it sounded as though he was being awfully put upon by the authorities."[226]

Allen Gray wrote to Dr. Chesley and explained his act:

> ...I assume you've since read the article quoted, and you must certainly admit that to the layman it appears unusually well documented. That is precisely the way it was presented, even to the qualification that we had never previously heard of the magazine, could not vouch for its authenticity, did not necessarily presume it to be true, but that it was, if true, rather startling. The press and radio is flooded with amazing claims of new medical discoveries, therapies and wonder drugs. And for that reason it's difficult to draw the line between fact and controversy....I promise in the future to get in touch with medical authorities before launching into that kind of story.[227]

While the radio message might have hurt the department's fight against rabies in this case, the media were of great help in tracking a rabies case four years later. A doctor from Le Mars, Iowa had phoned the department to report that rabies had been found in a dog that had bitten a 14-year-old boy. The boy and his father were on their way to Minnesota when they stopped at Le Mars to look at a trailer that was for sale. A dog bit the boy, and after first aid, the two continued their trip to Moorhead, Minnesota. The dog died and examination of the brain at Iowa State College revealed rabies. Trying to locate the boy quickly, the newspapers and radio stations made many announcements. Relatives of the boy, listening to a Sioux Falls, South Dakota, station, heard the report

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[222] BOH, *Minutes*, February 5, 1952.
[223] BOH, *Minutes*, May 15, 1957, MHS, p. 69.
[224] MDH, *Minnesota's Health,* Vol. VII, No. 2, February 1953, pp. 3-4.
[225] BOH, *Minutes*, May 28, 1951, MHS, p. 183.
[226] BOH, *Minutes*, October 16, 1951, MHS, pp. 313-318.
[227] Letter from Allen Gray to A. J. Chesley, M.D., October 2, 1951.

and called the family. Within a few hours the boy was being treated to prevent rabies.[228]

WCCO, KSTP and WTCN radio stations and the Minneapolis Star and Tribune and the St. Paul Dispatch and Pioneer Press newspapers all received letters of appreciation from the department for their assistance.[229]

The number of rabies cases in the state reached an all-time high in 1958 when 461 cases from 77 counties were reported.[230] Half of these involved skunks, but raccoons, squirrels, foxes, gophers, cattle, cats, dogs, swine and horses were affected as well. Minnesota was second only to Texas in the number of cases of animal rabies. Though there were no human cases in 1958, at least 260 people received anti-rabies vaccination treatment.[231]

Rabies was an economic problem to farmers who would have to destroy milk-producing cows or other livestock. The treatment of 14 injections given under the skin of the abdomen on 14 successive days was costly and unpleasant and carried a risk of severe reaction for humans.

With so many cases of animal rabies in the state, the department was expecting a case of human rabies. It happened in 1964. A ten-year-old boy in Wabasha County was bitten on the wrist and fingers by a skunk early in the morning, as he was sleeping in a tent with two other children in the farmyard.[232] Treatment was begun immediately, but the boy developed rabies and died a month later. The 1964 death was the first in Minnesota since 1917. A second death occurred in 1975, and there were no human deaths from rabies in Minnesota between 1976 and 1999.

"Parrot Fever" (Psittacosis /Ornithosis)

At the January 25, 1951, board meeting Dr. Viktor Wilson, head of the Rochester district office, said:

> Just before Christmas my boy said, 'Can I get a parakeet?' And I said, 'No, it's against the law.' And he said, 'Well, there are at least 20 of my friends who have them.' So I started to investigate. There is a Mrs. H. raising and selling parakeets in Rochester and a dentist's wife, Mrs. L., doing the same, and another woman doing the same....Mrs. H. sold about 50 just before Christmas for Christmas presents. Some of the additional information I got was that there was one in Jim O'Connor's clothing store in the boys' department, and he said, 'They are safe; there is even one in St. Mary's Hospital.' Out at St. Mary's there were two polio patients, one in a respirator, Representative Madden's son, had a canary. The other boy, who had been in a respirator for 4 ½ years, had a parakeet. Well, I called up Dr. Fleming about the regulation and he said it is not being enforced. The regulation prohibits the importation, purchase, breeding, sale or giving away of birds of the psittacine family. I talked with people, and they said it is going

[228] MDH, *Minnesota's Health,* Vol. 9, No. 4, April 1955, p. 2.
[229] BOH, *Minutes*, March 17, 1955, MHS, p. 50.
[230] MDH, *Minnesota's Health,* Vol. 18, No. 2, February 1964, p. 3.
[231] MDH, *Minnesota's Health,* Vol. 13, No. 5, May 1959, pp. 1-3.
[232] BOH, *Minutes*, October 13, 1964, MHS, p. 506.

> on all over Minnesota. They say there is a woman in Fergus Falls, one in St. Charles, one in Winona, and many stores in the Twin Cities selling them.[233]

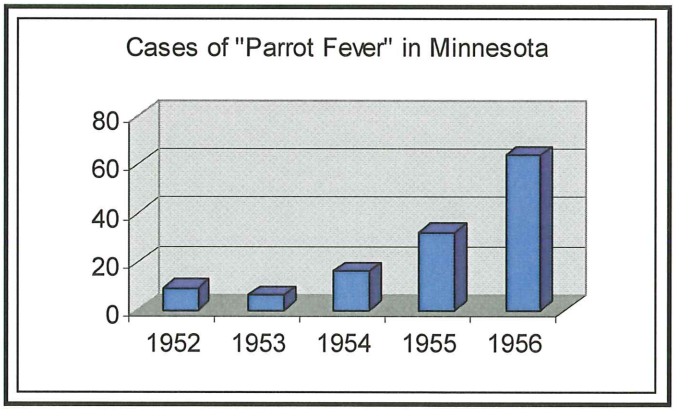
Dr. C. Barton Nelson, assistant director of disease prevention and control, added that parakeets, prohibited by state legislation, were listed in the classified directory of the telephone book.

The disease was brought to Minnesota in 1932 when a traveling carnival company gave parakeets or "love birds" as prizes. Later that year, there were 22 positive cases, one death and five suspected cases of psittacosis.[234] Four cases were reported in Minnesota between 1933 and 1949. A young boy in St. Paul who raised pigeons had a severe case of ornithosis in 1949.

A state health regulation prohibited the import and purchase, breeding, sale or giving away of birds of the psittacine family. As Dr. Wilson pointed out, the regulation was being openly ignored. The board debated whether it should even exist. "Parrot fever" was widespread among all birds, not just those of the psittacine family. The regulation was difficult or impossible to enforce. Under such circumstances the board decided there was no need to continue with the regulation. It was rescinded on May 23, 1952.

During the next few years, cases increased. The increase in cases was believed due to the popularity of parakeets and improved case finding. Symptoms resembled pneumonia, so in 1952 the department's public health laboratory began to test every sample with a diagnosis of virus pneumonia for psittacosis as well.[235]

Concerned over outbreaks of psittacosis in turkey flocks in other states, the Board of Health, the State Livestock Sanitary Board, the University of Minnesota School of Veterinary Medicine and the Minnesota Turkey Growers Association banded together to monitor the situation in Minnesota in 1957.[236]



There were a total of eight confirmed cases of psittacosis in Minnesota from 1972 through 1980. Then, the numbers increased. During the first 11 months of 1982 there were eight cases, and from December 1982 to February 1983 there were 15 cases in Minnesota. The department conducted tests of members of bird fancier clubs, workers at veterinary clinics and pet shop employees. The results indicated about a third or more were infected.[237]

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[233] BOH, *Minutes*, January 25, 1951, MHS, pp. 50-51.
[234] MDH, *Minnesota's Health,* Vol. 11, No. 4, April 1957, pp. 1-3.
[235] Ibid., p. 3.
[236] Ibid., p. 1.
[237] *St. Paul Pioneer Press,* "Bird-Carried Disease Proving Widespread," February 18, 1983, p. 1C.

Chapter 3

Polio: Minnesota's Crucial Role

"It was not until the late 19th century and early 20th century that epidemic poliomyelitis was defined. Few diseases were more feared than polio because it attacked healthy children, killed a few of them, confined some for life to a respirator (iron lung), and left many with permanent physical disabilities. These victims of polio never let you forget the terrible visitation. This was the driving force in the conquest of polio. The terror of the summer months has met its conqueror! A single dose of live oral polio virus vaccine containing the three types 1, 2 and 3, will protect the recipient from infection.

"The Minnesota State Department of Health Laboratories developed the use of a single oral dose of polio vaccine containing the three types, 1, 2 and 3; of the live attenuated Cox strains of polio virus. It is important, for the mass public health immunization programs, that the three types of virus be combined in a single oral dose. More than 100,000 Minnesotans volunteered to receive the Cox oral vaccine, which in this and other carefully designed testing programs, proved the oral vaccine to be safe and efficacious. The use of a single oral dose of the Cox vaccine provided for the uniform immune status of all persons getting the vaccine, which neither the Salk killed virus nor the Sabin live oral vaccine provided in the 1950s.

"The Sabin live oral vaccine, after it was licensed, is being produced with all three types of virus in a single dose as recommended. The Cox vaccine and the Sabin vaccine were arbitrated, and the conclusion favored the Sabin strains of polio viruses because the arbitrators felt the Sabin strains were more stable. The Salk vaccine was dropped because of the cost of needle injections and the difficulty in getting vaccinated individuals to return at set intervals for the second and third dose."

Henry Bauer, Ph.D.
Director of Public Health Laboratories, 1951 to 1976
Deputy Executive Secretary, 1960 to 1966
Minnesota Department of Health, 1938 to 1976

In the 1940s and 1950s polio terrified Minnesotans, as well as the rest of the nation. The disease struck suddenly and without warning, leaving visible reminders: paralysis, wheel chairs, and leg braces. One of the outcomes especially feared was confinement to an iron lung. Without sufficient muscles to breathe, the iron lung sustained life, but the patient was imprisoned with only his or her head exposed. A mirror was placed in such a position so that the patient could look in it. Nursing staff arranged books and other reading materials, but the patient often had little to occupy his or her time.

Even if a child of the 1940s and 1950s didn't suffer from polio or didn't know anyone who did, it affected his or her life. During the summer, fearful for their health, many

parents kept their children confined to the home and yard. Fairs and other mass gatherings were closed, as were swimming pools and even schools.

Thanks to the vigilance of public health workers, those days are memories. Minnesota played a very important role in the eradication of polio, not only statewide but nationally.

Polio became a reportable disease on October 20, 1908[238]. During the next four decades, the Board of Health received reports of polio cases and polio deaths every year. The highest death rate during this period occurred in 1946 with 9.8 deaths per 100,000 people.[239] The death rate in 1910 was almost as high: 9.7 per 100,000.[240]

By 1949, substantial strides had been made in the treatment of polio, but the knowledge and means to prevent it did not exist. There was a growing alarm in June 1949 when an increasing number of polio cases were reported to the board. Most of these were in the Twin Cities area, with a few cases in Freeborn and Fillmore counties. The population feared another epidemic similar to the one in 1946 that affected 2,881 people and resulted in 226 deaths. There were nearly 2,000 cases of polio and 110 deaths from polio in 1949. While high, the numbers did not reach the magnitude of the epidemic three years earlier. In 1950 the number of cases dropped to slightly more than 500. Unfortunately, the downward trend was only temporary. Annual cases and deaths in the early 1950s would top the 1946 epidemic.

Making Public Health Advisories with Limited Information

Throughout this period, and particularly when a polio epidemic threatened, the board was called upon to advise the public as to what they could do to prevent the spread of the disease. This was a difficult responsibility, as the transmission route for polio was still not definitively identified in 1955.[241] The board had less than perfect information on which to make its recommendations.

Various factors, such as mosquitoes, were suggested as causing polio. In 1949 Dr. Thomas Magath, state board of health president, was asked to support a campaign to fight polio by reducing the number of flies. Dr. Magath responded that killing flies would be good for other public health reasons, but he felt emphasizing it as the solution to polio would hinder the movement rather than help it.[242]

Some people noted that polio seemed to occur more frequently following tonsillectomies. Board members were uncertain of the role, if any, this surgery played

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[238] BOH, *Minutes*, January 12, 1954, MHC, page 27.
[239] Ibid.
[240] Ibid.
[241] Harold K. Faber, *The Pathogenesis of Poliomyelitis*, (Springfield, Illinois: Charles C. Thomas, 1955) pp. 14-28.
[242] BOH, *Minutes*, July 14, 1949, MHC, p. 240.

in the transmission of polio. If asked, they recommended that tonsillectomies be delayed if there was no immediate need.[243]

In attempting to reduce the risk of contracting polio, the State Fair was closed during the polio epidemic of 1946. In 1950, when the number of cases indicated another epidemic, the board considered closing the county fairs. They discussed the value of reducing interaction among people:

> Magath:"....When you don't know what to do, you just play it about as safe as you can. That is about all you can do. We have got that problem down in Rochester now and the City Health Board doesn't know just what to do. We have a good swimming pool and the local merchants have sponsored bringing groups of children from surrounding villages in to swim. They have some polio at Lanesboro and the other day sixty youngsters from Lanesboro were swimming in the Rochester pool along with the Rochester people. The City Board of Health wrote a letter to the Park Board and asked that they stop that. Nobody can shut down on intercourse of people in communities, but you can do no good by importing youngsters from neighboring cities when there is a polio epidemic. I hope nobody asks the Board of Heath for a statement of opinion, and I hope we don't have to go on record. It is very difficult to take a position. We will just have to say, 'Do everything you can within reason.' You can't close up everything, but I do think you can stop deliberately bringing 50 or 60 kids into a community where they are rubbing shoulder to shoulder....You have got to have the cooperation of the public in pubic health matters. If you deliberately buck them and try to hold them to something, you get into trouble. Up to yesterday we had no polio in Olmsted County, and this week we had one case."[244]

One board member likened the board's responses to the population of Minnesota to the relationship between patient and doctor:

> Lester Webb, D.D.S.: "We should treat the public as we treat the patient. Satisfy the public by doing something."[245]

Privacy Issues and Dealing with Public Fear

Newspaper photos of polio patients confined to iron lungs made deep impressions. Preventive solutions were not known or available. Fear of the disease intensified. Public health workers were left to deal with this aspect, as discussed by Dr. Gaylord Anderson, director of the University of Minnesota School of Public Health and Dr. Albert Chesley, executive officer of the board, at a board meeting in 1950:

> Anderson: "You really have two epidemics, an epidemic of polio and an epidemic of hysteria."[246]

> Chesley (Executive Officer): "...trying to satisfy the people and take care of the cases. It is a big mental problem. People who are normally perfectly stable go completely off the beam when anyone says 'polio.'"[247]

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[243] BOH, *Minutes*, July 14, 1949, MHC, p. 238.
[244] Ibid.
[245] BOH, *Minutes*, July 14, 1949, MHC, p. 240.
[246] BOH, *Minutes*, February 14, 1950, MHC, p. 65.
[247] Ibid., p. 67.

> Anderson: "There is panic with polio. You don't want a member of your family to go into a room occupied by a person who has just died of polio, although you know darn well there is no danger."[248]

Public fear increased as the statistics indicated an increase in cases and deaths from polio. At a board meeting in October 1952 the board struggled with ways to calm the public, as well as how to deal with privacy issues in releasing information to the media:

> H.Z. Giffin, M.D.: "Is it possible to publicize the small proportion of patients that develop paralysis? I see these reports come out in the paper every day and the radio announcer talks about them, and it seems to me that it would do an awful lot of good if people were told that a high percentage have no paralysis."
>
> Dean Fleming, M.D. (Director of Preventable Disease): "We will try to do that, Dr. Giffin."
>
> Giffin: "It wouldn't have to be an accurate statement. The people are all stirred up about them."
>
> Jerome Brower (Chief of Administration): "Mr. President, we are receiving a little more pressure than we have had in the past from newspaper reporters. Yesterday Mr. Martin from the St Paul Dispatch and Pioneer Press called and wanted to know why we couldn't give out the names of those dying from polio. We had a long unsatisfactory conversation about it and I had just a few minutes to talk to Dr. Fleming this morning. I think we could discuss this particular point. It seems the fact of a death is not covered anywhere as a confidential item. Information comes to us that somebody dies from polio. We are perfectly happy to give them the count, but they want to know who dies. I haven't got a satisfactory reply for them."
>
> Herbert Bosch: "What harm would it do if you did give it to them?"
>
> Brower: "I don't think any harm would come of it. We do not permit the indiscriminate viewing of birth and death records. We treat those as confidential. They have asked about those matters. What about the reports that are coming in? Why can't we see those and give information from morbidity reports? We point out that reporting on the communicable diseases is an extension of the doctor-patient relationship. Reports are public except where they are made confidential. In only two cases do we have regulations providing for privacy of records-- the venereal disease reports and the cancer reports, when that was undertaken, were made confidential. The same is true, of course, with the illegitimate birth records. We are not permitted to disclose any information of that kind. Therefore, since some are made strictly confidential, then the assumption must arise that others are not confidential."[249]

The department didn't release names of patients but sometimes did release the name of the hospital in which the patient died. The media would call the hospital and get the information.

> Fleming: "....They usually get it anyway and get annoyed with us because we don't give them the information. Vik Wilson feels quite strongly that it is important to give out every scrap of information about polio, especially deaths.[250]

The media were not the only ones who wanted information on polio patients.

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[248] BOH, *Minutes*, February 14, 1950, MHC, p. 63.
[249] BOH, *Minutes*, October 2, 1952, MHC, pp. 442-443.
[250] Ibid., p. 443.

> Fleming: "There has been a similar situation in regard to polio insurance policies. We had many requests from the policy holders....We referred them to the physician, saying that we didn't see why the Health Department should get in the middle. We have never given certifications unless occasionally when we have gotten letters from the patient and from the doctor or insurance company saying it was all right to do so."[251]

Information on some diseases was not given to the media because of the associated stigma, but this was not the case with polio. Board members were concerned that there may be inaccuracies in the information, particularly when it was given over the telephone. They also wondered where the requests for information would stop:

> Robert Barr, M.D. (Deputy Executive Officer): "Accidental deaths will be the next one they will be wanting to know. We are also investigating deaths of women that are pregnant or have been pregnant within three months. That is going to be a rat race if they start in with that."[252]

The board returned to its discussion of whether or not it should release data on polio cases and polio deaths.

> Brower (Chief of Administration): "Our arguments here are not down to the real crux of the matter. If a person dies, it is reported to us as such. It might be in error. If there is a correction, they can report it later. That is no concern of ours."
>
> Bosch: "But is it reported to us until we get the death certificate?"
>
> Brower: "No, it is not, but the newspaper can state in some language that it is a tentative or conditional report, or something of that kind."
>
> Charles Netz, PhmD: "It could lead up to the point where they might get a list of people every day."
>
> Brower: "They get them now. Also, they go to the Clerks of Court and health officers."
>
> Barr (Deputy Executive Officer): "That doesn't state the cause."
>
> Brower: "Sure it states the cause."
>
> Netz: "The newspaper account doesn't. I have wondered many times what a younger person dies of."
>
> Brower: "I am looking at the legal justification for withholding that information from them."
>
> Fleming (Director of Preventable Disease): "Dr. Wilson of Rochester might be able to give you some very good information."
>
> Barr: "I think the situation there is different. I think you are endangering the accuracy of your death reports, making them that much less accurate."
>
> Brower: "It doesn't."

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[251] BOH, *Minutes*, October 2, 1952, MHC, p. 444.
[252] Ibid., p. 445.

> Barr: "If it is generally known that the Health Department can release cause of death in various types of cases, then there is going to be much more reticence in putting down the true cause of death."
>
> Brower: "But everybody knows when a child in his community has polio."[253]

Managing the Cases

Children who contracted polio and could be kept at home were isolated for at least two weeks after the first symptoms appeared. A high proportion of polio cases that required hospitalization were sent to the Twin Cities. This placed undue stress on the facilities in St. Paul and Minneapolis, and the Twin Cities felt the brunt of the epidemic. To handle the influx in Minneapolis, the Minneapolis mayor's committee on poliomyelitis was established. Committee Chair Dr. Gaylord Anderson spoke to the board in 1950, appealing for statewide support:

> Anderson: "...it has become increasingly evident to us as a committee that this is not the sort of activity that can be done by a city committee in that polio does not respect city lines and our problems too often came down to trying to work out some of the problems that should have been the problems of areas removed from the city of Minneapolis. In other words, we were dealing as a city agency with what was a State problem and it would be presumptuous on our part, we felt, to carry out a great many of the activities that should be carried on in order to assure adequate hospital facilities for the State."[254]

A statewide committee was established for locating beds for polio patients. The intention was to find beds in out-state areas, as well as in the metropolitan area. In addition to distributing the load throughout the state, one member of the committee saw another advantage to finding hospital beds in out-state areas: "I think there are some very definite psychological factors involved when a community is encouraged to take care of its own problems."[255]

Health officers were relieved when the number of polio cases dropped to 586 in 1950.[256] Their greatest problem that summer was rabies, not polio. The following year,1951, was also reasonably light with 617 cases.[257]

In 1952, the number of cases increased dramatically. By the end of the year, there were 4,131 cases of polio and 220 deaths.[258] Minnesota had more cases of polio than any other state in the nation in 1952. The National Foundation for Infantile Paralysis had to supply 245 nurses from other states to help during the emergency. The foundation featured Minnesota in its annual report, complimenting the state on its response: "Under the challenge of the worst polio outbreak of all time, Minnesota

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[253] BOH, *Minutes*, October 2, 1952, MHC, p. 442.
[254] BOH, *Minutes*, February 14, 1950, MHC, p. 54.
[255] Ibid., p. 67.
[256] BOH, *Minutes*, attachment: report from disease prevention and control division, May 21, 1953.
[257] Ibid.
[258] Ibid.

reacted with calm intelligence. There was little panic and a calm attitude was evident everywhere." [259]

Gamma Globulin: A Glimmer of Hope

In addition to killing mosquitoes and avoiding tonsillectomies and mass gatherings of people, gamma globulin was publicized as a potential polio preventive measure. In October 1952 the "Journal of the American Medical Association" reported that immune globulin could effectively provide passive immunity from polio for about five weeks. [260] Limited supplies of gamma globulin became in vital short supply. . Executive Officer Dr. Chesley remarked about the situation:

> ....Very unfortunately the newspapers got hold of this idea and everybody thinks that if you get it you won't get polio and if you get polio you won't get paralyzed, etc. People get into an emotional spasm. Dr. Fleming will have to learn to say 'no' in several different languages.[261]

In March 1953 the federal defense mobilization office assumed control and allocation of gamma globulin, receiving all the supplies of the American Red Cross.[262] The department was already distributing gamma globulin free for the prevention of measles and hepatitis and was now designated the sole distributor of gamma globulin in the state. The allocation to Minnesota was determined by the office of defense mobilization and was based on the average number of polio cases reported over a five-year period, 1947-1951.

On April 23, 1953, the department announced plans for distributing gamma globulin as a preventive for polio, according to the plan developed by a poliomyelitis planning committee. One dosage represented one pint of human blood, so there was not sufficient supply for widespread use. Distribution was restricted to intimate contacts in members of households in which polio occurred, particularly in children age 15 years and under and pregnant women.[263] Most of the gamma globulin in Minnesota went to three counties – Stearns, Benton and Meeker – due to the seriousness of the polio epidemic in that area.[264] The results, however, were discouraging.[265]

Gamma globulin was still being distributed in 1954. It was stocked in 10 or 11 subsidiary stations throughout Minnesota, as well as the Health Department building.[266] Physicians had been told of its availability, and the board approved distribution, but it was reevaluating its effectiveness and usefulness as a prophylaxis of poliomyelitis.

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[259] MDH, *Minnesota's Health,* Vol. VII, No. 9, October 1953, pp. 1-2.
[260] W. Hammon, M.D., etal. "Evaluation of Red Cross Gamma Globulin as a Prophylactic Agent for Poliomyelitis. Preliminary Report of Results Based on Clinical Diagnoses," *JAMA*, 150:757-760, October 25, 1952.
[261] BOH, *Minutes,* December 22, 1952, MHC, Exhibit III.
[262] Ibid., Exhibit IV.
[263] BOH, *Minutes,* May 21, 1953, MHC.
[264] MDH, *Minnesota's Health,* Vol. VII, No. 9, October 1953, pp. 1-2.
[265] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 4.
[266] BOH, *Minutes,* June 1, 1954, MHC, p. 137.

Harold Habein, M.D.: "The thing that interests me is that gamma globulin has no effect. Why are we bothering with it at all and spending any money on it?"

Fleming (Director of Preventable Disease): "That is one of the things that made us think we shouldn't do any more work than we had to in distributing it. If a doctor wants it, we will send it to him but will keep no detailed records of the sort we kept last year. The National Foundation has put many hundred dollars into globuli purchase. It is not available commercially. The only means of distributing it is through health departments. We are the only agency in the state that could distribute it. A number of states have requested that gamma globulin be returned to commercial channels just as it always was. This year, at least, it is coming only through state health departments."

Ruth Boynton, M.D: "I think it is hardly fair to say hat there were no beneficial effects. I know that Dr. Hammond who did the original large-scale inoculations disagrees with that categorical statement because in their experience, while the effect was not too pronounced, still there was a difference. I don't think we are justified in saying it is no good and therefore we should not distribute it."

Fleming: "If it is used like the National Foundation for Infantile Paralysis says it should be used. From a practical standpoint, the way it was used last year was pretty good. You could tell you were at the peak only after the whole thing had subsided. That report has been published in the Journal of the A.M.A. this spring."[267]

The First Difficult Decision: Evaluating the Risk Involved

About the same time that gamma globulin provided a ray of hope in the prevention of polio, a second promising – but possibly risky – opportunity came. In 1953 the special advisory committee on active immunization of the National Foundation for Infantile Paralysis (NFIP) recommended that the foundation proceed with large trials to test the vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The NFIP developed a plan to begin active immunization, and wrote all state health departments, including Minnesota, asking if they wanted to participate.

The board was very uncertain as to what to do. There were risks involved, but there was also the potential to save lives. At its meeting on December 18, 1953, board members struggled with the decision and asked Dr. Gaylord Anderson, director of the School of Public Health at the University of Minnesota, to speak on the matter.[268]

We have had vaccines for a long while, very effective vaccines. It is the simplest thing in the world to immunize an experimental animal against polio. We have been able to do that for the last 25 years – if it survives. The problem is to find something that is effective and safe. The last splurge we have had on vaccines was in 1933 or 34 when Dr. Brodie came out with a vaccine which was...treated by formalin after a certain period of incubation. It was endorsed by the late Dr Park, who was at this time one of the most eminent in his field of biological products. Park endorsed it bag and baggage. At the same time another vaccine came out, namely the Kolmer vaccine. Bacteriologist at Temple, well known for the Kolmer test in syphilis. Both vaccines came out with very good scientific endorsement. There was quite a squabble at the time about them. The forerunner of the Foundation gave a strong endorsement in the Ladies' Home Journal, a long article about polio vaccine, how everybody should have their children given this

[267] BOH, *Minutes*, June 1, 1954, MHC, p. 138.
[268] BOH, *Minutes,* December 18, 1953, MHC, pp. 107-109.

vaccine in the field trials. Paul De Kruif, in typical fashion, left himself a loop-hole and when it was all over he said....About 10,000 doses of the Brodie vaccine were given down south and about 10,000 of the Kolmer vaccine in the middle of the United States. There were no adequate controls. Studies of the Brodie vaccine came up with the conclusion that it probably wasn't effective. Brodie's own argument was that if he incubated it too long with formalin it wasn't effective and if he incubated it not long enough it wasn't safe. He made it safe but not effective. The Kolmer vaccine was just the opposite. Of the 10,000 children inoculated nine developed paralytic polio in the second week after the inoculation. Twenty cases per 100,000 is a bad outbreak. The upshot was that the Kolmer vaccine was withdrawn very quickly. Five of the nine died. It was felt it was just plain too hot.

I mention this background because at that time a great many of us in positions you are in today took a beating for not using the vaccine. We refused to let the vaccine come into the State—moral persuasion. One doctor was going to get me fired because we weren't doing anything about it. But in retrospect we knew it was right. The next two or three years we had the same thing over again with nasal sprays for polio and again a statement that it was to be used widespread, and if you didn't do it you were dead wrong, and again we dropped it and found that those who opposed it were right. It was dangerous. But there was a lot of pressure. But not to begin to compare with what you have to take in 1953 and 1954.

Now, today we have got the situation of some new vaccines. Four have been developed. Only one is involved in this issue. The Salk vaccine. The Salk vaccine is a repetition of the Brodie vaccine. It has been treated with formalin and you carry the formalin in stock for a certain period at the temperature of melting ice. The only thing that Salk has that Brodie didn't have is that the virus is being grown on tissue culture. It is being grown in the Connaught Laboratories in Toronto and being shipped to this country for inactivation with formalin. It is believed to be effective against all three strains. At the time of the Brodie vaccine only one strain was recognized. Aside from that we have got a repetition of the Brodie vaccine.

The two issues which come up on the use of this sort of this are, (1) Is it safe? And (2) Is it effective? On the question of safety, I think it is fair to say that I represent a maybe somewhat noisy minority and skeptical minority in not being fully convinced that it is safe.[269]

Concerned about the magnitude of the decision placed on them, Prof. Bosch wondered if the Minnesota Medical Association had made an official statement on the Salk vaccine.

Barr (Deputy Executive Officer): "Yes. They took definite action that they had confidence in the State Board of Health and that they were standing by any action the State Board of Health and the Health Department would take in relation to this. It was put up to them basically that if anything was done relative to this it had to be done by the entire medical profession. They also indicated that they felt they had nobody on their Council who was competent to render a real opinion as to the relative value, safety, etc."[270]

Chesley(Executive Officer): "They are perfectly willing for the State Board of Health to take all responsibility. The vaccine will be sent from the National Foundation to the National Foundation, in care of the State Board of Health, and you are responsible the moment you sign that receipt."[271]

The NFIP planned to begin its trials in the southern United States, moving northward. It estimated it would be in Minnesota the latter part of March or early April. This gave the

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[269] BOH, *Minutes,* December 18, 1953, MHC, pp. 107-109.
[270] Ibid., 114.
[271] Ibid., 115.

board some time to decide whether it wanted to accept or reject the foundation's plan to immunize second graders in those Minnesota counties where the incidence of polio during the past five years was the highest.

On January 12, 1954, the board appointed a scientific advisory committee on polio vaccine to advise the board about participation in NFIP's poliomyelitis vaccination program of the National Foundation for Infantile Paralysis.[272] Members of this committee were:

- Dr. Gaylord Anderson, Mayo professor and director, University of Minnesota Public Health School, chair
- Dr. Irvine McQuarrie, professor and head, pediatrics department, University of Minnesota
- Dr J. T. Syverton, professor and head, bacteriology and immunology department, University of Minnesota
- Dr. Dennis W. Watson, professor, bacteriology and immunology department, University of Minnesota
- Dr. R. L. J. Kennedy, Rochester, president-elect, American Academy of Pediatrics
- Dr. G. B. Logan, Rochester, chairman, Child Health Commission, State Medical Association
- Dr. L. F. Richdorf, Minneapolis, Child Health Commission, State Medical Association
- Dr. F. G. Hedenstrom, St. Paul, Child Health Commission, State Medical Association
- Dr. C. O. Kohlbry, Duluth, Vaccination and Immunization Commission, State Medical Association

The committee met with Dr. Ruth Boynton, board chairman, on January 20, 1954.[273] Others attending the meeting were: Dr. R. N. Barr, deputy executive officer and director of local health services; Dr. D. S. Fleming, director of disease prevention and control; and Dr. A., J. Chesley, executive officer.

After much discussion, the committee made its recommendation:

> That the Board defer final action on the N.F.I.P. program until results of field trials of vaccination of 10,000 children with the commercially produced Salk vaccine are available for review; then provide for a Minnesota control study of poliomyelitis vaccination to meet requirements of the scientific advisory committee, the State Medical Assn., and the State Board of Health.[274]

In a March 3, 1954, internal memo to Dr. Chesley, Dr. Fleming reported that former Board President T.B. Magath supported the board's decision. Dr. Magath had spoken with Dr. Culbertson of Eli Lilly and Co., and Dr. Culbertson believed at least a year's work was necessary to evaluate the effectiveness and potency of the vaccine. The committee met again on April 7, 1954.[275] It agreed to reaffirm its earlier resolution to defer vaccination.

The board accepted the recommendation made by the committee, and a report was released to the press on April 13, 1954. Prof. Bosch read the release, which included this excerpt:

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[272] BOH, *Minutes,* January 12, 1954, MHC, p. 27.
[273] Ibid.
[274] Ibid.
[275] BOH, *Minutes,* April 13, 1954, MHC, p. 29.

"The Board emphasized its sincere concern with the problem of poliomyelitis in Minnesota and its desire to do everything possible to meet this problem. Preliminary planning for a vaccine program in 1954 has already been completed, in the event that such a program will be possible. It should be emphasized that under the most favorable circumstances vaccine would be available only to a small fraction of children in a few locations in Minnesota and that the program would be an experimental one with no established proof of the protective value of the vaccine. The Board's first concern is to avoid any possible harm that might result from premature use of the vaccine in Minnesota children and hopes that as much scientific data as possible will be gathered if and when the vaccine is used."[276]

Minnesota State Board of Health, April 13, 1954

The First Vaccine is Cautiously Distributed

By 1955, the board's advisory committee decided it could safely recommend the use of Salk vaccine in Minnesota. In trials outside the state the vaccine had proven to be 60 percent to 70 percent effective against Type I polio and better than 90 percent effective against Type II and III.[277] Committee Chair Dr. Gaylord Anderson reflected on Minnesota's decision to not deliver the vaccine in 1954:

> There is always going to be an element of risk, but the risks are infinitely less than the risk of polio. That we didn't know last year, and that is the reason we felt we should hold out. Those doubts have been resolved in my own mind.[278]

During the planning of a vaccination program, the committee deliberated over the age group which would receive the vaccine and how many doses should be given. It had not yet received recommendations from NFIP. It still was very cautious about use of the vaccine, as seen in its May 13, 1955, recommendations:

Recommendations of the State Advisory Committee on Poliomyelitis

1. ***The vaccine is safe so far as any vaccine is safe.***
2. ***The decision as to injections, the time and number, will have to wait until information is received from the National Foundation;***
3. ***Instructions should be given regarding using up of all the vaccine and regarding the significance of its change in color, etc.***
4. ***In addition to Grades I and II, priority should be given to children five years of age and under and to pregnant women, and then if there is enough vaccine left, move up; and***
5. ***That records be kept as per National Foundation of Infantile Paralysis.***[279]

On May 13, 1955, the committee and the board held a special meeting. At this meeting they definitely agreed to go forward with the vaccination program. Three decisions were made:

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[276] BOH, *Minutes,* April 13, 1954, MHC, p. 33.
[277] BOH, *Minutes,* April 14, 1955, MHC, p. 101.
[278] Ibid.
[279] Ibid., p. 92.

1. Go ahead, at the earliest possible moment when the vaccine is available, but not until adequate vaccine is available (both lots).
2. The second dose be given in two to four weeks after the first, depending upon availability of vaccine.
3. The Board issue a formal statement at this time covering some of the points brought out in the present meeting and stating that although every possible known test has been made as to the effectiveness of the vaccine, nothing definite can be stated, and there may still be new cases of polio, which may have developed in any case. [280]

Later that day Board Vice President Herbert Bosch released the following statement to the press:

> ***"The State Board of Health convened today with its Advisory Committee, and acting on the advice of that Committee, the Board has decided to go ahead when an adequate amount of vaccine becomes available. We should tell you that as of this date we have had official clearance of one batch of vaccine but have not yet had clearance on the other batch of vaccine, the smaller batch. When both batches are approved by the National Institutes of Health, there will be immediate distribution."*** [281]
>
> **Minnesota State Board of Health**
> **May 13, 1955**

A lengthier news release, issued May 16, 1955, emphasized that the board did not guarantee that the vaccine would provide complete protection against poliomyelitis. While not 100 percent effective, the board believed it was the first major breakthrough in the fight against polio. The news release ended with large type:

"POLIOMYELITIS VACCINE OFFERS THE FIRST AND ONLY EFFECTIVE MEASURE TO PREVENT THE PARALYTIC EFFECTS OF THIS DISEASE."[282]

The board worried about its decision to release polio vaccine. It was concerned that the public would have a false sense of the effectiveness of the vaccine. It worried about the number of polio cases that might be a direct result of the vaccine, as had happened in other parts of the country. After belaboring these issues at one meeting, Dr. Gaylord Anderson, director of the School of Public Health, addressed the need to take risks in public health.

> We have a lot of calculated risks. Just because we have many children getting drowned every summer, we don't forbid swimming. Just because children are killed in automobile accidents, we don't forbid automobile riding. Just because something went wrong with one or two lots of vaccine, we don't forbid vaccination. Some of us think it could have been done in a better way. The Salk vaccine program is two or three years ahead of where it should be. Every known safeguard that can be put around the vaccine for the second injections will be thrown around it except one, and that will be that it be given to a large number of children before we get our share

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[280] BOH and Scientific Advisory Committee on Poliomyelitis, *Minutes,* May 13, 1955, MHC, p.126.
[281] BOH, *Minutes,* May 13, 1955, MHC, p. 127.
[282] BOH, *News Release*, May 16, 1955.

of the lot. That is the last test. Can you give it to children? No test quite is as accurate as the human test."[283]

When the first batch of Salk vaccine from NFIP arrived, Dr. Chesley was hesitant about distributing for fear of a live virus in the batch. Two or three vials of the vaccine were taken in the dark of night to the office of Dr. Jerome T. Syverton, head of the department of bacteriology and immunology in the College of Medical Sciences at the University of Minnesota. Through Dr. Silverton's cooperation and help, the virulence of the vaccine was tested. No live vaccine was found, and the board felt more at ease about distribution.[284]

The first Salk polio vaccinations in Minnesota were given on May 20, 1955. Within the next month, 112,115 first and second grade children, out of 145,374 enrolled, received their first dose of vaccine. This was done using 288 clinics throughout the state.[285]

Dr Dean Fleming, head of the disease prevention and control division, was designated as poliomyelitis surveillance officer for Minnesota. He worked with the U.S. Public Health Service in providing information for the national poliomyelitis surveillance program. [286] Four centers in Minnesota were established to receive reports of cases of polio. They were located in the departments of health in Minneapolis, St. Paul, Duluth and Rochester. The division was assisted with its work by Dr. Leonard Schuman and Dr. Herman Kleinman as well as two medical students funded by NFIP.[287] Every case of polio was followed, especially whether or not the child had received the vaccine in May. Households were contacted and in the department laboratory viruses were isolated and identified for antibody testing.[288]

Out of the 112,000 children vaccinated, there were only two cases of paralytic polio during the summer of 1955. By comparison, there were eight cases of paralytic polio in the 33,259 non-vaccinated children in the same age group. The data indicated the vaccine was effective and gave hope that this dread disease might be conquered.[289]

Another Hard Decision: Who Should Receive the Limited Supply?

The board didn't know when another shipment of vaccine would come, but it knew it had to be ready to make hard decisions when the vaccine arrived. It needed to determine whether to use the shipment to give a second dose to those who had already received one or whether to give the vaccine to those who had not yet had any. Information about the vaccine was constantly changing. Based on what was known in June 1955, Dr. Anderson didn't support the idea of a second dose:

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[283] BOH, *Minutes,* June 17, 1955, MHC, p. 141.
[284] BOH, *Minutes,* January 31, 1961, MHC, pp. 19-20.
[285] BOH, *Minutes,* 1955, MHC, p. 187.
[286] BOH, *Minutes,* June 17, 1955, MHC, p. 135.
[287] Ibid., p. 136.
[288] BOH, *Minutes,* September 8, 1955, MHC, p. 214.
[289] Ibid., p. 214 and p. 218.

> Dr. Salk's protocols show the immunizing effect coming within two weeks of the first shot. Three weeks later you don't find much more immunity that you did after the first two weeks...which screams live virus to the heavens. A second shot given very shortly afterwards is not very important. I think immunity came from the first injection. [290]

Dr. Anderson led the continuing discussion, which emphasized that the board must be prepared to make a decision quickly:

> Anderson: "Personally, I would be very glad if we didn't get any vaccine until the end of the summer. I don't think we would be jeopardizing anybody by withholding it. That, I wish to say, is a personal belief. Some of the other members of the Committee may not share it with me. If, at the time you are faced with it and you want advice on the second shot, I will be glad to get the Committee together at that time. The situation is changing by the hour or by the day now. Any decision reached today might be completely out of date by tomorrow. "
>
> W. W. White, M.D.: "Maybe in the face of your opinion, if we should get a batch of vaccine, maybe the thing to do would be to say we can't get it yet, and sort of stall."
>
> Boynton: "I think there is another point there, too, and that is public opinion. I think the Board would have to make its decision one way or another. I don't see how we can stall."
>
> Bosch: "Administratively, I don't see how we can stall. On the day the second shot becomes available we must say either we are going to use it or we aren't going to use it."
>
> Edgar Huenekens, M.D.: "I feel as Dr. Anderson does, that the second shot can't do any harm. Then I don't see why we shouldn't give the second shot."
>
> Anderson: "The only thing is – if it turns out that the lot of Parke-Davis vaccine we got wasn't effective, then there might be danger in the second shot."[291]

The need to make a decision as to who should receive the next shipment of vaccine came in August when NFIP advised the board that the second dose of vaccine would arrive the end of the month. When should it be released? Who should receive it? To answer these questions, the board held a joint meeting with the poliomyelitis technical advisory committee on August 26, 1955. Committee members present for this major decision were: Dr R. L. J. Kennedy, pediatric professor, Mayo Foundation, Rochester; Dr. J. T. Syverton, professor and head, bacteriology and immunology department, University of Minnesota; Dr. C. O. Kohlbry, pediatrician in charge of school health program, Duluth; and Dr. Gaylord Anderson, Mayo professor and director, School of Public Health, University of Minnesota.

Some advisory committee members thought release of the vaccine should be delayed until October 1 or October 15. One who didn't agree was Dr. Syverton:

> You have nothing to lose and everything to gain by giving that second dose to the children. From a theoretical standpoint you stand to lose by delay. Now you propose to delay that further, and unless it is for the convenience of the physician, it is not good from the point of view of the children. I see no reason why the second dose shouldn't be given at the earliest possible date." [292]

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[290] BOH, *Minutes,* June 17, 1955, MHC, pp. 141-142.
[291] Ibid.
[292] BOH and Poliomyelitis Technical Advisory Committee, *Minutes,* August 26, 1955, MHC, p. 155.

The issue was put to vote, and in a close decision the advisory committee members present voted in favor of delaying release of the vaccine until October 1 or 15.[293]

While the surgeon general and the national advisory committee had designated the five-to-nine age group as the first priority group for receiving polio vaccine, it was possible to recommend a deviation. The group discussed whether or not it should give one dose to many people, rather than two doses to a selected few.

> Kennedy: "From your standpoint, isn't it true that it is your task to do the most good for the most people? If you have a certain amount of material to spread among a certain group, are you in a position to give it to as many individuals as possible rather than give it all to a limited number, leaving the population without any very good idea as to when they are going to be able to get polio vaccine from their doctor or anywhere else? We might give a single dose for first the 5-9 group and then the others in the 20 year age group and pregnant women."
>
> Boynton: "If we are going to give one dose to a lot of people, are we going to do as good a job? Presumably there won't be any more vaccine for several months."
>
> Anderson: "You have the question of efficacy of the second dose if you wait too long."
>
> Syverton: "I would think, looking at this (cases reported in 1955), that all children under 10 should be given two injections."
>
> Dr. Leonard Schuman: "You couldn't cover all. You would need over one million doses." [294]

A vote was called – one dose or two? Kennedy and Kohlby voted for one dose. Syverton voted for two.

Though the advisory committee had made a decision, the discussion continued:

> Boynton: "It does seem to me that if we are trying to put on an immunization program to give one dose to as many persons as possible with the available vaccine when you are most apt to get greater immunity from two doses – it seems to me that if we give just one dose, I wonder whether we are giving the public a false sense of protection, whether we are doing as good a job as we think we can do. Would it be the same as giving one dose of typhoid vaccine in the face of an epidemic when we think two or three should be given?"
>
> Dr. R. L. J. Kennedy: "Your statement carries weight only if you have an abundant supply of vaccine. If you stop a program because material isn't available, that is a different matter."
>
> Boynton: "Is it better to get to everybody under 19 years of age or to give two doses to all those under 10?"[295]

The board did not fully accept the advisory committee's recommendations. It decided to release the polio vaccine as soon as possible after it was received. [296]

The board approved the following distribution plan:

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[293] Ibid., p. 158.
[294] BOH and Poliomyelitis Technical Advisory Committee, *Minutes,* August 24, 1955, MHC p. 162.
[295] Ibid., pp.164-165.
[296] BOH, *Minutes,* August 26, 1955, MHC, pp. 167-170.

1. First priority group will be expanded to include ages 0 to 4, 5 to 9 and pregnant women.
2. Vaccine will be distributed as soon as received so this expanded group can receive their first dose soon. The expanded group will receive its second dose after the demand for the first dose has been met.
3. Each subsequent age group will be vaccinated with 2 doses of vaccine.
4. If the Surgeon General does not approve this plan, the 5 to 9 age group and pregnant women will be vaccinated as outlined above. The 0 to 4 age group will be given second priority.[297]

The second shipment of Salk vaccine from NFIP arrived September 12, 1955.[298] That vaccine was used immediately to provide a second injection to 106,753 first and second grade students.[299]

Other Barriers to Access

Children were not charged for the vaccine received through the NFIP program, but they were charged $0.50 for vaccine provided by the federal government, if they could pay it. The revenue collected made it possible to purchase vaccine and syringes. The federal Poliomyelitis Assistance Act of 1955 allotted the State of Minnesota $593,448 to use towards immunizing the estimated 1,111,005 Minnesotans included in the birth-19 age range and pregnant women. [300]

Gov. Orville Freeman was concerned about the 33,000 first and second graders who did not take advantage of the first shot of Salk vaccine and of those who might not be able to afford it. He expressed his concerns at a luncheon with the board on September 8. When told that any of those children could, within the next couple weeks, get the vaccine at a doctor's office, he replied: "That same group is going to be the least likely to go to a doctor or public official."[301]

Gov. Freeman did not want any barriers to stand in the way of a child being immunized:

> Gov. Orville Freeman: "There is a distinction between going through the school line and paying fifty cents and going to the doctor's office."
>
> Barr (Deputy Executive Officer): "People who can't pay go to the county for care. The doctor is used to taking care of those people. If he has a welfare patient sometimes he gets paid and sometimes he doesn't."
>
> Freeman: "The group I am talking about is the group who wouldn't take it because they would have to pay to have it administered. They just wouldn't go to the doctor's office. I have heard that this is the question, directed toward the medical profession: "If the doctor gets the vaccine free, why can't he give the shots free?"[302]

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[297] Ibid., pp. 190-191.
[298] BOH, *Minutes,* September 12, 1955, MHC, p. 314.
[299] BOH and Scientific Advisory Board, *Minutes,* December 5, 1955, MHC, p. 370.
[300] MDH Disease Prevention and Control Division, memo to Poliomyelitis Advisory Committee, August 26, 1955, MHC, p. 171.
[301] MDH, *Minutes,* September 8, 1955, MHC, p. 220.
[302] BOH, *Minutes,* September 8, 1955, MHC, pp. 224-225.

More Decisions on Distribution

On December 5, 1955, the board had another joint meeting with the scientific advisory committee on poliomyelitis to discuss distribution of limited supplies of vaccine. Twenty-seven persons were present to determine the first priority group for this vaccine and if they should authorize use of the vaccine for second injections. Opinions continued to differ as to whether the vaccine should be given to as many as possible or two doses to a smaller number.

> Vik Wilson, M.D.: "It seems to me that with this given amount of Federal aid vaccine we would do a most effective job for the people of Minnesota if we would give shots at least six months apart to the kiddies under 10 years of age."
>
> Karl Lundeberg, M.D.: "Suppose we play this very cagily and say, 'Let's do a good job with a few kids. It seems to me we are telling parents of other kids, 'No, you can't have it.' These older children have been denied this protection during the day of grace and then they have to get polio come next summer, and what is our excuse then? It would be all right if we had used up our vaccine. But if we don't and still deny some of these other older children—I would like to restate my belief that we would be safest in broadening the base for the first shot and then pick up the second shot." [303]

It was another difficult decision that potentially meant life or death for Minnesota citizens. Though much more was known about polio vaccine now than when the advisory committee first met nearly two years earlier, information was still limited. It knew that just one dose did help prevent polio, but it wasn't sure to what extent. It wasn't certain whether or not a second dose was essential. With ample supply, the decision might have been easier, but the supply was limited.

Several proposals for distribution were considered, and the advisory committee recommended extension of the base up to age 19 years of age. It also authorized a second dose at the discretion of the physician. The board approved the committee's recommendations.[304]

Several months later the board had to change its decision. On April 19, 1956, at the advice of the advisory committee, the board withdrew its authorization for a second dose of Salk vaccine, as demand was high and the supply still low. A large number of children had not yet received their first injection. The board decided it was important to give some protection to the maximum number of persons in the eligible age groups.[305]

In July 1956 the board was faced with another policy decision regarding the distribution of polio vaccine. Funds for polio vaccine were limited, and members wondered if they should use up all their vaccine and then let people obtain vaccine through commercial channels or if they should retain a certain amount for selected populations. Dr. Fleming thought the funds should be used up to purchase and distribute vaccine. Dr. Habein

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[303] BOH and Scientific Advisory Board, *Minutes,* December 5, 1955, p. 363.
[304] *St. Paul Dispatch*, Tuesday, December 6, 1955.
[305] BOH, *Minutes,* April 19, 1956, MHC, pp. 76-79.

wondered if the board should retain some funds to purchase vaccine for those who couldn't afford it.

Three choices were available: purchase vaccine and distribute all, purchase vaccine and retain some, purchase and distribute some vaccine but retain some of the money for later use. Gaylord Anderson thought the board should use up all the money and purchase vaccine and store the vaccine.

> All evidence I have indicates that it will store for a long time. You might as well buy it up and store it during the coming year for needs I don't think anyone has produced any evidence that the stuff deteriorates rapidly. I would simply say, handle it the way you do anything else, on a continuing basis.[306] Personally, I have always been of the opinion that when you are dealing with disease prevention the Board of Health has a responsibility for making this material available, no matter what. [307]

The question remained as to whether or not the board should authorize the giving of a third dose of vaccine. While Dr. Anderson thought the vaccine had a lasting quality, he was less certain about the immunization itself:

> I would feel that as of the 1st of September if you got vaccine and there was a need for it I would not hesitate to use it. Otherwise, I don't see any need for using it up now We don't know how long this vaccination is going to last. I haven't much faith in its lasting qualities, if it is of a nonliving character. There is no sense in giving a booster shot right at the end of the season. Better give it when it is going to be needed. That is a 'yes and no' answer, I confess, but I didn't know how to answer it now.[308]

At the October 3, 1956, board meeting Dr. Fleming reported there had been a marked drop in requests for polio vaccine. The board wondered if it should release its stores for a third dose. Dr. Barr said he saw no good reason for doing this. He thought that if the board authorized a third dose it would be gone over night.[309] Within a few months, however, adequate supplies became available.

Transition from Selected Distribution to General Promotion

As the supplies of polio vaccine increased, people of all ages were encouraged to receive the vaccination. The board produced a news release to help overcome public apathy among adults towards vaccination. Many needed encouragement. To set an example, physicians in the department offered polio vaccinations to departmental staff at a nominal cost.[310]

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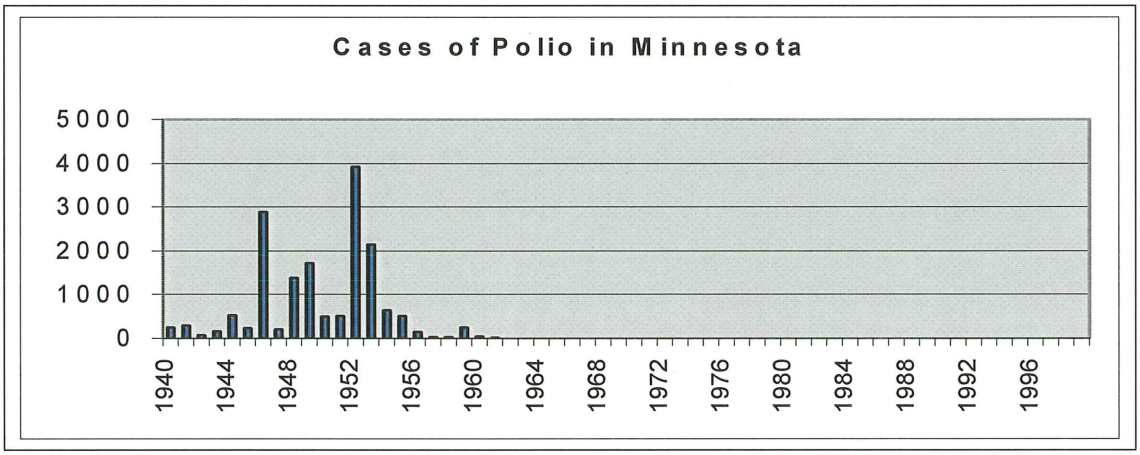
[306] BOH, *Minutes,* July 10, 1956, MHC, pp. 166-170.
[307] Ibid., p. 170.
[308] Ibid.
[309] BOH, *Minutes,* October 3, 1956, MHC, p. 200.
[310] BOH, *Minutes,* January 31, 1957, MHC, p. 8.

NFIP embarked on a campaign in 1957 to cover the entire nation. It had been cleared with the American Medical Association and would be cleared with state and local medical societies. The department had strong support from Gov. Orville Freeman who backed a program to immunize all people in the state against polio. Such a campaign had not been possible earlier due to the shortage of vaccine. Dr. Fleming was hesitant about organizing such a program, as the department was not in a position to administer such injections. He thought it might be better for the department to establish a fund for those who needed.[311]

By 1957, the department was able to look back on a successful campaign against polio. Minnesota was one of only three or four states that had used up its total allotment of funds from the U.S. Public Health Services for polio vaccine.[312] Polio was still occurring in patients who were immunized, but not paralytic polio. During the first seven months of 1957, 12 cases occurred. Eight of the persons had received polio vaccine, but none of the cases was paralytic. Four of the cases had not received the vaccine, and three of these were paralytic.[313]



There were still questions of safety about polio vaccine, but by 1961 most citizens were willing to be vaccinated. A survey of 600 persons was taken asking them: "If you had a chance, would you yourself be willing to take part in the test by taking the oral polio vaccine, or not?"c Seventy-three percent said they would be willing. The 27 percent who said they wouldn't, cited their reasons: "the new vaccine is not perfected yet and may not be safe," "I'm too old," "I already have had Salk vaccinations," and "I don't believe in taking drugs."[314] When the survey was repeated in 1962, the percentage of people willing to take part in a test had dropped to 54 percent. This was probably due to the unfavorable publicity Type III vaccine was receiving.[315]

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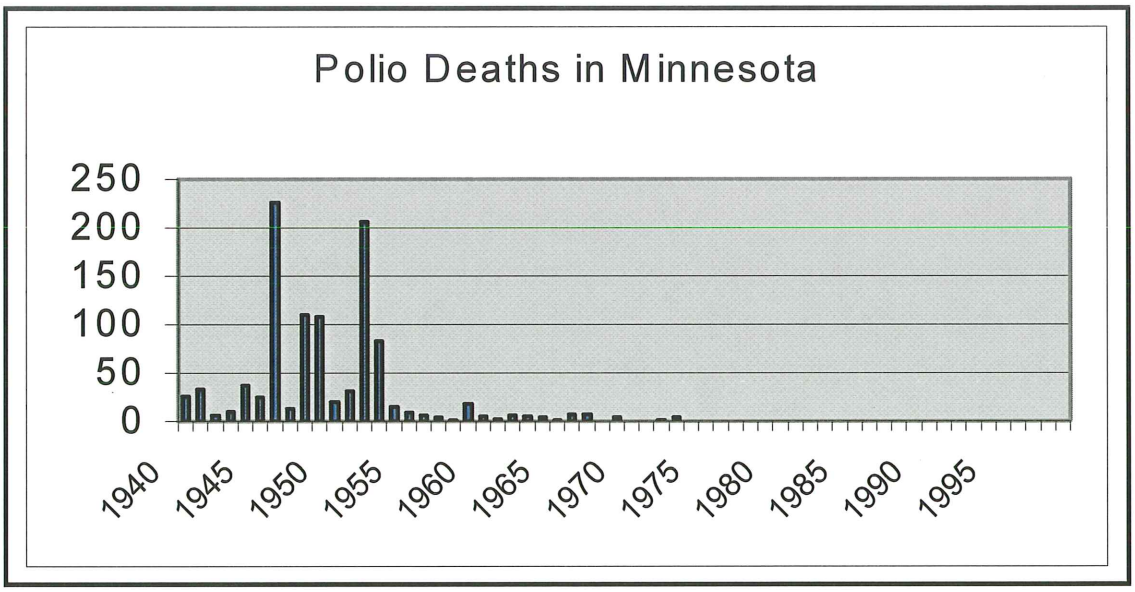
[311] BOH, *Minutes,* July 30, 1957, MHC, p. 123.
[312] BOH, *Minutes,* April 4, 1957, MHC, p. 35.
[313] BOH, *Minutes,* July 30, 1957, MHC, p. 122.
[314] MDH, *Minnesota's Health,* Vol. 15, No. 4, April 1961, p. 4.
[315] MDH, *Minnesota's Health,* Vol. 16, No. 10, December 1962, pp. 1-2.



In 1959 the polio advisory committee recommended that the department create a plan for distributing vaccine on short notice, in the event of another polio epidemic. The board authorized the staff to draw up such a plan.[316]

There never was another epidemic. In 1967, for the first time in the department's history there were no reported cases of polio in the state

Minnesota's Role in Polio Vaccine Studies

While the board and the advisory committee were making difficult decisions about the use of polio vaccine, the department's public health laboratory was setting off a spark that would help create worldwide interest in oral polio vaccine.

A revival in polio vaccine research and a new era of virology began in 1949 when Dr. John F. Enders, a bacteriologist at Harvard University, discovered polio virus could be grown in monkey kidney tissue cultures.[317] In 1953 the laboratory established a tissue culture laboratory for the isolation of the polio virus.[318] Dr. Henry Bauer, director of the laboratory, hoped to be prepared to do more laboratory work when there was a polio outbreak.

In 1955 Dr. Bauer set up a virus laboratory. Funding was received from the U.S. Public Health Service and later from the Sister Kenny Institute and Lederle Laboratories.[319] Dr. Bauer was very pleased with the results and said: "I think by this spring we will have a much better insight into what this polio season is about, which will give us some direction for next year as to how we should go about these things. We are quite pleased with the way this thing is going along." [320]

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[316] BOH, *Minutes,* August 11, 1959, MHC, p. 214.
[317] Unpublished report on polio by Dr. Henry Bauer.
[318] BOH, *Minutes,* December 18, 1953, MHC, p. 60.
[319] BOH, *Minutes,* October 3, 1956, MHC, p. 198; and January 13, 1959, MHC, p. 8.
[320] BOH, *Minutes,* September 8, 1955, MHC, p. 230.

The board was supportive of the innovative work that was being done in the department. Dr. Frank Krusen, board president, said: "I think the people of Minnesota owe a real debt of gratitude to Dr. Bauer and his staff for what they have done. I think a vote of thanks would be in order." The motion was passed.[321]

When continuation of the lab's program was discussed later in the year, the board showed its strong approval of the work that was being done:

> James Halvorson, M.D: "I think they should be commended for the tremendous job they have done and that we should instruct Dr. Barr to do everything in his power to maintain this service that has been set up."
>
> Boynton: "I was going to say the same thing. I think Dr. Bauer deserves a great deal of commendation and credit for having set this laboratory up in the short time he had to do it. I think certainly it should be continued, and with the polio vaccination program in the unstable state it is now, the only way we are ever going to learn and know anything about the value of it and the pitfalls of it is to continue this sort of a surveillance program, and the laboratory part is extremely important." [322]

In 1957 Dr. Bauer conducted an oral attenuated polio virus study, carried out jointly with Dr. M. Da Silva of the University of Minnesota, and Drs. Harold Cox and J.M.Ruegsegger of Lederle Laboratories. The vaccine used was the Cox vaccine, developed by Dr. Harold Cox. The study involved 25 infants, their parents and siblings. The infants were given the living polio virus and received no ill effects.[323] Results compared very favorably with the Salk vaccine, and all infants demonstrated satisfactory antibody response.[324]

The work done in Minnesota drew attention from other parts of the world. A polio outbreak in South America was starting, and the Pan-American Sanitary Bureau was interested in Minnesota's study because they concluded the Salk vaccine, due to its high cost, was not a satisfactory solution to the problem in Latin America. They thought the best solution would be a live vaccine which could be given by mouth and which could interrupt the spread of the more pathogenic viruses.[325]

Dr. Bauer proposed an additional orally attenuated live polio virus vaccine study. Residents of the University Village, a crowded university housing development near the health department, would be involved. Half would be fed the virus vaccine and half would be given a placebo.

While supportive of Dr. Bauer's efforts, the board was concerned about its liability in case of any illness in the study participants, either from polio or another condition. Mr. Brower, a lawyer, reduced some concerns when he explained that a project of this kind would come through a gift of money, and the conditions and terms would be stated with

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[321] Ibid., p. 231.
[322] BOH, *Minutes,* November 1, 1955, MHC, pp. 329-330.
[323] BOH, *Minutes,* April 4, 1957, MHC, p. 34; July 30, 1957, MHC, p. 124; October 9, 1957, MHC, p. 199.
[324] MDH, "Summary of Oral Polio Vaccine Trials in Minnesota (1957-1960)," May 1960, p. 1.
[325] BOH, *Minutes,* October 9, 1957, MHC, p. 199.

the money to indicate liability. It would be up to the governor or state treasurer to accept the gift, so the state would have responsibility for it.

> Boynton: "I still have some reservations about the State Board of Health, as a State organization, undertaking this kind of a research project, which it is, with as little work having been done on this as has been done. Less than 1,000 people have been fed this vaccine to date. There are so many unknowns in it, and I think the responsibilities which we assume if we undertake this are so great--I have great reservations."
>
> Krusen: "I agree with you to a certain extent, but at the same time I think it is in the interests of public health to get this information and it is still a study of a limited group in limited areas and it isn't as if you were subjecting everybody involuntarily in the entire State to take part in the study."
>
> Boynton: "That is very true."
>
> Krusen: "So I personally feel that this is of such great value that I am going to vote in favor of it myself, knowing all of your misgivings and reservations, which I am sure are justifiable."
>
> Harold Wente, M.D: "There is no other organization in the state that would have the opportunity to do this with the protection of the State behind them and while it is a serious obligation, it is quite a consolation to know that no private corporation or private medical group could afford to take the responsibility."

The final decision to go ahead with the study was close. Dr. Huenekens voted aye. Dr. Boynton and Mr. Peterson voted no. Other members didn't vote. The question was asked again. This time Dr. Wente and Dr. Huenekens voted aye. Dr. Boynton, Mr. Peterson and Prof. Bosch voted no. Mrs. Loevinger was undecided. Prof. Bosch said he would be willing to leave his vote to the medical members of the board, if he felt that the liability issue was satisfactorily addressed.

> Brower: "I was going to say that since no state money will be used in this program, all financing being by gift, all the Board would have to do would be to recommend to the Governor, the State Auditor and the State Treasurer the acceptance of this gift, and then a complete explanation could be made of the whole program and it would be up to those three men to accept or reject it. They might want to get an opinion from the Attorney General. They might reject it on the grounds that it has too much potential liability and it might require an act of the Legislature to authorize it. The recommendation of acceptance of this gift would be all that is necessary to start it."

Marie Ford, Marion Cooney, Dr. Kleinman, Dr. Henry Bauer, Unidentified, Anne Kimball
Press Conference on Polio, 1958

Krusen: "Would it be acceptable to the Board to have such a motion presented? Withdraw the previous motion and substitute a motion that we recommend the acceptance of a gift of funds to further this particular study? Would you be willing to withdraw your motion, Dr. Huenekens, and substitute this motion proposed by Mr. Brower and Prof Bosch?"

Huenekens: "I would be glad to, but I would like to know-- Would this be acceptable to you, Dr. Boynton?"

Boynton: "I think it would."

Bosch: "I would like to move that the Board recommend to the Governor the acceptance of a gift for carrying on the project of oral vaccination with the provision that (a) the project be approved by the Board's Polio Advisory Committee, and (b) that participation be on a completely voluntary basis on the part of the individuals receiving the vaccine."

The motion was passed.

Krusen: "I think this is a sound solution of this very difficult problem and does not involve the Board unduly in the situation, and we have a chance for sound advice all the way around."

Bauer: "I would imagine that would include, then, the authorization to accept funds."

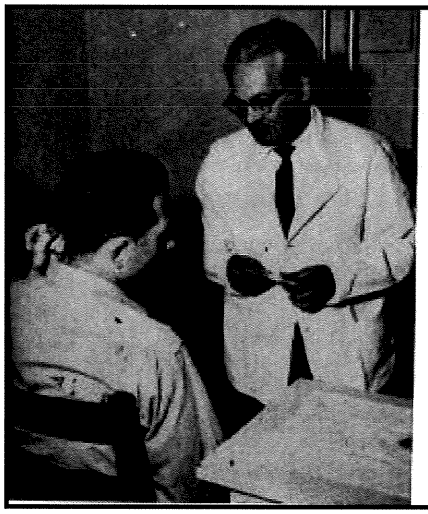
Krusen: "Yes, this implies acceptance."

Bosch: "This is actually a part of the motion."

Krusen: "It is understood, then, that it be so worded that we accept any gifts. Thank you very much, Dr. Bauer.[326]

Members of the advisory committee for the laboratory were Dr. Gaylord Anderson, Dr. John Anderson; Dr. Paul Elwood; Dr. John McKelvey; Dr. L.M. Schuman; and Dr. Dennis Watson; Mario McC. Fischer, M.D., director of public health, Duluth; Karl R. Lundeberg, M.D., commissioner of health, Minneapolis; Henry M. Moen, executive secretary, Minnesota Pharmaceutical Association, St. Paul; Frank W. Moudry, secretary, Minnesota State Board of Pharmacy, Minneapolis; R.B.J. Schoch, M.D., chief health officer, St. Paul; and V.O. Wilson, M.D., district health officer, Rochester[327]

The second orally administered attenuated polio virus vaccine study in University Village was conducted in 1958. A total of 551 persons in 149 families were given oral capsules at three-week intervals. Of the 551 participants, 111 received a placebo, 37 received one dose, 148 received two doses, and 255 received three doses. The greatest increases in the percentage of antibody titrations occurred in children receiving the vaccine. Results indicated the attenuated live virus was not as good an antigen for adults. The study ended June 1958, without any incidents or problems.[328] [329] . A letter received from Dr. W. Ritchie Russell, one of England's leading neurologists, congratulated the department for its courage in undertaking the study of orally administered live attenuated polio virus. He believed it was the only way to immunize against polio.[330]



AN INMATE IS checked by Dr. Herman Kleinman of the Minnesota Department of Health. Blood samples, stool specimens, and throat swabs were taken to compare four different methods of feeding oral polio vaccine (liquid vaccine before eating, liquid after eating, capsules before eating, and capsules after eating). If stool specimens contain attenuated poliovirus, this indicates that the vaccine was successful in causing virus to multiply in the intestinal tract. Blood samples show the polio antibody level of inmates, and throat swabs indicate whether poliovirus from the vaccine was present in pharyngeal tissues. Before receiving oral vaccine, most of the 170 volunteers had little or no immunity to the three poliovirus strains.

Having completed the second study successfully, Dr. Bauer planned a third. The Sabin vaccine was given in three doses, six weeks apart, creating problems in administration. After the first dose, people would have to return two more times for adequate coverage. It was likely some would not return and be unprotected. One dosage would solve this problem. Dr. Bauer wanted to determine if antibody production was as effective if all

[326] BOH, *Minutes,* January 7, 1958, MHC, pp. 16-19.
[327] Ibid., p. 92.
[328] BOH, *Minutes,* August 13, 1958, MHC, p. 217.
[329] MDH, "Present Status of Oral Polio Vaccine Study," distributed with BOH *Minutes*, August 13, 1958, MHC, pp. 167-168.
[330] BOH, *Minutes,* January 13, 1959, MHC, p. 8.

three types of virus were given at once. Again, he used the Cox oral polio vaccine. The board approved this request. [331] The third study was done in Grove East Village, St. Paul. A total of 230 persons from 65 families were involved in this study. This study indicated the trivalent form was not as effective in producing antibodies, especially for type II, however enough efficiency and advantages were present to recommend it for further attention.[332]

A fourth study was conducted at the St. Cloud Reformatory to determine whether gastric acidity played a part in lessening the effectiveness of the oral vaccine. [333] One hundred seventy inmates who volunteered and participated in this study were given vaccine in either liquid form or in gelatin capsules.[334]

Dr. Robert Barr, Dr. Henry Bauer and Dr. Kleinman at a polio conference in Washington, D.C., June 1959

The work done in Minnesota continued to receive recognition from outside the state and received special notice at a June 1959 conference sponsored by the World Health Organization and the Sister Kenny Foundation of Minneapolis. Dr. Gaylord Anderson reported that the high point of this five-day conference on live polio vaccine in Washington, D.C. was the presentation by Dr. Barr, Dr. Bauer and Dr. Kleinman on the oral vaccine study being done in Minnesota. Anderson said: "They gave added distinction to your Board."[335]

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[331] BOH, *Minutes,* December 4, 1958, MHC, p. 335.
[332] MDH, "Summary of Oral Polio Vaccine Trials in Minnesota (1957-1960)," May 1960, pp. 1-2.
[333] BOH, *Minutes,* May 26, 1959, MHC, pp. 132-133.
[334] MDH, *Minnesota's Health,* Vol. 13, No. 7, August-September 1959, p. 2.
[335] BOH, *Minutes,* August 11, 1959, MHC, p. 214.

In 1960 a gift of $100,000 for oral polio vaccine research made possible a fifth study, the 1960 field trials. It was at this time that the board thought it was important to refer to the oral vaccine as the Cox vaccine rather than the Lederle vaccine to differentiate from the Sabin vaccine. [336]

A total of 104,288 persons participated in the 1960 field trials: 31,335 in Minneapolis, 17,042 in St. Paul, 21,700 in Duluth, 16,000 children in Meeker, Kandiyohi and Swift counties, 8,100 children in Bloomington, and 10,000 children in St. Louis Park.[337] The studies were going very well. The department even had thoughts of licensing the polio vaccine. Dr. Carl Eklund of the U.S. Public Health Service visited Minnesota to determine if it was safe.[338]

Test Polio Pills
Taste Like Cherry Drops

Cherry-flavored polio vaccine that may be taken orally in the form of a pill is now under test by the Minnesota Department of Health. The "candy" vaccine is expected to be available for use early next year.[340]

Popular Mechanics
August 1959

Then, difficulties arose. The Cox vaccine was not approved for licensing by the Public Health Service, as it did not consider the Cox vaccine safe. In August 1960 the Public Health Service and National Institutes of Health authorized the production of Sabin vaccine.[339]

Dr. Anderson, director of the University of Minnesota School of Public Health, showed strong support for the board when he visited Surgeon General Lee Burney in Washington, D.C., on behalf of the department's work following the Public Health Service's announcement. He reported on his visit with the surgeon general to the board:

> I spent about an hour with him on Friday morning. Obviously, I couldn't ask him point blank at that time to make a decision or to do anything other than to listen to me. I told him I thought their decision had put us, as well as many others, in a very awkward and embarrassing situation in that what they were essentially saying to the American public was that here in the State of Minnesota something had been fed to the public that was not safe for further use, and that I did not see that they had any evidence to back up that sort of statement. His reply, which did not satisfy me, was that their decision was based not upon any field trials or any use of the material, but upon their monkey neuro-virulence tests. This is not correct, and he seemed a bit embarrassed when I pointed out to him that on the front page of his statement he had said otherwise. His front page says that decision is based upon use of the vaccine in field trials, on monkey neuro-virulence, the viremia, and field experience with all candidate strains. It is true from that time on they say nothing about field experience. They ignore it completely.
>
> We went on from there and discussed what evidence there was on danger of the vaccines, and it became quite apparent to me, and he essentially acknowledged it, that some of the data on comparative safety had not been presented to him. For example, the data on cases of polio in Karaganda in Russia, and in Moscow, following the use of the Sabin vaccine made in Russia.

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[336] BOH, *Minutes,* January 12, 1960, MHC, pp 10-11.
[337] MDH, "Summary of Oral Polio Vaccine Trials in Minnesota (1957-1960)," May 1960, p. 2.
[338] BOH, *Minutes*, May 24, 1960, MHC, p. 73.
[339] Surgeon General's news release on August 24, 1960.
[340] "Test Polio Pills Taste Like Cherry Drops," *Popular Mechanics,* August 1959, p. 91.

> These data had never been presented to him by his committee. He was unaware of their existence. We discussed the report that had been turned in to him by his staff--the boys who went over from CDC--and if I did not misinterpret him, he had never seen their report. He had merely been told about their report by his advisory committee.[341]

The advisory committee met on September 28, 1960, and considered options for the board on continued studies of polio vaccine at the department, given the decision by the U.S. Public Health Service. The committee recommended that the board go forward with a divided trial, giving half the recipients Cox vaccine and half Sabin vaccine. It did not recommend that the study be dropped, but it thought the board should consider such an action because of public relations issues involved.

The advisory committee also recommended that the board ask the Public Health Service to appoint an impartial advisory committee to the surgeon general, as the current one was loaded with people who had been working with the Sabin vaccine. Two were members of the National Foundation Advisory Committee, which had put money in the Sabin vaccine.

Executive Officer Dr. Robert Barr didn't agree with this recommendation as he thought it would tend to bring discredit to the surgeon general and the Public Health Service and would only do harm.

Prof. Bosch did not think the board should use the Cox vaccine until there was clearance from the Public Health Service. The board had promised 50,000 people the vaccine late in the winter or early next spring, and it was concerned it might not be able to give the vaccine.

The board decided to see if the surgeon general would grant approval for a continued study using the Cox vaccine. [342] The surgeon general wrote back to Dr. Barr on November 10, 1960:

> In your letter of October 20 you picture an embarrassing position with respect to the further use of live poliovirus vaccine in the State of Minnesota because of the issuance of our release on August 24.
>
> The release in question dealt with live poliovirus vaccine standards applicable to materials to be distributed under license; i.e., to be distributed freely and in an unrestricted way for sale in interstate commerce. The materials which you have used in Minnesota thus far have not been manufactured under license. They were supplied for purposes of controlled investigations designed to obtain information. This is perfectly proper and you are still free to carry out such controlled investigations with unlicensed biological products that are in course of development. This situation is covered both by Public Health Service and by Food and Drug Administration regulations. If, on the other hand, you wish to use licensed products only, you will have to wait until live poliovirus vaccine produced under license becomes available. "We agree with the thought expressed in the last paragraph of your letter and would add that such materials are or will be available from manufacturers for controlled investigations prior to licensing. We would be glad to be of assistance in making suggestions as to likely sources of such material.[343]

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[341] BOH, *Minutes,* September 13, 1960, MHC, pp. 338-339.
[342] BOH, *Minutes,* October 18, 1960, MHC, pp. 361-364.
[343] BOH, *Minutes,* December 19, 1960, MHC, p. 406.

With this letter, the board realized it was in a very different position and could safely proceed with the studies. [344]

While the surgeon general gave support for continued studies with the Cox vaccine in Minnesota, its failure to be accepted for licensing resulted in the loss of financial support. Lederle Laboratories, which had been supporting much of the polio studies undertaken by the department's laboratories, reduced its financial assistance. Lederle obtained Sabin strains in August 1960 and started developing oral vaccine with these strains.[345]

The department felt a general sense of disappointment that the Cox vaccine was not accepted for general use and Minnesota's research in polio vaccine ended. There was, however, great satisfaction when looking at the polio statistics for Minnesota.

The last reported case of polio in Minnesota was in 1981, and the last death in the state attributed to polio occurred in 1973. The fight against polio continues today, but it has now become one of the quiet parts of public health. Public health workers diligently work to ensure that children are immunized against polio. The effects of their efforts are not always noted, but because of them Minnesota children of today do not fear paralysis, iron lungs or death from polio.

The World Health Organization hopes to see polio, like smallpox, eradicated in 2001. When that goal is celebrated, part of the credit is due to the public health workers in Minnesota who worked so hard to free the world of this crippling disease.

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[344] BOH, *Minutes,* October 18, 1960, MHC, pp. 361-364.
[345] BOH, *Minutes,* July 11, 1961, MHC, pp. 307-309.

Chapter 4

The Atomic Age and Public Health

"It is with this world that we must deal, even as we strive and reach toward a better one. We must face reality, regardless of how desperately we wish for peace. The question of war or peace lies with the Kremlin, not with us. No one else can answer that question positively regardless of what the 'prophets' say. There is, however, one question we can answer: Is there a possibility of a third world war? Most certainly there is that possibility. This being true, we must prepare our citizenry for all of the implications in which we would be involved if that catastrophe occurs." [346]

Col. Miller, Director of Civil Defense
State of Minnesota, 1951

Protecting the Population from a Nuclear Disaster

With the atomic age, new public health issues emerged. In the 1940s and 1950s the perceived threat of an atomic attack from Russia, the other major power with nuclear warheads, raised concern that the public must be prepared for and protected from a nuclear disaster.

Health had a new and highlighted role, recognized by Dr. Chesley, executive officer and secretary to the Board of Health: "The National Emergency with its special emphasis on civil defense has made health services extremely important."[347]

Dr. F. W. Behmler, retiring president of the Minnesota Public Health Conference in 1950 and member of the Board of Health, also called attention to the large role health plays in the peace process:

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[346] State of Minnesota, *Report by the Department of Civil Defense*, December 31, 1951, p. 23.
[347] MDH, *Minnesota's Health,* Vol. V, No. 1, January 1951.

"In a world in which cooperation on the political level seems at present is an unrealizable dream, it is heartening to recall that it has existed for a long time in the field of health. Widespread public health is both an instrument and a condition of any lasting peace." [348]

Dr. F. W. Behmler, 1950

Minnesota Government's Response to Civil Defense Need

In response to this new danger, Minnesota state government began planning for the possibility of a nuclear attack. Essential governmental activities would be moved to Mankato, which was not expected to be a target for attack.[349] The three Minnesota cities considered prime targets for a nuclear attack were identified by Dr. Chesley at the January 25, 1951, board meeting: "Rochester, where they would kill off all the men connected with medical care; the Twin Cities, where you change cars; and Twin Port, where you get all the iron. I don't think there is anything else 'Uncle Joe' would be interested in." [350]

Civil defense became a high priority. In a 1950 letter to section chiefs at the department, Jerry Brower, head of departmental administration, disallowed any new budget requests, with one exception: "...ask only for moneys sufficient to continue the present rate of operations plus any special needs incidental to the Defense Program."[351]

The Minnesota Civil Defense Act, enacted by the Legislature in 1951, provided funding for state civil defense activities from July 1951 until July 1952. A total of $30,000 to $35,000 of the funding was earmarked towards a mobile health unit for use in the event of a disaster.[352]

While legislation was passed in 1951, Minnesota had begun civil defense preparations earlier. In October 1948 Gov. Youngdahl appointed Dr. Chesley a member of the Minnesota Civilian Defense Commission.

Dr. Chesley reported on the commission's activities at an April 25, 1950, board meeting:

> Chesley: "At the present very little is going out to the public about it because until they set up these radar airplane detection centers we won't be in a position to go ahead. That is going on very well and Col. Miller is holding meetings in small towns and explaining what the situation is now. It is different than before we had A and H bombs, etc. He is doing what he calls his preliminary mass psychology proposal to the people. Then they will have meetings of the various professional groups as to the strength and action, if anything can be done about it, in case we should be bombed. Of course the Suez and Panama Canal rate 1 and 2. It is only 6 hours from

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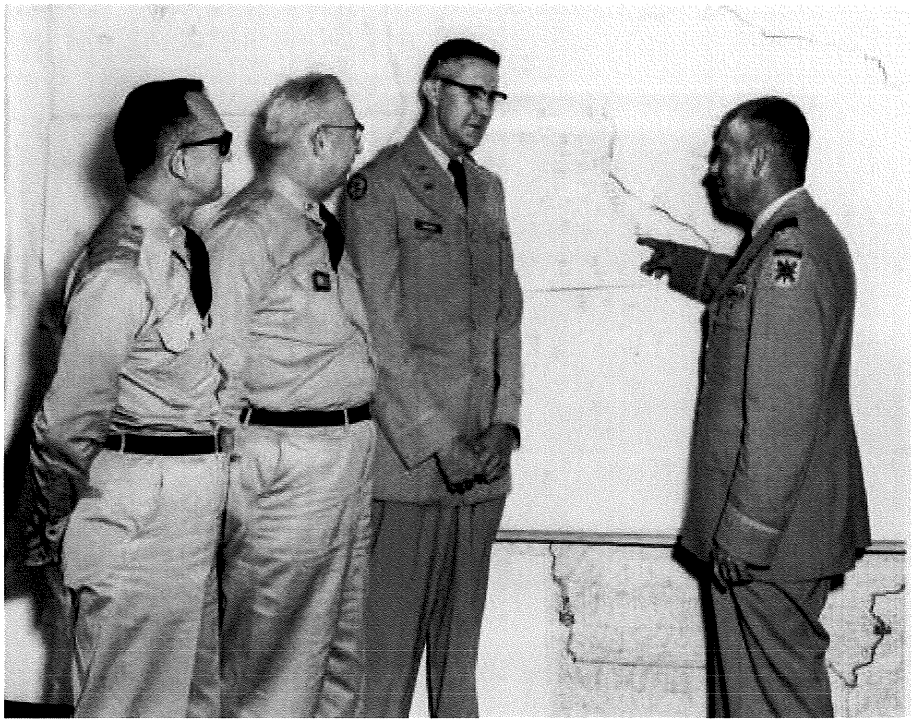
[348] MDH, *Minnesota's Health,* Vol. IV, No. 10, October 1950, p.2
[349] BOH, *Minutes,* July 10, 1954, MHC, pp. 171-172.
[350] BOH, *Minutes,* January 25, 1951, p. 76.
[351] Letter from J.W. Brower to Health section chiefs, August 21, 1950.
[352] State of Minnesota, *Report by the Department of Civil Defense,* December 31, 1951, p. 3.

Alaska to Duluth, and all during the war we sent those big planes up there for Russia and they know how to get down there. . . From my personal contact with the representatives of the Hon. Bolsheviks, I have no faith whatsoever in anything they promise to do." [353]



Dr. Henry Bauer and Dr. Robert Barr (two on left)

As Minnesota's chief health officer, Dr. Chesley directed the health section of the state's office of civil defense. He was chair of the civil defense medical advisory committee, organized to assist local civil defense councils in developing their health and medical programs.[354] Other members of this committee were: R. R. Rosell, executive secretary of the Minnesota Medical Association; C.V E. Cassell, D. D. S., secretary of the Minnesota Dental Association; Ragna Gynild, R. N., executive secretary of the Minnesota Nurses Association; Glen Taylor, executive secretary of the Minnesota Hospital Association; B. S. Pomeroy, D.V.M., secretary of the Minnesota Veterinary Medical Society; W. J. Hadley, Ph.D., secretary of the Minnesota Pharmaceutical Association; and D. S. Fleming, M.D., executive secretary of the Minnesota Public Health Conference (now Minnesota Public Health Association). [355]

By executive order, the governor assigned the secretary and executive secretary of the Board of Health as Minnesota's chief of the health, medical and special weapons defense service. The mission of this service was to:

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[353] BOH, *Minutes,* April 25, 1950, MHC, pp. 231-232.
[354] MDH, *Minnesota's Health,* Vol. V, No. 1, January 1951, pp. 1-2.
[355] Ibid., pp. 2-5.

> ...provide emergency medical care and treatment of the local population, including Civil Defense personnel, emergency public health services to meet disaster conditions, and preventive and remedial measures to minimize the effects of plant and animal biological warfare and chemical warfare. [356]

Survival Plan

A civil defense survival plan was prepared by the military affairs committee of the Minnesota Medical Association, the civil defense committee of the Minnesota Hospital Association and the Department of Health and approved by Gov. Freeman.[357] Under this survival plan, all medical supplies and equipment in the state were under the control of the health and medical service during a civil defense emergency.

Health professionals were under the control of the civil defense manpower service. If time permitted, the plan directed that health professionals could be requisitioned and relocated to target areas during a disaster. Emergency treatment stations were to be established on the periphery of the disaster; and non-targeted hospitals were expected to expand by ten times their licensed capacity. Medical treatment for casualties would be provided at the hospital facilities or expanded treatment service, whole blood would be collected by each hospital every day, and public health nursing services would be expanded. Emergency environmental health measures and plant and animal biological warfare and chemical warfare defense measures were to be established or expanded. Mobile medical personnel and equipment support were to be provided as needed.[358]

The survival plan designated 78 communities as the points at which definitive hospitalization and medical care would be provided. It directed that these communities organize to receive an overwhelming number of medical evacuees. The plan prescribed routes of evacuation from the disaster areas and asked that each community organize a team to control traffic and direct the overflow of patients along the evacuation route. It prescribed, in a general way, the medical responsibilities of each person in the state.

The survival plan clarified that the Health Department was responsible for emergency medical care, radiological defense and mortuary services during an emergency. A staff member from radiation and occupational health was assigned the role of state chief of the radiological defense service; and the chief of the mortuary science unit was assigned as the state chief of mortuary service.

A New Public Health Challenge

Many members of the board and the department staff brought skills and perspectives from their recent military experiences to address this new public health challenge –

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[356] BOH, *Minutes,* May 26, 1959, pp. 158-162.
[357] Ibid.
[358] Ibid.

preparing for an atomic attack and safeguarding the population from atomic fallout. Dr. Chesley, and board members Dr. Frederick Behmler and Dr. Theodore Sweetser had served in World War I. Dr. Robert Barr, Dr. Henry Bauer, and Mr. Jerome Brower, all heads of sections at the department, were veterans of World War II, as was board member Mr. Herbert Bosch. Others in the department had served in the Korean War, as well as World Wars I and II. They were familiar with the contingency planning needed in situations where the potential for mass destruction and a high number of human casualties exist.

To prepare for a national emergency, Dr. Chesley thought the local health service was extremely important. Every community needed to be able to establish health services which would include care of the wounded and sick civilians, protection of civilians against atomic, chemical, and biological warfare, maintenance of sanitation, provision of medical supplies, organization of emergency hospitals and mobilization of professional health personnel and trained helpers.

Like Dr. Chesley, Dr. John T. Smiley, director of the department's District Office No. 6, was an advocate of civil defense preparation by the population and wrote an article, "Our Part in Civil Defense," for the department newsletter in 1951:

"The enemy's strategic aim is not to kill civilians per se, but to put our productive capacity out of operation. The destruction of a plant that manufactures essential military equipment is much more important to the enemy than the killing or maiming of any number of civilian people. Our aim in civil defense, therefore, is to be so thoroughly prepared against possible attack that it will be unprofitable for anyone to attack us. Our principal interest is not in protecting individuals but in saving our nation. This may sound like a rather inhuman approach, but it is the only realistic one. In the present situation, we cannot allow ourselves to be primarily concerned with individual persons or individual places. We must concentrate our defense efforts on the protection of our country as a whole.

"We must prepare to save lives and minimize injuries--not just for the sake of the individuals concerned (which would in itself be proper) but also, and most important, for the protection of our entire population. We need to be so well prepared that the enemy will know he would gain little or nothing by attacking us The more thoroughly we prepare, the less likely we are to be attacked. We can do much to forestall the danger that we fear if everyone of us does his full share in planning and carrying out civil defense measures." [359]

John T. Smiley, M.D.
1951

The department established a health mobilization program that had administrative responsibility for the department's civil defense activities. It was located within the local health administration division. Program responsibilities included recruiting, orienting and training staff for emergency duties; maintaining an inventory record and status

[359] MDH, *Minnesota's Health,* Vol. V, No. 1, January 1951, pp. 2-5.

review of medical and radiological equipment and supplies; and keeping operational survival plans current.[360]

Marvin Tyson was civil defense coordinator in the department's division of local health administration. In 1958 he visited 25 county medical societies and met with regional hospital groups and district nurses organizations to explain the plan to them and garner their support. His promotion of the plan contributed to Minnesota's progress in the area of civil defense.[361]

To safeguard the population, the department concentrated its civil defense efforts in education and training, stockpiling supplies, establishing blood donor lists, and establishing statewide distribution procedures. The department also began surveillance of radioactive materials.

Education and Training for Survival

In 1951, the department began educating the population about the atomic bomb and how individuals could better prepare themselves. The department responded to speaking requests from communities with a presentation that included: 1) a brief explanation of what happens during an atomic explosion; 2) overall emphasis of the point that there is no complete defense against the atomic bomb – to impress the necessity for participation; and 3) information on where individuals could get the supplies they needed.

> ***"The importance of preparation for this is the grave possibility that germ and toxic attacks may be launched by the enemy weeks or months before the bomb attacks."***
>
> **Howard Johnson**
> **Federal Department of Civil Defense**
> ***St. Paul Dispatch*,1951**

The department paid special attention to one aspect, biological warfare. In 1951, 75 St. Paul citizens took part in the production of a film designed to explain germ warfare and what measures need to be taken to combat it. Produced by the federal civil service department, in cooperation with the Red Cross, local hospitals and the department, the 10-minute film, "What You Should Know About Biological Warfare," was distributed nationwide.[362]

At the end of 1951, a report published by Minnesota's civil defense department included a description of biological warfare:

> Biological Warfare. This is nothing more or less than germ warfare. It is a type of warfare as old as Man himself. We are continually engaging in biological warfare. The only thing that is new is the methods of bringing that weapon to humans, animals, plant life, and foodstuffs. It is an actual

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[360] MDH, Public Health Education Section, "Minnesota Department of Health Organization and Functions," April 1966, p. 21.
[361] BOH, *Minutes,* May 26, 1959, MHC, p. 129.
[362] *St. Paul Dispatch,* "Film Shows Simulated Germ Warfare Attack on City," July 4, 1951, p. 19.

> fact that Russia has conducted for a number of years, intensive research in this field and in perfecting methods of delivery, both from sabotage and from the air. Specially constructed bombs have been developed, as has apparatus for the spraying of crops by plane. This type of warfare, of course, effects the rural areas and food production centers tremendously. [363]

Despite voiced concerns about the threat of an atomic attack and despite promotion and education by the department, Dr. Chesley and Dr. Smiley were not satisfied with communities' interest. The seriousness with which Dr. Chesley took this new public health challenge was noted in an excerpt from a 1951 board meeting:

> Chesley: "I admit that I considered the World War II blackouts etc., a farce, but now that you have the new gadgets on hand I don't consider it that way a bit. I have taken it seriously from the start." [364]

In 1957 the department, in cooperation with the U.S. Public Health Service, held a workshop on civil defense for the state's key health personnel in "target" cities. The three-day workshop at the University of Minnesota School of Public Health was the first training course of its kind in the state. Topics covered included health problems of modern war; mental health aspects of civil defense; chemical warfare; biological warfare; radiological warfare; control of natural epidemics; casualty care; and sanitation problems such as inset control and control of food, milk and water supplies.[365]

In 1961, the state's civil defense department and highways department built a civil defense training center on the New Brighton Arsenal grounds.[366] Extensive training plans were made to train one million Minnesota citizens on how to take care of themselves in the event of a disaster. One person in each household was expected to be able to take care of the other people in that house.[367] This medical self-help training program was offered to citizens for six weeks. Two nights a week during this period they studied radioactive fallout and shelter; hygiene, sanitation and vermin control; water and food; shock; bleeding and bandaging; artificial respiration; fractures and splinting; transportation of the injured; burns; nursing care of the sick and injured; infant and child care; and emergency childbirth. The program was based on the possibility that in an atomic attack, the services of physicians might not be available to people.

Training was also provided for health care professionals. In the early 1960s the department distributed the NATO handbook, "Emergency War Surgery," to key people, hospitals, and nurse training schools. [368]

In 1963, when civil defense activities began declining, the U.S. Public Health Service and the Department of Defense's office of civil defense asked each state to continue with the medical self-help training program and provided training kits. Training kits included 12 lessons, a projector, extension cord, screen and pointer, visual aids,

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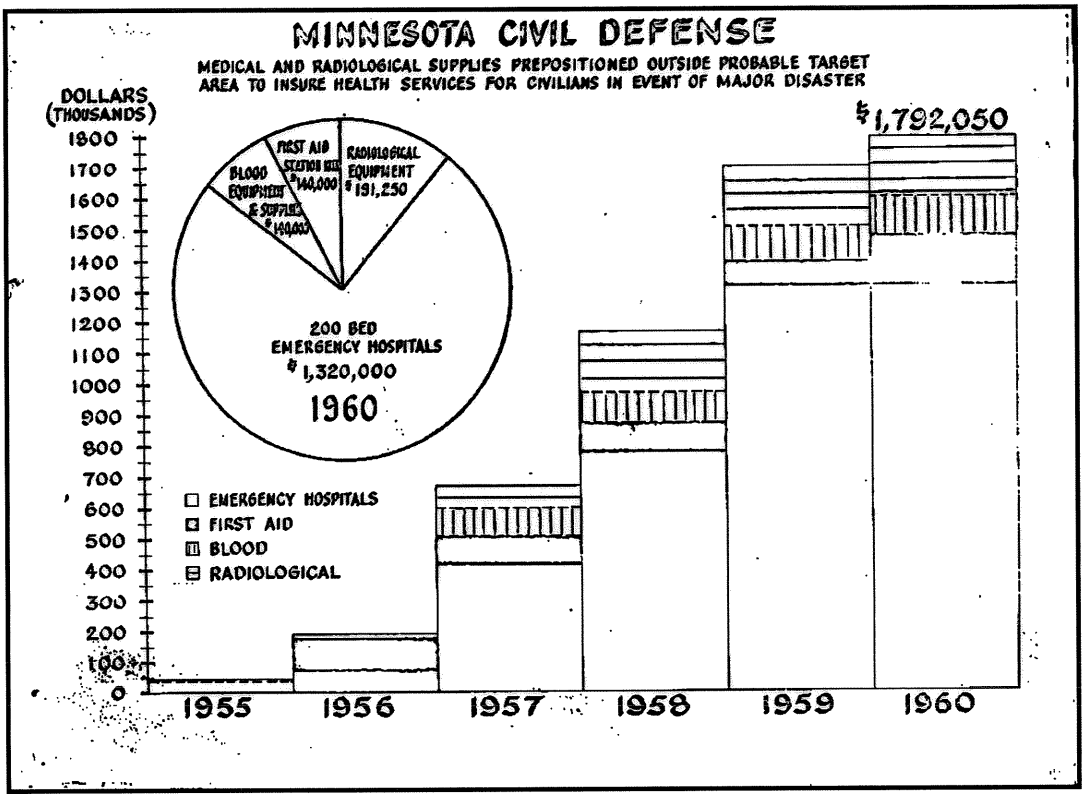
[363] State of Minnesota Report, Department of Civil Defense, December 31, 1951, p. 22.
[364] BOH, *Minutes,* September 29, 1951, pp. 292-293.
[365] MDH, *Minnesota's Health,* Vol. 11, No. 2, February 1957, p. 1.
[366] BOH, *Minutes,* July 11, 1961, MHC, p. 321.
[367] BOH, *Minutes,* October 31, 1961, MHC, p. 380.
[368] BOH, *Minutes,* January 31, 1961, MHC, p. 35.

instructor's guide, instructor's lesson folder, course introduction, student study handbooks, examination questions, answer sheets, examination grading template, reference manual, graduation certificates, and replacement materials for 100 students.[369] Unfortunately, funds to ship the training kits to the communities were not available, so they were not used to their fullest capacity.



First Aid Stations and Stockpiled Medical Supplies

In the fall of 1952, 21 aid stations were established throughout Minnesota to provide medical care following an emergency. These were organized on the recommendation of the military affairs committee of the Minnesota Medical Association, on the approval of its house of delegates and the Minnesota Department of Health. The first aid stations were located in Anoka, Bemidji, Brainerd, Buffalo, Cambridge, Cloquet, Ely, Faribault, Grand Rapids, Hibbing, Hutchinson, Mankato, Northfield, Owatonna, Princeton, Red Wing, St. Peter, Stillwater, Virginia and Willmar.[370]

The medical team at each station was to consist of two physicians, two dentists, three nurses, eight nurse's aides, one administrative assistant, one pharmacist, seven first-aid technicians, three orderlies, one chaplain, three clerks, 103 litter bearers, six ambulance drivers, six ambulance orderlies, and one group leader. Physicians acted as team

[369] BOH, *Minutes,* January 22, 1963, MHC, pp. 78-86.
[370] BOH, *Minutes,* May 21, 1953, MHC, Exhibit VII.

captains, and each team received a complete set of medical equipment that was specially packaged to last for many years.[371]

The department, responsible for planning and coordinating the stockpiling of emergency medical supplies throughout the state, began placing supplies in strategic locations in 1955. That first year the value of supplies was $35,000, provided by federal defense funds.[372] By 1961, the value of stockpiled supplies was estimated at almost $2 million.[373] Supplies included 200-bed emergency hospitals, first aid station kits, cots, radiological equipment, blood donor kits and blood plasma expanders.[374] Forty thousand World War II surgical bandages, compresses and dressings were also added to the emergency stores. The bandages were kept at the St Cloud Reformatory, because of its proximity to the St. Cloud Veteran's Administration Hospital, the relocation site for the University of Minnesota hospitals. In the event of a disaster, this 1,400-bed St. Cloud hospital would become a medical treatment center with a 14,000-bed capacity.

Establishment of Blood Bank System

In 2000, Dr. Henry Bauer, medical laboratories director from1949 to 1976, reflected on the blood bank program that he helped establish in the 1950s:

> There is no substitute for whole human blood. Any disaster in peace or war where there are injured people requires whole human blood. The recipient should feel secure that the blood has been processed by qualified personnel. (Lest we forget, human blood is needed for organ transplants and routine uses in the hospital.)
>
> The atomic bomb dropped during World War II on Hiroshima and Nagasaki, Japan, brought into sharp focus the immediate devastating destruction on the environment and the horrendous number of deaths and horrible injuries experienced by the people of those two cities. Blood transfusions are required immediately for the injured who have lost blood and later for casualties resulting from exposure to atomic radiation.
>
> The preceding statements attested to the need for the development of a Civil Defense and Disaster Blood Supply Program in Minnesota. Essentially, the program plan was proposed to help communities develop a statewide natural aid program supply in blood, when and where needed. In 1957, when this program was being developed, there were 118 hospitals, bleeding centers and blood banks expected to participate in the disaster blood program. The program covered four areas: stockpiling of blood collection supplies, training personnel to draw and process blood, expansion of blood donor lists and establishment of a coordinated method to distribute blood in the event of a major disaster or civil defense emergency. Stockpiled blood collecting supplies would be put into routine use to assure rotation and eliminate loss due to deterioration. Hospital and bleeding centers would assure the cost of replacing supplies, as they were used.
>
> The second area of the program was to provide a large enough reservoir of personnel to draw and process blood in an emergency.

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[371] BOH, *Minutes,* May 21, 1953, MHC.
[372] MDH, *Minnesota's Health,* Vol. 14, No. 7, August-September 1960, p. 1.
[373] MDH, *Minnesota's Health,* Vol. 15, No. 1, January 1961, p. 4.
[374] Ibid.

> The State's plan proposed to assist in setting up a program to train bleeders to collect blood, as well as refresher training for blood technicians to type, cross match and prepare blood for use when indicated. It was hoped that eventually each blood collection center would have at least three trained bleeders certified by the National Institute of Health, who could draw blood in a major disaster. (There are strict regulations covering blood which is shipped interstate. It must be collected carefully to prevent contamination and only personnel certified by the National Institute of Health can collect and process blood for interstate use.)
>
> Even if the State never faced a disaster which required a large volume of blood, the training program would help to improve the routine, daily collection of blood for treating the sick and injured. By training bleeders and by providing refresher courses for blood technicians, the program would allow for more efficient blood collection and processing, particularly in rural areas of the State.
>
> In addition, it would supplement the third major aim of the program, expansion of the blood donor lists. To accomplish this, the State Health Department provided supplemental typing services to hospitals, blood banks and bleeding centers. Groups who participated in the program were required to keep the blood donor list current. To facilitate collection and distribution of blood in a disaster, hospitals, blood banks and centers informed the State Health Department of the total number of donors in each blood groups and the number of members in each RH type. With this information the Department could set up a central registry leaving the amount and types of blood available in all areas of the State. This is the fourth aim of the blood program – enabling the State, in the event of a major disaster, to coordinate and integrate systematically the blood resources into its overall Civil Defense Plan.
>
> The American Red Cross Regional Blood Center, the Minneapolis War Memorial Blood Bank, and the University of Minnesota, in cooperation with the Minnesota State Medical Association, the Minnesota Hospital Association, the Minnesota Department of Civil Defense and the Minnesota Department of Health assisted in the training program. They participated in development of the disaster blood program and approved in principal.

In the 1950s an estimated 150,000 bottles of whole blood were collected annually in Minnesota. In 1951 the Minnesota Medical Association's committee on Red Cross and disaster raised concerns about the availability of blood in the event of a disaster. What developed, the Minnesota civil defense and disaster blood program, became a model for the nation.

The program, developed by the department in 1957, used a plan created by Dr. Henry Bauer, public health laboratory director. This program ensured that an adequate blood supply would be available throughout the state in case of an emergency. It provided for stockpiling of blood collection containers, training personnel to draw and process blood during an emergency, the development of donor lists, and the creation of a central registry.[375] Coordinated methods for distributing blood in the event of a major disaster or civil defense emergency ensured trained persons would be able to make on-the-spot collections.[376]

The initiative to provide a safe margin of error by stockpiling blood collection supplies began in 1955. The department, in discussion with the Minneapolis War Memorial

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[375] BOH, *Minutes,* May 23, 1962, MHC, p. 216.
[376] MDH, *Minnesota's Health,* Vol. 11, No. 1, January 1957, pp. 1-2.

Blood Bank, the Red Cross Blood Center, the Minnesota Hospital Association and the director of civil defense; recommended purchase of one year's supply of blood containers, donors and recipient sets.[377] Federal matching funds were available, so a request for half the estimated cost was submitted to the Legislature for biennium 1955-57. State funds were allotted for the blood program, and Chapter 653, Laws 1957, invested power in the Board of Health to procure and arrange for storage in hospitals and other facilities of materials for collecting blood for transfusion.

More than 50,000 sets for drawing and distributing blood were distributed to 100 hospitals throughout the state in 1958.[378] By 1966, 62,400 blood collecting containers, an equal number of donor kits, 48,200 recipient sets and 124,000 pilot tubes were placed in 129 hospitals and blood banks throughout the state.[379] None were stockpiled in the Twin Cities, the expected target of an attack, where they would likely be destroyed.

In 1958 Dr. Mattson of the Minneapolis War Memorial Blood Bank presented Minnesota's blood bank plan to the American Association of Blood Banks at their 11th annual meeting, held in Cincinnati. The president of the association requested an outline of the program be sent to each of the 48 states.[380] At the same meeting, the department received an award for its Minnesota civil defense disaster blood program exhibit.[381]

The state's capacity to supply blood in an emergency was strengthened in 1959 when legislation directed all county civil defense directors to establish a blood bank committee for each hospital within a county that was not owned or operated by the federal government. The committee was charged with establishing a blood bank and donor list. The blood bank was to have complete blood transfusion service, including collection processing, storage and administration of human blood and its component parts. The committees were required to report the number of donors on the blood donor list, the respective blood groups and RH types to the department.[382]

Initially, the Red Cross was not fully supportive of the state's plan to have blood bank committees with donor lists. It questioned the propriety of doing this and believed its control over the hospital was gone.[383] Meetings with the Red Cross assured officials there was no attempt to usurp their position, and a strong and cooperative relationship was established.

The structure of the blood program is still in effect in Minnesota. When established, it had been agreed that maintenance of supplies was the responsibility of the more than 118 hospitals, bleeding centers and blood banks receiving supplies. They would

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[377] BOH, *Minutes,* March 17, 1955, MHC, p. 54.
[378] *Minneapolis Star,* "100 Hospitals to Receive Blood Donor Equipment," May 14, 1958, p. 1B.
[379] MDH (public health education section), "Minnesota Department of Health Organization and Functions," April 1966, p. 22.
[380] BOH, *Minutes,* January 7, 1958, MHC, p. 16.
[381] BOH, *Minutes,* January 13, 1958, MHC, p. 9.
[382] BOH, *Minutes,* August 11, 1959, MHC, pp. 225-227.
[383] BOH, *Minutes,* November 10, 1959, MHC, pp. 256-257.

routinely draw and replace from the stockpiled blood collection supplies, assuring rotation.

Minnesota's civil defense medical program drew praise from outside the state. Harold W. Brunn, executive secretary of the Minnesota Medical Association, delivered a report on the state's survival medical plan at a 1959 meeting in Colorado of the American Medical Association's council on national defense and its disaster medical care committee. Dr. Harold Lueth, committee chairman, said Minnesota's program "demonstrated what can and should be accomplished." Dr. Laudeutscher, the Region VI medical officer, said, "In my opinion, Minnesota is one of the leaders, if not the leader, in medical preparedness in the nation." Further praise came from Dr. Robert Smith of the U.S. Public Health Service:

> It must be evident that each state must obtain the coordination of public health and organized medicine as is evident in Minnesota's report, and each state department of health must both establish a medical plan and secure its implementation as Minnesota has accomplished.[384]

Decline of Civil Defense Activities

Civil defense activities started to wind down in the 1960s, as funding began to decrease. The 1961 Legislature did not approve continued state appropriations for two full-time department employees who had been developing a comprehensive civil defense plan for the medical aspects of an emergency.[385]

Gov. Karl Rolvaag continued to emphasize civil defense, even though funding had ended. He designated June 1963 as "Government Employees' Month." Employees at all levels of government – federal, state and local – were offered a 12-hour survival course. The course provided each employee with an understanding of the functions of government in an emergency, particularly a nuclear attack; a knowledge of the basic principles of personal and community protection; and the ability to assume the employee's responsibilities during such an emergency. The five lessons offered information on the nature of the Communist threat and American vulnerability; the characteristics of nuclear weapons; protective measures; principles of fallout shelter construction; and decontaminating the human body, emergency sanitary measures, foods, rationing, keeping a money economy, decontaminating streets, and other issues related to living in a shelter.[386]

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[384] Letter from M. D. Tyson to Harold Brunnat, Minnesota Medical Association, April 29,1959, MHC, pp. 156-157.
[385] BOH, *New Dimensions for Minnesota: Planning Guide for 1963-1973.*
[386] BOH, *Minutes,* May 20, 1963, MHC, pp. 404-407.

By the 1970s, little was done at the department to promote civil defense. It was no longer considered a serious concern. While less attention was being paid to civil defense, more was being given radiation, nuclear power plants and other outgrowths of the atomic age.

ID Tags

While there were a large number of civil defense activities, Minnesota, unlike many states, didn't require the wearing of metal identification tags that could be worn around the neck or wrist and the National Defense Administration urged everyone to wear one. In 1951, Dr. Smiley commented on these tags:

"We have all felt that it was a swell idea but a great many are highly dubious about how many tags will be found on the individual. They may be hanging in the bathroom at home or the boys may give the to their girl friends or something like that." [387]

Radiation and Radioactive Fallout

Radiation became a recognized public health problem of the 1940s and 1950s. A radiation program, began under the direction of Frank Woodward, director of environmental health and sanitation, concentrated on the four main sources of radiation: natural or background, fallout, nuclear wastes and radiation from the use of x-rays and radioisotopes.

Much of the early work by the department was done in the area of surveillance. In 1949 the department surveyed shoe-fitting x-ray machines, mobile x-ray units and x-ray equipment in hospitals and doctor's offices. Beginning in 1953 the department participated in a national network to gauge radioactive fallout from atomic explosions. In 1955 it began reviewing a proposal to construct the first nuclear power reactor in Minnesota. Two years later, in 1957, regulations for control of "sources of ionizing radiation, and the handling, storage, transportation, use and disposal of radioactive isotopes and fissionable materials were developed."[388]

By 1955 radioisotopes were in use for medical treatment in hospitals, research in colleges, measuring thickness gauges and static eliminators in paper plants, checking casting in preservation and other industrial needs. [389] In 1957, Gov. Freeman, concerned about atomic energy's potential to affect the state, appointed a committee to study atomic development problems. The committee was to gather and make available for dissemination to the public reliable information on atomic energy; promote the utilization of atomic energy within Minnesota; control and protect the public from its health hazards; protect and conserve natural resources; and protect both users and possible victims of injury against loss through insurance or other means.

Surveillance of Radiation

The Minnesota civil defense radiological program began in 1951, under the leadership of Leon Schuck, with training courses for monitors and field visits. The program was

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[387] BOH, *Minutes,* October 16, 1951, MHC, p. 336.
[388] BOH, *Minutes,* May 22, 1958, MHC, pp. 143-144.
[389] MDH, *Minnesota's Health,* Vol. 10, No. 5, May 1955, pp. 2-3.

somewhat limited until 1956 when the national civil defense organization provided guidelines for training and programming. The passage of the Ostertag Amendment in Congress provided funds for the purchase of radiological instruments. The recipients of the instruments were civil defense organizations, which would train at least 20 people in the use of the instruments. By 1960, an estimated 10,000 persons in Minnesota were trained to use the 502 Ostertag instrument sets. [390] In 1962 there were 356 monitor stations throughout the state.[391]

In 1953, the department became one of 44 agencies that were part of the U.S. Public Health Service's national surveillance of radioactivity in the air. A vacuum cleaner device for collecting daily samples was installed on the roof of the department's building on the University of Minnesota campus in Minneapolis.[392] F. C. Labernik, a public health engineer, measured the radioactivity using a Geiger counter.[393] Daily samples indicated Minnesota was within the acceptable level at this time.

Rainwater was also collected on the roof of the Health Department building and analyzed for radioactive counts. In addition, a milk-sampling program and an extensive water-sampling program at about 70 statewide locations were regularly used to keep tabs of the levels of radioactivity in the state.[394]

In 1956, the department, in cooperation with the U.S. Public Health Service and the Atomic Energy Commission, became one of 27 stations in the country monitoring radioactive fallout.[395] Following Pacific exercises involving the hydrogen bomb, the department took air samples seven days a week and sent them to the Atomic Energy Commission to determine the effects of the bomb.[396]

Expertise in the area of radiation was growing and developing within the department. One employee, Russell E. Frazier, chief of the engineering laboratories section, received a state merit award from Gov. Freeman in 1960 for designing an instrument for measuring radioactivity. The charger and counter were built using materials on hand, at a cost of approximately $150. It was estimated that the equipment would have cost $2,850, if built commercially.[397]

Radioactive Milk?

The department began sampling milk for radioactivity in 1958. Initially the program concentrated on the presence of strontium-90, but tests for iodine-131 were added in 1961 following an increase in fallout after Soviet nuclear tests. Minnesota was the only state that had its own network of radio-iodine stations and the only state that regularly

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[390] BOH, *Minutes,* January 12, 1960, MHC, pp. 54-59.
[391] BOH, *Minutes,* January 16, 1962, MHC, pp. 37-38.
[392] MDH, *Minnesota's Health,* Vol. 13, No. 1, January 1959, p. 2.
[393] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, pp. 2-3.
[394] MDH, *Minnesota's Health,* Vol. 13, No. 1, January 1959, p. 2.
[395] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, pp. 2-3.
[396] BOH, *Minutes,* April 19, 1956, MHC, p. 69.
[397] *Capitol News*, June 1960, pp.1 and 20.

ran strontium-90 as a network study. Minnesota did more testing to measure radioactivity than any other state during the 1950s.[398]

Reports indicated there was a large increase in radioactive fallout in September 1961, possibly due to testing by Russia and the United States. Because of concern over the levels of radio iodine in the milk, thought was given to stockpiling dried milk.[399] Minnesota's milk was criticized throughout the country for being higher in strontium-90. The U.S. Public Health Service assisted the department in trying to determine why.[400]

Weather patterns of 1962 caused more fallout to the Midwest than other parts of the country. Reports from eight sampling stations throughout the state – Bemidji, Duluth, Fergus Falls, Little Falls, Mankato, Minneapolis, Rochester and Worthington – found an increasing amount of iodine-131 in milk.

Minnesota had the highest accumulated dose level of iodine-131 of any of the 50-some sampling points now operating in the United States. The Federal Radiation Council had established an accumulated dose maximum of 36,500 micromicrocuries for a one-year period. From September 1, 1961, to May 30, 1962, Minnesota had an accumulated dose maximum of 31,000 micromicrocuries. It appeared that Minnesota would exceed the maximum dose before the one-year period was over.

In July 1962, Dr. Warren Lawson, director of the occupational health and radiation control program, reported to the board that he had been working with the dairy industry to plan counter-measures that weren't too expensive or impractical. One option was to let the milk sit for several days before drinking. Dr. Lawson believed an explanation and warning to the public was needed, particularly for sensitive people, such as infants. A joint statement from the department and the dairy industry was planned to inform the public about the situation and recommend the availability of especially constituted milk for infants, nursing mothers and pregnant women.[401]

Board members liked the way Dr. Lawson was handling the situation:

> Mr. Herbert Bosch (member of the Board of Health): "I think Dr. Lawson is to be congratulated for what he has done with the milk industry, because potentially this thing could be very, very dangerous not only to the health of the people but also it could be extremely damaging to the industry. After all, we are tied in with this industry from the standpoint of the general economics of the State, and I think Dr. Lawson and Dr. Barr and Mr. Woodward should be congratulated on their wisdom in proceeding on this. As Dr. Lawson says, this State has gone much further in terms of radiochemistry than any other state health department in this area, and I think the State Board of Health's Advisory Committee on Radiological Health has been a big asset as a sounding board. I would like to express to you, Dr. Lawson, on behalf of the Board, congratulations on the manner in which you have carried this forward, because I think this is a very worthwhile contribution to the health of the people of this State, and also economically.[402]

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[398] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, pp. 2-3.
[399] BOH, *Minutes,* October 31, 1961, MHC, pp. 382-383.
[400] BOH, *Minutes,* January 16, 1962, MHC, p. 37, and attachment: "Report on Strontium-90 in Milk Produced in the Brainerd Milkshed."
[401] BOH, *Minutes,* July 10, 1962, MHC, pp. 327-329.
[402] BOH, *Minutes,* July 10, 1962, MHC, p. 329.

By August 6, 1962, accumulated levels of iodine-131 for the year had reached 33,700 micromicrocuries. Realizing the maximum level would soon be exceeded, the governor's advisory committee to the dairy industry recommended that dairy farmers voluntarily take measures to reduce the level of iodine-131 in the milk. The dairy industry voluntarily adopted control measures. Beginning August 23, until September 15, about 50 percent of dairy herds were not grazed on the open field. They were fed feed that had been stored under cover and aged at least 21 days. They did not do open field grazing. These measures were in place through September 10 and were successful in reducing the levels of iodine-131 in milk to an acceptable range. [403] [404]

X-ray Shoe-Fitting Machines

Radiation presented a number of new public health issues. In the 1940s and 1950s it was the practice of many shoe stores to determine the correct shoe size using x-ray machines. In 1950, the department conducted a survey of the approximately 200 x-ray shoe-fitting machines in the state. The study indicated many machines were operated somewhat carelessly or that control features were lacking. As a result of recommendations made by the department, some machines were taken out of service. The city of Minneapolis wanted to prohibit them entirely and asked the board to support this. Legislation would be necessary for such an action. While Dr. Frank Krusen, board president, believed it appropriate to discourage their use, Prof. Bosch thought the board should "be reasonably sure that we had our ducks set up in a row" before making any decision. The board was hampered by limited research to help make policy decisions related to radiation.[405] When the board issued regulations on radiation in 1958, the shoe-fitting machines were outlawed.

First Nuclear Reactor

In 1957 the board learned plans were in place to install a nuclear reactor in Elk River. It was to be constructed by the Atomic Energy Commission for the Rural Cooperative Power Association. The board wondered if it should consider a regulation that would force the Atomic Energy Commission and others involved to work with the department.

A hearing was scheduled for March 7, 1958, to determine if there was any substantial evidence to prevent the Atomic Energy Commission from issuing an operating license to Elk River. Board member Dr. Ruth Boynton referred to the public's expectation that the board would protect them:

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[403] MDH, *Minnesota's Health,* Vol. 16, No. 7, Aug-Sept 1962, pp. 1-2.
[404] BOH, *Minutes,* October 3, 1962, MHC, pp. 391-397.
[405] BOH, *Minutes,* July 30, 1957, MHC, p. 123.

> The public is going to expect the State Board of Health to take some part in the hearing and either say that we have assurance from the Atomic Energy Commission and that we will get reports from them, or else we say we haven't been able to arrive at any agreement with them. [406]

While the board's role in addressing communicable disease and sanitation issues was much clearer by comparison, there was limited guidance as to the department's role with atomic energy. Minnesota had no laws governing the use of radioactive materials. It had not been clarified which agency had responsibility for this new area. The department's involvement was based on its authority to regulate practices that were a menace to public health. Frank Woodward, environmental sanitation division director, described the situation: "We're having to live with a new item in our environment, one which requires new tools and techniques to safeguard the public's health. However, by adapting our sanitation practices to meet this problem, there is no reason to think that we cannot protect against hazards from nuclear reactors, radioisotopes, and other sources of ionizing radiation.[407]

Dr. Robert Barr thought the state needed to be cautious in adopting regulations until adequate evaluation had been done. Dr. Boynton agreed, but also said:

> I think that is very true, but on the other hand I think we as the State agency which has been designated by the Legislature to be responsible for the supervision of the health of the people in relation to this, should certainly offer our cooperation. We will want to work closely with an industrial group of this sort that will be expanding. We should be in close touch with what they are doing. [408]

The board, led by Herbert Bosch, who had been the department's environmental sanitation division director and the World Health Organization's first chief of its environmental sanitation section in Geneva, Switzerland, thought the whole issue of atomic energy critically important. It involved broad issues and policy making with long-range effects, whether or not control of radiological hazards remained in the department. The board was concerned that the Legislature did not view radiological health as a serious public health matter. [409]

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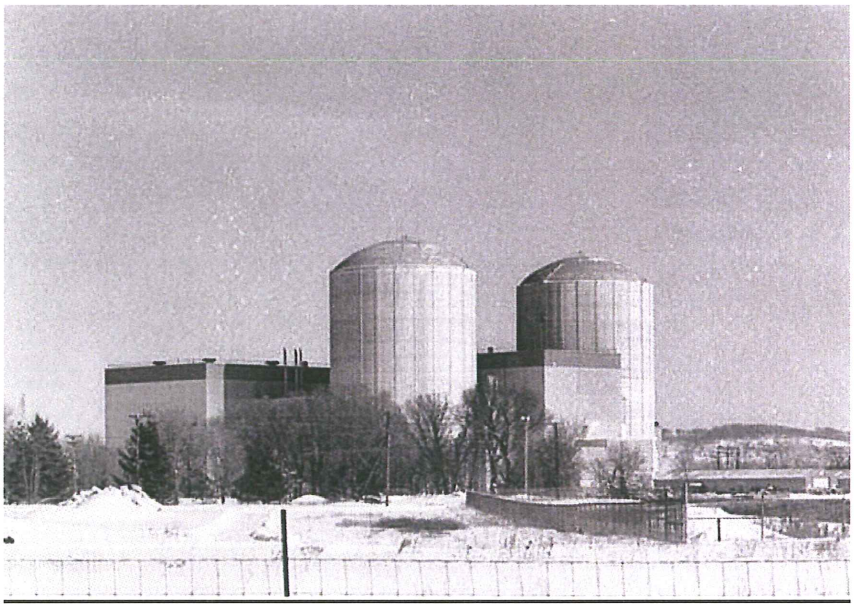
[406] BOH, *Minutes,* January 31, 1961, MHC, p. 22.
[407] MDH, *Minnesota's Health,* Vol. 10, No. 5, May 1955, pp. 2-3.
[408] BOH, *Minutes,* July 30, 1957, MHC, p. 123.
[409] BOH, *Minutes,* May 22, 1958, MHC, pp. 143-145.



Nuclear Plant at Prairie Island, 1975

First Ionizing Regulations Passed

The department's role in ionizing radiation was significantly changed in 1957 when the Legislature granted it authority to adopt regulations for the control of "sources of ionizing radiation, and the handling, storage, transportation, use and disposal of radioactive isotopes and fissionable materials." Regulation 1153, developed in cooperation with the state's atomic development problems committee, with Lee Loevinger as chair and Dr. Robert Barr as member, was adopted by the Board of Health on December 4, 1958, and approved by the attorney general on December 17, 1958.[410]

Regulation 1153 affected 6,000 to 7,000 users of ionizing radiation equipment and radioactive material in the state. These individuals and institutions had to register with the board by April 1, 1959, and were required to register annually thereafter. They had to provide information on the owner, the source of radiation, as well as what safety precautions they were undertaking to insure unnecessary radiation.[411]

There was a lack of interest by some doctors in registering as required by the new regulations. Dr. Donn G. Mosser, member of the Minnesota Medical Association's radiation and radioactive isotopes committee and the Board of Health's radiologic safety advisory committee, requested the department's help in urging physicians to register.[412]

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[410] BOH, *Minutes,* January 13, 1959, MHC, p. 10.
[411] MDH, *Minnesota's Health,* Vol. 13, No. 1., January 1959, p. 1.
[412] BOH, *Minutes,* May 23, 1961, MHC, p. 165.

Dr. Barr responded by supporting the regulation as a standard approach in public health:

> The accumulation of such information will help determine the future direction of control efforts. Regulation is extremely important in the development of a program to evaluate the potential hazard to health of the population as a result of radiation exposure. The acute effects of massive doses of radiation are well known. What are not as well known are the effects of low-level, long-continued exposures to radiation.[413]

Regulation 1153 established a standard radiation symbol to indicate radioactive materials. Rules were made for the handling and transport of these materials. With Regulation 1153, Minnesota became the first state to require submission and approval of plans for any nuclear reactor, nuclear fuel reprocessing plant, or any permanent or temporary nuclear waste disposal facility. As part of this, no nuclear reactor could begin operating without the approval of the Board of Health.[414]

The Atomic Energy Commission held a hearing in Germantown, Maryland, in November 1959, to consider health and safety questions involved in construction and operation of the nuclear reactor at Elk River and invited Gov. Freeman to attend. He wrote back that the federal government must be aware of Minnesota legislation that gave the Health Department responsibility for monitoring the safety of nuclear reactors. He objected that construction permits were issued by the federal government without official prior or concurrent assurances that the federal government, as owner of the reactor, would comply with Minnesota laws and regulations relative to nuclear reactors and water pollution. He asked that compliance with state laws and regulations be a condition of issuance of the construction permit.[415]

In 1959, a proposal was made to transfer the Atomic Energy Commission to the state. Dr. Warren Lawson, then chief of radiation and occupational health, supported such a transfer. He thought it was a logical next step in development of the department's radiological health program. He believed the staff was competent to do this. Dr. Barr thought the department should be cautious with such a move. He didn't want the board to become subservient to the Atomic Energy Commission. He wondered if it shouldn't be discussed with the U.S. Public Health Service.[416]

Feeling a greater need for expert opinion to advise it on the difficult decisions related to radiation, particularly those of the Elk River plant, the board established a radiologic safety advisory committee. Members included: Dr. Maurice Visscher, physiology department chair, University of Minnesota; Dr. Richard Caldecott, associate professor of plant genetics, University of Minnesota; Dr. Herbert F. Isbin, professor of chemical engineering, University of Minnesota; Dr. Donn G. Mosser, associate professor of radiology, University of Minnesota; Dr. Sheldon C. Reed, director of the Dight Institute of

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413 MDH, *Minnesota's Health,* Vol. 13, No. 1, January 1959, p. 2.
414 Ibid., p. 1.
415 BOH, *Minutes,* attachment: letter (11/2/59) from Gov. Orville Freeman to secretary of the Atomic Energy Commission, November 10, 1959, MHC, pp. 318-320.
416 BOH, *Minutes,* November 10, 1959, MHC, p. 252.

Genetics, University of Minnesota; Dr. Cyrus Hanson, radiologist, Minneapolis; Dr. Marvin Williams, radiation physicist, Mayo Clinic in Rochester; and Dr. Finn Larson, Honeywell Company.[417]

The advisory committee, headed by Dr. Maurice Visscher, saw no compelling reason to oppose putting in a reactor in provisional operation at Elk River. It thought the board should receive full information concerning the radio-nuclide composition of waste gases from the Elk River reactor; and the Department of Health should receive information on the operating records of discharge of radioactive materials into the environment, as a result of the operation of the Elk River reactor, as a right, not a courtesy. Dr. Visscher said:

> We are not happy about one thing: namely that the Atomic Energy Commission isn't really willing to give the State Board of Health access to operational information as a matter of right rather than as a matter of courtesy. We have not the slightest doubt that the Atomic Energy Commission is going to give you that information. It may be months late, unless something untoward happens, but you are going to get this information. The question that bothers us is whether as a matter of principle the State Board of Health should not have such information on installations being put up within its domain as a matter of right rather than as a matter of courtesy. There are many points that can be made in this connection. It is a hornets' nest and it involves the prerogatives of the Atomic Energy Commission generally, because they may feel that although it is appropriate to do this sort of thing for the State Board of Health in Minnesota it might not be appropriate somewhere else under somewhat different circumstances. They may not want to establish precedent. But in summary, I would say that your committee can find no reason to believe that every precautionary measure that is humanly possible is not going to be taken. We would say that the engineering seems to members of our committee, like Herbert Isbin, who is involved in this thing, to be adequate, and since power reactors of this type are in the public interest so far as development and operation are concerned, we feel that the reactor should be approved and should not be opposed, but we are not happy about the fact that you will not get day-to-day information about how much Iodine-131 is going into the atmosphere, and we just leave it to you to decide what you think ought to be done about that aspect of the problem. We throw it in your lap with the recommendation that you do not oppose the operation of the reactor, because we think it is as safe as it is possible to make it, but that you should think very seriously about he question of whether you should not have the operating information as a matter of right rather than as a matter of courtesy.
>
> The State had a right to the information legally but didn't think it would be a wise political move to make a legal demand. They feel a legal demand would essentially be fighting a battle for all states.
>
> They feel the first step is to directly ask the Atomic Energy Commission to authorize their subordinates to release data to the Department. They feel it is better to send the request to the top level in Washington, DC, by-passing the Chicago Operations Office. The Department intends to establish a long-term monitoring program and hopes to work cooperatively with the Atomic Energy Commission. I feel that there is no use bumping your head against any more walls than are necessary, and I would give the Atomic Energy Commission a chance to play ball.[418]

The first untoward incident with radioactive materials occurred September 26, 1959, when a vehicle owned by the X-Ray Engineering Company of California was involved in

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[417] BOH, *Minutes,* November 10, 1959, MHC, pp. 253-254.
[418] BOH, *Minutes,* December 19, 1960, MHC, pp. 409-412.

a collision in Coon Rapids. Radioactive material was dislodged from its protective lead cask and presented a serious hazard to everyone in the area. It was returned to its cask, and no excessive exposure was known to have occurred, but it did serve as an alert to the potential for accidents of this type and the board's need to aggressively demand that regulations be followed.[419]

Dr. Barr stressed that the solution to the problem of ionizing radiation could not be done individually. He advocated community action, with education and participation in the planning and developing of preventive programs.[420]

Though the department was quite progressive in its efforts to monitor and regulate radiation to safeguard the citizens, not everyone shared that feeling. In 1962 one citizen wrote:

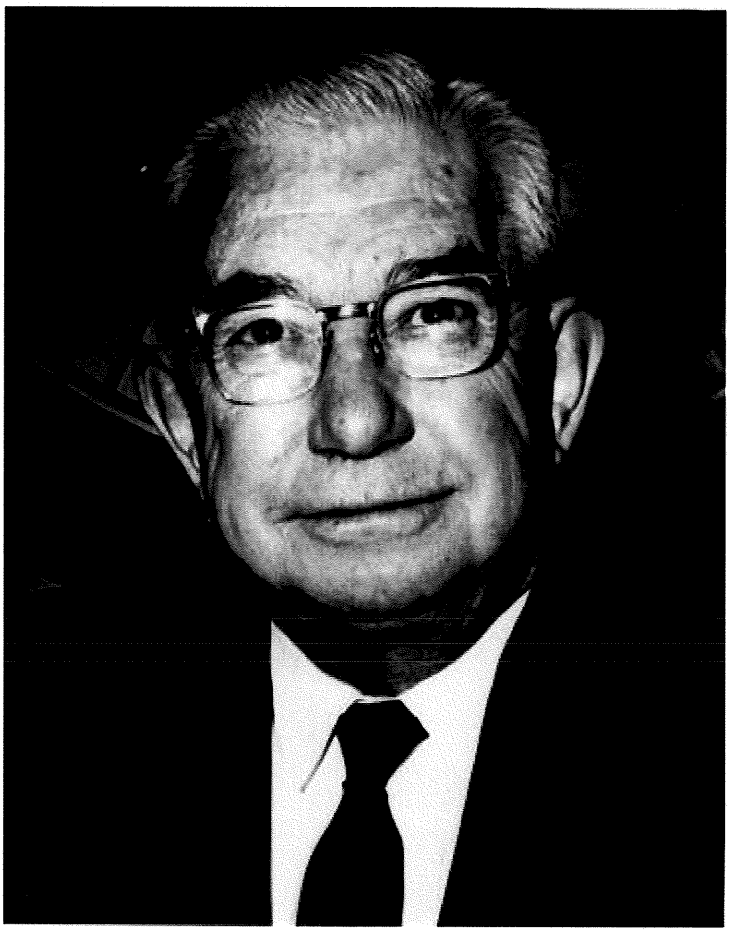
> I had hoped that the State Health Department would cooperate in protecting the people from the hazard of radioactive materials and radiation. Since the Board of Health does not agree in my contention that it is necessary, I am obliged to ask for the resignation and removal from office of all those in the State Health Department who are responsible for this negligence. Your cooperation in accomplishing this will be appreciated.[421]

(Note: Additional material on the history of radiation and nuclear power at the department is continued in Chapters 8, 9,13 and 17.)

[419] BOH, *Minutes,* November 10, 1959, MHC, p. 309.
[420] MDH, *Minnesota's Health,* Vol. 13, No. 1, January 1959, pp. 1-3.
[421] BOH, *Minutes,* October 3, 1962, MHC, p. 389.

Chapter 5

End of an Era – 1955 to 1970



"Mr. Public Health": Secretary and Executive Officer of State Board of Health, Dr. Robert N. Barr

The transition from Dr. Chesley to Dr. Barr in 1955 was a smooth one. The two men shared similar visions about public health and the Health Department. Both were strong advocates of public health, willing to work on the front lines and eager to fight for the health of the people of Minnesota. Dr. Barr continued many of the activities and used the same approaches as practiced by Dr. Chesley and other former public health leaders. Evidence of Dr. Barr's respect for the previous health officer was indicated by the framed portrait of Dr. Chesley he kept on his office wall during his years as secretary and executive officer.[422]

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[422] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1956, p. 4.

In contrast to Dr. Chesley's quiet demeanor, Dr. Barr was effervescent and colorful. He was frank and direct, and has been described as a "salty character." Dr. Barr was especially well liked by the department's employees. Nearly 30 years after his death, former employees remember him warmly. "He would let us out early when there was a snowstorm or the basketball tournaments were at Williams Arena."[423] He "was full of heart," or he was "someone who always said hello." [424]

His popularity resulted in a surprise party by his employees shortly after his appointment as secretary and executive officer. While he attended a board meeting away from the department office building, the staff prepared festivities. Board members, aware of the party, tried to move through the agenda quickly, but Dr. Barr kept bringing up more and more topics to discuss. When the meeting finally ended they walked back to the department on the University of Minnesota campus, and Dr. Barr found a party, complete with silver tea services and all metropolitan employees, waiting to celebrate his new position.[425]

Lyle Smith, Elmer Slagle, Dr. Robert Barr and other employees at a MDH party celebrating Dr. Barr becoming Executive Officer, April 19, 1956.

One recipient of Dr. Barr's friendship and thoughtfulness was Orianna McDaniel, M.D., who in 1896 was the department's first female employee. Dr. McDaniel retired from the department at age 74 in 1946 and lived to see her 100th birthday. Dr. Barr and Fritz E. Michaelson, a member of the staff since 1931, continued to visit Dr. McDaniel, and on her birthday and Christmas they brought her a dozen red roses. When Mr. Michaelson suddenly died in 1968, Dr. Barr continued the tradition.[426]

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[423] Interviews with former employees, March 5, 1999.
[424] Interviews with former employees, January through April, 1999.
[425] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1956, p. 4.
[426] MDH, *Minnesota's Health,* Vol. 22, No. 4, March 1968, p. 4.

Dr. Barr was born in Kansas. The son of a Presbyterian minister, he attended high school in Fergus Falls. After graduating from Macalester College he taught high school physics and physical education for one year before beginning studies at the University of Minnesota School of Medicine.[427] He earned his master's degree in public health from Johns Hopkins University.[428] Dr. Barr began work at the Health Department in January 1934 as an epidemiologist. He worked as director of rural health services, becoming chief of the department administration section in January 1946 and chief of the special services section in May 1948. Dr. Chesley appointed him his deputy in 1949, and he remained in that position until Dr. Chesley's death in 1955.

Dr. Barr's style was described in the department newsletter:

> Dr. Barr employed his gift for forceful communication, backed by near-encyclopedic knowledge, common sense, and logic. Friends and associates recall that some chuckles were often mixed into Dr. Barr's discussions of public health. But, although friendly and outgoing, he never hesitated to speak bluntly when the State's health was concerned.[429]

Working with Others

Dr. Barr was especially gifted in maintaining cooperative working relationships with other public health organizations. Throughout his tenure, a close association existed between the department and the University of Minnesota School of Public Health, the Minnesota Medical Association and other public health organizations in the state. The board depended on these organizations for assistance in making decisions. They supported each other in achieving their common public health goals.

At the May 23, 1962 board meeting, which met with representatives of the Minnesota Medical Association, President Dr. Frank Krusen expressed his gratitude for their working relationship and praised Dr. Barr's work:

> I think we of the Association can be pleased with the knowledge that we have in Minnesota one of the most efficient and effective departments of health of any state. It has been a ground for the development of health officials who have gone to other parts of the nation, and under Dr. Chesley and Dr. Barr much has been done to develop health services throughout the nation. As a member of the Board I would like to say how pleased we have been with the effective cooperation the Council and members of the State Medical Association have given to the State Board of Health. We are grateful for your cooperation, which has been so helpful in promoting the health of the people of the State.[430]

Advisory committees flourished during Dr. Barr's administration. He actively used outside expertise to help deal with public health issues. Advisory groups working with the department in 1961 were:

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[427] MDH, *Minnesota's Health,* Vol. 24, No. 10, December 1970, p. 2.
[428] MDH, *Minnesota's Health,* Vol. 17, No. 8, October 1963, p. 2.
[429] MDH, *Minnesota's Health,* Vol. 24, No. 10, December 1970, p. 2.
[430] BOH, *Minutes,* May 23, 1962, MHS, p. 218.

Minnesota Advisory Board on Problems of Alcoholism (established 1953)
J. S. Hopponen, John B. Budd, Walter P. Gardner, M.D.; Mary Laddy; Marten Lampi; W. W. McKenna; W. A. Newman; Raymond Schoenrock; Robert Stevenson

Civil Defense Disaster Committee, MSMA
C. W. Waldron, M.D.; A. I. Balmer, M.D.; Mario Fischer, M.D.; John W. Gridley, M.D.; Wayne S. Hagen, M.D.; William C. Harrison, M.D., M.P.H.; John C. Ivins, M.D.; Richard H. Jones, M.D.; William A. Klein, M.D.; Karl R. Lundeberg, M.D.; John B. Miettunen, M.D.; A. Eugene Muller, M.D.; C. W. Rumpf, M.D.; Joseph M. Ryan, M.D.; Alvin Sach-Rowitz, M.D.; M. D. Tyson; L. F. Wasson, M.D.; Virgil A. Watson, M.D.;

Examiners in Mortuary Science
Thomas G. Bell, Jr., John L. Werness, Eugene M. Larson, Robert C. Slater

Hospital Administrators Registration Law Advisory Board (established 1947)
James Hamilton, Ray M. Amberg, Dina Bremness, R. N.; Walter P. Gardner, M.D.; Benjamin W. Mandelstam, M.D.

Hospital Survey Committee (established 1945 – same membership as State Advisory Council on Hospital Construction (established 1946)
Ray M. Amberg; Sister M. Vivian Arts, R.N.; Dina Bremness, R.N.; Walter P. Garnder, M.D.; Kenneth J. Holmquist; Harold C. Mickey; Glen Taylor; Harold Brunn; Frank J. Elias, M.D.; Earl C. Elkins, M.D.; Victor P. Hauser, M.D.; Carl L. Lundell, M.D.; Russell O. Sather, M.D.; Viktor O. Wilson, M.D., M.P.H.; Donald R. Mackay, D.D.S.; Thelma Dodds, R.N.; Henry M. Moen; Victor C. Gilbertson; Robert A. Olson; Howard Smith; James Flavin; G. Fred Loucks; Mrs. Rahle Nelson; Robert N. Barr, M.D., M.P.H.; Morris Hursh; David J. Vail, M.D.

Hospital Licensing Law Advisory Board (established 1951)
Ray M. Amberg; Theodore J. Catlin, M.D.; Earl Hagberg; Winston R. Miller, M.D.; Richard L. Olsen; John Poor; Sidney Shields; David J. Vail, M.D.; Sister M. Lenore Weier

Advisory Committee on Problems of Human Genetics (established 1959)
Sheldon Reed, Ph.D.; John A. Anderson, M.D.; John E. Anderson, Ph.D..; Ray C. Anderson, M.D.; Tague Chisholm, M.D.; Robert Gorlin, D.D.S.; E. Adamson Hoebel, Ph.D.; John S. Pearson, Ph.D.; Frank M. Rarig, Jr.

Oral Poliovirus Vaccine Committee
Gaylord W. Anderson, M.D.; John A. Anderson, M.D.; Paul Ellwood, M.D.; John L. McKelvey, M.D.; Leonard M. Schuman, M.D.; Dennis Watson, Ph.D.

Plumbing Examiners
Louis R. Reichel; Rosy Gustafson; Myhren C. Peterson, M.S., C.E., B.S.

Certification of Public Health Nurses
Marion Murphy, Ph.D.; Alberta B. Wilson, R.N., M.P.H., Ella Christensen, R.N.; Leonora Collatz, R.N., Mario Fischer, M.D.

Public Health Nurse Stipends for Accredited Training
Leonora C. Collatz, R.N.; Ruth Abbot, R.N., M.A.; Ella Christensen, R.N.; Amelia Logar, R.N.; Marion Murphy, Ph.D.; Alberta B. Wilson, R.N., M.P.H.

Radiological Safety (established 1960)
Maurice Visscher, M.D, George S. Michaelson, M.S.; Cyrus Hansen, M.D.; Herbert Isbin, Ph.D.; Finn Larsen, Ph.D.; Donn G. Mosser, M.D.; Alfred O. C. Nier, Ph.D.; Alan Orvisk Ph.D.; Sheldon C. Reed, Ph.D.

Four County Project for Retarded Children (established 1957)
Maynard C. Reynolds, Ph.D.; Harriet Blodgett, Ph.D.; Robert Bergan, M.D.; Frances Coakley; E. J. Engberg; Reynold Jensen; Frank M. Rarig, Jr.; Roberta Rindfleish; A. B. Rosenfield, M.D., M.P.H.; Dean M. Schweickhard, Ph.D.; David J. Vail, M.D.; Gerald F. Walsh; George Williams, M.D.; Alberta B. Wilson, R.N., M.P.H.

Rheumatic Fever Committee of Minnesota Heart Association (established 1960)
Robert A. Good, M.D.; Earl E. Barrett, M.D.; James DuShane, M.D.; Paul F. Dwan, M.D.; John B. O'Leary, M.D.; Evelyn Parkin; Jose G. Quinones, M.D.; Lewis W. Wannamaker, M.D.

Joint Committee of the Minnesota Department of Health and the Minnesota Department of Education (established 1949)
A. B. Rosenfield, M.D., M.P.H.; Carl Knutson

Tuberculosis Consultation Committee (Tuberculosis Mortality Committee) (established 1944)
Corrin H. Hodgson, M.D. ; Arthur C. Aufderheide, M.D.; J. Richard Aurelius, M.D.; Ejvind P.K. Fenger, M.D.; F. G. Gunlaugson, M.D.; Norman G. Hepper, M.D.; Willard E. Peterson, M.D.[431]

[431] MDH, *Minnesota's Health,* Vol. 15, No. 3, March 1961, pp. 1-4.

When Dr. Barr became head of the agency, the team approach was flourishing in Minnesota. Health education was being stressed as the answer to many ills. The public health system thrived on volunteers who organized events, did housekeeping services, and helped out at the schools.[432] Media activities, begun under Dr. Chesley's leadership, continued through Dr. Barr's term.

In 1956, 21 stations in Minnesota broadcast a series of 10 radio programs on "The State of Your Health." The most pressing health problems were discussed, and it was hoped communities would be encouraged to look at their needs and take action. Interviews with board members and department employees and Bee Baxter, well-known radio and television announcer, continued.[433] The radio series, produced under the auspices of Blue Cross-Blue Shield, won first prize for its entry of the series in a public service award competition.[434]

A 30-minute film, "The State of Your Health," was produced by KSTP-TV based on the 10 interviews. The film was used to show how communities must exert continued vigilance to control certain disease. The film offered suggestions for combating new health problems, such as the aging population. Highlighted areas were maternal, child and infant health, dental health care, environmental sanitation, and communicable disease control.[435]

World Health Organization National Assembly

A major event that occurred in 1958 was the hosting of the World Health Organization's national assembly in Minneapolis. Dr. Barr was given credit for holding this prestigious public health meeting in Minnesota. Representatives from 86 countries gathered to celebrate the 11th annual anniversary of the World Health Organization and Minnesota's 100th birthday.

It was the first time the World Health Organization had held its meeting in the United States. The honorary chair of its national assembly and the state's centennial health committee was Gov. Orville Freeman. Chair of the committee was Dr. Charles W. Mayo, Mayo Clinic. Much of the work was done by Dr. Barr and Mr. Thomas Cook, executive secretary of the Hennepin County Medical Society. The event drew 229 individuals and 51 sponsoring organizations from around the world to Minneapolis.

Dr. Barr was also instrumental in bringing the Pan American Health Organization to Minneapolis for a conference in 1962. The Pan American Health Organization met in Minneapolis from August 21 to September 6, 1962. Twenty-six countries were represented.

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[432] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 8.
[433] MDH, *Minnesota's Health,* Vol. 10, No. 7, August-September 1956, p. 3.
[434] MDH, *Minnesota's Health,* Vol. 10, No. 9, November 1956, p. 2.
[435] Ibid.

At the World Health Organization 11th World Assembly held in Minneapolis, Dr. Thomas Parran, former U.S. Surgeon General, commented on the need for funding for public health:

"With such funds, and the sentiment behind them, malaria eradication would be speeded up; smallpox, tuberculosis, syphilis and yaws would be next on the list to go. . .Then WHO could turn its energies more fully to improved nutrition, to promoting physical and mental vigor, to expanding scientific health knowledge, and finally, to the most difficult task of all, the improved harmony of human relations." [436]

Dr. Thomas Parran
1958

Employees

When Dr. Barr became executive officer, he chose Jerome Brower as his deputy. Other than that one change, the management team in place when Dr. Chesley was executive officer remained during the early years of Dr. Barr's administration.

The 1950s and 1960s were a time when many employees had only one employer during their entire career. In keeping with this trend, there were many long-term employees at the department. In 1957, when service awards were presented, 49 of the department's 296 employees were recognized for 20 or more years of service. They included:

45 Years
Miss Gladys Casady, Administration

40 Years
Mrs. Margaret Lenis, Administration

35 Years
Mr. Albert Anderson, Medical Laboratories
Mr. Floyd Carlson, Executive Office
Miss Mary Giblin, Medical Laboratories
Miss Anna Schellberg, Executive Office

"Our department's accomplishments are due in great part to what each of these employees has done over the years each in his own way doing the best job possible. Many have stayed here because they like their work and the people they work with. Loyalty is one of the greatest strengths of the Department. Our achievements are not due so much to what persons at the administrative level have done but to the faithful and dedicated service of employees at every level." [437]

Dr. Robert Barr
1970

[436] World Health Organization, press release for 11th World Assembly held in Minneapolis, May 30,1958.
[437] MDH, *Minnesota's Health,* Vol. 24, No. 1, January 1970, p. 1.

30 Years
Miss Stella Barstad, Administration
Miss Lillie Brockman, Administration
Miss Kathrine Gram, Disease Prevention & Control
Dr. Harry Irvine, Disease Prevention & Control
Miss Ethel McClure, Hospital Services
Mrs. Grace Moberg, Local Health Administration
Mr. Henry Oldfield, Environmental Sanitation
Miss Edith Rentz, Administration
Miss Naomi Rice, Administration
Mr. Harvey Rogers, Environmental Sanitation
Mr. Frank Woodward, Environmental Sanitation

25 Years
Mrs. Marian Croal, Environmental Sanitation
Miss Laura Hegstad, Hospital Services
Miss Nora Hoffman, Medical Laboratories
Miss Edith Johnson, Executive Office
Miss Mary Johnson, Local Health Administration
Mr. Amandus Larson, Environmental Sanitation
Miss Ruth Lundholm, Medical Laboratories
Mr. Frithjof Michaelsen, Medical Laboratories
Mr. Henry Oldfield, Environmental Sanitation
Mr. Elmer Slagle, Hospital Services
Miss Florence Thompson, Administration
Mrs. Jane Winholtz, Administration

20 Years
Dr. Robert Barr, Executive Office
Miss Eleanor Barthelemy, Special Services
Miss Elsie Brandtjen, Administration
Mr. Carl Bratberg, Environmental Sanitation
Mr. Jerome Brower, Executive Office
Miss Muriel Eastman, Administration
Mr. Arthur Erickson, Environmental Sanitation
Mr. Bertil Estlund, Administration
Miss Lucy Claire Finley, Disease Prevention & Control
Mrs. Urcella Gaslin, Medical Laboratories
Miss Frances Hanger, Executive Office
Mrs. Gertrude Henning, Special Services
Dr. Anne Kimball, Medical Laboratories
Mrs. Helen Lange, Disease Prevention & Control
Mrs. Martha Lohner, Disease Prevention & Control
Dr. Hilbert Mark, Local Health Administration
Mrs. Agnes Ostby, Disease Prevention & Control
Mr. Myhren Peterson, Environmental Sanitation
Mrs. Myrtle Sather, Disease Prevention & Control
Mr. Harry Smith, Environmental Sanitation[438]

At the 1957 ceremony men received a button and women received a pin. The value of the pin or button increased with years of service.

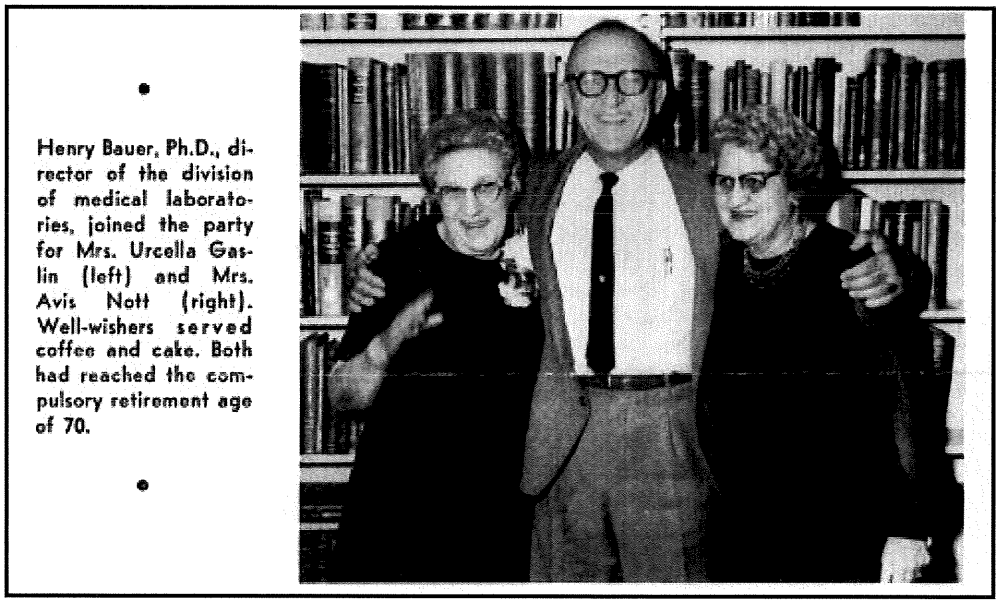
Gladys Casady, receiving a service pin from Dr. Robert Barr, began work at the Department of Health in 1908. When she retired in 1961, she had been a Department employee for 53 years. In her last position she served as Assistant Chief of the Section of Vital Statistics.

[438] MDH, Memo to department heads from Dr. Robert Barr, Aug 1957

The 20-year button or pin cost the department $0.81, and the 45-year pin cost $5.72.[439]

Harvey G. Rogers was an example of one of the long-serving employees who retired during Dr. Barr's administration. He studied at the Harvard Graduate School of Engineering and Public Health, graduated from the University of Minnesota, and joined the department in 1927 as a public health engineer. During World War II he served with the U.S. Army Corps of Engineers. When the department created a water pollution section in 1946, Harvey Rogers was made chief. He held that position until his retirement on December 14, 1961. He died September 18, 1962, and in the board minutes he was described as a steadfast and understanding friend who showed loyalty, solicitude and devotion to his work.[440]

Gladys Casady retired in 1961, after 53 years of service to the department. The only other person to receive a pin for 50 years of service during that period was Anna Schellberg, who was awarded one in 1959. Miss Schellberg had spent many of her years at the department handling the records of Dr. Albert Chesley.[441] Another long-serving employee was Naomi Rice, field representative in vital statistics. She received recognition for 45 years of service to the department.[442]



Henry Bauer, Ph.D., director of the division of medical laboratories, joined the party for Mrs. Urcella Gaslin (left) and Mrs. Avis Nott (right). Well-wishers served coffee and cake. Both had reached the compulsory retirement age of 70.

On January 2, 1968, three women retired when a 1967 state law made retirement mandatory at age 70, except for physicians. Mrs.Urcella Gaslin, a personnel supervisor in medical laboratories had worked for the department 32 years; Avis Nott had worked as a switchboard operator for 23 years; and Louise Hedges had worked as a senior clerk in the hospital division for 23 years.[443]

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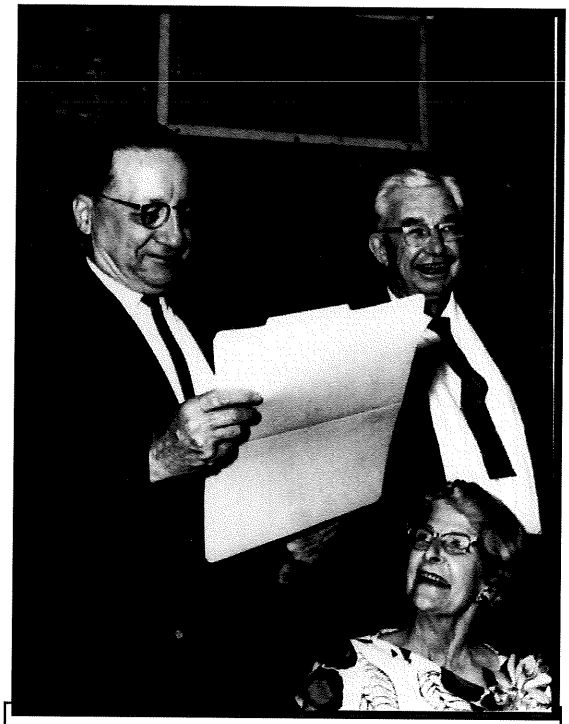
[439] MDH, list of service awards as of September 30, 1957.
[440] BOH, *Minutes,* October 3, 1962, MHS, p. 383.
[441] MDH, *Minnesota's Health,* Vol. 24, No. 1, January 1970, p. 1.
[442] Ibid.
[443] MDH, *Minnesota's Health,* Vol. 22, No. 1, January 1968, p. 4.



Frank Woodward and Dr. Barr

Frank L. Woodward, environmental health director, retired in 1968, after working with the department for 41 years. At his retirement he reflected on his service:

> There are many frustrations in this job, but one eventually learns to roll with the punch. I used to think that the big job was the technical solution to problems. I have learned that this is only a part of the bigger problem of economics and public awareness.[444]

Elmer Slagle reached mandatory retirement age in 1970, after working 40 years for the department. For the last 14 he had been assistant director of hospital services. Prior to that, he had been a public health engineer in hospital services for nine years. His first work with the department was as a sanitary engineer, with emphasis on water pollution. Dr. Helen Knudsen, director of hospital services, spoke about Mr. Slagle's service to the state:

> There is no question about it. Elmer Slagle knows more than anyone in the State about physical plans of hospitals and nursing homes. He used his knowledge of functional plant layout to achieve coordination of services and conservation of manpower. He truly left his mark on the health care facilities of Minnesota."[445]

Service to the department was recognized and appreciated in a number of ways, including letters from the board. In 1965, each recipient of an award received a letter from Dr. Raymond Jackman, board president. The letter included these words:

> The accomplishments of our Department are not so much what people at the administrative level have done as what you and other people like you have done – each doing his own job in his own way and at all times attempting to do the best job that could be done. Loyalty of our employees is one of the real strengths of the Department. You have stayed here because you liked the people you work with and liked your work. We can view with pride the many diseases and health hazards brought under control within the span of your tenure with the Department. Here indeed is tangible evidence of the results of many years of devoted public service.[446]

State Board of Health

Dr. Frank Krusen was board president from 1955 to 1963. He was recognized nationally and internationally for his contributions to physical medicine. This expertise was especially valuable during the years Minnesota was dealing with polio and its

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[444] MDH, *Minnesota's Health,* Vol. 22, No. 7, August-September 1968, p. 2.
[445] MDH, *Minnesota's Health,* Vol. 24, No. 7, August-September 1970, p. 3.
[446] Letter from BOH President Raymond Jackman to employees, October 13, 1965.

aftereffects. Dr. Krusen was executive director of the Sister Kenny Foundation and director of the Kenny Rehabilitation Institute from 1960 to 1963.[447] In 1953 Dr. Krusen received the Physician's Award from President Eisenhower for his services to the physically handicapped. In 1958, Dr. Krusen received the American Medical Association's 1958 Distinguished Service Award, considered one of the medical profession's highest awards. He received the award for his work in the rehabilitation of persons by sickness or accidents and in general for outstanding scientific achievement during his professional career.[448]

Dr. Jackman, from Rochester, Minnesota, was board president from 1963 to 1970. A member of the board since 1961, Dr. Jackman was chief of the proctology department at Mayo Clinic and professor of the Mayo Foundation Graduate School of Medicine at the University of Minnesota. He wrote "Lesions of the Lower Bowel," published in 1952, as well as 62 scientific papers on diseases of the colon and rectum and six scientific motion pictures on diseases of the intestines and biopsies of the prostate. Dr. Jackman was an active member of the Minnesota Medical Association and an honorary member of the Alaska State Medical Association and the Proctologica Latina (Italy)[449].

In the early part of Dr. Barr's administration, polio dominated board meetings. Later, expansion of health facilities through the Hill-Burton Act received much attention. Towards the latter part of Dr. Barr's administration, board meetings focused more and more on environmental risks and the administration of federally mandated programs.

Diseases discussed at board meetings during this period included: psittacosis, hepatitis, tuberculosis, diphtheria, rabies, whooping cough, typhoid fever, salmonellosis, toxoplasmosis, histoplasmosis, syphilis, measles, rabies, rubella, mumps, rheumatic fever, ornithosis, and encephalitis. Increasing attention was given to cardiovascular disease, cancer, and other chronic diseases.

Some of the other issues addressed by the board at this time included: the shortage of public health nurses, pollution, radioactivity, "silo-filler's disease," tapeworm, lead paint, the poison information center, Asian flu, civil defense, migrant labor regulations, the lack of local health services, establishment of a cancer registry, shoe-fitting x-ray machines, health care for American Indians, new building, dairy and milk inspection, mobile home parks, fluoridation of drinking water, unsafe cranberries, genetics, phenylketonuria, Medicare, tobacco use, Elk River reactor, ionizing radiation, coin-operated dry cleaning machines, and the NSP power plant in Oak Park Heights.

The board was confronting an increasing number of difficult environmental issues in the 1960s. One controversial decision that came before the board in 1965 was whether or not it objected to the proposed Northern States Power steam-electric plant at Oak Park Heights on the basis of air pollution. Board President Dr. Raymond Jackman reminded the board of the question it was deliberating: "Is this or is this not a health hazard to the

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[447] MDH, *Minnesota's Health,* Vol. 18, No. 9, November 1964, p. 3.
[448] BOH, *Minutes,* attachment: *Rochester Daily Post-Bulletin* clipping, May 22, 1958, MHS, p. 183.
[449] Information from MDH library.

people of Minnesota and particularly to that vicinity?" The board agreed that it had no foreseeable objections, as far as the health effects of air pollution were concerned.[450] The next day's newspapers carried the headline: "State Health Board Clears NSP Plant."

The board was developing increasing regulatory responsibilities and was working at determining when and where it should intervene. Individual cases often brought general issues in a particular profession or facility to its attention. In 1959, for example, the board deliberated over what it should do with a mortuary home that used misleading advertising in connection with the practice of mortuary science. The home inaccurately represented itself to its clients as a non-profit corporation with union members who had joined together to hold down the costs of funerals.[451] . Some members thought this wasn't a board issue. Board member Wente was of the opinion that the board had lost control of the situation early on and felt it important that the board "doesn't go out on a limb" again. [452] The question was raised over how much control the board should have over the ethics of any profession. Board members understood that problems existed in all fields but had not surfaced because there had been no problem cases reported. While supporting a study of operations and procedures in the case being discussed, the members recognized the much larger issue they needed to address. Prof. Herbert Bosch said: "To single out any one of our activities, while it might do some immediate good, is only a fragmentary approach to our over-all problem." [453]

In addition to issues that directly affected the health of the state, the board dealt with a number of administrative matters. One of these was the salary of the executive officer, Dr. Barr. In 1961, 12 department staff members received salaries greater than Dr. Barr's. The executive officer's salary was set through legislation, and a bill to increase his salary did not pass in 1961.[454] In order to raise Dr. Barr's salary, the board transferred him to the classified service as a Public Health Physician III, giving him the working title of acting secretary and executive officer. Through this maneuver, his salary was increased to $15,600 but not to the $16,000 the board wanted.[455] Finally, legislation passed in 1963 increasing Dr. Barr's salary to $21,750.[456]

Salaries were becoming an issue, not just with the executive officer, but throughout the department in the 1960s. The result was increased turnover of employees. The rate of resignation at the department in 1963 was 18.5 per 100 employees, compared to the statewide resignation rate of 11.0 per 100 employees. In 1963, there were a total of 60 resignations among the 324 full-time positions. The majority of these were attributed to non-competitive salaries. [457]

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[450] BOH, *Minutes,* January 12, 1965, MHS, pp. 15-16.
[451] BOH, *Minutes,* November 10, 1959, MHS, pp. 261-262.
[452] Ibid., p. 243.
[453] Ibid., pp. 258-259.
[454] BOH, *Minutes,* April 24, 1961, MHS, p. 99.
[455] BOH, *Minutes,* July 11, 1961, MHS, p. 360.
[456] BOH, *Minutes,* April 24, 1963, MHS, p. 203.
[457] BOH, *Minutes,* April 14, 1963, MHS, p. 177.

Organization and Funding

In 1955, when Dr. Barr became secretary and executive officer, the department had five divisions: environmental sanitation, local health services, administration, disease prevention and control, and medical laboratories. In 1956, the department had its third major realignment since 1947. Two new divisions, special services, headed by Dr. A. B. Rosenfield, and hospital services, led by Dr. Helen Knudsen, were formed. Dr. Hilbert Mark became director of the local health administration division, a position previously held by Dr. Barr.[458]


•Dr. Rosenfield • Dr. Mark

Other organizational changes occurred in 1963. The environmental sanitation division was renamed the environmental health division. The supplies and services section was transferred from the medical laboratories division to the administrative services division. A school health unit was established in the maternal and child health section. Public health nursing was transferred to the administrative services division. [459]

In 1963, the Legislature established the Water Pollution Control Commission. The water pollution control section had previously been a division of water pollution control in the Health Department. It remained a controversial decision. Sen. Rosenmeier opposed this legislation and thought the activities of water pollution control should be placed in an independent commission or agency. He said, "The major problem with the present Minnesota water pollution control commission is its dependency on state health department staff. With the health department, pollution control is a sideline at best." [460]

By 1970, the end of Dr. Barr's administration, there were seven divisions: administration, environmental health, medical laboratories, disease prevention and control, local health administration, special services and hospital services.

During Dr. Barr's administration, the department continued to receive a growing portion of its funding from the federal government, first through the Hill-Burton Act and later through Medicare and other federal programs. In 1950, only 3 percent of the department's total funds came from the federal government, but in 1955 this had increased to 37 percent. In 1956, 60 percent of the department's total expenditures came from the federal government. Between 1957 and 1970, 40 percent to 58 percent of the department's programs and activities were financed by federal dollars. Not everyone was pleased with this change because of the uncertainty of continued funding, accompanying constraints by the federal government, and an increased administrative role in managing federal programs.

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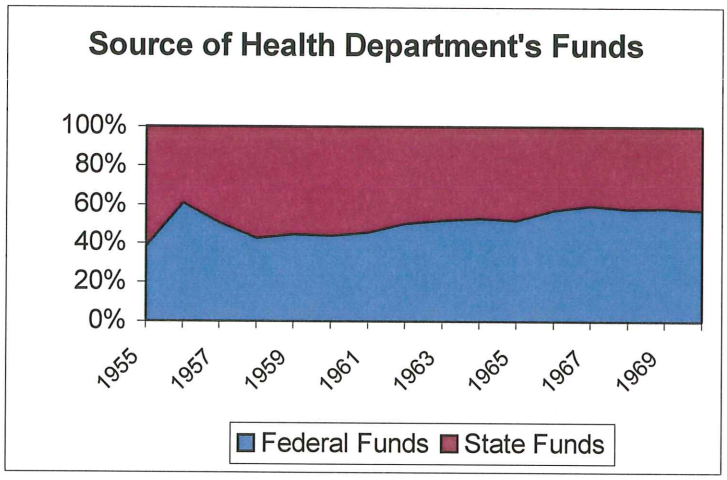
[458] MDH, *Minnesota's Health,* Vol. 10, No. 9, November 1956, MHS, p. 1.
[459] BOH, *Minutes,* October 8, 1963, MHS, p. 464.
[460] *St. Paul Pioneer Press,* "Pollution Unit's Reliance on Health Agency Hit," March 21, 1965.



Public Health Challenges – Nursing Homes and Environmental Issues

In 1956, Dr. Barr stated the main public health needs in Minnesota were care of the aged, environmental sanitation in food handling and water pollution and local health services.[461]

Dr. Barr had a special interest in the elderly and their needs. He said: "Unless we keep this older group a producing and real part of our society, our whole standard of living will fall." [462]

His first concern was the number of available beds. In the 1950s there was a shortage of nursing home beds for the elderly, as well as a shortage of beds for other patients. In 1956, there were 508 chronic disease beds in Minnesota but an estimated 3,098 were needed. To meet the U.S. Public Health Service standards, 2,765 more mental hospital beds, 8,993 more nursing home beds, and 2,317 more general hospital beds were needed. The federal Hill-Burton Act, administered by the department, provided funding for expansion of health facilities in the state and was a partial solution to the shortage. Another was conversion of tuberculosis beds to other needs – there were 1,553 tuberculosis beds in the state but only 990 patients.[463] By 1964, the board began to be concerned about the possible overbuilding of nursing homes. The issue now was not so much the number of beds, as it was the appropriate geographical distribution and condition of the homes.[464]

While the number of facilities was increasing, personnel to work in health facilities was not keeping pace. The state was particularly short of nurses. The problem was exacerbated when nursing schools began closing due to the high costs. Scholarships,

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[461] BOH, *Minutes,* October 3, 1956, MHS, p. 190.
[462] MDH, *Minnesota's Health,* Vol. V, No. 11, November 1951, p. 4.
[463] MDH, *Minnesota's Health,* Vol. 10, No. 1, January 1956, pp. 1-4.
[464] BOH, *Minutes,* May 18, 1964, MHS, p. 325.

refresher courses and recruitment were used to try to increase the number of practicing nurses.

The population was exploding. "Baby boomers" created increased demands on all government services, including health services. In 1959, there were 88,333 births in Minnesota, the highest number ever recorded. This number exceeds the births in 1999 by about 20,000. [465]

(Note: The development of health care facilities is described in greater detail in Chapter 6.)

The aim of clean drinking water in the state had been a challenge since the board was established. The percentage of public water supplies "acceptable from a sanitary standpoint" had increased from 30 percent in 1947 to 90 percent in 1960. [466] While an impressive improvement, 10 percent of water supplies were still not safe. In addition, new concerns that affected water supplies emerged. The groundwater was being contaminated by industrial wastes, pesticides, insecticides, household detergents and a multitude of toxic materials.[467]

New technologies and product developments in the 1950s and 1960s created other challenges in public health. During the first six months of 1959, for example, eight infants in Minnesota died from suffocation by plastic bags. The poison information program was established by the department to provide information about toxic agents to physicians who treated poison victims. Operating in 11 sub-centers throughout the state, the Minnesota Poison Information Center provided information to identify a product's ingredients, estimate of toxicity and past experience.[468]

The effects of many new products were unknown, and concerns by the public were raised, including whether or not birth defects were related to radioactive fallout, pesticides and some of the other new unknowns. Concerns in this area resulted in Minnesota becoming the first state to establish, in 1959, a human genetics program. No funds were authorized, but legislation authorized the department to accept federal grants and donations from private organizations. The purpose of the human genetics counseling program at the department was to collect and analyze data on human hereditary diseases, conduct studies and give genetics counseling to physicians and hereditary counseling to families.[469] An advisory committee on human genetics was formed to provide direction. This committee met with Lee E. Schacht, Ph.D., head of the department's human genetics unit.[470]

The department was active in civil defense preparations throughout the 1950s, but towards the end of the decade more attention was directed to atomic energy and its

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[465] Minnesota State Demographer's Office, *Minnesota Vital Statistics Resident Summary*
[466] MDH, *Minnesota's Health,* Vol. 16, No. 8, October 1962, pp. 1-4.
[467] MDH, *Minnesota's Health,* Vol. 13, No. 6, June-July 1959, p. 2.
[468] MDH, *Minnesota's Health,* Vol. 11, No. 10, December 1957, pp. 1 and 4.
[469] MDH, *Minnesota's Health,* Vol. 13, No. 6, June-July 1959, p. 3.
[470] BOH, *Minutes,* October 18, 1960, MHS, pp. 395-396.

potential dangers. The first nuclear power plant was built in the state during this period, leading to the formation of a 15-member atomic energy board. The purpose of the board was:

> ...to secure the fullest possible advantage for the state and its people from knowledge and techniques developed in the field of nuclear and atomic energy, to promote industrial use, to protect the people, and to promote and disseminate the greatest possible knowledge and information. [471]

Atomic energy aroused strong emotions in the public. The department often did not have answers to the public's questions in this new and unknown area. Frustration was exhibited, as is indicated in this excerpt from a letter to the board, written by a citizen concerned about the dangers of radioactive materials in the state:

> I had hoped that the State Health Department would cooperate in protecting the people from the hazard of radioactive materials and radiation. Since the Board of Health does not agree in my contention that it is necessary, I am obliged to ask for the resignation and removal from office of all those in the State Health Department who are responsible for this negligence. Your cooperation in accomplishing this will be appreciated. [472]

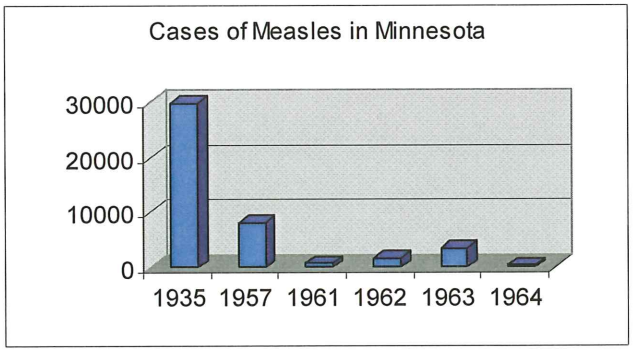
(Note: The department's role in atomic energy and related issues is described in greater detail in Chapter 4.)

Public Health Challenges -- Infectious Disease

The number of cases of and deaths from infectious diseases in Minnesota continued to drop through the 1950s and 1960s due to improved sanitation, vaccination and immunization, improved obstetric and pediatric training, modern hospitals, skilled medical and nursing care, new antibiotics and drugs, and blood replacement.[473] The death rate from communicable disease fell from 58.5 per 100,000 in 1949 to 43.5 in 1958.

The isolation of the poliovirus was a major breakthrough that paved the way for the development of polio vaccine.[474] It became commercially available in 1956. Mumps vaccine was available in 1968.

(Note: The Department's role in polio is described in greater detail in Chapter 3.)



Measles vaccine, licensed in 1963 by the U.S. Public Health Service, made it

[471] BOH, *Minutes,* February 24, 1959, MHS, p. 33.
[472] BOH, *Minutes,* October 3, 1962, MHS, p. 389.
[473] MDH, *Minnesota's Health,* Vol. 14, No. 1, January 1960, p. 4.
[474] MDH, *Minnesota's Health,* Vol. 14, No. 2, February 1960, p. 2.

possible to eliminate measles in Minnesota. There were 359 cases of measles in 1964, and for the first year since 1910 no deaths from measles were reported. It was a vast improvement over the state's all-time high for measles of 29,759 cases and 66 deaths in 1935. [475]

Though it was now possible, through immunization, to control measles, and other communicable diseases, in Minnesota, the challenge was getting the vaccine to the population. Without disease cases, public health workers were concerned as to whether or not the population would continue to receive the immunizations necessary to prevent recurrence of diphtheria, measles, and other infectious diseases. Dr. Dean Fleming, director of disease prevention and control, thought the population would develop a false sense of security and become too complacent. He said:

> ***"The availability of a vaccine alone will not control the spread of communicable diseases. Only when the individual takes a personal responsibility to make use of available preventive measures for the protection of his own health, that of his family, and of the community are such measures completely effective."*** [476]
>
> **Dr. Dean Fleming, Director of Disease Prevention and Control, 1964**

Dr. Barr knew that without constant monitoring, immunizations and vigilance, gained ground could be lost. Tuberculosis and venereal disease control were of special concern. [477] Disease prevention and control focused on developing ways and methods to ensure the population remained protected from disease.

Unfortunately, vaccine necessary for immunizations was not always readily available. In 1957, for example, distribution issues resulted when there was a shortage of vaccine during an outbreak of the "Asian flu."[478] To address issues related to the distribution of vaccines and to develop a policy on vaccine distribution, the board formed a committee in 1959. Committee members were: Dr. Wente, chairman; Dr. Huenekens and Mr. Atkinson. They met with Dr. Barr and Dr. Fleming.[479]

Overconfidence in the value of recently developed antibiotics may have contributed to another problem in the state. There was an increase in staphylococcal infections. The board strongly supported further studies to try to address this growing concern. In addition to the personal habits and techniques of health professionals, it decided to investigate the environmental side – air transmission and air conditioning systems.[480]

(Note: The department's role in other communicable diseases is described in greater detail in Chapter 2.)

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[475] MDH, *Minnesota's Health,* Vol. 19, No. 6, June-July 1965, p. 4.
[476] MDH, *Minnesota's Health,* Vol. 18, No. 10, December 1964, p. 4.
[477] MDH, *Minnesota's Health,* Vol. 16, No. 8, October 1962, pp. 1-4.
[478] BOH, *Minutes,* October 9, 1957, MHS, p. 203.
[479] BOH, *Minutes,* February 24, 1959, MHS, p. 3.
[480] BOH, *Minutes,* July 30, 1957, MHS, p. 124.

Public Health Challenges: Animal-to-Human Diseases

Diseases transmitted from animal to human were common during the 1950s and 1960s. Those of concern to people of Minnesota included: brucellosis, Q fever, rabies, bovine tuberculosis, anthrax, salmonella infections, psittacosis and leptospirosis.

Dr. Joe R. Held, a veterinarian, was hired to help prevent and control diseases transmitted from animals to man. He acted as a liaison between the Health Department, State Livestock Sanitary Board and University of Minnesota Medical School, working closely with Dr. Henry Bauer, medical laboratories director.[481] In one case, Dr. Held wondered why a herd of cattle continued to harbor typhoid fever. Visiting the barn one day, he noted human feces on the floor. A stool sample tested positive for typhoid fever. The hired man was infected, and the disease was being transmitted to the cattle through their feed. Dr. Held carefully talked to the farmer and hired hand, the source of the infection was eliminated, and the typhoid in the cows disappeared.[482]

Toxoplasmosis, which causes severe damage to the brain and eyes of unborn children, was common in Minnesota. An estimated 30 percent of the population had had the infection in the 1950s. One out of every 6,000 births was infected with toxoplasmosis. Thirty-eight children with congenital toxoplasmosis were reported from 1949 to 1959. Of these, eight died and the others were mentally retarded. [483]

In 1956, the department received a three-year grant to study toxoplasmosis. Dr. Anne Kimball, chief of special laboratory studies; Marion Cooney, chief of the virus and rickettsia section; and Dr. Henry Bauer collaborated on this project, along with Dr. Charles Sheppard, a physician in Hutchinson.[484] [485] Their report, published in 1959, indicated birds, chickens, ducks, geese, pigeons, sparrows and parakeets may transmit toxoplasmosis to humans, but the report did not indicate it could be acquired through household pets, horses swine or from eating pork, raw eggs or drinking raw milk.

Histoplasmosis was also common in Minnesota. A study was being conducted on about 150 families in Mound to determine why family members were positive to histoplasmosis test. In addition to skin and blood tests, the climate, nature of soil and domestic animals were being studied.[486]

Disease Prevention and Health Promotion

Chronic diseases, including cancer control and heart disease, were drawing more attention as communicable diseases decreased. Many initiatives in these areas were

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[481] MDH, *Minnesota's Health,* Vol. 10, No. 9, November 1956, p. 2.
[482] Interview with Dr. Henry Bauer, April 16, 1999.
[483] MDH, *Minnesota's Health,* Vol. 13, No. 8, October 1959, p. 3.
[484] MDH, *Minnesota's Health,* Vol. 10, No. 7, August-September 1956, pp.2-3.
[485] MDH, *Minnesota's Health,* Vol. 13, No. 8, October 1959, p. 3.
[486] BOH, *Minutes,* January 13, 1959, MHS, p. 9.

led by Dr. A. B. Rosenfield, director of special services. Some of the areas he helped focus attention on included services for newborns, maternal mortality, nutrition, and home accident prevention.

Dr. Rosenfield, was considered by many to be ahead of his time. He joined the department as an epidemiologist in 1946, was chief of the maternal and child health section from 1949 to 1956, and became chief of the special services division in 1956.

Dr. Rosenfield encouraged the department's involvement in these new areas of public health, refusing to let the lack of a budget or specific mandate prevent him from moving forward. In 1957 Gov. Orville Freeman awarded Dr. Rosenfield a bronze plaque for his work in accident prevention, noting his initiatives were beyond legal mandates. When Dr. Rosenfield was selected by the Minnesota Safety Council's committee for an award, the committee commented: "The Health Department's initiative in conducting home safety inspection training without a budget and without statutory requirements to do so is particularly noteworthy."[487]

Another person who helped the department become respected for the professional manner in which it spread public health messages was Mrs. Marie Ford, chief of the health education section since 1954. The section flourished under Mrs. Ford's leadership. She started work at the department in 1949, with a background in education and a graduate degree in public health. Mrs. Ford was skillful at developing relevant messages that would capture attention. During Dr. Barr's tenure, the department continued its tradition of outreach to citizens, distributing a free catalog listing free health literature and other available education materials and teaching aids to anyone on request.[489] Mrs. Ford developed many of the pamphlets and brochures. These were used by other agencies, local health departments and citizens.

"Public health has advanced to the point where people themselves have to take action for further progress. We must educate and motivate them to protect their health and the health of the community. But in some areas we need a base line before we can really get started. For instance, we know that accidents are the leading cause of death through age 34, but we have little data on non-fatal accidents. Unless we know when, where, and to whom these accidents occur, we don't know how to pinpoint our educational efforts."[488]

Marie Ford, MPH
Public Health Education, 1961

For many of her years with the department Mrs. Ford edited *Minnesota's Health*, the department's monthly publication sent to thousands of persons throughout the state. When Marie Ford retired in 1971 due to ill health, Betty Bond, Ph.D., continued as editor.[490]

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[487] MDH, *Minnesota's Health,* April 1957.
[488] Public Health Committee of the Paper Cup and Container Institute, Inc., "Profiles of Personalities in Public Health," *Health Officers New Digest*, Vol. XXVII, December 1961, No. 12, p. 2.
[489] MDH, *Minnesota's Health,* Vol. 16, No. 3, March 1962, p. 4.
[490] MDH, *Minnesota's Health,* Vol. 25, No. 5, May 1971, pp. 2-3.

Tobacco Control

On January 11, 1964, a major event affecting the future direction of public health, and particularly health promotion, occurred when the advisory committee to the U.S. surgeon general issued a 387-page report that included this message:

> ***"Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action."***[491]
>
> **Advisory Committee to the US Surgeon General**
> **January 11, 1964**

Up to this time, the Board of Health had been very careful to avoid a message indicating cigarettes caused smoking, as scientific evidence wasn't conclusive. The board made a change in its policy and three days after the above report, on January 14, 1964, it passed a resolution:

> **Resolution on Smoking and Health: Minnesota State Board of Health**
>
> ***"Whereas, the report of the Advisory Committee to the Surgeon General of the Public Health Service on Smoking and Health makes the following judgment: "Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action": and***
>
> ***Whereas, the Advisory Committee finds that cigarette smoking is associated with an increase in the age-specific death rates of males, and to a lesser extent with increased death rates of females; and***
>
> ***Whereas, the Advisory Committee finds that cigarette smoking is causally related to lung cancer, is the most important of the causes of chronic bronchitis in the United States, and increases the risk of dying form chronic bronchitis and emphysema; and***
>
> ***Whereas, the Advisory Committee considers it more prudent from the public health viewpoint to assume that the established association between cigarette smoking and deaths from coronary disease and many other cardiovascular diseases has causative meaning than to suspend judgment until no uncertainty remains; and***
>
> ***Whereas, these separate and distinct disease entities are of great concern to many health agencies, public and voluntary, as well as to the State Board of Health; and***
>
> ***Whereas, the State Board of Health recognizes its responsibility to provide leadership in this as in other health problems of public concern: Now therefore, be it***

[491] MDH, *Minnesota's Health,* Vol. 18, No. 1, January 1964, p. 2.

Resolved, That the Minnesota Department of Health take prompt and vigorous action to increase its program of education of the public and of children of school-age in particular on the subject matter of this report, and be it further

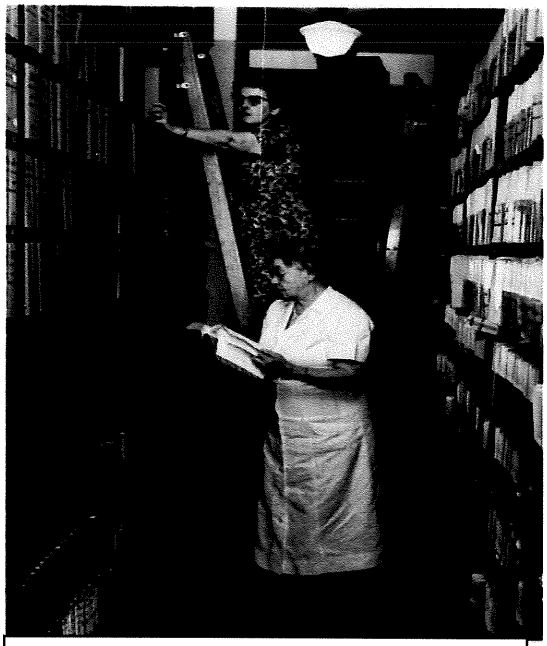
Resolved, That the appropriate staff of the Minnesota Department of Health take leadership in the implementation of the recommendations of this report including the coordination of the education efforts of the various agencies concerned about the health implications of the subject matter of this repot to avoid confusion and to minimize duplication of effort." [492]

Minnesota State Board of Health, January 14, 1964

Public support for no-smoking initiatives was not strong. A December 1963 poll conducted by the Minneapolis Star and Tribune found that 69 percent of the people believed cigarette smoking "had proved to be a health hazard." Half of the people interviewed did not want a national campaign to discourage people from smoking. Their objections were based on the grounds that "the individual should decide for himself whether he will smoke."[493]

Vital Statistics/Surveillance

During Dr. Barr's administration, significant advances and strides were taken in data collection to better identify and target public health problems. One of the areas where improvements occurred was birth registration. Statewide registration of births in Minnesota had begun in 1871. At that time it was the responsibility of the secretary of state. The responsibility was transferred to the Board of Health in 1887. In his vital statistics report for 1886-88, Dr. Hewitt, the state's first medical officer, wrote: "The intention of the present law is to make the vital statistics of the population contribute directly to a knowledge of the character, location, extent, and fatality, of the diseases causing sickness and premature death among them."[494]



Employees Working in Vital Records

With a particular focus on reducing maternal and infant mortality and morbidity, an increased interest in utilizing birth certificate data developed during the 1950s. A detachable medical supplement was added to the fetal

[492] MDH, *Minnesota's Health,* Vol. 18, No. 2, February 1964, p. 2.
[493] Ibid.
[494] BOH, *Minutes,* attachment, May 16, 1966, MHS, p. 312.

death certificate in 1957 and to the birth certificate in 1962. A revised birth supplement in 1965 included questions related to fertility and resulted in the availability of data to recommend improvements in the medical care of mothers and children.

While more than 94 percent of physicians provided the supplemental information in 1966, there were several non-participating physicians. There was criticism that too much data were being collected, they were not being used, and the information was not confidential. Non-participating physicians felt the question related to the date of the mother's first marriage was an invasion of privacy and the question related to education of parents was embarrassing. Several physicians were particularly irritated when they received a letter from the Crippled Children's Service of Minnesota reporting a child in their care had a birth defect. The head of the Crippled Children's Service reported the information came from the Department of Health. The physicians believed they no longer had confidentiality.[495] Some didn't want to waste their time filling out reports. The lack of cooperation from these physicians disrupted the programs.

On September 24, 1962, Robert Hiller began his 30-year career with the department. Hiller, who later came to play a pivotal role in establishment of the community health services system, began as chief of vital statistics. Robert Hiller found birth certificates that weren't filed for six months. He began sending letters to those who didn't file, stating the law required filing and informing them they were in violation of the law. One recipient of a letter complained to Dr. Barr. He called Robert Hiller in for a meeting. Mr. Hiller traveled from his offices in St. Paul to the executive offices in Minneapolis. At the meeting Dr. Barr told Hiller to keep writing the letters, but with a little more diplomacy.

Surveillance of health problems, a basic tenet of public health, took on renewed energy in the 1960s. Some examples of the initiatives in this area are described below:

- A rheumatic fever registry was begun in 1960. It indicated rheumatic fever was far more common than thought. By 1965 there were 10,688 cases listed in the registry. Armed with these data, prophylactic treatment was made possible through the cooperation of the Minnesota State Pharmaceutical Association, significantly reducing recurrence.[497]

- A leukemia surveillance program

> ***"All of the activities carried on by the divisions and sections perform services of direct benefit to the people of Minnesota. In all of them program emphasis has shifted as new problems have been created in a changing society. At the same time constant surveillance must be maintained to insure that old problems remain under control. In all of the programs the work load increases as the state's population continues to grow and new knowledge expands the areas in which public health measures can bring health and safety hazards under control and as changes in the age composition of the state's population create new problems."*** [496]
>
> ***Minnesota's Health,* January 1966**

[495] BOH, *Minutes,* attachment, May 16, 1966, MHS, p. 312.
[496] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, p. 4.
[497] Ibid., p. 2.

to study the distribution of cases in Hennepin and Ramsey counties was started July 1, 1966. The project was directed by J. Jeffrey McCullough, M.D., acting chief of the chronic disease section, assisted by Grant A. Mason, M.D., cancer control officer. Between 1950 and 1964 there were 4,186 deaths from leukemia in Minnesota, indicating a higher incidence than the national average. In 1960 there were 8.52 deaths per 100,000 people from leukemia in Minnesota, compared to 7.8 deaths per 100,000 nationally.[498]

- Expecting outbreaks of Asian flu the winter of 1967-68, the department established "listening posts" in Bemidji, Crookston, Duluth, Fergus Falls, Little Falls, Minneapolis, Rochester, St. Paul, Worthington and the University of Minnesota. Specimens were collected and submitted to the public health laboratories to get an early warning of possible outbreaks.

Emergency Health Services

Dr. Barr's administration was the period when health facilities underwent, or began to undergo, a major overhaul. Included in this effort was the emergency health response system.

A 1966 survey discovered that 37 percent of the ambulance attendants in the state did not have even basic first aid training. Dr. Rosenfield did not accept that an ambulance driver's role should be limited to providing transportation. Dr. Rosenfield felt the ambulance driver had a critical role in life saving and needed training. In addition, to receive Medicare payment, ambulances were required to have an attendant with advanced first aid training. Only 17 percent of the emergency vehicles in Minnesota met that requirement.[499]

The department, in cooperation with a 16-member emergency medical services committee, established a training program for rescue squad members, ambulance attendants, firefighters, police officers, nurses and hospital emergency room personnel. The first professional emergency care course was held in Rochester in March 1967. This 12-hour course, consisting of four three-hour dinner meetings, was given by physicians from the Mayo Clinic and others who had specialized training. Subjects included: common medical emergency conditions, emergency childbirth, resuscitation procedures, shock, bleeding, bandages, emotional difficulties, conduct at the accident scene and transportation.[500] Sixty-one participants attended this first course.[501] A one-day institute on home safety for homemakers was held in Minneapolis in March 1967. Additional classes for emergency personnel were held during the fall of 1967, with 680 persons attending classes.[502]

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[498] MDH, *Minnesota's Health,* Vol. 20, No. 9, November 1966, p. 1.
[499] MDH, *Minnesota's Health,* Vol. 22, No. 3, March 1968, p. 4.
[500] BOH, *Minutes,* January 10, 1967, MHS, p. 32.
[501] BOH, *Minutes,* April 11, 1967, MHS, p. 111.
[502] MDH, *Minnesota's Health,* Vol. 22, No. 3, March 1968, p. 4.

A plan to establish a statewide emergency medical services system was formulated in 1968. A federal grant was received, and Dr. Rosenfield was the project director. The plan included provisions for training ambulance crews, establishment of a statewide comprehensive plan for location and types of services needed, development of standards for equipment and vehicles, development of standards for maintaining and coordinating medical records and accident reports.[503]

The department helped with upgrades of the emergency medical system by providing equipment. Forty rural communities received funds to purchases ambulances in 1969. The first community to receive funding was Prior Lake. The funding was used to replace a 1954 limousine.[504] By 1971, 60 more ambulances had been placed in rural communities. Dedication ceremonies in Cannon Falls on June 1, 1971, marked the placement of the 100th ambulance.[505]

A 1969 state law required that all ambulances in Minnesota be licensed by the Board of Health. In order to qualify for licensure vehicles had to be available for service 24 hours a day, every day of the year; vehicles must carry minimal equipment recommended by the American College of Surgeons; and drivers and attendants must have a current advanced first aid certificate.[506]

Medicare

In August 1965, the department learned it would be certifying facilities for Medicare (P.L. 89-97) effective July 1, 1966, for hospitals and July 1, 1967, for nursing homes.[507] Federal certification requirements for Medicare facilities were placed in the Medicare services unit under the direction of Dr. McCarthy.

Transitions

Between 1959 and 1962 several significant transitions occurred in the b and the department.

Jerome Brower, Dr. Barr's deputy executive officer, died suddenly on May 28, 1959, at age 49.[508] A native of Cloquet, he had served as a special agent for the FBI in World War II.[509] Jerry Brower first worked for the department in 1933 as an antitoxin record clerk. He worked and attended school at night, completing a bachelor's degree in 1937 and a law degree in 1941. He was the top ranking member of his law school class. In 1947 he received a master's in public administration. He served as chief accountant for

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[503] MDH, *Minnesota's Health,* Vol. 22, No. 3, March 1968, p. 4.
[504] MDH, *Minnesota's Health,* Vol. 22, No. 9, November 1968, p. 3.
[505] MDH, *Minnesota's Health,* Vol. 25, No. 4, April 1971.
[506] MDH, *Minnesota's Health,* Vol. 23, No. 10, December 1969, p. 3.
[507] BOH, *Minutes,* October 13, 1965.
[508] MDH, *Minnesota's Health,* Vol. 13, No. 6, June-July 1959, p. 1.
[509] MDH, *Minnesota's Health,* Vol. 9, No. 19, December 1955, p. 1.

the department, deputy registrar of vital statistics, and director of the division of departmental administration until he became deputy executive officer in 1955. Mr. Brower was a patient in the Variety Club Heart Hospital, a facility that was financed partially with Hill-Burton funds. Mrs. Brower wrote to Dr. Barr: "No man could ever love work more than he did nor his colleagues in the whole Department of Health."[510]

Mr. Brower wasn't the only loss experienced by Dr. Barr in 1959. His son, who was going to begin his freshman year at the University of Minnesota, was killed in a traffic accident in Montana that summer. After the accident Dr. Krusen, board president, wrote Dr. Barr:

> Life itself teaches us we must not and cannot cling to the things that are dearest to us, but that does not prepare us for the tragic suddenness of Bobby's death. The courage to accept the inevitable and to take solace in fulfillment of the lives of those who were his close companions takes the support and encouragement of all who are your friends. It is in this spirit that this letter is written. [511]

In 1961 and 1962, the board lost two of its hardest working members, Dr. Ruth Boynton and Herbert Bosch. They worked as a team, serving together on several committees. Each had, at one time, worked as a department employee and retained a strong interest in and knowledge of the department's activities. They refused "rubber stamp" decisions, and met with division directors and section chiefs when they felt it was necessary.

Dr. Barr, Dr. McCarthy and Ernest Kramer at an exhibit on Medicare Certification

[510] Note from Mrs. Jerry Brower to Dr. Robert Barr, November 9, 1959.
[511] Letter from Dr. Krusen to Dr. and Mrs. Barr, September 14, 1959.

Dr. Ruth Boynton, retired in 1961 after 22 years on the board. She graduated from medical school at the University of Wisconsin in 1921 and began work at the Health Department in 1921 as director of the child hygiene division. She left the department in 1923 to work as an assistant professor of medicine at the University of Chicago. Dr. Boynton returned to Minnesota in 1928 as an instructor and later assistant professor of preventive medicine and public health at the University of Minnesota. In 1936, she became director of the University's student health service. Never married, she devoted her life to her work. With Dr. H. S. Diehl, she was co-author of a book, "Healthful Living for Nurses." [512] She received a Fulbright research scholarship in 1951 for study in the United Kingdom. She retired in 1961 and moved to Miami, Florida. She had been a member of the board from 1939 to 1961, 22 years.[513] With Dr. Boynton's retirement, Professor Bosch became the board member with the most seniority, having joined in 1952.

On September 16, 1962, Herbert Bosch died of a heart attack while on a cultural exchange mission to inspect Russian sanitation and environmental facilities. Prof. Bosch began work at the department in 1936 as a public health engineer. He worked in the U.S. Army Sanitary Corps during World War II. For his work in repatriating thousands of displaced persons, he was awarded decorations from Belgium, France and Holland. After the war, Prof. Bosch returned to the department as chief of the environmental sanitation division. In 1950, he became the first chief of the environmental sanitation section for the World Health Organization in Geneva, Switzerland. He returned to Minnesota in 1952 and joined the University of Minnesota faculty.[514] Prof. Bosch, appointed to the board in 1952, was known for his high sense of duty and his frank, cheerful nature. [515]

HERBERT M. BOSCH

The board lost many years of experience and institutional knowledge with the retirement of Dr. Ruth Boynton and the death of Herbert Bosch. By 1964, only one board member, Dr. Huenekens, was able to say he had served while Dr. Chesley was executive director. Dr. Heunekens, a pediatrician, served on the board from 1955 to 1967. He was especially valued for his role with polio.

Three other board members who served at least three terms and ended their service during Dr. Barr's administration were Leo Thompson who served on the board from

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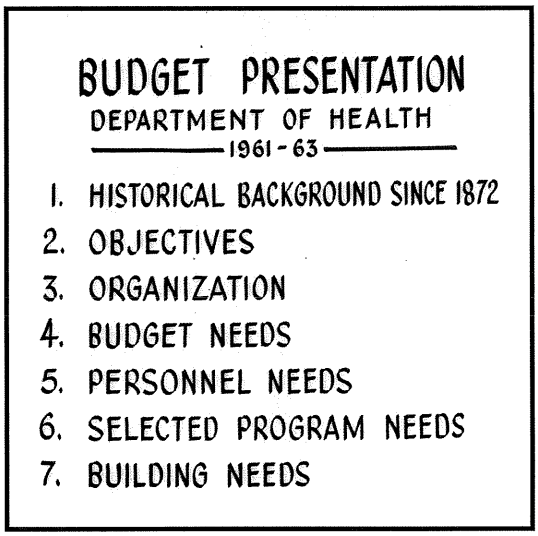
[512] MDH, *Minnesota's Health,* Vol. IV, No. 3, March 1950, p. 4.
[513] MDH, *Minnesota's Health,* Vol. 17, No. 8, October 1963, p. 3.
[514] MDH, *Minnesota's Health,* Vol. 16, No. 9, November 1962, p. 1.
[515] BOH, *Minutes,* October 3, 1962, MHS, p. 381-382.

1940 to 1957, Dr. Raymond Jackman who served from 1961 to 1970, and Dr. Frank Krusen who served from 1955 to 1963.

Following Jerry Brower's death, Dr. Barr was left without a deputy. On January 12, 1960, Dr. Henry Bauer, director of the public health laboratory, was appointed to fill this post. Dr. Bauer had been with the department since 1938 when he was began work as a bacteriologist. Dr. Bauer received his Ph.D. degree in 1949 and was appointed director of the laboratories. Dr. Barr and Dr. Bauer had served together in the military during World War II.

Dr. Bauer's new work assignment included presenting the budget to the Legislature. He planned his presentations carefully, using charts and graphs, stressing the economic value of public health interventions. Dr. Bauer focused on the value the state was receiving for the funding received and the savings that result from public health interventions. The 1963 narrative and exhibits were tied to the budget to enable the department to evaluate every three to six months if it was accomplishing what it said it was going to do.[516]



Dr. Bauer wanted to make sure legislators understood the department and what it was doing. He thought some legislators made a common mistake of confusing the work done by the department with that done by the University of Minnesota, thinking funds appropriated to the University were also for the Health Department. Dr. Bauer explained that though the Health Department was located on the University of Minnesota campus and though they worked together closely, they were two separate entities. Dr. Bauer also emphasized the need for the University of Minnesota School of Public Health and the department to be located close together and to work closely together.[517]

The thorn that had been bothering Dr. Barr and others for years was the lack of a new building. Severe overcrowding in the University campus building and the separate locations of employees made operations difficult and sometimes unpleasant. The conference room was a converted storage room. There was one elevator that carried passengers, freight and supplies. There was only one small rest room for women. Records were often kept in corridors because of lack of space. [518] Dr. Barr felt the department was missing out on grants because the office space for extra employees was not available. Minnesota couldn't apply for the grants and was missing opportunities. When he appointed Dr. Bauer as his deputy, Dr. Barr gave him a charge: "Get a new building!"

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[516] BOH, *Minutes,* July 9, 1963, MHS, p. 421.
[517] BOH, *Minutes,* December 19, 1960, MHS, pp. 407-408.
[518] MDH, *Minnesota's Health,* Vol. 14, No. 5, May 1960, p. 1.

Dr. Bauer took on the challenge. Federal Hill-Burton funds became available to assist in 45 percent of the laboratory areas, and he seized this opportunity. Through his efforts the Legislature authorized a new building. Dr. Bauer ended his position as deputy executive director on January 6, 1966, as he needed to spend more time in the medical laboratory. He needed to develop a biochemistry laboratory associated with chronic disease, there was a shortage of staff in the laboratory, and Medicare was placing increased demands on it. Plus, he had successfully accomplished his assignment: the new building was a reality.[519]

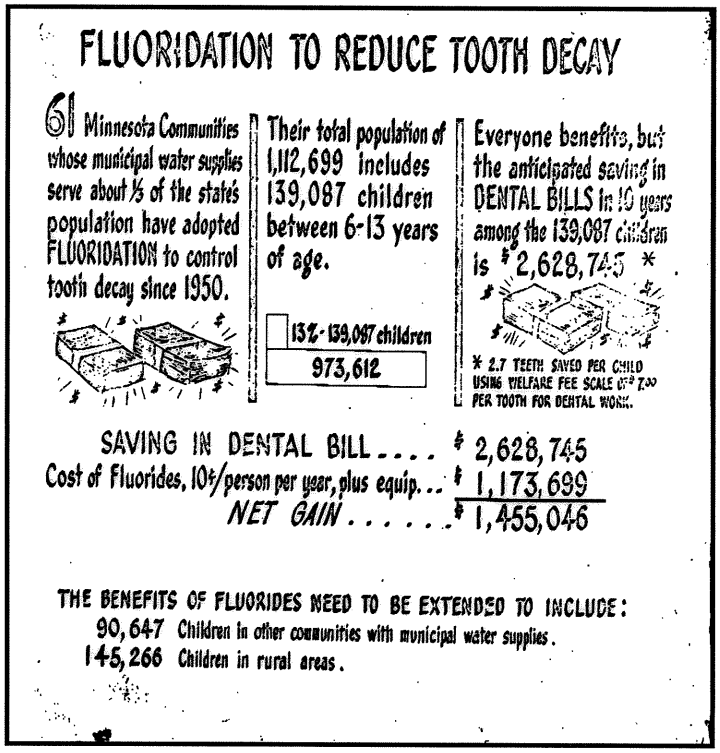
Employees moved into a new Health Department building in 1969. Dr. Barr was present to dedicate the new building for which the department had first requested funds in 1947. The people who had been involved in the effort to get a new building included some of the public health greats of the century.

(Note: The history of the new building is described in greater detail in Chapter 7.)

When Dr. Bauer completed his service as deputy executive officer, Dr. Barr appointed Dr. Warren Lawson, a department employee since 1941.

Changes and End of an Era

By the time the new building was completed, public health was changing dramatically, particularly at the Health Department. The department was beginning to be overwhelmed with activity. The still-new Medicare and Medicaid programs demanded much time. The department was settling into a new space, with an autonomy not experienced previously. A recent initiative required all statewide planning coordinated and managed through the Department of Planning. The governor appointed a committee on reorganization of the state. The governor's office outlined a series of planning areas showing health districts, hospital planning regions, proposed coordinated hospital systems, and tuberculosis outpatient clinics. Dr. Barr felt it might be necessary to change outpatient clinic boundaries to conform to the governor's



[519] BOH, *Minutes,* January 11, 1966, MHS, p. 26.

planning areas. When a statewide review of all state health regulations was suggested, there was little time to do it. The department had a full plate.[520]

Dr. Barr wrote a colleague at the Department of Health and Social Services in Wisconsin for information on the reorganization of state government in Wisconsin. His friend detailed the changes and added a final line to the letter: "We are living in a time of rapid change, Bob, and I guess we just have to learn to adjust to these changes." [521]

Another friend of Dr. Barr's, Dr. Gaylord Anderson, director of the University of Minnesota School of Public Health, wrote his thoughts on public health in an article in the American Journal of Public Health in 1966:

> For lack of a generally accepted definition of public health, I should like for our purpose, to think of public health as an organized community program designed to prolong efficient human life. I use the term 'organized' because I include only those activities that are designed for the specific purpose of health protection, though I recognize that there are many social, economic and political forces that contribute to improved human health and that some of these forces at times may be more important and effective than our public health measures. I refer to public health as a community program to emphasize the fact that it is not solely a governmental activity, but rather it includes the contributions of voluntary as well as official agencies. It is equally important to stress the point that the goal of public health is not merely to reduce the incidence or prevalence of certain specific diseases, to prevent a certain number of deaths, or even to merely delay the advent of death, but that it aims to keep people in such a state of well-being that they can continue as useful and independent members of the community.[522]

Dr. Robert Barr died on December 26, 1970, working almost to the end of his days. Sometimes referred to as "Mr. Public Health" by many, Dr. Barr is seen as the last health officer to belong to the "old school" of public health. Dr. Hewitt, Dr. Bracken, Dr. Chesley and Dr. Barr had led the department for nearly 100 years, working the front lines of public health. The health officers to follow were viewed more as administrators, probably appropriate for the time but different. The end of the 1960s seemed to mark the end of an era. Subtle, quiet changes were paving the way for the more obvious and dramatic ones to follow.

In 1963, Barr received the annual Francis E. Harrington Award for public health leadership and achievement at the 17th annual conference of the Minnesota Public Health Association. The award was presented by Mrs. Walter W. Walker, the 1962 recipient, who described Barr:

> He is a man of broad interests, of keen insight, and a gentleman who extends his interests beyond the field of health. He is a man who can encompass a broad sweep of public health problems, or focus with intensity on a local issue. His judgment is keen, his insights are sharp. He is a witty man, he is a serious man. He has a commitment to service to people and to the field of public health, which seems to know no limitations in terms of time, effort or energies expended. He is a dynamic person, a dedicated public officer, and he is a gentleman who has the capacity to draw talented and dedicated people around him. [523]

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[520] BOH, *Minutes,* January 9, 1968, MHS, p. 8.
[521] Letter from Dr. E. H. Jorris to Dr. Robert Barr, June 14, 1968.
[522] MDH, *Minnesota's Health,* Vol. 20, No. 6, June-July 1966, p. 2.
[523] MDH, *Minnesota's Health,* Vol. 17, No. 8, October 1963, p. 2.

Minnesota Health Department Library in old building on University of Minnesota Campus

In recognition of the value he placed on education, the department's library has been named the R.N. Barr Library.

Chapter 6

Hospitals and Long-Term Care Facilities

"The ultimate goal is the provision of adequate hospital facilities for all of the people." [524]

Dr. Helen Knudsen, 1951

Note: The photo of Dr. Helen Knudsen is missing from this file, as the disk did not have sufficient memory for it.

Helen L. Knudsen, B.S. in Medical Technology M.D., M.P.H.

Director of Division of Hospital Services, 1948 to 1974

Minnesota Department of Health, 1944 to 1974

Hospitals, nursing homes and other health facilities in Minnesota underwent a transformation between 1949 and 1999. With the institution of regulations by the Health Department in the 1950s, standards were established and the quality of care received in all facilities was more closely monitored. Unable to meet the standards, houses converted to converted nursing homes and other small facilities began to disappear, replaced by larger, modern buildings. Overall, the number of hospital and nursing home beds began to increase. This was due in large part to the availability of federal Hill-Burton funding, administered by the department for more than 20 years. Payment through Medicare, Medicaid and insurance further encouraged growth of the industry, as well as improving quality of care. The 50-year period began with concern over a shortage of hospital and nursing home beds. By the 1970s concern was raised over the excess numbers.

Hill-Burton: Hospital Growth Begins

Very few hospitals were constructed between 1929 when the Depression started all through the mid-1940s, and communities needing hospitals did not have them.[525]

The stage was set for a post-war hospital building boom all through the mid-1940s, made possible in 1946 by the Hospital Survey and Construction Act, better known as the Hill-Burton Act. This created a five-year program in which $75 million in matching grants would be provided annually to states to build hospitals in underserved areas.

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[524] Helen Knudsen, M.D., M.P.H., "Where the State Agency Fits In," *Modern Hospital*, April 1951, pp. 77-79.
[525] *American Hospital Association News*, August 14, 1995.

The law also appropriated $3 million for all states to inventory their health facilities. For the first time the nation would have a comprehensive picture of where the need for hospitals was most urgent and each state would have a planning process for meeting that need.[526]

The Hill-Burton program was extended later to provide grants for building nursing and each state would have a planning process for meeting that homes diagnostic centers and chronic disease hospitals.

The boom in hospital building and the transformation of health facilities throughout the nation began when the 79th Congress passed federal Public Law No. 725, the Hospital Survey and Construction Act in 1946. This law authorized an annual grant to states to assist in constructing and equipping needed hospitals and public health centers. Before a state could receive federal grants for construction purposes, it had to submit an overall state plan to the U. S. Public Health Service for approval. The initial plan for Minnesota was completed in early 1948 after a comprehensive study of existing facilities and a determination of present and future needs.

The first funds from this program were used to survey hospital needs, plan the location of facilities, and cover up to one-third of the construction costs of facilities in underserved areas.[527] Funding for equipment was also offered. In return, hospitals had to make services available to all members of the community, and they were expected to provide charity care for a period of 20 years. Some hospitals have continued to provide charity care after the 20-year period ended.[528]

Sponsored by Sen. Lister Hill (D-AL) and Sen. Harold Burton (R-OH), the bill which began the changes to health care facilities, was signed into law by President Harry S. Truman August 13, 1946. Funds from this federal program were intended to give first priority to rural and minority populations currently without adequate hospital service. According to designs promoted by the Public Health Service, hospitals were to create a "human" setting. Sites were to be chosen to make sure every patient could receive sunlight in his/her room.[529]

The Health Department was the agency designated to plan and distribute Hill-Burton funds in Minnesota. Chapter 485, Laws of Minnesota 1947, charged that the Board of Health cooperate with the U. S. Public Health Service in the conduct of this program. For the first time, the board had a significant role in directing health care facilities and was in a powerful position to determine the location of hospitals throughout the state. The board made the final decisions as to which communities received federal Hill-Burton funding for designated facilities.

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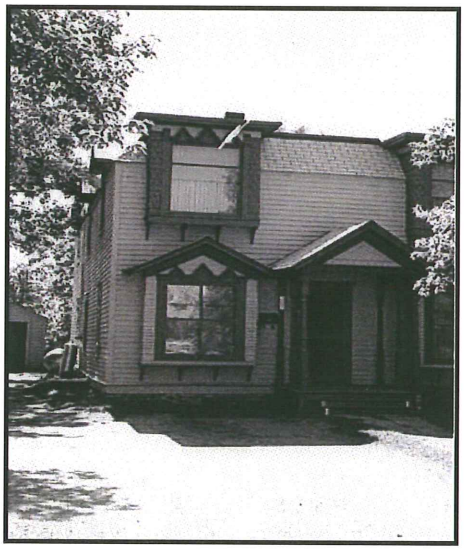
[526] *American Hospital Association News*, July 20, 1998.
[527] *P.L. 725*, 79th Congress, c. 958.
[528] Jack Bess, "If You Build It...", *American Hospital Association News*, July 20, 1998, p. 7.
[529] Ibid.

Between 1948 and 1974, Minnesota received $80,942,230 in Hill-Burton grants.[530] These funds were used to assist with the construction of health facilities in the state. The amount Minnesota received represented nearly 10 percent of the total estimated cost of health facility construction costs during that period.[531] The Hill-Burton funds also represented a large percentage of the Health Department's operations. In 1956 nearly 60 percent of the department's total revenue was from Hill-Burton funds.

The Hill-Burton Act of 1946 helped finance the construction of hospitals and public health centers, and in 1954 the law was amended to include nursing homes, chronic disease hospitals, diagnostic or treatment centers and rehabilitation centers.[532] In 1964, it was again amended to authorize grants for area-wide planning and consolidation of the chronic disease hospitals and nursing homes into one category – "long-term care."[533] A final amendment in 1970 established a new category, outpatient facilities, in lieu of diagnostic and treatment centers and offered loans, as well as grants.[534]



First Hospital in Thief River Falls
Negative No. 0482-8 **Location No.** MP3.9 TR7.1 p1

Minnesota Historical Society· 345 Kellogg Blvd. West, St. Paul, MN· 651.296.6126 Copyright © 1999

The hospitals and nursing homes in Minnesota in 1949 were quite different from what existed 50 years later, in 1999. In 1949 hospitals and nursing homes might be converted dwellings. The hospital in Cambridge, for example, had a large staircase on which patients were helped or carried up and down, as there was no elevator. In some hospitals the surgical and operating rooms were in the same area or the emergency rooms and the operating rooms shared a space. Many facilities did not have sprinkler systems to better protect the residents from fire. Change was needed.

Dr. Helen Knudsen

The person in charge of this important program was Dr. Helen Knudsen. She was pragmatic, organized, and determined to make certain the citizens of Minnesota had adequate access to hospital facilities. Her detailed reports from 1948 through 1974 chronicle the expansion and improvements of health care facilities in Minnesota.

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[530] MDH (health facilities division), *Minnesota Hospitals: 25th Annual Revision, 1973-74*, January 1974, pp. VIII, pp. 5-25.
[531] MDH (health facilities division), "Minnesota State Plan for Hospitals, Public Health Centers, and Related Medical Facilities" (news release), January 16, 1974.
[532] *P.L. 482*, "Medical Facilities Survey and Construction Act of 1954," 83rd Congress, 2nd Session, C. 471).
[533] *P.L. 88-443*, "The Hospital and Medical Facilities (Hill-Harris) Amendment of 1964."
[534] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, pp. VIII, pp. 5-25.

The Health Department almost missed the opportunity to have Dr. Knudsen lead the program. Nearing the end of her internship at the University of Minnesota Hospitals in 1944, she hoped for a career in internal medicine. She asked Dr. Cecil Watson, chief of medical service, about the possibility of a fellowship. He explained, "I've never taken a woman, and I wouldn't take anyone without a year in pathology first."[535]

It was Dr. Ruth Boynton, head of the student health service at the University of Minnesota and a member of the Board of Health, who suggested that Dr. Knudsen talk to Dr. Albert Chesley, secretary and executive officer of the board about an open position at the department. Dr. Knudsen met with Dr. Chesley in the library of the old Health Department building on the University campus. He offered her a position as head of the emergency maternity and infant care program. She accepted. Walking back to the University of Minnesota Hospitals, 10 minutes after her conversation with Dr. Chesley, she was paged by Dr. Watson. He now offered her a fellowship in internal medicine, without the prerequisite year in pathology. Fortunately for the Health Department and the hospital system in Minnesota, Dr. Knudsen replied, "I'm sorry, but I'm going into Public Health."[536]

Dr. Knudsen was also offered a fellowship in neuro-surgery by Dr. William Peyton. She turned this down, too, explaining, "Who would go to a woman for a brain tumor?" Dr. Peyton replied, "I need help, and I know you would work hard."[537]

Dr. Knudsen began work for the department on October 1, 1944. The program she ran provided maternity care and infant care up to age one year for families of the four lowest paid ranks in the armed forces. The job waiting for Dr. Knudsen was indeed challenging. Cases hadn't been processed and forms lay in huge piles on her desk. She discovered the $75.00 fee limit for obstetrical care wasn't always observed. Finding extra charges by the Mayo Clinic, she met with the business manager and no further problems resulted.

In 1946, Dr. Knudsen took a leave from her work at the department to earn a master's degree in public health at the University of Minnesota, where Dr. Gaylord Anderson headed the program. Classmates of hers included Dr. A. B. Rosenfield and Dr. William Harrison, both employees of the department. Another classmate, in an earlier speech class, was Hubert H. Humphrey. For two quarters she sat two seats from him, and describes the experience as "frustrating." Graduating in 1947, Dr. Knudsen was appointed chief of the department's hospital services section on June 6, 1947.[538] This was later named the health facilities division.

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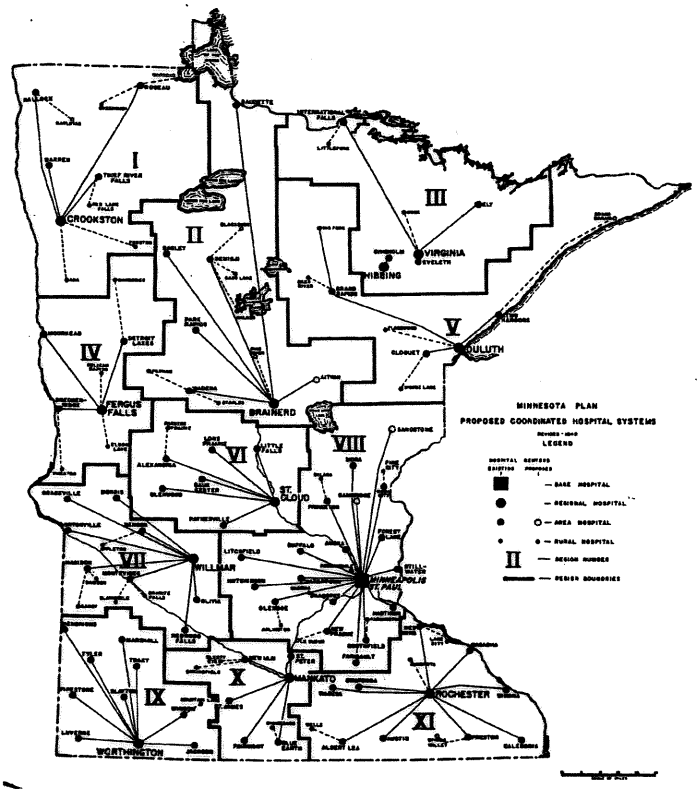
[535] Conversation with Dr. Helen Knudsen, Minneapolis, Minnesota, March 10, 1999.
[536] Ibid.
[537] Ibid.
[538] MDH, *Minnesota's Health*, Vol. 10, No. 1, January 1956, p. 4.

Hill-Burton: State Hospital Plan

The road map for Dr. Knudsen's actions was contained in the hospital plan that was created with the input of a state advisory council on hospital construction appointed by the governor. Dr. Viktor Wilson, chief of the department's special services section, was the first chair of the committee. Later, Mr. Ray Amberg, superintendent of the University hospitals, was chair for many years. Mr. Glen Taylor, executive secretary of the Minnesota Hospital Association, was a member, and other members included representatives of hospitals, medicine, dentistry, nursing, pharmacy, architecture, labor and farm groups, plus governmental agencies.

The objective of the state hospital plan was to develop a uniform distribution of general hospitals reasonably available to the population and capable of rendering qualified service. To obtain quality service, consideration was given to hospital sizes consistent with efficient and economical operation. In areas of sparse population, it was found necessary to compromise on the hospital size to obtain reasonable availability of service. The actual determinants involved were hospital location, service areas, and sizes of institutions.

The first Minnesota plan for hospitals and public health centers, approved by the Surgeon General of the U.S. Public Health Service on March 5, 1948, was based on a comprehensive study that defined what facilities existed in Minnesota and what was needed.[539] [540] The plan identified priorities for selecting a particular community, targeting communities with the greatest needs.



Gov. Youngdahl announced the hospital plan for the state in 1948. According to the plan, everyone in Minnesota would live within approximately 20 miles of a hospital. The plan called for regional hospitals in 11 locations: Crookston, Hibbing-Virginia, Duluth, Fergus Falls, Brainerd, St. Cloud, Willmar, Mankato, Worthington and Rochester. Regional hospitals would receive the highest priority. The University of Minnesota Hospitals in Minneapolis, equipped to handle all types of patients, would serve as the base hospital for the state.

[539] MDH, *Minnesota Hospitals 1973-74*, January 1974.
[540] MDH, *Minnesota's Health*, Vol. II, No. 6, June 1948, p. 2.

Originally, up to one-third of the construction costs of a hospital were financed with federal funds.[541] This limit was increased to 45 percent in 1950.

Hill-Burton: Selecting Sites

Determining which communities received funds was politically challenging, as usually each community wanted its own hospital. In order to be eligible, a project must have a high priority rating. [542] Communities had to demonstrate they had the financial ability to complete and operate the facility. The hospital must be owned and operated by public or non-profit corporations or associations, and there had to be assurance that the facilities would be open to provide medical services to anyone in the community.[543]

The advisory council[544] reviewed each situation and made recommendations to the Board of Health as to which projects should receive funding. The advisory council usually scheduled its meetings just before board met. Given the political nature of the decisions, the board had to keep the governor and Legislature informed as to the basis for its decisions. Dr. Chesley commented on this at one board meeting:

> ***"You have a change of administration and there are going to be questions raised about 'My Home Town.' If the Governor knows this is a stated policy and we have adhered to it through two administrations, it won't do any harm."***[545]
>
> **Dr. Albert Chesley, 1955**

Despite the board's efforts to focus on need, some persons felt its decisions were political. At one board meeting, Dr. Litman said, "...there seems to be some underlying rumors that if there had been better representation on the Board of Health they might have had better consideration by the Board." [546]

Applicants for projects were ranked by number. At one board meeting, members discussed the ranking of one hospital. Dr. Barr said, "We have had two telephone calls from the Governor to ask that we give consideration to the request of this hospital. My frank opinion is that the man in charge is a promoter..."[547]

Representatives of communities whose projects had not been funded sometimes complained. When, in 1957, the City of Minneapolis requested an additional allotment and was turned down by the board, Minneapolis Mayor Peterson wrote U.S. Sen. Edward J. Thye. Sen. Thye contacted the U.S. Public Health Service, which informed

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[541] MDH, *Minnesota's Health*, Vol. II, No. 2, February 1948, p. 2.
[542] MDH, *Minnesota's Health*, Vol. III, No. 8, August 1949, p. 3.
[543] MDH, *Minnesota's Health*, Vol. 9, No. 3, March 1955, pp. 1-2.
[544] The Health Facility Advisory Council was established in 1951 as the Health Facility Advisory Board (Minnesota Laws 1951 c304 s9). The law was changed in 1975 (Minnesota Laws 1975 c 234). The Council was abolished in 1983 (Minnesota Laws 1983 c260 s 68).
[545] BOH, *Minutes,* January 10, 1955, MHS, p. 16.
[546] BOH, *Minutes,* May 26, 1959, MHS, p. 123.
[547] BOH, *Minutes,* August 1, 1950, MHS, pp. 359-367.

Sen. Thye it was a decision to be made by state and local authorities. Sen. Thye supported the board as the key decision maker.[548]

Sometimes communities were dissatisfied when a neighboring community received funding for a facility and they didn't. A lively session was held at one board meeting when community representatives advocated funding for a hospital in St. James and challenged the funding of a nearby community:

> St. James Community Representative: "How large a hospital is being planned at Long Prairie?"
>
> Dr. Barr: "Thirty beds."
>
> St. James Community Representative: "If that area is so poor, how can those people be able to go to that hospital?"
>
> Dr. Barr: "No matter how poor you are, you have a right to good hospital care."[549]

A few health facilities were selected as recipients of Hill-Burton funding due to special reasons. A general hospital in Big Fork was justified by the distance people had to travel. Fairview-Southdale Hospital was recommended for Hill-Burton funding on the basis of its unique character as a satellite in a rapidly growing suburban area in conjunction with a well-developed downtown hospital and the potential for study in several areas relating to the conservation of personnel and economies in operation.[550] The Olmsted Community Memorial Hospital in Rochester was justified because of the high demand for hospital beds in Rochester due to the large number of people from outside Minnesota who came to the Mayo Clinic.

A representative from the Health Department always attended the bid openings in communities. In the early years Dr. Knudsen made sure she attended each one, traveling around the state, sometimes on bus. Bid openings were also attended by Dr. Knudsen's assistants, Mr. Elmer Slagle and Mr. Eugene Koepp. Mr. Slagle, assistant director of the hospital services section, was a long-serving employee of the department. He began working for the department in 1930 in the Duluth district office as a sanitary engineer.[551] Mr. Koepp, auditor for the division, was praised for his excellent management skills.

The first hospital in the state to be completed with the help of Hill-Burton funds was a 20-bed community hospital in Greenbush, opening on February 1, 1950.[552] The first public health center financed with Hill-Burton funds was the Rochester Public Health Center, completed in 1950. In addition to providing space for offices, laboratory and clinic facilities of the Rochester-Olmsted County health unit, and city welfare offices, it housed the department's district office.[553]

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[548] BOH, *Minutes,* October 9, 1957, MHS, p. 228.
[549] BOH, *Minutes,* September 23, 1954, MHS, p. 35.
[550] BOH, *Minutes,* July 9, 1963, MHS, p. 428.
[551] MDH, *Minnesota's Health*, Vol. 20, No. 1, January 1966, p. 4.
[552] MDH, *Minnesota's Health*, Vol. IV, No. 2, February 1950.
[553] MDH, *Minnesota's Health*, Vol. III, No. 8, August 1949.

When a hospital, financed with the help of Hill-Burton funds, was dedicated, persons from the Health Department were invited. Dr. Knudsen attended three of these dedications with Sen. Hubert Humphrey, the fellow student in her speech class at the University of Minnesota.

Community Challenges: One Hospital per Community

The hospital plan called for only one hospital per community. If a community wanted to use Hill-Burton funds, it sometimes had to determine which of two institutions it would support. A Catholic and a Lutheran hospital in Crookston joined together, as did two hospitals in Mankato and two hospitals in Fergus Falls, for example.

Not all communities, however, readily agreed to join together, and this could lead to disharmony within the community. An example of this type of challenge faced by Dr. Knudsen and others was the situation in Tracy, Minnesota.

There were two hospital facilities in Tracy, the Tracy Hospital and the Clinic Hospital. The board was prepared to approve Hill-Burton funding for the Tracy Hospital, if it would operate as a hospital for the whole community. The Tracy Hospital was owned and operated by 84-year-old Dr. W. H. Valentine. Years earlier, in 1927, two other physicians, Dr. W. G. Workman and Dr. Hoidale, had formed an institution in Tracy known as the Clinic Hospital. The Clinic Hospital had been ordered by the state fire marshal to provide a sprinkler system and complete other changes by April 1, 1959. They felt this was an unwise expenditure, as the facility was quite inadequate in other respects.[555] Wanting to continue to work in Tracy, Dr. Workman and Dr. Hoidale met with Dr. Valentine and

Method of Determining Priorities

Priorities were developed to aid in the equitable distribution of Hill-Burton funds for construction and modernization of eligible health care facilities. Priority was based upon an evaluation of bed need for each category of health care facility in each area based on these factors:

- A factor of utilization experience was expressed in terms of the current area use rate (total patient days per 1,000 area population per year)
- An occupancy factor was utilized 85% for general hospital beds and 95% for long-term care beds
- Population estimates and projections were made for each area. Adjustments were made based on anticipated change in use rate, opening or closing of a hospital, new industry, changes in availability of physicians' services and utilization patterns derived from patient origin studies.
- Separate priorities for new construction and modernization were developed for each category of facility in each area. The priorities were developed through the survey made of each facility as required by the Hill-Harris amendment to the Hill-Burton Act in 1964.
- Special priorities were given to those communities with two hospitals that merged under one management, operating as one facility.[554]

[554] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. III–1 and 2.
[555] BOH, *Minutes,* October 8, 1963, MHS, pp. 539-541.

agreed that if an addition were built onto the Tracy Hospital, Workman and Hoidale would work there. Dr. Workman and Dr. Hoidale instituted a community fund drive. A total of $118,000 was collected – not enough to cover the lowest bid of $142,723. The funds were returned to the donors. Without a unified community effort, the board moved that the hospital did not meet its definition of an acceptable community hospital in terms of the master hospital plan of the state and funding was not approved.[556] [557]

Workman and Hoidale then proposed building a new hospital in Tracy and requested $330,000, 55 percent of the total cost of the hospital, from Hill-Burton funds. A total of $600,000 was needed, and they planned to raise the remaining $270,000 through a bond issue. A vote was scheduled June 9, 1959.[558] The bond issue passed, but there was a question of legality. Still trying to support a community hospital, the department approached Dr. Valentine and asked if he would serve all physicians, establishing a new board for the hospital. He declined.

The bonds were to go up for sale in the fall, but there was an injunction against the sale of local hospital bonds. Dr. Knudsen had to appear in district court in Jackson, on September 24, 1959, relative to the injunction. The plaintiff was required by the court to post bond in the amount of the Hill-Burton share ($283,090) on the grounds of damage to the community. The bond wasn't posted by the due date. Tracy again advertised the sale of its bonds.[559]

Dr. Valentine was not satisfied with the course of events and requested a meeting with the Board of Health on January 12, 1960. He was given 20 minutes. He explained why he could not work with the other facility. The following interchange took place between board members and Dr. Valentine:

> Dr. Edgar Huenekens: "...I am getting close to your age, too. I, too, remember Dr. Bracken and all the others as well as you do. I would say to you that accepting as 100% correct what you said, you still are in the wrong because I think you are interfering with the health of your community by your attitude. Accepting everything you have said as right, I still think your final conclusion is wrong because you are standing in the way of the health of the community. I would like to say this to you. As I say, I am a man almost your age and I might have taken the same attitude you have taken in what has happened, but I still say it is wrong if you look at it from the broadest sense of helping your community."
>
> Dr. W. H. Valentine: "Just what is your basis, may I ask you, of your conclusion that the service rendered at the Tracy Hospital at the present time is detrimental to human beings or insufficient?"
>
> Dr. Frank Krusen: "I didn't hear him make such a statement, Doctor."
>
> Valentine: "Well, you thought I was all wrong in asking to keep the Tracy Hospital open. I beg your pardon if I am incorrect."
>
> Krusen: "I don't think he made such a statement as that, either."

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[556] Letter from Dr. W. H. Valentine to Dr. Frank Krusen, Board of Health president, May 14, 1959, MHS, pp. 135-138.
[557] BOH, *Minutes,* February 24, 1959, MHS, pp. 38-39.
[558] Letter from Dr. W. H. Valentine to Dr. Frank Krusen, Board of Health president, May 14, 1959, MHS, pp. 135-138.
[559] BOH, *Minutes,* November 10, 1959, MHS, p. 249.

> Valentine: "What was the statement, then, please?"
>
> Huenekens: "When I said I thought your attitude was interfering with the health of your community, it has nothing to do with your hospital. What I mean is that Tracy and any other community needs a community hospital where every doctor can practice, and no matter what differences of opinion exist between you and Dr. Workman, the fact that you can't work in the same hospital is interfering with the health of the community."
>
> Krusen: "We now have consumed 40 minutes, Doctor. We want you to know that you have been given more than the time promised you. You have spoken, I know, from the bottom of your heart with regard to your own feelings. We hope that you understand that the Board is sympathetic with you and in your interests. We hope you understand that the Board has definite obligations to the people of the State as a whole. We can't be involved directly in local jurisdictional problems which would be to the detriment of the health of the people of the State as a whole. We are eager to serve the people of the State to the best of our ability. We will, I assure you, give careful consideration to what you have just said. I want to be certain that you feel you have had a chance to say everything that you want to say to the Board and if you have any final statement now we will be glad to receive it." [560]

During the next three years, department representatives continued to work with the Tracy community, trying to resolve the inadequacies of the hospital. The hospital had many deficiencies and had some unusual features. When Dr. Knudsen examined one patient's chart, she read the diagnosis as "lazy." The "patient" was using the hospital as a hotel, paying for room and board.[561]

By January 1963 the issue of what to do with Tracy Hospital had still not been resolved. At the board meeting, members considered the two hospitals in Tracy and wondered if they should close one. Dr. Swenson recommended the closing of Tracy Hospital since one hospital, adequately staffed, was the best thing for the health of the people of Tracy. Dr. Barr responded:

> I think the question is, should we lower the boom on the Tracy Hospital and close it out except as a nursing home? Or should we indicate that we are very reticent but that we will give a limited license for a hospital provided certain steps are taken, as discussed when the Department representatives were at Tracy, so that this can and will be converted to a nursing home by the end of 1963.[562]

Following the meeting Dr. Valentine expressed interest in converting the facility to a nursing home.

Hill-Burton: Challenges for the Department

Administering the Hill-Burton program and managing the health services division was challenging. Dr. Knudsen arrived early and worked late. She had to deal with divisiveness within communities, politics, funding changes by the federal government, competition among health facilities, failure of projects to meet deadlines, increased

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[560] BOH, *Minutes,* January 12, 1960, MHS, pp. 13-14.
[561] Conversation with Dr. Helen Knudsen, March 1999.
[562] BOH, *Minutes,* January 12, 1960, MHS, pp. 13-14.

costs of projects, and more. One organization advertised the availability of Hill-Burton funds as part of their $500,000 fund drive for a new 50-bed hospital, even though the board had not yet approved them for funding. The board was not pleased with this approach to fund raising, but eventually approved funding for this new hospital. [563]

Sometimes communities did not meet deadlines, causing difficulties for the Board of Health. Two Harbors did not meet its deadline, and it was extended. The extension was not met. The board felt the community needed the funds to improve services but were concerned about giving Two Harbors special treatment through another extension. It was discussed at a March 17, 1955, board meeting:

> Bosch: "Extend the deadline. But will we be placed in any embarrassment with Cloquet and other commitments of the Board?"
>
> Knudsen: "It will be a hot situation, I suppose."
>
> Dr. W. W. White: "Essentially you are changing your order."[564]

After considerable discussion, the board agreed to extend the deadline one more time.

Another difficulty more common in the early years of Hill-Burton was the marked discrepancy between the estimated and actual costs of projects. This was caused by inadequate planning in the preliminary stages, decisions to upgrade the work after the initial plan had been approved, unrealistic cost estimates by the architects, and the inclusion of items that were deluxe. Substantial portions of the subsequent fiscal allotment had to be used in order to complete projects in process. This delayed new projects, disrupted community plans and slowed down the overall expansion of hospitals in the state. The state advisory council discussed the issue in 1955. It made a recommendation, approved by the board on November 1, 1955, establishing a policy which limited the board's financial responsibility: "Any increase in Federal funds between Part 1 and Part 4 of the Application will be limited to five (5) per cent of the original estimate, with the costs over and above this amount assumed wholly by the applicant."[565]

While unplanned expenditures delayed the expansion of health facilities in the state, quick actions by the department brought additional funds to the state and expedited the growth of facilities. On January 3, 1958, the regional office in Kansas City phoned the department requesting immediate information on how much Hill-Burton Part C and Part G funds Minnesota could use. The request was to go to Washington for the Subcommittee of the House Appropriations Committee. The department responded immediately, sending an eight-page report to Washington, D. C., by airmail.[566] Due to the department's quick reaction, additional funding was obtained.

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[563] BOH, *Minutes,* December 5, 1955, MHS, p. 378.
[564] BOH, *Minutes,* March 17, 1955, MHS, p. 71.
[565] BOH, *Minutes,* attachment: letter (6/18/57) from Dr. Robert Barr to Rep. Edward J. Thye, October 9, 1957, MHS, pp. 230-232.
[566] BOH, *Minutes,* January 7, 1958, MHS, p. 13.

Sometimes communities resisted plans for a new or improved hospital or the closing of one. In these cases, Dr. Barr, Dr. Knudsen and others from the department visited the communities to explain the state plan and its purpose. For example, when Hastings was unable to raise matching funds, Dr. Knudsen spoke at an area wide meeting, explaining the need. When there was resistance to closing the hospital in Milaca, department representatives went to the Milaca to try and encourage local participation. Sometimes representatives from the U.S. Public Health Service accompanied department members.

Dr. Knudsen also had to deal with communities that operated outside of the state plan. In 1960, there was increasing concern about the number of hospital beds that were being planned in small communities when the state had surveyed the area and found it too small for a hospital. The Minnesota Medical Association sent a letter to each physician in the state asking them to inform the Department of Health if they were aware of any plans for a hospital in their area that had not been discussed with qualified hospital authorities. The last sentence of the letter read: "Such action on your part is the duty of a good citizen and a conscientious physician and may help to avoid unnecessary and wasteful expenditures of much time and a great deal of money." [567]

While the Hill-Burton program encouraged only those hospitals that were most needed, there were many more hospitals built without Hill-Burton funds and, consequently, not affected by the program's priorities and guidelines. In 1963, there was concern with the lack of community-wide planning and resultant overbuilding of hospital beds in the big cities. Referring to the cost of extra beds and expressing concern that there was no assurance Minnesota would continue to have a first-class medical plant, Thomas P. Cook, executive secretary of the Hennepin County Medical Society and a respected spokesman for area doctors, said: "All this is one of the biggest problems we've had in a long time." [568]

Nursing Homes and Long-Term Care

In 1949, 20 of Minnesota's 87 counties did not have a single nursing home, and 57 counties did not have a home for the aged. Nearly all homes had waiting lists.[569] There were few places for patients to go, if a home closed.

By 1955 there was an estimated shortage of 2,000 nursing home beds in Minnesota.[570] Dr. Helen Knudsen was receiving calls from distraught children who couldn't find space for their aging and infirm parents. To respond to the need, women began setting up a few beds in their homes. A home could have up to two beds for unrelated persons without requiring a license.[571]

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[567] BOH, *Minutes,* May 24, 1960, MHS, pp. 90-91.
[568] *Minneapolis Morning Tribune,* "Report on Our Hospitals," February 25 to March 2, 1963, p. 1-4.
[569] MDH, *Minnesota's Health*, Vol. III, No. 3, March 1949, p. 4.
[570] BOH, *Minutes,* March 17, 1955, p. 81.
[571] Conversation with Dr. Helen Knudsen, March 1999.

The board received requests from facilities to add additional beds. Hesitant to approve such requests, there didn't seem to be another solution. Dr. Robert Barr commented on the difficult position in which they found themselves: "The only thing we can do is blink at our standards in most instances. Pressure is on more and more to fill them up. There is no place to put them..."[572]

In 1957, the department's hospital services division estimated that 17,798 nursing homes and homes for the aged beds were needed in Minnesota. This was 4,854 less than the state had.[573]

An intense interest in nursing home construction started in the 1950s, no doubt generated by the availability of funds through Hill-Burton when federal legislation made this change in 1954. While most nursing homes in the 1940s were converted houses, this began to change in the 1950s. It wasn't until 1958, however, that the construction of new homes exceeded the conversion of buildings. [574] Dr. Knudsen estimated that there would soon be an abundance of beds in Minneapolis where empty beds were already appearing in new homes, as well as old converted homes.

Between 1950 and 1963, the number of licensed nursing homes and boarding care homes increased from 284 to 580. The number of beds increased from 7,951 to 22,562.[575] There were fewer and fewer reports of shortages of nursing home beds. In 1962, empty beds were beginning to appear in older nursing homes and even in some new ones in areas where there had been substantial construction.

By 1963, the state began expressing concern about the overbuilding of nursing homes in particular areas. The board recognized that privately owned homes would probably suffer, as they would not be completely occupied and it would be difficult financially to make it. The Federal Housing Authority required certification of need for nursing home construction, and the Health Department was responsible for determining whether or not there was a need. In 1962 Dr. Barr felt the approval of building plans should go with a warning:

> We feel that while we can give a certification of the need, we must include a warning as well. Even though we say there is a real need for so many beds here, we must add to this that the owner is going to face some real tight competition in the future. We should tell these people that most of the beds in Minnesota are nonprofit, that they have to build good beds or else they are in trouble, and that the poor beds are going by the wayside, so they know what they are facing. We will continue to encourage the nonprofit homes of high quality. [576] We are going down the middle of the line and are going to tell the people the facts. [577]

The concept of long-term care, a facility for patients with chronic debilitative disease, took hold during the 1940s and 1950s. In 1944 hospitals were classified as general hospitals or specialized hospitals. At that time, large chronic or convalescent homes

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[572] BOH, *Minutes,* March 17, 1955, p. 84.
[573] BOH, *Minutes,* July 30, 1957, MHS, p. 145.
[574] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 82.
[575] MDH, *Minnesota's Health*, Vol. 17, No. 9, November 1963, p. 3.
[576] BOH, *Minutes,* April 9, 1962, MHS, p. 111.
[577] Ibid., p. 112.

that did not fit into the home-for-the-aged category were classified as chronic or convalescent hospitals. In 1947, when hospital administrators were required to be registered, it became necessary to define hospitals and classify institutions. Five of the large nursing homes became chronic disease hospitals and two became other specialized hospitals."

Dr. Barr was a strong supporter of long-term care facilities for those who needed rehabilitative care. In 1950 he said:

> Most people think that a chronic disease hospital is a place to put old seniles. Its primary purpose is to put someone in there who has a chronic disease over a long period of time for physical and occupational therapy to rehabilitate that person. But that should be operated at less cost than are the general hospitals.[578]

Dr. Barr, always a supporter of care for the elderly and disabled, advocated for long-term care facilities again at a 1956 board meeting:

> Acute hospitals do not have facilities for rehabilitation. Where a man loses a leg they keep him in a general hospital until the thing is completely healed and then send him home. If that individual as quickly as possible, is transferred to a hospital which has facilities for physiotherapy, you have got him rehabilitated using that artificial extremity as soon as possible. That is only one example. That is the thinking in connection with chronic hospitals. There is some question whether they should be built in a small community. If there is no trained individual to take charge of the physiotherapy work then you are simply supporting another bed and accomplishing nothing. Actually that bed is no different in a chronic hospital than if it is in an acute hospital. If you can do something there about rehabilitating him rapidly, then you are doing something. The latter group should be classified as a nursing home and have them near where they could have acute hospital facilities care.[579]

Hill-Burton: Its Effects in Minnesota

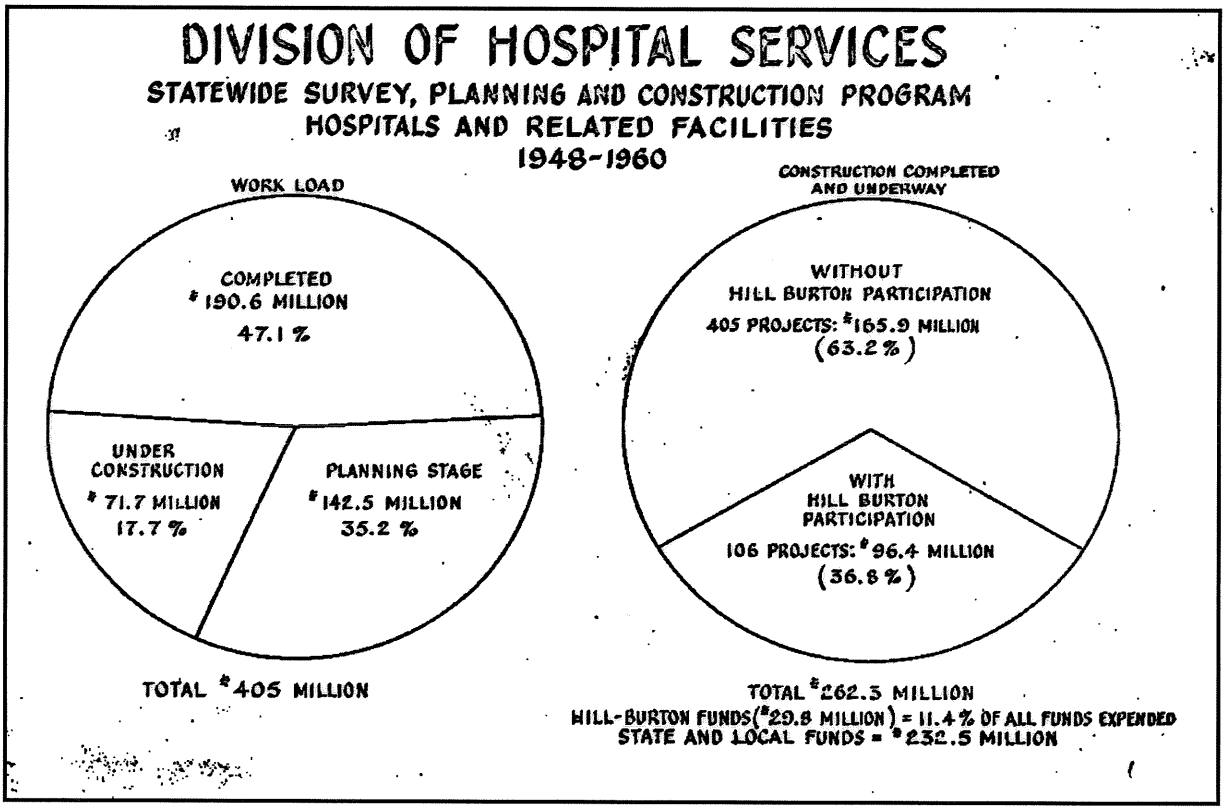
The types, locations and sizes of hospitals and other health facilities in Minnesota changed and evolved during the 1950s and 1960s. The list of facilities that received federal Hill-Burton funding and the year funds were awarded is given in Appendix E. Between 1950 and 1973 a total of 120 general hospitals, seven public health centers, four mental centers, five chronic disease units, three chronic psychiatric, nine psychiatric units, seven rehabilitation centers, four diagnostic and treatment centers, six mental retardation facilities and 45 nursing homes received some federal funding through the Hill-Burton program. Awards ranged from $23,625 to $2,000,000. This funding was helping to create more efficient and effective health care facilities for the people of Minnesota.

While modern community hospitals increased, small hospitals such as maternity home hospitals began to disappear. Maternity home hospitals once served a large portion of maternity cases in the state. Some of them used the kitchen table for the birth and, when overcrowded, a new mother and baby might stay in a storage room. With the transition of the facilities in the 1950s, these homes began closing. One of the last to

[578] BOH, *Minutes,* February 14, 1950.
[579] BOH, *Minutes,* October 3, 1956, MHS, p. 191.

close was the Moehl Maternity Home in Morristown, Minnesota. The owner and operator was 87 years old when she decided to end her services. [580]

Many changes were taking place in the area of mental health hospitals. While the Department of Public Welfare had authority for the state mental hospitals in Anoka, Fergus Falls, Moose Lake, and Rochester, the Health Department had authority for areas within hospitals. Representatives from the Department of Health and the Department of Public Welfare were uncertain as to whether or not a mental health center should be in a hospital.[581] To help with these decisions and plan the construction of mental health centers and institutions for the mentally retarded, the Minnesota Mental Health Planning Council was organized in 1963. From 35 to 49 agencies representing interests in mental health served on this council.[582]



Though a lot of facilities had been added through Hill-Burton, the number of hospital beds in the state was still reported as insufficient in 1962. An estimated 5,500 additional general hospital beds and 12,690 long-term care beds were needed within the next eight years.[583]

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[580] BOH, *Minutes,* August 11, 1959, MHS, p. 237.
[581] BOH, *Minutes,* April 24, 1961, MHS, p. 107.
[582] BOH, *Minutes,* July 9, 1963, MHS, p. 433.
[583] BOH, *New Dimensions for Minnesota*, p. 31.

Improving Service Delivery

In addition to facilitating assistance with funding for construction, the department offered technical support to health facilities, particularly small rural ones with fewer employees. Some of the initiatives offered by the department included:

- The first annual homes for the aged Institute was held March of 1949. It was jointly sponsored by Health and Social Welfare. At the first institute, the nursing home of the future was described. It was emphasized that it should be for the benefit of the resident, and the one-story building was advocated.

- In 1950 the department sponsored five classes for University hospital staff on the rehabilitative care of cardiac, diabetic, cancer and physically handicapped patients. Indicative of the interest, on the night of the worst blizzard in years, 48 people still showed up for classes.

- In 1951 the first annual nursing homes institute was held, jointly sponsored by the Health, Social Welfare and the Minnesota Nursing Home Association. In the 1950s the topics of the Institutes shifted from patient care to administration.

- In 1951 department staff provided assistance to nursing homes in Rice County and the St. Cloud area in setting up classes patterned after the nursing home institute.

- In 1954, the department coordinated with the Minnesota Dietetic Association, the Minnesota Hospital Association, the University of Minnesota and the Minnesota Medical Association to offer training for hospitals with no regular dietician. The first workshop on diets, menu planning, food buying, cost control, hygiene, sanitation and safe working conditions for dietary service personnel was offered in Fergus Falls on March 26 and 27, 1954.[584]

- The department was one of the sponsors of a demonstration for hospital personnel on how to evacuate patients in the event of fire or another catastrophe. The demonstration was held at Coffey Hall on the University's St. Paul campus on April 29, 1954.[585]

In addition to the above, the department published a newsletter on hospital licensure, helped the Minnesota Nursing Homes Association prepare a handbook of procedures for nursing home personnel, developed a booklet for supervisory nurses, prepared forms that could be used for record keeping, prepared displays on the floor plans of nursing homes and nursing home care for exhibition throughout the state, supported the volunteer visitor program, and conducted surveys and studies on nursing homes.

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[584] MDH, *Minnesota's Health*, Vol. 8, No. 3, March 1954, p. 4.
[585] MDH, *Minnesota's Health*, Vol. 8, No. 4, April 1954, p. 3.

The department received two federal grants that were also used to strengthen the health delivery system in the state. In 1956 the department received a three-year grant from the U.S. Public Health Service. Funds were used to investigate quality of care within five hospital service areas – nursing anesthesia, dietetics, medical technology (including blood banking), medical records and physical therapy. Recommendations for improvements were made as to recruitment of personnel, refresher training, in-service training and extension courses in postgraduate fields.[586]

Another federal grant supported the improvement of care through better coordination and planning of services. A demonstration project for planning health care resources began in 1962. Using funds from the U.S. Public Health Service, the department promoted area wide planning and assisted local communities in developing planning councils. The first planning councils were located in Fergus Falls and St. Cloud.[587]

Regulation of Health Facilities: Standards and Licensing

In addition to expansion of facilities and technical support, another development that changed Minnesota's health delivery system was the increased monitoring of patient care through regulation. In the 1940s and 1950s the board was especially concerned with the condition of nursing and boarding care homes in Minnesota.

The first comprehensive health facility licensing law in the nation was enacted by the Minnesota Legislature in 1941. [588] Amended in 1943 and 1945, this law required the Health Department to license hospitals and other institutions, including maternity hospitals that provided hospitalization or chronic or convalescent care for aged or infirm persons. In 1951 the definition was broadened to include personal or custodial care, and in 1952 homes were classified as nursing homes or boarding care homes.[589] The Board of Health was responsible for issuing an annual license to institutions, and this must be accompanied by clearance by the state fire marshall.

While the board was charged with ensuring the safety of health facilities by issuing licenses, in 1949 it had no regulations. When the board denied a license to the Kenwood Rest Home because it felt it was detrimental to the welfare of patients staying there, the difficulty of operating without regulations was noted. Jerry Brower, head of departmental administration, said:

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[586] Robert Barr, M.D.; Helen L. Knudsen, M.D.; William Harrison, M.D.; and Bernard Wolcyn, Ph.D. "Program for Improving Patient Care Services: What Minnesota Found in a Three-Year Study, *Hospitals*, Vol. 37, October 16, 1963, pp. 81-94, 149.

[587] Robert Barr, M.D.; Donald Van Hulzen, and Helen L. Knudsen, M.D. "Establishing Functional Relationships Among Health Care Facilities," *Hospitals*, Vol. 39, June 1, 1965, pp. 45-51.

[588] Laws 1941, Ch. 549 (Minn. Statutes 1957 Sections 144.50 to 144.58, inc.)

[589] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 81.

". . .our case has been made necessarily weak by the fact we have no regulations as such. Those that we have are standards. That is one of our first orders of business to see that they are adopted as regulations."[590]

Jerry Brower, 1949

The board proposed regulations of homes for chronic or convalescent patients in 1949. Three proposed requirements provoked considerable discussion. The controversial regulations called for an increase in space for each patient, the availability of a recreation room, and a drastic change in the supervising nurse requirement, among other requirements. Dr. Robert Barr stated that if these homes were to be called nursing homes, the person in charge should be a licensed practical nurse or a registered nurse.

The regulations were adopted by the board on December 16, 1949, and submitted to the attorney general on December 20, 1949. The attorney general held an informal conference on January 10, 1950, and questioned the authority of the Board of Health, under the Hospital Licensing Law, Section 144.50, to adopt regulations for all phases of the operation of homes for chronic and convalescent care patients. The attorney general decided that Section 144.56 did not adequately define the area regulated by the board. The board withdrew its proposed regulations but made them available as guidelines.[591] Legally, however, health facilities were not held to the requirements.

Amendments to the M. S. 144.56 in 1951 made it possible for the board to promulgate regulations for nursing homes. The regulations prepared two years earlier were reorganized, restated and strengthened. A public hearing was held November 7, 1951, and the first regulations for hospitals, nursing and board care homes became effective February 1952.[592]

These early regulations established requirements for medical attendance, nursing and other personnel, patient areas, as well as furnishings and equipment for care.[593] Two of the biggest concerns with nursing homes and boarding care homes were fire safety and overcrowding. Nursing homes were required to install sprinkler systems. The board set minimum space standards of 60 square feet of useable floor area per bed, with beds at least three feet apart.[594] This was later increased to 80 square feet. Space requirements proposed for all health facilities were challenged. In a February 1953 Star and Tribune article, overcrowded hospitals were cited as the cause of tuberculosis cases and deaths. An interchange between Dr. Robert Barr, always a proponent for better patient care, and state Rep. Claude Allen was reported:

Allen: "Does a patient actually need 70 square feet?"

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[590] BOH, *Minutes,* January 20, 1949.
[591] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 39.
[592] BOH, *Minutes,* January 10, 1955, MHS, pp. 47-68.
[593] MDH, Minnesota's Health, Vol. VI, No. 7, July-August 1952.
[594] BOH, *Minutes,* July 10, 1952.

Barr: "Certainly. A patient lives in that one room. And 70 square feet is small. None of the rest of us has bedrooms as small as 70 square feet – and we don't spend as much time there as a mental hospital patient."[595]

Representative Leonard Johnson cited two cases of large families in Minneapolis who lived in small quarters:

Johnson: "And they pay taxes. I guess if they want better living quarters, they ought to go to one of our State institutions."

Barr: "I don't see why their situation is any justification for pulling down State standards."[596]

The regulations, combined with educational programs, were geared to raise the standard for patients in all health facilities. Unfortunately, it was difficult for many of the homes to meet the new regulations.

At the December 18, 1953, board meeting Dr. Barr said: "If we apply present regulations to the nursing and boarding care homes in Minnesota we would have to close half of them. We have got to pick out one at a time until we have got them all up to reasonable standards."[597]

Licensure requirements were difficult for many homes that had been operating informally. They did not keep careful records, as described in a department report: "Some homes did not have even the age or address of a patient on file. It was necessary to search through many boxes of letters or slips of paper to obtain the most meager information."[598]

One regulation that was especially difficult for many homes, particularly the small ones, was the nursing supervision requirement. A survey in November 1952 found 97 of the 293 nursing and boarding care homes in the state did not have a qualified nurse. On the recommendation of the advisory board, the state allowed homes of less than 20 beds to employ a registered nurse or a practical nurse on a part-time basis to meet the requirements.[599]

Throughout the 1950s and 1960s, there was a shortage of personnel for health facilities, particularly in rural areas. A shortage of physicians in rural areas was discussed at the National Conference on Rural Health in Denver in 1952. Dr. Kenneth Kaisch of Philip, South Dakota, gave some hints on how to attract and keep a doctor in a small town: "To obtain a doctor, provide adequate hospital facilities and personnel, office space for a doctor to rent, the type of town in which a person would want to live. To keep a doctor, treat him as a human being: try working with him instead of against him." Mabel, in Fillmore County, and Kerkhoven, in Swift County, were two communities that took steps to attract doctors by constructing new clinics.[600]

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[595] *Minneapolis Tribune*, "TB Death Rate Blamed Overcrowded Hospitals," February 13, 1953.
[596] Ibid.
[597] BOH, *Minutes,* December 18, 1953.
[598] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 63.
[599] Ibid., p. 41.
[600] MDH, *Minnesota's Health*, Vol. VI, No. 4, April 1952, p. 2.

One gray area in nursing home regulation was fire safety. At its December 18, 1953, meeting, the board struggled with the decisions of approving or not approving the licenses of three hospitals in Hastings and one in Otter Tail County that it felt were fire hazards. The department's responsibility in the area of fire safety was not entirely clear. Hospitals were licensed based on U.S. Public Health Service standards. Although the department was authorized to develop standards and regulations, the standards for fire safety were not in regulation form.

Dr. Sweetser checked the state law to learn what options were open for the board:

> Dr. Sweetser: "It says here, 'The state department of health is hereby authorized to issue licenses to operate hospitals, sanatoriums, rest homes, nursing homes, or other related institutions, which after inspection are found to comply with the provisions of sections 144.40 to 144.58 and any reasonable regulations adopted by the state department of health.' If they don't comply with those two sections of the law, they don't get a license whether they comply with the regulations or not. I was thinking that these two sections of the law might give us grounds for refusing the license, aside from any regulations."
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> Prof. Bosch: "It seems to me we have got a bad situation either way. For long-time correction, I think the Board of Health should institute or put into operation today the mechanism to adopt as a regulation that hospitals should be satisfactory from a fire protection standpoint and whether they are satisfactory should be determined by the Fire Marshall. To me it would seem that the safest thing to do would be to, on the first of the year, actually issue, but as of this day have the Board of Health adopt a resolution directing that there be a hearing on each on of these to show reason why their license should not be revoked because of the fire hazard."
>
> Dr. Sweetser: "Because of conditions detrimental to the welfare of the patient."
>
> Mr. Brower, Attorney for Health Department: "That requires a tremendous amount of definition."
>
> Prof. Bosch: "I think that is the safest way out on this. First, start the mechanism, which takes practically 90 days. Secondly, take the necessary legal steps today to invite these people to show cause why their license should not be revoked. Give them thirty days' notice and give them the right of a hearing."
>
> Dr. Behmler: "We certainly should adopt some regulations so we don't get into these things."
>
> Dr. Barr: "Another thing we will have to do, we will have to have some policy on issuance of these things before the next meeting of the Board. All these things go through certain growing pains. You don't want to go out and slap them down."[601]

After further discussion, the board decided to invite representatives of the hospitals in question to a meeting at the department to discuss the situation with them. Board member Herbert Bosch thought that was a good idea because "You can record the discussion and can get away from that local emotionalism, and people are used to going to the teepee of the Great White Father."[602]

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[601] BOH, *Minutes,* December 18, 1953.
[602] Ibid.

In 1955 the department proposed additional hospital regulations, sent out the required notices, and mailed 400 or 500 copies to interested parties. The department received no negative responses, held the hearing, but when the regulations were approved, resistance from the community appeared. The board met with Mr. Glen Taylor of the Minnesota Hospital Association and with Mr. Mattson of the attorney general's office on March 17, 1955. [603]

Because of the resistance, Mr. Mattson felt a new hearing should be rescheduled and agreed to hold one in May. He felt that some of the regulations should be grandfathered for older hospitals. He pointed out the political pressure they were under:

> Mattson: "...in view of the large number of persons representing hospitals, that are concerned with this, that the best way to handle this would be to call an additional hearing and give them an opportunity to come in and be heard. I think the manner in which the notice was given conforms to the statutes, however all these powers to make regulations are subject to the will of the legislature and the members who contacted me are very concerned about it. These regulations may be putting some of the small hospitals out of business. If you call an additional hearing and grant them an opportunity to be heard, I think it would be the only fair action you can take." [604]

The difficulty of implementing any changes in regulations was recognized:

> Taylor: "I don't think you are going to have a law for minimum requirements without having certain complaints. We ran against the same thing under the Hill-Burton Law. Some of the hospitals began be being quite irritated to think we wouldn't accept their old hospital and build onto it or allow additions. It was interesting to me that after a few meetings, to have these people reverse themselves when they knew the facts. I think in some cases we certainly are not going to have 100 per cent. You are going to have complaints. I don't think there is any reason at all why we should not meet with these people and if possible, make changes, if we can do so without hurting the public. We realize that there could be some factors in them that aren't properly thought out. They could be worked over again without harm."[605]

While trying to ensure the well-being of the residents in Minnesota health care facilities, the board had to consider the power of the citizens and the Legislature:

> Brower: "What I think is important is the attitude of the Legislature. They could by a very simple bill curb our rule-making powers."
>
> Mattson: "I can say that the ones that contacted me were very concerned about the situation. One did state, feeling that these regulations were already in effect, 'We will have a law passed to take care of that.' I think it is a situation that should be taken into consideration."
>
> Bosch: "I think it is a very important thing. I think legislators have always been concerned about this, and not only in connection with the State Department of Health."
>
> Mattson: "They are very concerned about how much power the departments and Board have with regard to regulations. I think you have to consider not only the legal aspects, but give them a chance to come in."[606]

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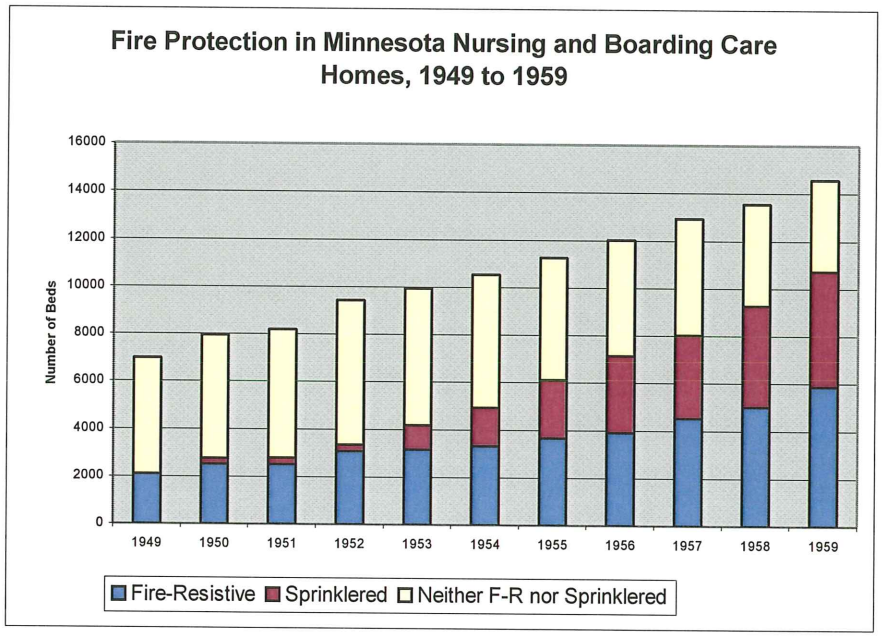
[603] BOH, *Minutes,* January 10, 1955, MHS, pp. 58-68.
[604] BOH, *Minutes,* March 17, 1955, MHS, p. 59.
[605] Ibid., pp. 58-68.
[606]

The board adopted new health facility regulations on August 13, 1955. The new regulations clarified the difference between a chronic disease hospital and a nursing home. The distinction between these two was becoming more difficult to make but had ramifications in connection with payments by insurance companies and assistance programs. The new regulations clarified that a chronic disease hospital serves patients with chronic illness, excluding tuberculosis and mental illness.[607]

In 1957, Minnesota had 423 nursing homes and boarding care homes and 13,400 beds, many in converted houses. Of these, 4,685 were classified as unsuitable. That meant they were beds housed in buildings that were neither fire resistive nor sprinklered and did not conform to minimum nursing home requirements. Still, progress was being made. The number of unsuitable beds in 1957 was 44 less than the 4,729 unsuitable beds that existed in 1956.[608]



In 1957 the Legislature required the state fire marshal to adopt a fire safety code for hospitals and related institutions. The fire safety code for nursing homes and board care homes was approved by the attorney general and filed with the secretary of state on March 24, 1959.[609]

By 1958, when the shortage of nursing home beds wasn't as acute, Dr Robert Barr actively promoted that nursing homes should either meet standards or be closed. He cited some of the horrible examples that had occurred which gave nursing homes a bad name. [610]

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[607] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 42.
[608] BOH, *Minutes,* July 30, 1957, MHS, pp. 143-144.
[609] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74,* January 1974, p. 48.
[610] BOH, *Minutes,* May 22, 1958, MHS, p. 154.

The 1950s were times when the board was figuring out its role and responsibilities in licensure and regulation of health facilities. What belonged within the domain of the Health Department? What was the responsibility of another agency? Some states were transferring nursing home regulation to their social services (welfare) departments in the late 1950s. Dr. Helen Knudsen opposed this and felt it needed to remain in the health departments in order to maintain health standards. She suggested this issue as an agenda item for the Surgeon General's Conference, which she regularly attended.[611] Responsibility for nursing home regulations in Minnesota was still in the Department of Health in 1999.

There was every indication that the department's role in regulation of health facilities would increase. In 1961 the possibility of Medicare, referred to as "old age insurance," was discussed at the board meeting. [612] Four years later, the board learned it would be responsible for certification of Medicare facilities. Effective July 1, 1966, the department began certifying hospitals and on July 1, 1967, added nursing homes.

Nursing homes received increased public scrutiny through the 1960s and 1970s, with strong public activism to improve conditions. [613] As a result, the office of health facility complaints was established by the Legislature in 1976.[614] This office was formed to receive and respond to complaints on the conditions and treatment received in health facilities. Ernest Kramer was appointed its director in October 1976.[615]

Regulation – Challenges to Enforce

Enforcement of health facility regulations was often challenging for the department. Nursing home regulations were especially difficult to enforce in the early years due to the shortage of beds. One example of the difficulty faced was demonstrated at the Samaritan Nursing Home in Minneapolis. State Sen. Ralph Mayhood, a nursing home operator, had gone three years without a license, as nursing home requirements were not met. The board decided he couldn't continue to flaunt its authority, and in January 1960 directed that a formal hearing be held to revoke the license.[616]

The hearing was scheduled for May 30, 1960. One day before that date, Mr. Stenzel, from the attorney general's office, discussed a waiver in view of the fact the home would be sold within two months. The hearing was cancelled pending receipt of the signed agreement from Sen. Mayhood. Mr. Stenzel resigned from his position, and the agreement was not returned. The board agreed to send a letter to Sen. Mayhood, stating that the hearing would be held in 30 days unless the agreement was signed and returned.[617]

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[611] BOH, *Minutes,* January 13, 1959, MHS, p. 10.
[612] BOH, *Minutes,* January 31, 1961, MHS, p. 23.
[613] Note: Some of these cases are discussed in Chapter 9.
[614] Minnesota State Statutes, 144A.52.
[615] BOH, *Minutes,* October 14, 1976.
[616] BOH, *Minutes,* January 12, 1960, MHS, p. 19.
[617] BOH, *Minutes (appendices),* May 24, 1960, MHS, p. 147.

The 60-day period to sell or discontinue the home expired on July 31, 1960. Possible new owners contacted the department on August 9, so the board did not move forward immediately on revoking the license.[618] The sale did not take place, so on September 13, 1960 the board ordered the home to complete the removal of all patients and to cease operations on or before October 14, 1960.[619] This was nearly four years after intervention was first initiated.

A problem with the board's efforts to regulate homes was the typical disparity in legal counsel. The state usually had bright but inexperienced new law school graduates from the attorney general's office. The nursing home owners often hired the top judicial officers in the state to defend them.

A number of obstacles stood in the way of the board's attempts to improve the care of the elderly in Minnesota. One example was a situation in Duluth. The board refused to grant one license to a care home on the basis of the owner's lack of cooperation over a period of several years. The board's decision was made November 10, 1959, and the attorney general's office was contacted for assistance several times the next few months. On April 19, 1960, the department learned a new attorney had been assigned to it and he would review the file. The new attorney called the department May 24, 1960, to report action was being considered. The department representative, the attorney general's office representative and the owner met on August 24, 1960, and the owner signed an agreement that she would meet the requirements necessary for licensure as a boarding care home. That fall a complaint of maltreatment was filed against the owner by one of the patients. The owner submitted plans for remodeling work, but the work was halted due to lack of finances. On December 5, 1961, a complaint was filed for operating a nursing home without a license. A six-member jury trial was held January 6, 1962.

One doctor was sworn in and testified relative to the condition of his patient in the home. The patient, a 62-year-old stroke patient, was paralyzed on one side and required complete bedside care. She had a retention catheter, needed help with feeding, had side rails and was lifted out of bed with a mechanical lift. She needed help with oral hygiene and received medications including a sulfa drug. The catheter required irrigation and was changed about once a week. Special care to the back and pressure areas was needed. The doctor testified that the patient required no treatment or care that required any special training or skill. When the judge asked about the catheter, the doctor testified that catheterization required no skill and an untrained person could administer and care for a catheter.

Another doctor testified that an 83-year-old patient needed no treatment or care that required any special skill or training. The patient was paralyzed on one side, unable to speak, incontinent and required complete bedside care. Following these testimonies,

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[618] BOH, *Minutes,* September 13, 1960, MHS, p. 311.
[619] Ibid., p. 73.

the defense attorney made a motion to dismiss the case, and the judge said he had no recourse but to dismiss it.[620]

Trying to uncover problems, department inspectors made unannounced visits to nursing homes and other facilities. Inspectors did not cover the same areas of the state; a facility could expect a different inspector each time.

When facilities did not meet standards necessary for licensure, it could take several years before it was closed down. An example is the Tracy Hospital. In 1963, the board failed to license the Tracy Hospital. It approved operation of the facility as a nursing home, but it wasn't certain whether it needed to hold a hearing on this action.[621] The board had the authority to reclassify institutions, but the law did provide that it hold a hearing when licensure was refused. In effect, the board was refusing to issue a hospital license. The board decided it could justify its actions on the basis that it was trying to upgrade the hospital care in the community and could not do this by continuing to divide hospitals.[622]

State Sen. Gordon Rosenmeier from Little Falls and State Sen. Leo J. Lauerman attended the October 8, 1963, board meeting to talk about the Tracy Hospital situation. Sen. Rosenmeier began:

> State Senator Gordon Rosenmeier: ". . .In Tracy, and I am not familiar with Tracy, it is out of my area, traditionally there have been two hospitals. One had been a municipal hospital, the other a private one. The private one was established because of a need for it. I saw it last week. To me it's a very impressive substantial building. It looked to me well kept, well landscaped, cheerful, well ventilated and every room had an outside window; not a big building, but from the standpoint of the community it seemed to me quite suitable. I'm speaking to you as a layman, not as an expert. Sometime ago, apparently the need for a new municipal hospital was made known and this Department of Health saw fit to approve an application for Hill-Burton money and a hospital was built. I didn't go in to that hospital, I saw it from the outside. It seems to me a very impressive good looking building. . . .Tracy Hospital has been operating and serving that community for several years. Its value today is probably a quarter of a million dollars. It has been privately endowed wholly. There is no tax money in it, it has no debts, it is operating at a profit, a small one but a profit, it has a small surplus, it is wholly a private non-profit organization.. . . The hospital has been going for many years serving this community and until this year as far as we know there has been no complaint at all. There never was complaint, Mr. President, until the municipal hospital came into the picture. Up to this time the hospital not only has had no complaint from this Department but it had praise. Its administrator is a new one I understand, Mrs. Weinzetl, who is recognized by this Department as being an outstanding administrator. . .Now I want to emphasize this - at present the staff of this Department of Health, the staff of this board, has said that this board will not issue a license. That is this Board's staff. We are here because we think this Board is exercising discretion of its own. The complaints that are made today about this private hospital which has the virtue at least of standing on its own feet, have never been made before. They were never made until the municipal hospital developed a shortage of patients. Now if I seem cynical about this, it's because that's my observation that's my information. So today the people I represent, that Sen. Lauerman represents, are faced with the fact that there is a hospital serving a community doing a job, a hospital that 900 people are going to ask this Board to continue, faced with a loss of its property, its right to service the

[620] BOH, *Minutes (attachment),* January 16, 1962, MHS, pp. 87-89.
[621] BOH, *Minutes,* January 22, 1963, MHS, pp. 28-29.
[622] Ibid., p. 29.

community because the staff of this Department says that they won't have a license.. . .The said corporation was licensed to operate a hospital by the Minnesota State Board of Health and has been since its incorporation. The State Board of Health has refused to renew such license in the year 1963. Now may I say this, I don't know when the Board refused to renew this license. I ask you, Mr. Chairman, if it ever did?

Dr. Raymond Jackman: "Yes it did."

Rosenmeier: "Does the Statutes require a hearing? The Statutes do require a hearing before you can refuse it. Has your staff informed you of that?"

Jackman: "Informed me of what?"

Rosenmeier: "The fact that you must have hearing before you refuse to renew a license."

Jackman: "Oh, yes."

Rosenmeier: "You haven't had a hearing?"

Jackman: "No."

Rosenmeier: "So you refuse without a hearing?"

Jackman: "Yes."

Rosenmeier: "I think this is important, Sir. The statutes set down the limits of the requirements. I didn't assume that this Board had refused this license without a hearing but I now understand it has."

Jackman: "Senator, this has been going on for at least six years."

Rosenmeier: "It doesn't make any difference, Sir. The law sets out the scope of the authority of this Board. Now I am informed that you have refused a license already."

Jackman: "That's correct."

Rosenmeier: "Then is that decision irrevocable?"

Jackman: "No, not necessarily."

Rosenmeier: "All right."

Dr. Rosenmeier goes through each of the complaints made about Tracy Hospital and explains how they can be taken care of.

Swenson: "I think you were a little bit in error when you said this license had already been revoked. It has been suspended pending the hearing. This license can't be revoked until after the hearing but this is a preliminary action so a hearing can be held."

Rosenmeier: "I couldn't believe, Sir, that this Board could set itself up to refuse to issue a license. The complaint, signed by Dr. Barr, says that this Board has refused to issue a license. I'm sure you haven't done so."

Swenson: "Pending the hearing. It's a matter of semantics."

Rosenmeier: "It's not a matter of semantics. It's a matter of rights."

Anderson: "Sen. Rosenmeier, we can go back over these things a little later, but there has been work on this for several years. This is not new. The hospital has been appraised of these things time and time again. It is not an arbitrary action, we, all of a sudden, didn't decide this is it. I know that last year we had a special meeting down there, the State Hospital Association and all interested doctors. They all went down there and met with them. They have been working with them for years to get this resolved. We are not arbitrarily trying to put anyone out of business, we want them to stay in business, but as we build more hospitals in the State and raise our standards as we are supposed to do, it is necessary for the others to raise their standards."

Rosenmeier: "I would be the last one to say a hospital shouldn't meet your standards. It stands to reason, and I'm not here to argue that you should grant a license in the event that this hospital does not. But I am here to say this hospital and the people I represent are prepared to met these standards. Now I cannot say anything about its reputation in the past.

Rosenmeier: "May I suggest to you, respectfully, you can't refuse to renew a license without a hearing, we are prepared to undertake all demands for a formal hearing plus judicial review too. It is our purpose in being her today to assure you that is not necessary. If you have reasonable requirements they will be met."

Huenekens: "I want to make the point that you are talking about the personnel on the Board. I've been on this Board for 9 years and while we may have the power to change things down there, no matter how we used that power, we never got anything, Now you offer some new evidence that we've never had before."

Rosenmeier: "Now I'm new at this, so is Sen. Lauerman. I have no reason to doubt that these people mean what they say. If I doubted it I wouldn't be here.

Swenson: "I have here a letter that was written to Dr. Valentine way back in 1957 when this Department conducted a survey of the Tracy Hospital during a visit to the hospital relative to proposed elevator installation. You see they have been told about these things and I think it is too bad that we have to hold a hearing or threaten not to renew a license in order to get these things done."

Mr. Hibbert Hill: "Is this a new board or how new is the board?"

Lauerman: "in the early days Dr. Valentine ruled it with an iron hand and now the whole community has elected a hospital voluntary committee and I have met with the committee and been assure that reasonable requirements will be met and I may add I don't know how long they have served but do think Billy Mitchell has been on it for a long time. He has a tremendous reputation with the Veterans Hospital. Billy Mitchell is the one who called me last night and I asked him if they would meet all requirements if granted a license and he said yes. When it comes to building the addition, however, that can't be done overnight and since it is a non-profit organization they have to raise the money for that addition but I am assure they can do that because they are out of debt."

Dreves: "I take it there is a need for the two kinds of hospitals or are there nursing home facilities in the area or are they available?"

Rosenmeier: "It is tradition to have two hospitals. I couldn't answer the question on nursing homes except the 'Board of the Hospital felt that it would cost just as much or maybe more to convert into nursing home than remodeling and the addition to the hospital. The main thing is that they do not want to convert it into a full time nursing home. They want a hospital. Because at one of the meetings they had down there one lady said she had eight babies in that hospital and if she was going to have anymore she would be able to have them in that hospital. The

> people around there are very loyal to that hospital. They are willing to do everything necessary to qualify. Thank you very kindly."[623]

The board felt it should not get involved in the matter directly. It agreed to write a letter to the hospital outlining the action needed. The letter stated that Senators Rosenmeier and Lauerman promised that all reasonable corrective measures would be done. A schedule as to when those measures would be done was requested. A copy of the letter was sent to the two senators. The board decided any communication with the senators and the board of the Tracy Hospital would be made by registered mail with a return receipt requested.[624]

The board refused to grant licenses to several hospitals that didn't meet the requirements. One hospital that did not get a license was the hospital in Moose Lake. It closed voluntarily in January 1960 but later community members wanted to open it. The Moose Lake Hospital had had a confusing history, according to a community member. In September 1960, a Moose Lake delegation attended the board meeting to discuss the situation and appeal to the board to give the hospital a license to operate after remodeling:

> Community representative: "We admit the hospital was not run the way a hospital should have been. Dr. M got in there from the very first beginning and at that time the shareholders, of course, they had a board of directors, and so forth, and they put Dr. M in there and then they forgot all about it. Everything died away completely. Nobody knew who the shareholders were. Dr. E at Willow River was one of the leaders, and Dr. B at Barnum was another. They are all dead. Most of the directors and the board members are dead and gone. So it was quite a job to get this straightened out again and get a board appointed, also the shareholders. Dr. M didn't care what happened to the hospital. He got the gravy out of it. That's about all he got. He didn't run it like a hospital should be run. He ran it just as cheap as possible. That's why we got to have a new roof. It should have been there quite a long time ago. He probably just patched it if it leaked too bad. So you see how the situation has been up there. It is really Dr. M's fault, in a way, because he let it go to the dogs."[625]

The board decided to write the Moose Lake community that it was of the opinion that a new hospital would be preferable to remodeling, but if they remodeled it and met all the requirements of the board, the board would have no option but to license it.

As the building was not operating as a hospital, requirements included that it be made of fire-restrictive construction according to the attorney general. Therefore, the Moose Lake Hospital building could not be licensed for use as a hospital.[626] It was difficult and expensive to remodel a hospital and it usually was preferable to build new. The hospital in Red Wing remodeled a part of the existing structure, and afterwards wished they had built a brand new facility.[627]

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[623] BOH, *Minutes,* October 8, 1963, MHS, pp. 539-541.
[624] Ibid., pp. 480-494.
[625] BOH, *Minutes,* September 13, 1960, MHS, pp. 321 to 324.
[626] BOH, *Minutes,* December 19, 1960, MHS, p. 423.
[627] Conversation with Dr. Helen Knudsen, March 1999.

Regulation: Health Facilities Personnel

M.S. 144.61 was passed in 1947 and charged the board with licensing hospital superintendents and administrators. To do this, it depended on the help of the Advisory Board of Hospital Superintendent Registration Law. The working relationship between this advisory group demonstrated a challenge that sometimes occurred when the board failed to accept the recommendation of an advisory group.

In 1956, the Advisory Board of Hospital Administration Registration Law decided not to recommend registration for a doctor who had applied to work as an administrator of a mental hospital in Minnesota. The doctor had been chief of neuropsychiatry at three different hospitals during the last six years.[628] The law required that the applicant have "hospital administrative experience" defined as "two years of hospital experience in one or more duly established positions requiring a knowledge of hospital procedure and techniques, and the exercise of independent judgment, supervision of other personnel, program planning and formulation of policies." The advisory board did not feel the applicant met those requirements.[629]

The Board of Health decided not to accept the recommendation and registered the applicant. Following this, Dr. Krusen, board president, received a letter from Mr. Ray Amberg, administrator of University of Minnesota Hospitals and chairman of the government relations council of the Minnesota Hospital Association. He expressed his discontent. Excerpts from the letter, dated April 23, 1956, read:

> This matter has caused considerable stir among the members of the Minnesota Hospital Association, and, as chairman of the Council on Government Relations, I will be compelled to bring it before the Council, but I wish to inform the Council that I have exhausted every effort in this matter before they take it up as a matter of business. My feeling is that the amenities that usually exist between advisory boards and boards of final disposition have not prevailed in this situation, and that the attitude of all advisory boards that have to work with the Department of Health will be prejudiced unfavorably by what has transpired.[630]

When the matter was discussed jointly, Dr. Krusen, board president, pointed out the role of the committee: "I would like to point out that according to democratic processes an advisory committee cannot be autonomous and that the parent organization must always have the final say as to what action is taken." [631]

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[628] BOH, *Minutes,* April 19, 1956, MHS, p. 68.
[629] Meeting of advisory board on hospital superintendent's registration law, April 5, 1956, MHS, p. 107.
[630] Minnesota MHS, p. 130.
[631] Minnesota MHS, p. 192.

Chapter 7

Brick and Mortar of the State Health Department

"In addition to the advantages of centralization, there is the fact that the facilities in the new building are bigger and better. E. A. Erickson, chief of laboratory services, said that he expected his department to do a 'much better job' in the new building. His section is, among many other things, responsible for preparing all the tuberculin used in Minnesota and for doing all the dishwashing and sterilization for the department.

"Mrs. Yvonne Finke, chief of the serology section, added that she could now perform tests which were impossible with the old facilities.

"For example, in order to perform certain tests which required darkness, her staff members had to get under a black cloth like an old-time photographer. In the summer the temperature under there would sometimes rise above 100 degrees.

"The heat could affect both the sample being tested and the morale of the unfortunate staff member who had to perform the test.

"'Now,' said Mrs. Finke, 'it's a pleasure to come to work.'"[632]

Excerpt from article on the new Health Department building printed in *The Minneapolis Tribune*, July 9, 1969

Where is the Minnesota Department of Health? At present, the executive offices and several divisions are in rented spaces in St. Paul, and other divisions are in Minneapolis in the one building recognized as belonging solely to the Department of Health. Only one time during its history, from 1969 to 1987, were employees housed in one location.[633] The department seems destined to a history of searching for a safer and bigger building to accommodate employees and coordinate effectively and efficiently protect the health and well being of the citizens of Minnesota.

Locations of First Health Departments

When the Board of Health was first formed in 1872, it operated from the upper floors of the Keystone Building in Red Wing, Minnesota.[634] This was the office of the first

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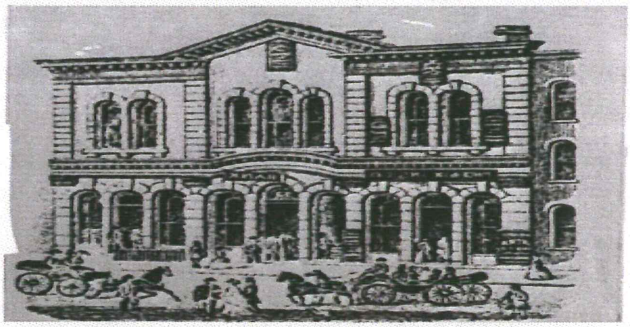
[632] *The Minneapolis Tribune,* "Health Department Pulls Itself Together," July 9, 1969, p. 15.
[633] Does not include health department employees working in the field offices.
[634] Minnesota Department of Health, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p. 3.

secretary and executive officer, Dr. Charles Hewitt. He used another building, since converted to a home, as his laboratory and vaccine station. When the supply of smallpox vaccine in Minnesota was inadequate and the purity questionable, in this laboratory Dr. Hewitt produced the pure smallpox vaccine, which he distributed to physicians throughout the state.[635]

In 1893, by the action of the University Board of Regents and at Dr. Hewitt's request, the Health Department laboratory was moved to the Mechanics Arts Building on the University of Minnesota campus.[636] One year later, in 1894, the board's offices were moved from Red Wing to the Pioneer Building in St. Paul. Called the "old State Capitol," it is now demolished.



First State Board of Health Location
Keystone Building in Red Wing

In 1902 the Legislature appropriated funds for a health animal house on the University campus, with space for personnel nearby.[637] Space was needed to house animals inoculated with specimens from sick people to determine the course of their disease. This was a very dangerous procedure for the laboratory personnel in such an unsuitable facility, and some department workers became permanently infected.[638]

Dr. Hewitt's Laboratory in Red Wing

1970s photo
Negative No. 02942-19 **Location No.**
MG6.9 RW3.2 p61
Minnesota Historical Society· 345 Kellogg Blvd. West, St. Paul, MN· 651.296.6126 Copyright © 1999

In 1907 the Pathology Building, now known as the Psychology Building, was constructed on the University of Minnesota's Minneapolis campus in the Pathology Building, now known as the Psychology Building.[639] Part of this building space was designated for the Health Department laboratories, and the keystone in the building reads, "Institute of Public Health and Pathology." By 1922, department employees had worked in four different locations on the University campus in Minneapolis: the Psychology Building, Wesbrook Hall, Eddy Hall and the basement of Millard Hall.[640] [641]

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[635] MDH, *Minnesota's Health,* Vol. 12, No. 10, December 1958, p. 3.
[636] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p.1.
[637] MDH, Notes on building history written by Executive Office in October 1979.
[638] Report from Henry Bauer, Ph.D., former director of MDH public health laboratories, June 2000.
[639] MDH, *Minnesota's Health,* Vol. 23, No. 5, May 1969, p. 6.
[640] MDH, Notes on building history distributed at open house for new building at 717 Delaware Street in 1969.
[641] MDH, *Minnesota's Health,* Vol. 23, No. 5, May 1969, p. 6.

Psychology Building on University of Minnesota Campus, 1923

Beginning in 1894 and through 1969, department employees were housed in Minneapolis and St. Paul. The building used most frequently in St. Paul was the State Office Building, where department employees worked from 1932 until 1969 when staff from vital statistics; mortuary science; hotels, resorts and restaurants; and plumbing moved to the new building in Minneapolis.[642]

In 1938 a new five-story building, supplemented with a WPA grant, was constructed on the University of Minnesota's Minneapolis campus at a cost of $324,900.[643] Unfortunately, this building was not designed to protect the safety of the laboratory workers who had to handle infectious materials daily. In addition to safety issues in the laboratory, insufficient space was a problem from the beginning. The new building was not large enough to accommodate all department employees, and 66 employees continued working in St. Paul.[644]

Less than 10 years after the building was constructed, in 1947, the Board of Health unsuccessfully presented the Legislature with a $1,000,0000 proposal for a new building.[645] [646]

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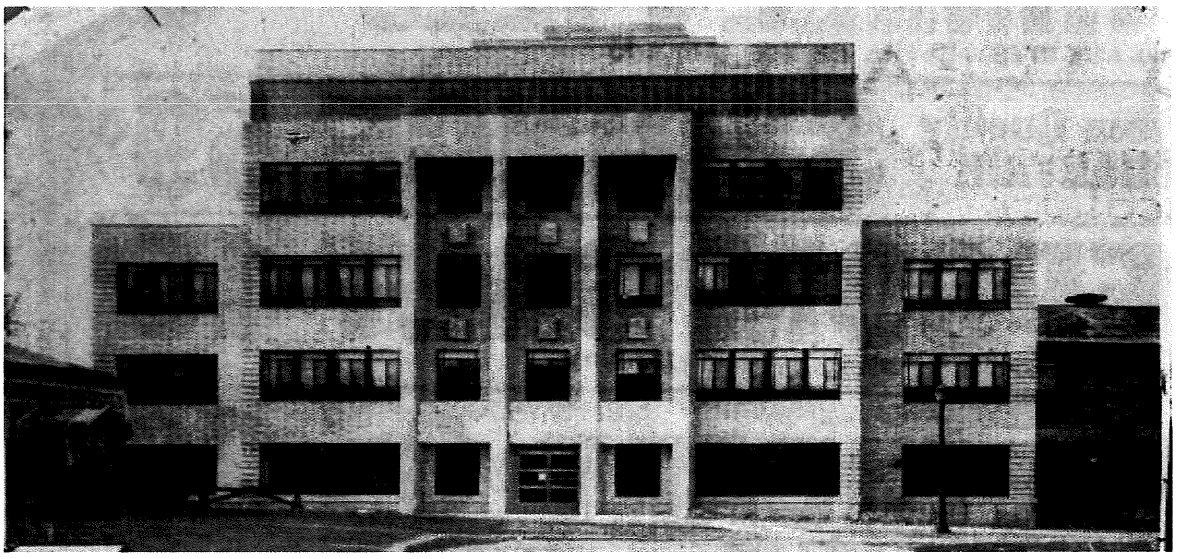
[642] MDH, *Minnesota's Health,* Vol. 23, No. 5, May 1969, p. 6.
[643] MDH, Notes on building history distributed at open house for new building at 717 Delaware Street in 1969.
[644] Ibid.
[645] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p. 1.
[646] BOH, *Minutes,* attachment: "Building Needs of State Board of Health," August 13, 1958, MHC, p. 203.



Health Department, 1938 to 1969, Building on University of Minnesota Campus

Efforts to Finance New Building Space

At the August 1950 board meeting the possibility of using Hill-Burton funds for up to 45 percent of the costs of the laboratory for a new department was discussed. There was agreement that this was a good idea and the time was right. Dr. Albert Chesley, executive officer and secretary to the board, said: "If war doesn't bust all this stuff up, now is the time to do it. Get it now while the getting is possible. As soon as the depression comes along where will you get it then?"[647]

Despite strong agreement of the need for a new building, the required legislative support was not present. Requests for funding were turned down in 1955 ($1,900,000), 1957 ($2,655,000), and 1959 ($3,333,800). [648]

A 1959 study determined it was not possible to expand and remodel the existing building on the University of Minnesota campus.[649] Dr. Gaylord Anderson, director of the University School of Public Health, suggested the possibility of a joint School of Public Health-Health Department building.[650] The board agreed this would be desirable. A location was designated, but the idea did not develop further. Reflecting on this several decades later, Dr. Henry Bauer reports it didn't occur, as the department would be occupying University of Minnesota property and would not have as strong an identity. In addition, the growing student body and staff of the University created practical concerns, such as where department employees would park and whether or not there would be sufficient office space.

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[647] BOH, *Minutes,* August 1, 1950, MHC, pp. 394-395.
[648] BOH, *Minutes,* attachment: "Building Needs of State Board of Health," August 13, 1958, MHC, p. 208.
[649] MDH, "New Dimensions for Minnesota," Minnesota State Board of Health Planning Guide for 1963-1973, June 1962, p. 2.
[650] BOH, *Minutes,* January 12, 1960, MHC, pp. 20-21.

By 1961, 268 department employees were working in a space on the University of Minnesota campus that had been designed for 168 people.[651] The average working space per employee was 86 square feet.[652] The building was crowded, with desks often facing each other. The desks were so close that in order for some employees to get to their chairs, other employees had to stand up. Without a lunchroom, employees ate at their desks. While they ate, fly ash from the public health laboratories would sometimes drift onto desks from the ceiling vents above.

The building was especially uncomfortable in the summer when the temperatures soared. Without air conditioning, employees sat with wet towels around their necks, with some even passing out from the heat. Employees who worked there remember it as a "filthy" place. Located 600 feet from a coal-burning generator station, a thin dusting of coal seeped in. In addition to constant dusting, the old wooden desks had to be periodically sprayed for cockroaches. A dress code was in place. Women had to wear skirts, and men had to wear ties, but because of the conditions those clothes became dirty very quickly.[653] One employee who worked in the State Office Building in St. Paul in the 1960s said that, while his working conditions were not good, he could not complain because they were so much better than that of his co-workers housed in Minneapolis[654]

A 1961 proposal to fund a new building was authorized by the Legislature, but the Supreme Court ruled that it could no longer sanction expenditures beyond the state's

[651] MDH, *Minnesota's Health,* Vol. 15, No. 1, January 1961, p. 1.
[652] MDH (executive office), five-page history of building, October 1979.
[653] Interview with Donna Nolting and Ethelyn Yliniemi, Minneapolis, March 5, 1999.
[654] Phone conversation with Fred King, Minneapolis, March 1999.

constitutional debt limit established in 1858. Voters removed this obstacle at the November 6, 1962, election[655] by supporting Amendment No. 2 which permitted debt beyond the limit, if a building program passed by 60 percent or better vote in both houses. [656] Still, the department didn't get the green light for building, and the lack of space became an increasingly greater problem.

Problems due to inadequate space for the department were highlighted in 1950 by the Governor's Commission on Efficiency in Government. This commission cited the location of department staff in both St. Paul and Minneapolis as a "serious management problem." The report identified inefficiencies and impairment of services as a result of the diffusion of operations. It noted increased costs for the department due to the time involved in intra-departmental communications and the need for increased telephone facilities.[657] All of these issues continued to exist, through the 1950s and into the 1960s. The Jacob's report of 1950, the self-survey task force report of 1955-58, the legislative research committee report of 1956, and the self-survey task force report of 1959 all said the same thing: the Department of Health needs a new building.[658]

The lack of space was translating into reduced programs and services to the people of the state. Because of space shortages, the department was unable to take advantage of federal grants and additional personnel available at no cost through the U.S. Public Health Service.[659] Nationwide, more and more research was being done in the field of public health, but the department couldn't join in with the movement because of space limitations. The University of Minnesota had no additional space to offer. They needed all the room they could find to accommodate a growing enrollment of baby boomers who had reached college age.

Proximity to University of Minnesota

Unlike other large state agencies, the Health Department has been unique in its location in Minneapolis, rather than part of the capitol complex in St. Paul. The Minneapolis campus location was chosen to support the close working relationship and ties between the University of Minnesota and the Board of Health. These ties dated back to the beginnings of the board. When the University Board of Regents created a "Department of Instruction of Public Health" in 1873, they asked Dr. Charles Hewitt, the first secretary of the Board of Health, to be in charge.[660] Dr. Hewitt rapidly developed public health courses, delivering lectures in personal hygiene and sanitary science. He also took an active role in organizing the University's college of medicine, and he unsuccessfully advocated that the medical school be built around the department of public health, which he viewed as the foundation of medicine.

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[655] MDH, *Minnesota's Health,* Vol. 16, No. 4, April 1962, p.1.
[656] MDH, program distributed at open house for new building at 717 Delaware.
[657] J. L. Jacobs & Company, "Summary and Report for the Efficiency in Government Commission, State of Minnesota," October 1950, pp. 25-26.
[658] MDH, *Minnesota's Health,* Vol. 15, No. 1, January 1961, p. 1.
[659] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p. 14.
[660] Philip Jordan, *The People's Health*, 1953, p. 61.

The relationship continued through the years, and in the 1950s the board worked closely with health professionals from the University for help with difficult public health problems, such as polio. The University of Minnesota and the Department of Health worked together on research projects, and exchanged public health expertise. This relationship was most profitable and beneficial for the public health of Minnesota.

Dr. Albert Chesley, executive director and secretary to the board, was one of the strongest promoters of locating the department close to the University of Minnesota:

> ***"I don't think there is any question in anybody's mind now about the necessity of having the University and the State Board of Health on the same premises. It took a long time to bring these things about."***[661]
>
> ***"I feel very strongly on that point. I think it would be a great mistake, tragic as a matter of fact, if the State Board of Health laboratories and everything were put over in St. Paul."***[662]
>
> **Dr. Albert Chesley**
> **Executive Director and Secretary to State Board of Health, 1950**

A close physical relationship made it easier for the Board of Health and the University to exchange scientific and technical information, as well as the joint use of staff. Recruitment and retention were easier because of the teaching and research possibilities. The main disadvantage was the confusion legislators and others sometimes had in that the board and the University were not one and the same.[663] Located on the University of Minnesota campus, apart from legislative activities in St. Paul, may have also put the board at a disadvantage. It wasn't visible to the legislators and other decision makers. Nestled in the campus, to many it appeared to be a part of the University of Minnesota, rather than a state agency. Even the department's address included one line, "University Campus," making such thinking easy to understand.

The Board of Health and the University had what Dr. Albert Chesley, executive director and secretary to the board, referred to as a "gentlemen's agreement" regarding the board's occupation of the Psychology Building.[664] The money for the building had been appropriated to the University, not to the Board of Health. The building was owned by the University, and it paid for heat, electricity, and some maintenance costs such as painting.[665] This arrangement wasn't entirely satisfactory to the board, as seen in the following conversation that took place as Deputy Executive Secretary Dr. Robert Barr prepared for a meeting with representatives from the University in 1954:

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[661] BOH, *Minutes,* August 1, 1950, MHC, pp. 394-395.
[662] BOH, *Minutes,* January 10, 1955, MHC, p. 28.
[663] BOH, *Minutes,* attachment: "Building Needs of State Board of Health," August 13, 1958, MHC, p. 209.
[664] BOH, *Minutes,* June 1, 1954, MHC, p. 120.
[665] Ibid., pp. 87-88.

> Barr: "I would like to see it set up so that the Board of Health would pay any bills for cost of operation of this building, and get away from this service on the part of the University. When we wanted things we were reticent about asking for them. When we asked to have this building painted. . ."
>
> Boynton (Board member Dr. Ruth Boynton): "If we should get a building separate from any University department, I think such a thing could be done."[666]

Dr. Barr supported a separation in that he felt the department needed to be viewed as autonomous, not a part of the University.[667]

While the University of Minnesota generally supported having the department located nearby, it wasn't unanimous. In 1954 the board met with representatives of the University to discuss the possibility of two potential sites on the University campus for a Board of Health Building. Later, board member Thomas Netz, who was chair of the committee selected to work with the University on this issue, met with the vice president of the University. Professor Netz reported on his unsatisfactory meeting at the October 1954 board meeting:

> He said, 'What building?' And I said 'Why, we have a State Board of Health building in the tentative stages of planning. We had some communications between the University officials and Dr. Chesley, representing the Board, and we went over the whole thing---sites A and B. The site we selected was the one opposite Powell Hall.' He said, 'I don't know anything about that. That site is going to be used for the Medical School, and anything else will be over my dead body.' [668]

Prof. Netz described what he felt were the University vice president's preference: "He wants it outside the periphery of the campus 50 years hence."[669]

Increasing Space Needs and Increasing Efforts

Given the cramped quarters and inability to expand, in May 1958 Dr. Barr was willing to suggest that the board forego the idea of a physical location close to the University of Minnesota. He said the need for space was so critical that a building should be found outside of the campus, if necessary, even though he knew the board wanted to remain close to the University of Minnesota. The department had received $150,000 in research money, but if it had adequate space, Dr. Barr felt it could have tripled or quadrupled that amount.[670] Minnesotans were losing out.

At an August 1958 legislative hearing, statements emphasized the overcrowding, the inefficiency created by being housed in both St. Paul and Minneapolis an anticipated increase in staff as public health shifted to research, and the overall handicap the

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[666] BOH, *Minutes,* October 8, 1954, MHC, p. 113.
[667] Ibid.
[668] Ibid., p. 84.
[669] Ibid., p. 88.
[670] BOH, *Minutes,* May 22, 1958, MHC, p.154.

present situation created for a strong public health system in Minnesota.[671] The arguments were not sufficient to get a new building.

The board sought the support of its friends – the Minnesota Medical Association, the University School of Public Health and the State Dental Association – to urge appropriations for a new building.[672] They realized this had to be a joint effort. At a 1959 board meeting, Dr. Harold Wente said:

> I see, then, a dinner meeting called by the Head of the State Board of Health with all these people present, with the material documented and laid in front of them. I really think it will be another five years if we approach them by word of mouth. It should enjoy some concerted effort on our part. I would like to do something. [673]

The need for additional space became even more urgent in 1961 when the board learned that it might soon be expected to certify health facilities and investigate complaints in these facilities, as part of the federal Medicare program being proposed by Congress.[674] New responsibilities in the areas of family planning, emergency services, genetics and environmental control all required more space. Still, the building remained unfunded.

There were a number of reasons given as to why the board was having such a difficult time getting funding for a building that seemed clearly needed. Dr. Barr felt the legislators had a lack of understanding as to the purpose and objectives of the department. He emphasized that everyone who was in contact with legislators needed to be a health educator.[675] Others recognized that the department was competing with construction needed for state schools and colleges to accommodate the large population of baby boomers. The confusion between the department and the University of Minnesota was also cited.

In 1960 Dr. Barr made an additional plea for a new Health Department building. Unless adequate space was found, loss of funding for research would continue and service would decline.[676] Realizing the importance of space, in 1960 Dr. Barr gave his new deputy executive director, Dr. Henry Bauer, a specific charge: "Get us a new building!"

Dr. Bauer was happy to take on this assignment. As head of the public health laboratory, he was well aware of the limitations and dangers of the existing building and had a strong motivation for getting larger and up-to-date facilities. The present laboratory was not safe. Two microbiologists working in the tuberculosis laboratory contracted the disease. Because of the design of the existing hood, three laboratory workers became infected with encephalitis. A microbiologist examining stool specimens contracted typhoid fever. Dr. Bauer and a co-worker who was working on a research project for the eradication of Brucella infection spent a month out of work, having

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[671] BOH, *Minutes,* attachment: "Building Needs of State Board of Health," August 13, 1958, MHC, p. 203.
[672] BOH, *Minutes,* August 13, 1958, MHC, p. 203.
[673] BOH, *Minutes,* February 24, 1959, MHC, p. 39.
[674] BOH, *Minutes,* January 31, 1961, p. 23.
[675] BOH, *Minutes,* October 18, 1960, MHC, p. 365.
[676] BOH, *Minutes,* May 24, 1960, MHC, pp. 75-76.

contracted brucellosis in the lab. [677] The building was hazardous for employees, it was costing the state money in lost grants, and it was inefficient. For more than 20 years it had been recognized as contributing to serious management problems.

At his first appearance at the Legislature, Dr. Bauer sensed what he needed to do. He prepared clear explanations, particularly with respect to the cost. Dr. Bauer developed his own guidelines for dealing with the Legislature: believe in what you're doing, use cost numbers and put the burden of proof on the opponent.[678] Armed with facts and figures, charts and graphs, Dr. Bauer pointed out the dangers, safety issues, and lost services for the state. He clarified what was needed to make the department an effective, safe and pleasant place. Over and over again, he stressed the economic costs: "...health problems involve economic issues as well as preventing and curing illness. Sick people are not producing for the economy. Thus, those who care for the sick keep man-power hours out of economic production."[679]

Aerial View Showing Sites of old and new Health Department Buildings
University of Minnesota Campus

Dr. Bauer felt things were progressing well, so he was surprised by an article in the December 1962 *Star Journal*. It included a list of the buildings that the state building commission was considering, and the Health Department was not there. Dr. Bauer had kept an open line of communication with the commission and its secretary, Mr. Burdick. He immediately contacted Mr. Burdick who told him the purchase of land for the department building was included in the total request of $29 million for the state building program. Dr. Bauer reminded Mr. Burdick that the land for the new department building must be off campus but in close vicinity of the University of Minnesota Hospital and Medical School.

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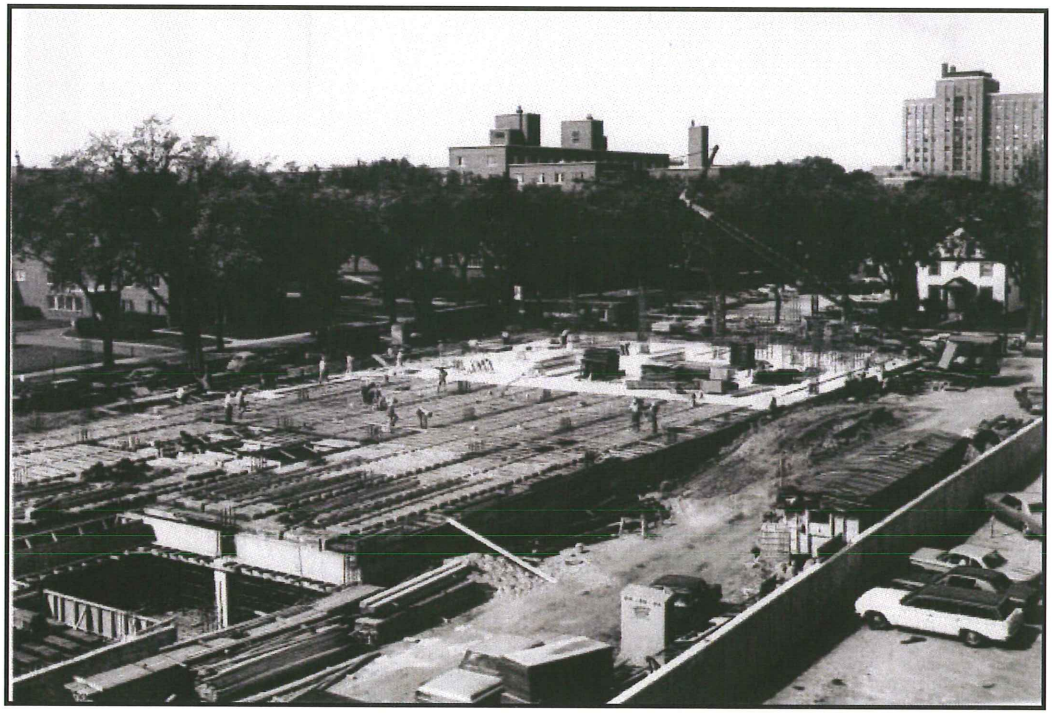
[677] Conversation with Dr. Henry Bauer, February 1999.
[678] Ibid.
[679] *Minnesota Daily*, "Health Board Announces Plans for Campus Office," August 1965, pp. 1 and 3.

In the same way he approached disease, Dr. Bauer was always alert and mindful of what was going on in order to ensure the department building would be considered.[680] Knowing the importance of keeping everyone informed, he used the skills of Marie Ford, director of public health education, to prepare and distribute regular reports on the progress being made towards a new Health Department building. Working with Dr. Bauer and Dr. Barr, Marie Ford sent regular reports to the board members, the department's accounting office, the state comptroller's office and the state purchasing department.[681]



Work on New Health Department Building Begins in 1967

New Building at 717 Delaware Street

Dr. Bauer's efforts eventually paid off. In 1965, five years after Dr. Bauer was given the assignment of getting funding for a new building, the Legislature approved construction and equipment of a new building, and Gov. Elmer Anderson signed the bill authorizing funding. Of the total funding designated for the building, $3,826,000 came from state funds and $1,054,000 from Hill-Burton funds. The plan, designed by Ellerbe Architects in 1960, provided for 165,000 square feet, which compared very favorably to the 65,000 square feet the department was currently using.[682] The plan was designed so two additional floors could be added, if they were needed in the future.

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[680] BOH, *Minutes,* January 22, 1963, MHC, p. 15.
[681] Communication with Dr. Henry Bauer, June 29, 2000.
[682] BOH, *Minutes,* September 13, 1960, MHC, p. 325.

The department was fortunate in having John Magney of Ellerbe Architects as the lead architect in designing and constructing the new building. Each division director submitted space requirements for his/her division to Mr. Magney. He reviewed these and worked closely with persons from the department to make sure the needs of divisions were met. Of special concern were the public health laboratories, where highly infectious organisms were routinely examined and the chance for becoming infected was high. The new design separated the handling of the air from the fifth floor laboratory from the rest of the building. New safety methods were implemented, including the incineration of used laboratory air before it was released to the outside.[683]

In 1967 Bor-Son Construction, Inc. began work on the new building at 717 Delaware Street S.E. near the University of Minnesota Hospital. The site covered an area of one-half block between Walnut and Oak, close to Washington Avenue. Completed in 1969, the Health Department building was built under budget. In fact, $7,000 was returned to the state.

By the time construction on the new building began, the department was spread in three different locations, in addition to the seven field offices. Administrative services, vital statistics, mortuary science, plumbing and the hotels, resorts and restaurants section were housed in the State Office Building in St. Paul. The local health administration division, health mobilization coordinator, local health services, special services, maternal and child health, nutrition, human genetics, family education, and dental health were located in the Student Health Service Building on the University of Minnesota campus in St. Paul.[684] Remaining divisions and sections were located in Minneapolis on the University of Minnesota campus.

Unified Health Department – 1969

With the completion of the new building in 1969, for the first time in its 97-year history, all department employees, with the exception of those in the seven field offices, were in one place. A total of 340 Health Department and 70 Minnesota Pollution Control Agency employees moved into the six-story building.

In 1969 the floors were used for the following purposes:

Basement
Garage for 95 cars and radioactive counting room

First Floor
Boardroom (later named Chesley Room), shipping and receiving, and storage areas for supplies

Second Floor
Administrative Services, Environmental Health Division, Hospital Services Division, Executive Offices, Central data processing, conference rooms, and vault for vital statistic records.

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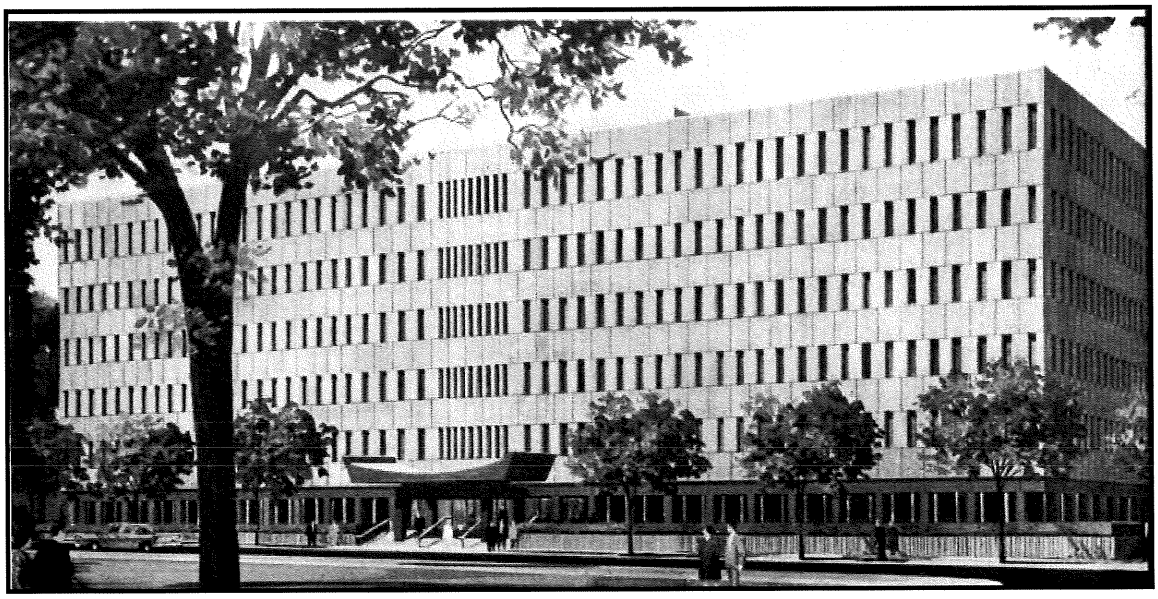
[683] Report from Dr. Henry Bauer, June 29, 2000.
[684] MDH, *Minnesota's Health,* Vol. 20, No. 6, June-July 1966, p. 4.

Third Floor
Special Services Division, Medicare Services, Minnesota Pollution Control Agency, lunchroom and library.

Fourth Floor
Environmental Health Analytical Laboratory Services Section, Local Health Administration Division, Disease Prevention and Control Division, Nursing services and medical laboratory records.

Fifth Floor
Virology, serology, microbiology, cytogenetics and rickettsia disease medical laboratories.

Sixth Floor
Quarters for experimental animals.



State Department of Health Building, 1969

Built with Minnesota granite, the new building was an attractive environment with several interesting features. One unique addition was an electronic "trouble shooter" which provided 24-hour surveillance of heating, refrigeration, and sensitive electrical laboratory equipment. Linked electronically with sensing devices, equipment was monitored around the clock and potential breakdowns detected before they occurred.[685] The laboratory housed an independent ventilating system to ensure the safety of workers. On the sixth floor air locks were installed to prevent airflow in and out of the animals' quarters. Structures under the roof housed mechanical and air sampling equipment.

[685] MDH, *Minnesota's Health,* Vol. 23, No. 5, May 1969, pp. 1-2.

Another interesting feature was an elevator-file in the disease prevention and control division. These files provided fingertip access to all venereal disease records dating to 1918 when the venereal disease program first began. When the appropriate button was pressed, a revolving drum would stop at the desired alphabet letter.[686]

More than 800 people attended a dedication ceremony and open house at the new building on July 13, 1969. The lobby, boardroom and selected spots were filled with flowers from well-wishers. Gov. Harold Levander was present to accept an oversized symbolic gold key for the building. Employees served as hosts and hostesses and tour guides. A special attraction for the day was a ready-to-take-off helicopter on the roof, provided by the emergency medical services unit. Telegrams and letters were received. One was from Robert B. Howard, M.D., dean of the College of Medical Science at the University of Minnesota:

"You and your colleagues have lived and worked under unimaginable difficult circumstances for these many years, and I am sure this beautiful building is most welcome. I look forward to a continuation of the excellent relationships that have always existed between the State Board of Health and the College of Medical Sciences, especially the School of Public Health. I hope these relationships will grown even stronger now that we are physically closer to one another."[687]

Dr. Robert Howard, Dean of College of Medical Science at the University of Minnesota, 1969

Shortage of Space/Multiple Locations – Again

Metropolitan-area department employees remained together at 717 Delaware Street for almost 20 years. As programs grew and the number of employees increased, however, capacity was reached and divisions had to find alternative office space. The Minnesota Pollution Control Agency left the building in November 1973. In 1987, the health resources division, which was responsible for certifying and licensing health care facilities, moved to rented space in the Central Medical Building in the Midway area of St. Paul. In 1989, the environmental health division moved to the Dinnaken Building, one block from 717 Delaware Street.

The department had grown to 881 employees in the metropolitan area in 1990. This was more than 2-1/2 times the number of employees who moved into the new building in 1969. Even with the loss of two large divisions, the capacity of 717 Delaware was exceeded. A series of moves began, and only the divisions of disease prevention and control and the public health laboratory were not affected by relocation. Perhaps the most significant move occurred in 1997 when the executive office relocated in the Metro Square Building in downtown St. Paul.

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[686] MDH, *Minnesota's Health,* Vol. 23, No. 5, May 1969, p. 5.
[687] MDH, *Minnesota's Health,* Vol. 23, No. 6, June-July 1969, p. 3.

By 1999, the department's metropolitan employees – totaling more than 1,200 – were housed in several locations:

717 Delaware Street Southeast Minneapolis, MN	Disease Prevention and Control Public Health Laboratory Center for Health Statistics Library Services
Snelling Office Park 1645 Energy Park Drive Saint Paul, MN	Conference/ Meeting Rooms Copy Center Mail and Distribution
Golden Rule Building 85 East 7th Place Saint Paul, MN	Commissioner's Office Facility and Provider Compliance Family Health Environmental Health
Metro Square Building 121 East 7th Place Saint Paul, MN	Environmental Health Health Policy and Systems Compliance Community Health Services Finance and Administrative Services Policy and Communications

In the early 1990s the architectural firm of Lindberg Pierce conducted a study of the department's space needs. They recommended construction of a new Health Department building with 342,000 usable square feet.[688] The Department of Administration supported this recommendation in its strategic plan for state agencies in 1992. [689]

Beginning in the 1980s, proposals for a new building have been submitted to the Legislature several times. At present there are no confirmed plans for a new space.

The department seems destined to a history of searching for a bigger building and employees working in temporary locations in different sites.

[688] MDH, "Facilities Planning Criteria and Building Site Selection," 1991.
[689] Zimmer Gunsul Frasca Partnership, "The Strategic Plan for Locating State Agencies," 1993.

Minneapolis/Saint Paul Metropolitan Area Locations of the Minnesota Department of Health -- 1999

Chapter 8

Environment

"Much of the progress in public health protection has resulted from improvements in basic hygiene, food production and handling, and water treatment."[690]

Minnesota Department of Health
Minnesota Public Health Goals
1995

Protecting the public from exposure to environmental health hazards is a fundamental role of public health, and sanitation was one of the biggest concerns of the newly formed Minnesota Health Department in 1872. It was of such importance that "learned in sanitary science" was the one requirement for members of the original Board of Health, as written in Minnesota Statute 144.01. One of the first divisions of the department, environmental sanitation, was formed in 1906.[691] At this time outbreaks of water-borne illnesses, such as typhoid fever, were common. The department promoted education and regulation, which resulted in a marked reduction of all water-borne illnesses.

By 1949, the domain of the environmental health division had expanded to include protection from food-borne disease, radiological agents and chemical substances. The division was called the environmental sanitation section at this time, and the units included municipal water supply, water pollution control, general sanitation, industrial health, and hotel and resort inspection.

While the focus remained on water and sanitation, in 1949 the board was being called on with increasing frequency to advise the public on the safety of new materials and products. For example, in 1949 the public wondered whether aluminum was safe. Herbert Bosch, M.P.H., head of the environmental sanitation section, assured the public that aluminum was safe and there was no evidence it caused cancer, as was rumored. He felt the dangers of aluminum, like the dangers of tin cans, were part of the "folklore of public health" sometimes used by business people to encourage customers to purchase their products. [692]

Another new product in 1949 was parathion, an insecticide supposedly six to seven times as effective as DDT. As in other cases, it wasn't always clear which state agency or which part of the Department of Health should be addressing a new product or new

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[690] MDH, "Minnesota Public Health Goals," March 1995, p. 123.
[691] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p. 91.
[692] MDH, *Minnesota's Health,* Vol. III, No. 12, December 1949, pp. 3-4.

area. This is pointed out when parathion was discussed at the board meeting on July 14, 1949:

> Dr. Theodore Sweetser: "What about food poisoning? What becomes of insecticides when they are used? Isn't there some danger of food contamination?" How about DDT?"
>
> Herbert Bosch: "If there is some question on these insecticides, there is on DDT too."
>
> Sweetser: "Is that our responsibility?"
>
> Bosch: "The primary responsibility lies with the Food and Drug Act and with the Department of Agriculture. . . . There is going to be a borderline case someday, and I don't know whether the State law would exclude the State Board of Heath from that."
>
> Dr. Thomas Magath, Board President: "I don't think it would, but I don't think we can get in to that until it happens." [693]

In the 1960s, environmental issues began receiving greater attention nationwide. The environmental movement, combined with urbanization, suburban growth, industrial expansion, atomic energy, new technologies and a growing population, led to increased activities of the department's environmental health division.[694] One of the new activities was regulation of coin-operated drycleaners. New to the public in the 1960s, 25 existed in the state in 1961, and the department was authorized to develop regulations.[695] While new areas such as this were emerging, the main focus in the early 1960s remained on water and sanitation.

In 1963 the Board of Health assessed environmental health in Minnesota and recommended areas needing expansion. The areas selected were sewage disposal, industrial waste, and water pollution, particularly in the metropolitan areas; ground water contamination and the provision of municipal water supplies; plus effective food and lodging control programs for protecting those who use the services.[696]

Legislation passed in 1969 emphasized the department's growing role in radiation and occupational health. The department was assigned responsibility for monitoring sources of ionizing radiation and the handling of storage, transportation, use and disposal of radioactive isotopes and fissionable materials.[697] Additional legislation granted the department authority for investigating and controlling occupational diseases through the provision of a technical advisory medical, engineering and laboratory service.[698] By the 1980s, the environmental health division consisted of six sections: hotels; resorts and restaurants; occupational health; public water supply; radiation control; health risk assessment; and analytical services.

In 1995, all divisions at the department identified goals to protect, maintain and improve the health of Minnesotans. Those selected by the environmental health division were in

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[693] BOH, *Minutes,* July 14, 1949.
[694] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p.16.
[695] BOH, *Minutes,* July 11, 1961, MHS, p. 313.
[696] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-1973," June 1962, p. 16.
[697] Minnesota State Statutes, Section 144.12.
[698] Minnesota State Statutes, Section 144.34.

these areas: public and private water wells, municipal water supplies, lead, radon, sanitation at food and beverage establishments, exposure to radiation through x-rays, and work-related injury and illness such as that caused by asbestos exposure.[699] While new areas were becoming part of the domain of environmental health, the emphasis remained, in the late 1990s as in earlier years, on ensuring safe water supplies and appropriate sewage disposal.

Water Supply and Sewage Disposal

The first municipal water supply in Minnesota had been constructed in 1868. The board introduced water supply standards in 1937. In 1947, in keeping with the board's emphasis on education and cooperation, a safety rating scale, devised by O. E. Brownell, C.E, chief of the municipal water supply program, was introduced. Interestingly, Mr. Brownell's hometown of Ely was the first municipality in the state to install a complete water treatment system – in 1903. [700]

A score of 100 on the rating system indicated maximum safety, 90 or above a high degree of safety, 85 to 90 reasonable, and less than 85 was poor to hazardous. A total of 338 factors were considered in determining the rating. The water rating system proved very useful and was adapted by three other states. Unfortunately, many water supply operators who ultimately had responsibility for the safety of the system were not adequately trained in the 1940s. To address this problem, the department began offering courses for water supply operators.

The emphasis on education and prevention in maintaining safe water supplies has been evident in the department's approach to flooding in the state. One of the worst floods, from a public health standpoint, occurred in 1950 when the Red River overflowed. The height of the flood hit Crookston at 11:00 p.m. on April 22. As with all flood crises, a public health engineer and a health educator from the department traveled to the area to distribute instructions for disinfecting private well supplies and to confer with local officials about municipal water supplies. The flood covered thousands of acres, and many water supplies were unfit for human use. Water samples were taken at pumping stations and sent to the department laboratory for analysis. Some indicated that pollution had entered their water supply system. Other areas that were flooded severely were the Mississippi at Aitken, the Rum River at Cambridge, the Redeye River at Sebeka, the Root River at Preston and Peterson and the St. Louis River at Floodwood.[701]

The floods of 1951 did not seriously endanger community water supplies, except in North Mankato, Redwood Falls and Marshall. In North Mankato, which was completely abandoned by the population, the water supply was put out of commission. In Redwood Falls, the water treatment plant was flooded. At Marshall, the reservoir was surrounded

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[699] MDH, "Minnesota Public Health Goals," March 1995, pp. 121-134, pp. 153-162.
[700] MDH, *Minnesota's Health,* Vol. 10, No. 2, February 1956, pp. 2-3.
[701] MDH, *Minnesota's Health*, Vol. IV, No. 9, September 1950, pp. 1-3.

by floodwaters. O. E. Brownell used the opportunity to advocate preventive public health:

> The Health Department's real aid to communities likely to be flooded is basically preventive. When Water supply sources are flooded, there is nothing that can be done to insure the safety of the water until the flood recedes and the clean-up job is undertaken. If, however, the wells and water treatment plants are situated on high ground completely above the flood level, the maximum protection of the supply has been assured, and on of the major efforts of the department over many years has been to develop water supplies on high ground out of reach of floodwaters. During the flood, district public health engineers were constantly examining the water, advising when a water source should not be used and advising residents on boiling water and chlorinating wells. [703]

"But perhaps the greatest single source of satisfaction must be the vindication of some of our efforts in improving the safety of public water supplies as was brought out by the unprecedented floods of 1965. Although most of the streams of the State were in flood stage to a greater extent than ever before and dozens of communities were under water no one public supply was totally out of service and apparently no one became sick from drinking from these supplies. If this flooding had occurred in 1920 we would have had thousands of cases of typhoid fever and other water-borne diseases." [702]

Frank Woodward at his retirement in 1968

Much improvement in municipal drinking water supplies throughout the state had been made during the 1940s. In 1947, the department's district offices, which inspected water supplies in communities, had found that only one-third of water supplies inspected were acceptable.[704] Two years later, in 1949, they found 70 percent acceptable.[705]

One of the challenges in improving the water supplies was persuading some communities that there was a danger. One community resistant to improvements was Waverly. Waverly's water supply system had been installed in 1907 and took water from the lake. Every sample collected in the last 15 years had been positive, indicating it was unsafe for the town's 450 citizens. Others were also at risk, as the town was on the main highway, with travelers stopping and eating at restaurants that used the town's water. No obvious health problems had been reported, however.[706] The situation was discussed at the July 10, 1952, board meeting:

> Frank Woodward: "I have indicated 'Waverly,' and immediately following is a letter to Dr. Chesley for the purposes of the Board relating to the situation which you will recall I brought up some months ago. Waverly being one of the places in the State which absolutely refuses to provide a safe water supply for its people, and we had originally planned to call the village officials in to meet with the Board or a committee of the Board to explain why they took the attitude they did regarding the water supply. After a one-way correspondence with them during the winter, we decided it was useless to attempt to get them to come in because they would ignore any invitation to come in. So we visited them and got some bit of assurance that they would take some action. The purpose at that time in doing it was to establish a policy with regard

[702] MDH, *Minnesota's Health*, Vol. 22, No. 7, August-September 1968, p. 3.
[703] MDH, *Minnesota's Health,* Vol. V, No. 5, May 1951, p. 2.
[704] MDH, *Minnesota's Health,* Vol. VII, No. 7, July-August 1953, p. 7.
[705] Ibid.
[706] BOH, *Minutes,* July 10, 1952.

to licensing the eating and drinking establishments in the village. We held up the licenses for 1952 until we got some kind of assurance and then the licenses were issued provisionally with each license being told that his license was provisional and it depended on what the village was going to do about its water supply. We gave them six months in which to do something. They finally, for the first time in years, replied to a letter saying that they weren't going to do anything in the village, and that is the basis on which we began to take the action necessary to require the provision of safe water supplies for the various establishments." [707]

Dr. Theodore Sweetser: ". . .if they want an epidemic in their own family, that is all right, but they have no right to have a licensed place give them an epidemic. I think that is where our police power should come in and I think we should make it stick. In these days people travel a good deal. I might stop there and eat lunch on my way someplace west of here."[708]

The board discussed options for dealing with this problem.

Dr. Ruth Boynton: "I think education of the people would be the better approach."

Frank Woodward: "This thing should have been handled a long, long time ago because it has not changed. We have been issuing licenses. The meeting I had out thee with the mayor and some councilmen got rather unpleasant. He said, 'If you think you are going to force us into this thing by holding up these licenses you have another think coming.' I told him we were using that as a lever. We don't propose to have the public exposed to the type of water supply they had. I think within the next few months we will explore the possibility of education out there. They tell us that every letter that comes from here is published in the paper, so that rules out the possibility of putting in some scare headline in the paper. They know all about it."[709]

The possibility of involving various community groups was discussed.

Dr. Sweetser: "I would like to make a motion that we support our Director in everything he has done and encourage him to apply all the pressure that may be necessary to bring this to a head and carry it through to conclusion without further delay. Since 1907 this has been going on?"

Dr. Frederick Behmler: "It's about time we called a halt."[710]

The housing boom of the 1950s and the rapidly growing suburban areas were contributing to waste disposal and water supply problems in the state. Private wells and septic tanks were being used when there was no community sewerage system. Private wells were often contaminated, and a private sewage system was more likely to pollute.

Minnesota's Health, the department's newsletter, reported on the conditions of the water supply system in some parts of the state as late as 1959:

. . a homeowner invited about 30 guests to his home. Every one of the guests came down with an intestinal disorder. Investigation revealed that a contractor had developed the household water supply by drilling a well about 80 feet deep in limestone. He also installed the cesspool in the limestone 'because seepage would flow away so fast.'

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[707] BOH, *Minutes,* July 10, 1952.
[708] Ibid.
[709] Ibid.
[710] Ibid.

> In one county outside the Twin City area every member of a family became ill and complained of diarrhea. They did not respond to medication or treatment so the family doctor suggested water sampling. The first sample showed extreme contamination, and investigation showed seepage in the back yard and on basement walls." The well was disinfected, and a new sample taken. Fluorescent dye was put in the toilet stool. Within 15 minutes, the dye was visible in the backyard, along one entire wall of the basement, and on the floor where children played. It was found in the kitchen tap water. The sanitarian estimated that of each gallon of water taken from the well, one gallon was sewage.[711]

The disposal of household sewage in the 1950s was becoming more complicated with garbage disposals, dishwashers, and synthetic detergents. New industries with new types of waste, the use of insecticides and herbicides, and the waste materials from radioactive isotopes in medical diagnosis and therapy, all created new challenges. By the 1960s the two major sources of water pollution were domestic sewage from communities and industrial wastes.

To eliminate problems caused by wastewater, many communities began constructing sewage treatment plants, and industries began installing waste treatment works to reduce or prevent pollution.[712] In 1955, 85 percent of the people in Minnesota lived in communities that had sewage treatment plants. Two hundred fifty-five sewage treatment plants served 275 municipalities and an estimated population of 1,653,860. A total of 245 industrial waste control plants existed, and 79 had been completed in the last two years.[713] The building of sewage treatment plants accelerated in July 1956 when aid for construction became available through the Water Pollution Control Act, PL 660.[714]

As of July 1, 1963, there were 410 municipalities in Minnesota without sewer systems. Two, Coon Rapids and Minnetonka, had populations over 10,000. Nine had populations over 3,000: Blaine, Deephaven, Eden Prairie, Little Canada, Mound, Moundsview, Orono, Plymouth and Shorewood.[715]

In 1963, armed with new legislation giving it the power to bring legal action, the state took a tough stand with communities that were still polluting the water. On August 5, 1963, the Water Pollution Control commissioner notified 39 communities without sewage treatment and disposal facilities and 59 communities with inadequate facilities that they must proceed immediately to rectify the situation. They were given 60 days to submit information on their plan of action.

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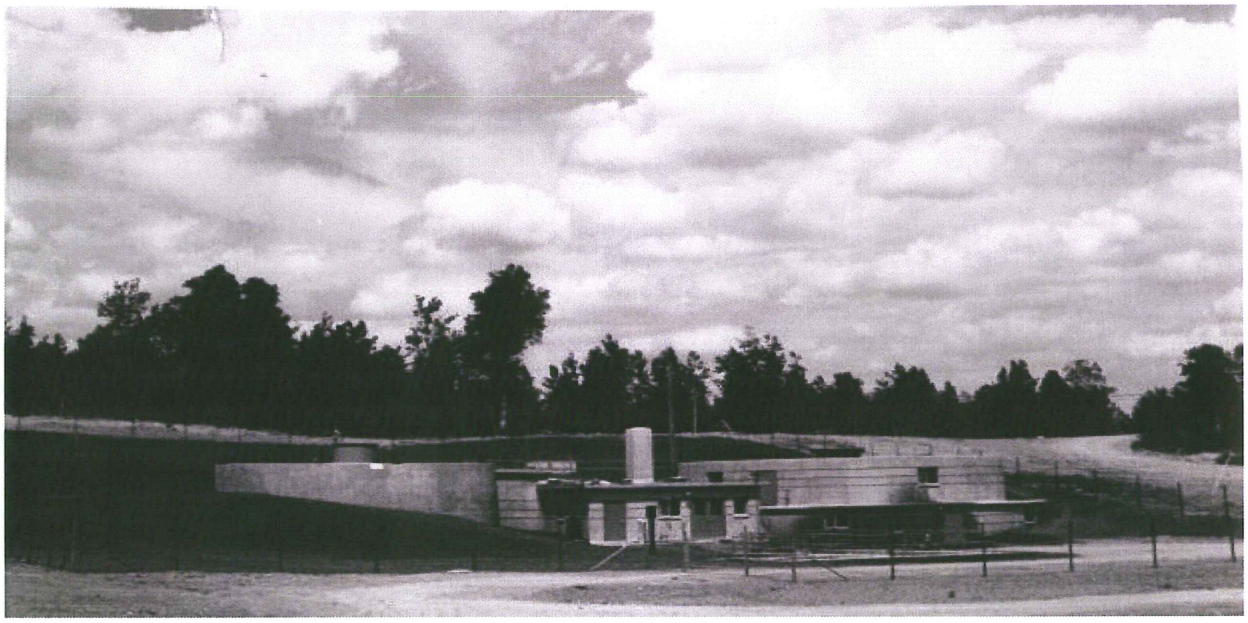
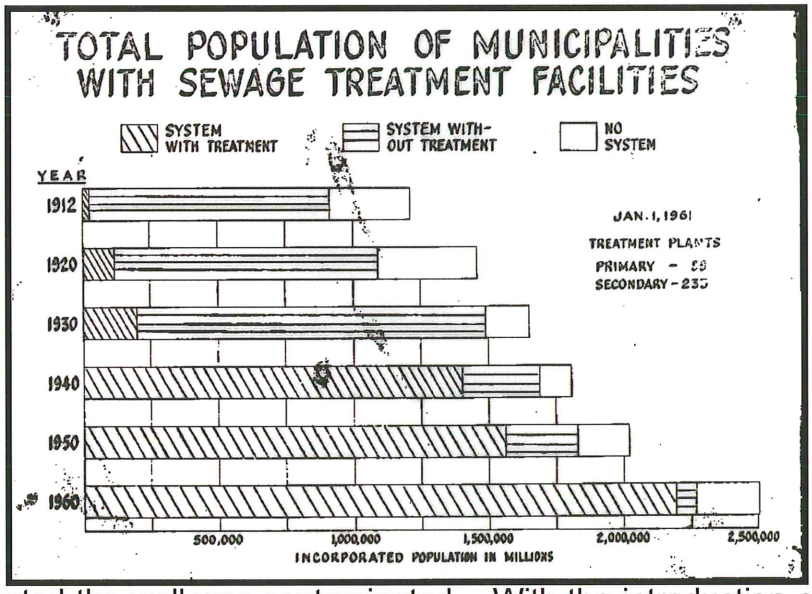
[711] MDH, *Minnesota's Health,* Vol. 13, No. 10, December 1959, p. 3.
[712] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 5.
[713] MDH, *Minnesota's Health,* Vol. 9, No. 4, April 1955, p. 3.
[714] MDH, *Minnesota's Health,* Vol. 17, No. 3, March 1963, pp. 1-4.
[715] MDH, *Minnesota's Health,* Vol. 17, No. 9, October 1963, p. 3.



Treatment Plant at Sandstone

In 1963 the board set measurable objectives for the water and sewage system in Minnesota. By 1970, all public water supplies were to be acceptable; all communities with sewer systems were to have adequate sewage treatment facilities.[716] This goal covered municipal water supplies but not private wells. The department did not survey private wells at this time, unless requested by a local health officer or physician or in an emergency situation, such as a flood. In 1968 the department began testing water samples from private wells. The presence of coliform organisms, nitrate or surface active agents indicated the well was contaminated. With the introduction of biodegradable detergent in 1965, fewer reports of surface active agents were found but they still were present.[717] To help ensure safe drinking water for the public, Minnesota adopted a mandatory plumbing code in 1970. The first plumbing code was advisory. It had been adopted in 1937 with amendments in 1939, 1947 and 1951.[718]



[716] MDH, "New Dimensions for Minnesota: State Board of Health Planning Guide for 1963-73," June 1962, pp.16-17.
[717] MDH, *Minnesota's Health,* Vol. 24, No. 1, January 1970, pp. 2-3.
[718] MDH, *Minnesota's Health,* Vol. 24, No. 3, March 1970, p. 2.

Municipal Populations in Minnesota with Treatment of Sewage

	January 1, 1956	January 1, 1966	Change
Municipal Population in Minnesota	2,092,525	2,731,737	+30%
Population Served by Municipal Sewers with Treatment	1,722,311	2,529,893	+32%
Population Served by Municipal Sewers without Treatment	189,167	22,237	-88%
Population not served by Municipal Sewers	181,047	179,607	-0.8%

Sanitary Sewer Districts/Servicing the Suburbs

Disposal systems for suburban areas had become the biggest problem in sanitation in the 1950s. A 1959 survey of suburban communities in Minnesota indicated slightly more than 50 percent of the suburban wells showed contamination.[719] Tests on water samples taken from Coon Rapids found that much of the drinking water contained detergents and elevated nitrates.[720]

As more suburbs began establishing their own water and sewage systems, Dr. Robert Barr, secretary and executive officer of the board, realized some intervention was necessary to ensure safe systems. Since neither water nor sewage follow political divisions, it was difficult to base boundaries by those set by municipalities. Dr. Barr advocated the creation and expansion of sanitary districts, including all communities. In 1959 he felt the board needed to take on a strong leadership role, as the chance would soon be lost. [721]

On October 18, 1960, the board went on record as favoring a metropolitan approach to the sewage problem.[722] The department strongly advocated the establishment of sanitary districts that would provide an area-wide program to solve waste and water problems. The department envisioned that a district would include townships, villages and cities. The department also advocated that the local government be given the basic authority to control the installation of water supplies and sewage systems in each residential area.[723]

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[719] BOH, *Minutes,* January 12, 1960, MHS, p. 12.
[720] BOH, *Minutes,* May 26, 1959, MHS, p. 120.
[721] BOH, *Minutes,* November 10, 1959, MHS, pp. 250-251.
[722] MDH, *Minnesota's Health,* Vol. 11, No. 7, August-September 1957, pp. 1-6.
[723] MDH, *Minnesota's Health,* Vol. 11, No. 2, February 1957, p. 2.

The board worked with the Water Pollution Control Commission, which had been created through the State Water Pollution Control Act in 1945. The commission was given the principal authority for dealing with water pollution, including the building of disposal plants, while the Board of Health retained authority over water and sewage disposal matters that affected the public's health. The commission coordinated water pollution control efforts among all relevant agencies, including Conservation, Agriculture, Dairy and Food, Livestock Sanitary Board, and Health. The secretary and executive officer of the Board of Health served as the commission's secretary. [724]

Water Pollution and Sewage Disposal – A Political Issue

Water pollution and sewage disposal became hot issues in the state in the 1960s. The board drew criticism, such as that expressed in the following letter, written June 8, 1962, in response to an editorial published in the St. Paul Pioneer Press:

> The St. Paul Pioneer Press of June 7, 1962, carried an editorial entitled "Minnesota Moves to 'Clean up' Mississippi." It has something to say about cleaning up the pollution in the Mississippi River. You and your people have been warned about this pollution for a long time. This is no doubt the time to get some publicity, and this is the way to get into the picture.
>
> Dr. Barr, you and your Department have been very lax about sewage pollution in the State of Minnesota. Anybody who can advocate lagoons and the dumping of domestic sewage and industrial waste into open lagoons should not cry about the pollution of the Mississippi River. Seepage from these open lagoons contaminate the groundwater, the odors are terrible and even poisons birds and other wildlife. If it has not been for the fight carried on by the Minnesota Emergency Conservation Committee, you would have carried out one of the worst things ever perpetrated.
>
> We have had enough people like you working for this State and there is only one thing that will cure it and that is that you give up your job and go elsewhere. I have no patience with people like you, who were willing to sit by in the fight we were carrying on, because you were afraid to speak the truth.[725]

The state's efforts to intervene in communities' water disposal systems were not always appreciated. Communities did not always want to hear that their water was unsafe. At his retirement in 1968, Frank Woodward reflected on one community that resisted strongly, Waverly, the home of then Vice President Hubert Humphrey. Woodward described the challenge:

> For 45 years the Department had tried without success to get the village to abandon its polluted and untreated lake water source and construct a well supply. We had to get a little tough by preparing to revoke the restaurant licenses unless safe sources of water were obtained. Village officials capitulated and installed a safe well supply. The village is happy with the turn of events, and I am sure that its number one citizen would approve of the action.[726]

Other communities resisted attempts by the board to encourage joint efforts with neighboring communities or any monitoring of systems. In 1963, the North Suburban

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[724] MDH, *Minnesota's Health,* Vol. 11, No. 7, August-September 1957, pp. 1-6.
[725] BOH, *Minutes,* attachment: Exhibit VII, July 19, 1962.
[726] MDH, *Minnesota's Health*, Vol. 22, No. 7, August-September 1968, p. 2., Vol. IV, No. 9, September 1950, pp. 1

Sanitary Sewer District presented a summons to the staff of the Board of Health and the Water Pollution Control Commission challenging the right of these two agencies to approve or disapprove the development of disposal systems and dumping of waste into the pool from which Minneapolis draws its water supply. The issue was taken to the courts.[727] The courts ruled that the North Suburban Sanitary District must observe the rules and regulations of the Water Pollution Control Commission. [728]

Dr. Robert Barr felt that the public criticism received regarding water pollution was due to the lack of knowledge of what the state had accomplished and what it was doing to control water pollution. He believed the state must do a better job of health education and information in this controversial field.[729]

As secretary of the board, Dr. Barr often signed letters jointly with the Water Pollution Control Commission. Because of this relationship, the Health Department was sometimes criticized for actions of the commission and accused of "running the commission." In response, a bill,[730] commonly referred to as the Rosenmeier Bill, greatly extended the authority of the Water Pollution Control Commission, transferring duties related to water pollution from the board to the commission. It also called for the creation of a health commissioner, appointed by the governor.[731] Mr. Frank Woodward, director of environmental sanitation[732] from 1950 to 1968, did not support this bill. He thought it lacked a long-range master plan, which was essential from a public health standpoint.[733]

The 1964 bill did not pass, but state Sen. Gordon Rosenmeier continued to advocate for the changes it proposed. He blamed dissatisfaction with the state's water pollution control program on the fact both the Water Pollution Control Commission and the Board of Health were in the hands of appointed boards rather than commissioners.[734] He did not support the existing relationship of the two agencies and felt the Water Pollution Control Commission should be independent of the Health Department. He said: "The major problem with the present Minnesota Water Pollution Control Commission is its dependency on State Health Department staff. With the Health Department, pollution control is a sideline at best."[735]

O. E. Brownell, responsible for many of the improvements in water supply and waste disposal in the state, wasn't working at the department when most of his efforts were coming to fruition. After 35 years with the department, heading the municipal water supply program during much of that time, he retired in 1955. At the time of his

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[727] BOH, *Minutes,* January 22, 1963, MHS, p. 2.
[728] BOH, *Minutes,* April 9, 1963, MHS, pp. 129-130.
[729] BOH, *Minutes,* May 20, 1963, MHS, p. 382.
[730] "A Bill for an Act, Relating to the Organization and Administration of the State Government in Respect of the Department of Health, the State Board of Health, and the Water Pollution Control Commission; Amending Minnesota Statutes 1961, Sections 144.02, 144.03, 144.04, 115.02, and 144.38, Subdivision 2."
[731] BOH, *Minutes,* May 18, 1964, MHS, pp. 329 and 337.
[732] The environmental sanitation division was renamed the environmental health division in 1964.
[733] BOH, *Minutes,* April 9, 1963, MHS, pp. 129-130.
[734] *Minneapolis Tribune,* "State Water Pollution Control Criticized," October 4, 1964.
[735] *St. Paul Pioneer Press*, "Pollution Unit's Reliance on Health Agency Hit," March 21, 1965.

retirement his co-workers honored him with a party. Called a "Cornerstone Removing Ceremony," the menu featured "water tank roasted squab," "O.E. rsd'oeuvres," "fresh caught salmon-ella," and "hash Brownell potatoes." [736]

Frank Woodward

Director of Environmental Sanitation/Environmental Health
1950 to 1968

Frank Woodward, also responsible for the many of the improvements, reflected on his retirement in 1968:

> We realized that the sewage being discharged into the ground was becoming a part of the drinking water obtained from the relatively shallow wells. We brought this to the attention of the municipalities involved. We surveyed areas representing many thousands of individual wells and found that nearly half of the wells were affected by the recirculation of sewage. We don't know how many people previously using such wells in the built-up areas are now furnished water from safe central or municipal sources, but the figure must be close to 300,000.[737]

Food and Lodging

Established in 1905, the hotel and resort inspection division is one of the longest-standing units of the department. In 1949, the division inspected and licensed hotels, lodgings, boarding houses, restaurants and cafes, tourist rooms, and cabin camps annually. The inspectors looked for faulty equipment, improper housekeeping and other infractions that created health risks. The biggest problem was food handling. If a problem was found, the owner received a notice requiring compliance with the law. The owner had a certain period of time to correct the defect. If it wasn't corrected, a second order was sent. If no correction was made, the license was revoked. In 1949, the division played an important role in the state's tourist business. Nine field inspectors inspected some 2,600 resorts during the summer.[738]

The environmental health division crosses over into the areas of other state agencies, and several times in its history has had to work with other agencies to determine the appropriate role of each. In its report, released in 1950, the Governor's Commission on Efficiency in Government addressed interagency issues between the Health and Agriculture departments. It cited certain inspection functions done by both Health and Agriculture as "perhaps the most glaring example of duplicated and overlapping inspection activities in the state service."[739]

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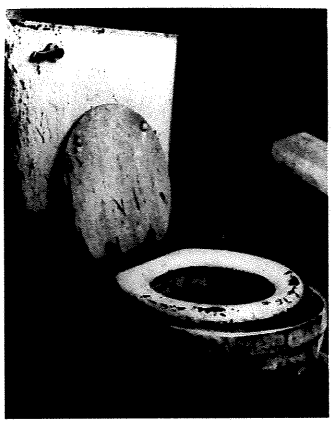
[736] MDH, *Minnesota's Health,* Vol. 10, No. 2, February 1956, pp. 2-3.
[737] MDH, *Minnesota's Health*, 22, No. 7, August-September 1968, p. 3.
[738] MDH, *Minnesota's Health,* Vol. III, No. 7, July 1949, pp. 1-2.
[739] BOH, *Minutes,* January 9, 1953.

The commission did not, however, support placing most inspection functions in the Health Department. It recommended:

> Responsibility for the inspection of lodging places, food and food service and all other sanitary inspections should be placed in the Department of Agriculture, and any such functions now performed by the State Department of Health should be transferred to the Department of Agriculture. The Boat Inspection function now performed by the Department of Health should be transferred to the Department of Conservation and be the responsibility of that Department's game wardens.[740]



A newspaper article quoted Myron W. Clark, commissioner of agriculture, as supporting the commission's recommendation: "The Agriculture Department has a statewide inspection organization which can take over all sanitary inspections."[741]

Some challenges regarding agency roles in food safety were already occurring because of recent legislation. As a result of legislation passed in 1948, there was some confusion as to whether the Health Department or the Department of Agriculture was responsible for inspecting food at the State Fair. At a board meeting on November 14, 1950, Mr. Frank Woodward described the difficulties:

> There was a lot of conflict at the State Fair this year. We assumed that we were to make inspections of eating places at the Fair and found that the Department of Agriculture was everywhere with more people than we had and their recommendations were quite different than ours. [742]

Progress in the working relationship between the two agencies in this area was made in 1951. The Health Department and the Department of Agriculture coordinated inspections of food and drink concessions at the State Fair. They agreed on standards acceptable to both departments. They designated a meeting place where inspectors got together at the beginning of each day.[743]

Despite the recommendation of the Commission on Efficiency in Government, the Department of Health has retained responsibility for environmental health inspections in a variety of areas. These include:

- Camps: Regulations had been established to monitor logging camps in 1937. At this time a large number of men were housed in barracks and eating in mess halls. After World War II, the logging industry started to abandon these camps in favor of "shacker" camps. Many of them had less than five men, so the department's Regulation 250 no longer applied. Representatives of Local 12-29, International Woodworkers of America-C.I.O., the U.S. Forestry Service and

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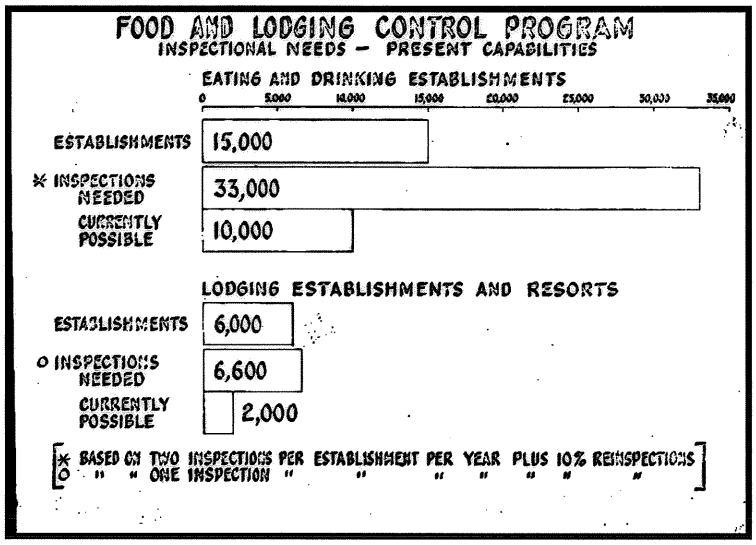
[740] BOH, *Minutes,* January 9, 1953.
[741] *Minneapolis Tribune*, "Official Backs Single Agency for Inspecting," January 17, 1953.
[742] BOH, *Minutes,* November 14, 1950, MHS, pp. 472-475.
[743] BOH, *Minutes,* October 16, 1951.

other members of the logging industry supported the adoption of regulations that would cover these "shacker" camps.[744]

- Swimming Pools: In 1949 a total of 140 swimming pools in the state were inspected by the municipal water supply division, under the direction of O. E. Brownell. Brownell's division approved plans for the pools. Regulations also included adequate toileting, dressing and shower facilities. One problem was athlete's foot, and swimmers were encouraged to wash and dry their feet thoroughly or wear wooden sandals.[745]

- Mobile Homes: A large increase in mobile home parks in the 1970s created new demands on the environmental health division. The hotels, resorts and restaurants section was in charge of conducting a site survey, primarily to check on sewage disposal problems, flooding and drainage and general hazards. They reviewed plans and specifications for parks, checking the size of lots, spacing, and the plans for water and sewage disposal. The department made inspections at the end of construction.[746]



In 1961, a special effort was made to win support for an expanded program in food service and lodging control. Charles Schneider, from the hotels, resorts and restaurants section, presented a crash program in the techniques of food handling in 12 communities in February and March. The department backed legislation seeking additional resources to conduct more classes for food handlers.[747]

Legislation passed in 1963 expanded the existing food and lodging sanitation law and emphasized education, improved technical service and clearly defined enforcement authority. The law created a graduated fee schedule for licensing. The flat annual fee of $3.50 from each food and lodging establishment was abolished, starting January 1, 1964. Additional appropriations added five district sanitarians.[748]

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[744] BOH, *Minutes,* January 13, 1959, MHS, p. 23.
[745] MDH, *Minnesota's Health,* Vol. III, No. 7, July 1949, p. 3.
[746] MDH, *Minnesota's Health,* Vol. 24, No. 6, June-July 1970, p. 3.
[747] BOH, *Minutes,* April 9, 1962, MHS, pp. 113-114.
[748] MDH, *Minnesota's Health,* Vol. 17, No. 5, May 1963, p. 1.

Milk Inspection – Interagency Activities

Many of the areas within environmental health have overlapped with areas outside of public health. This has necessitated working with other agencies. In 1983, the environmental health division identified other state agencies that worked most closely with each section:

Analytical Laboratory: Pollution Control Agency, Department of Transportation

Occupational Health: Department of Labor and Industry

Public Water Supply: Pollution Control Agency, Departments of Natural Resources and Agriculture

Health Risk Assessment: Pollution Control Agency, Environmental Quality Board, Departments of Agriculture and Education,

Radiation Control: Department of Transportation, Pollution Control Agency

Hotels, Resorts and Restaurants: Departments of Administration, Agriculture, and Public Welfare[749]

It often has been unclear where the lines of responsibility begin and end. An example of this is the relationship between the Department of Health and the Department of Agriculture in determining roles and responsibilities related to milk-related illnesses and milk inspection. Prior to 1949, the responsibility for milk inspection had been transferred from the Department of Health to the Department of Agriculture. This created problems, as some states would only accept milk that had been certified grade A by the Health Department. Wanting to regain responsibility for milk inspections, Board President Thomas Magath saw the trade difficulties created for the dairy industry as an opportunity to challenge the existing legislation giving responsibility for milk inspection to the Department of Agriculture: "Yes, I think we could do a little missionary work to show the inefficiency of the law and the necessity for reconsideration of correcting. I wish we could get some of these letters out to the public."[750]

The Rochester Dairy Cooperative was one of the businesses hurt by the legislative change. They lost $100,000 in sales, as they were unable to sell in other states as a result. They offered to pay part of the cost of a milk sanitarian who would work for the Health Department and certify their milk for sale. The board wasn't sure it should accept this offer, and the Department of Agriculture didn't seem to support the idea. President Thomas Magath, from Rochester, thought it would be okay as long as:

> "...we stipulate very specifically that the State Board of Health recommends the acceptance of this gift provided we receive in writing the complete and unqualified approval of the Department of Agriculture. Throw it right square in their lap."[751]

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[749] MDH, "The Minnesota Department of Health in 1983: Activities, Programs & Purposes," 1983, p. 10.
[750] BOH, *Minutes,* May 5, 1949.
[751] Ibid.

On June 22, 1949, R. A. Trovatten, head of the Department of Agriculture, wrote a letter to the U.S. Surgeon General in support of the Health Department's plan to hire and supervise a milk sanitarian. This was done in response to a request from the Board of Health.[752]

The board then negotiated with the U.S. Public Health Service, which assigned a person to the department to establish a program for the continuous supervision of the sanitary quality of milk produced by the Rochester Dairy Cooperative.[753] A milk sanitarian, under technical and administrative control of the department, was employed. The Rochester Dairy Cooperative paid salary and travel expenses.

An advisory board was established to counsel and advise Mr. Herbert Bosch on the establishment of the milk control program. Four representatives from the Department of Agriculture and two from the School of Public Health were invited to serve on the board. An invitation was sent to selected committee members in July 1949. Shortly after, Dr. Chesley received a response from Commissioner Trovatten of the Department of Agriculture, Dairy and Food. The Department of Agriculture did not want to participate. Mr. Trovatten wrote:

> Inasmuch as this will become more or less of a study of how to eliminate trade barriers between states, where such barriers are based on health and sanitation standards, and in as much as this involves health departments of other states, it would seem to me that the Department of Agriculture, Dairy and Food should not become involved in such a controversy.
>
> For several years our National Association of Commissioners, Secretaries and Directors of Agriculture has had under discussion this particular question. For the last ten years I have been a member of the Council of State Governments. This Council has made an exhaustive study of this problem and among other things they have found instances where the state agency in charge of food sanitation in one state will condemn products which have been approved by the state agency having charge of food sanitation in the state where the produce was manufactured or processed. This has been true regardless of whether both states have been using the U.S. Pubic Health Code as a standard of measurement.
>
> States importing dairy products are buying up milk cows and feed in the surplus producing states and arbitrarily fixing prices on their products and at the same time shutting off surplus producing states through arbitrary and discriminating sanitary standards and through milk control laws.
>
> The losses sustained by surplus producing states on milk alone is tremendous, as is shown by the following statistics[754] relating to the average price received by farmers for milk sold at wholesale per hundred weight, according to the U.S. Department of Agriculture, Bureau of Agricultural Economics;
>
> How this question can best be solved, whether it should be done by court procedure or whether it should be doe by national legislation is a question that has been up several times for discussion in our national meetings. Because of the many factors involved and the complexity of the problem, it must of necessity require a very exhaustive study and it will be impossible for us to devote enough time and energy from this Department to participate in such a program.

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[752] BOH, *Minutes,* July 14, 1949.
[753] Ibid.
[754] Average prices were: Minnesota ($4.25), Wisconsin ($4.43), Texas ($6.40), Florida ($7.20) and Louisiana ($6.80).

> It would seem to us that it is largely a matter of impartial enforcement of the U.S. Public Health Code at the state level. From the foregoing table of prices received by farmers for milk sold at wholesale, you can readily see the losses sustained by such states as Wisconsin and Minnesota. An impartial enforcement of the US. Public Health Code by such states as Texas, Louisiana and probably other states should be used as a measure of the quality of production rather that to be used as a state barrier. This would in our opinion alleviate considerably the situation of the dairy farmers in surplus producing states.
>
> I feel, therefore, that merely setting up a state agency to try to counteract an evil that has been going on throughout the nation for many years past will not produce the desired results, but that much encouragement should be given to a more exhaustive study by the Council of State Governments was well as by the Congress of he United States.[755]

Board member Dr. Theodore Sweetser commented on the difficulties of sharing responsibilities between two or more agencies:

> About 25 years ago I had considerable to do with the Boy Scout movement and one of the slogans was that fixed responsibility gets results. You have a program here that has been carried on during a long period of time. Then you get another program in here and if they don't work together in closer cooperation you are going to get friction and problems that will confuse the situation and the public considerably. If they don't go at it the same way, people are going to be confused."[756]

The sanitarian was hired and continued working without incident. In 1950, the board agreed to hire another full-time sanitarian who would work in the central office and be used by Buffalo, Delano and St. Michael. He would spot check with the Department of Agriculture on the work of the Minneapolis Health Department and would report to the U.S. Public Health Service on the quality of that supervision.[757]

Board members were surprised by a show of support from the Department of Agriculture, as indicated at the February 14, 1950, board meeting:

> Dr. Ruth Boynton: "I think I'm confused. I am not quite clear as to our relationship with the Department of Agriculture. Do they concur that this is necessary and essential?"
>
> Mr. Frank Woodward: "They do because there are some states which don't. . ."
>
> Herbert Bosch: "They concur because of the Rochester situation."
>
> Woodward : "They have seen from the Rochester situation that we can get along very well. We are requesting this other man." [758]

The Department of Agriculture began accompanying the Health Department on health surveys. At the April 1950 board meeting, however, it was announced that they might stop, as they were finding themselves too busy. Mr. Woodward, assistant chief of environmental sanitation, described the situation:

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[755] BOH, *Minutes,* July 14, 1949.
[756] Ibid.
[757] BOH, *Minutes,* February 14, 1950, MHS, pp.20-21.
[758] Ibid., p. 21.

> Supervision is apparently a new word to the Department of Agriculture. They didn't realize what it meant. They are taking on the supervision of some of the milk sheds and a great deal more work and they are finding out they can't spread themselves all over this field. [759]

Dr. Ruth Boynton saw the situation as a possible opportunity to regain full responsibility for milk inspections. She wondered:

> Do you think there is enough public opinion being built up for the State Department of Health to get back full control if an attempt is made to change the legislation?[760]

It did not appear so, as Mr. Woodward replied that the Rochester Dairy Cooperative did not get the outcome it expected:

> The Rochester program which we started last fall folded up this winter largely because the Rochester Dairy Cooperative was trying to cover too large an area in its program, taking in three whole milk sheds. The Advisory Committee suggested that they take a smaller area. This winter they found that they weren't able to sell milk just by having a program going on without any results. So they had to terminate the program whereby they were paying into the State treasury funds for a milk sanitarian. Fortunately we had a place to put Mr. Dalton in the central office. What Rochester plans to do now is to arrange with the Rochester City Health Department to supervise a portion of the outlying shed, eventually bringing it up to the quality for Rochester. They will have to bring it up to the treasury. It is a question of how much they will be able to put in. About 100 farms at present time. Not enough to be gained by that to employ and pay the salary of a full-time man. Some arrangement with Dr Wilson will be made on this matter. We hope they will be able to work it out. We would be glad to have local health departments take charge of the milk sanitation locally.[761]

A national conference on interstate milk shipments, held in June 1953, recommended that receiving states should accept ratings made only by certified rating officials of either the U.S. Public Health Service or the state health department or department having sole jurisdiction of milk sanitation, providing the survey officials are certified by the Public Health Service.[762]

On December 3, 1957, Gov. Orville Freeman sent a letter to Dr. Barr rescinding the order of Gov. Luther W. Youngdahl to create a milk sanitarian position in the Board of Health. [763] The department accepted its limits related to the control of milk supply as limited to investigation and control of milk-borne communicable disease; advisory services to local milk control programs and activities delegated by the U.S. Public Health Service related to interstate quarantine regulations.[764]

The board thanked the advisory committee for its service and discharged the committee. The position formerly held by the milk sanitarian was filled with a sanitarian to work in the area of children's camps, lumber camps and labor camps, an area that was not covered adequately.[765]

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[759] BOH, *Minutes,* April 25, 1950, MHS, pp. 115-116.
[760] Ibid., p. 116.
[761] Ibid., p. 117.
[762] BOH, *Minutes,* January 7, 1958, MHS, pp. 77-78.
[763] Ibid., pp. 79-80.
[764] Letter from Dr. Robert Barr to Gov. Orville Freeman, December 12, 1957.
[765] BOH, *Minutes,* January 7, 1958, MHS, p. 19.

In 1962, a National Milk Sanitation Act, authorizing the Public Heath Service the right to establish standards, operate surveillance of state programs and certify milk as meeting standards, was proposed. This act would make milk free for shipment from one part of the country to another, and it would make the bootlegging of milk much more difficult. The board approved the proposed legislation stating that " . . .the Board of Health is opposed in principle to using health as a trade barrier as such in the movement of milk and for that reason are in favor of the proposed legislation."[766]

Industrial Health

The first Minnesota occupational health program was established following federal legislation passed in 1939. Funds were designated for state industrial health programs, and the department used them to conduct studies, provide consultation, evaluate hazardous materials and assist in establishing medical services and adult hygiene programs. Rather than inspecting plants and identifying occupational hazards, the department provided education and medical supervision. [767]

The board felt the value of this program was not apparent to outsiders. At a board meeting in 1954, members discussed the need for additional funding and the benefit of activities:

> Herbert Bosch: "I think one of the least publicized and yet one of the most important things done was down at St. Mary's on packaging some of the new organic insecticides. Mr. Michaelson worked very quietly with both the labor and management groups. They introduced practices which reduced very significantly the hazards from handling those substances."
>
> Miller: "I think you could get support from a number of industries. When they have a case of silicosis in Red Wing Pottery they get terrific heat. There is a terrific compensation angle to it."
>
> Woodward: "Obviously industry was suspicious of anything that would bring conditions out for the scrutiny of the court. Management was still a little bit suspicious and labor was very suspicious. But over the years we found that it meant what it said. We have had industry ask us to come in and help with what was bothering them, knowing that it wouldn't be heard."[768]

The work involved cooperation with more than 6,000 industrial plants in the 1950s. Frank Woodward, director of the environmental sanitation division, noted the approach taken by the department: "Because of the number and geographical distribution of the state's industrial plants, it is impossible to provide individual service to each. An industry-wide approach provides benefits of value to all plants." [769]

Between June 30, 1948, and June 30, 1958, a total of 4,886 occupational disease cases were filed under the workmen's compensation act. Sixty of these resulted in

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[766] BOH, *Minutes,* April 9, 1962, MHS, p. 110.
[767] MDH, *Minnesota's Health,* Vol. 13, No. 4, April 1959, pp. 2-3.
[768] BOH, *Minutes,* May 11, 1954.
[769] MDH, *Minnesota's Health,* Vol. 13, No. 4, April 1959, pp. 2-3.

death. [770] In 1990 an estimated 400 work-related injuries occurred each day, but complete and valid data to measure the incidence and severity of illness and injury in the work place was not available. The department concentrated much of its efforts on developing and testing a surveillance system in order to better identify needs in this area.[771]

Throughout the period from 1949 to 1999, more concern grew over the potential dangers to the public from the products of industry. Some examples include:

- In 1959, Minnesota joined a national concern when it was discovered that the weed killer aminotriazole was taken up by the cranberry plant and was present in the cranberries when they were harvested. As this chemical is a carcinogen, there was considerable publicity throughout the country. The U.S. Department of Health, Education and Welfare recommended that no one buy or use cranberries unless they had been proved to be free of aminotriazole.[772]

- In 1959, Dr. Dean Fleming, director of the disease prevention division, expressed special concern over the nitrates in the water that was used for making formulas for infants. He felt it could contribute to methemoglobinemia, a condition that deprives the blood of its ability to carry oxygen to the lungs. If untreated, babies would turn blue and could die.[773] Nitrate poisoning in infants had been reported earlier. In 1947, 1948 and 1949, 146 cases of nitrate poisoning in infants had been reported in the state. Two deaths occurred the latter part of 1950. Most cases were from southern Minnesota.[774]

- On June 21, 1961, a 50-gallon drum of DDT emulsion concentrate fell from a farmer's truck in Red Lake Falls, broke open, and the material ran into the sewers. It was raining at the time, and an estimated 50 gallons of concentrate were in the sewer within one hour. The Crookston health officer phoned Mr. Kirkpatrick of the environmental sanitation division at 11 p.m. The Department of Conservation expected all insect life in the river to be killed, as their food would be eliminated. The Health Department asked the people of East Grand Forks and Grand Forks to report any different taste and odors in the drinking water supplies, as their water comes from the river. No reports of any problems were reported.[775]

- In 1960, a study by Dr. Evelyn Hartman, director of the maternal and child health bureau; Dr. Wilford E. Park, chief of occupational health service; and H. Godfrey Nelson, public health chemist at the Minneapolis Health Department, found that chipping paint may be a lead hazard to children. The study was published in the

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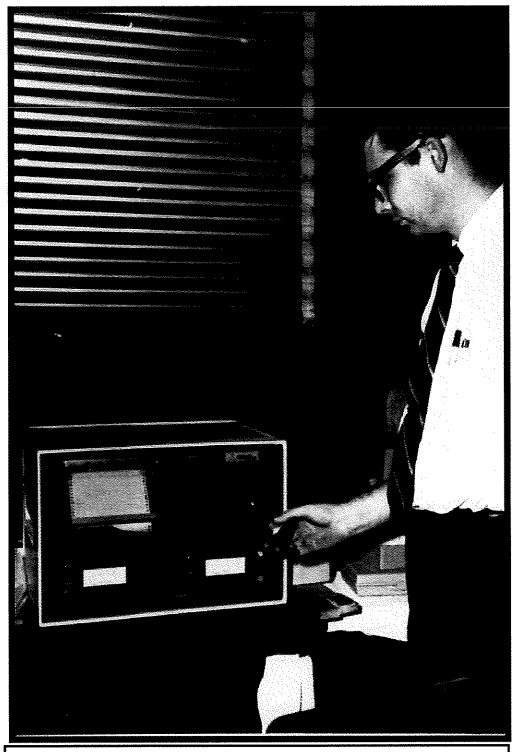
[770] MDH, *Minnesota's Health,* Vol. 13, No. 4, April 1959, p. 1.
[771] MDH, "Minnesota Public Health Goals," March 1995, p. 155.
[772] BOH, *Minutes,* November 10, 1959, MHS, p. 255.
[773] BOH, *Minutes,* May 26, 1959, MHS, p. 120.
[774] MDH, *Minnesota's Health,* Vol. IV, No. 11, November 1950, pp. 2-3.
[775] BOH, *Minutes,* July 11, 1961, MHS, p. 319.

July 1960 issue of "Public Health Reports" and was based on a study of children attending a well-child clinic between August 1958 and October 1959.[776]

- Lead was the identified culprit when, in 1963, 12-15 head of cattle in Dakota County died. Investigations by the Department of Agriculture and the University School of Veterinary Medicine found that a sufficient level of lead deposited on vegetation could cause lead intoxication. Lead was found in silage hay and topsoil. It wasn't found in plants, indicating there was no uptake of lead by the plant.[777]



Dave Gray, Research Scientist

The pulse polarograph, an instrument designed by David Gray made it possible to more accurately detect 80 toxic elements in the water, air, blood and urine. It was 100 times more sensitive than the conventional polarograph.

In 1957 the Health Department established a central program to provide information about toxic agents as an aid to physicians in treating poison victims. The Minnesota Poison Information Center operated through 10 poison information centers established in the Twin Cities and seven in regional hospital centers in Duluth, Mankato, Fergus Falls, Worthington, St. Cloud, Virginia, and Rochester.[778] Information given out through these centers included identification of the product's ingredients, an estimate of toxicity and any past experience with similar cases. Twenty-four-hour a day service was available.

The Poison Information Center was under the direction of Dr. A. B. Rosenfield, director of the special services division. Dr. Warren Lawson, then chief of the environmental health section, was director of the center and spent half his time running it. To assist, an advisory committee, including representatives of several health disciplines as well as laypersons, was formed.[779] Advisory committee members included Dr. Harold Brunn, Minnesota Medical Association; Dr. Frank Ubel, Ramsey County Medical Society; Boris Levich, St. Paul Department of Public Safety; Dr. W. E. Parks, Minneapolis Division of Public Health; Dr. Donald Roach, Minnesota Academy of General Practitioners; Glenn Prickett, Minnesota Safety Council; Henry Moen, Minnesota State Pharmaceutical Association; Dr. James Fox, Minnesota Academy of Occupational Medicine and

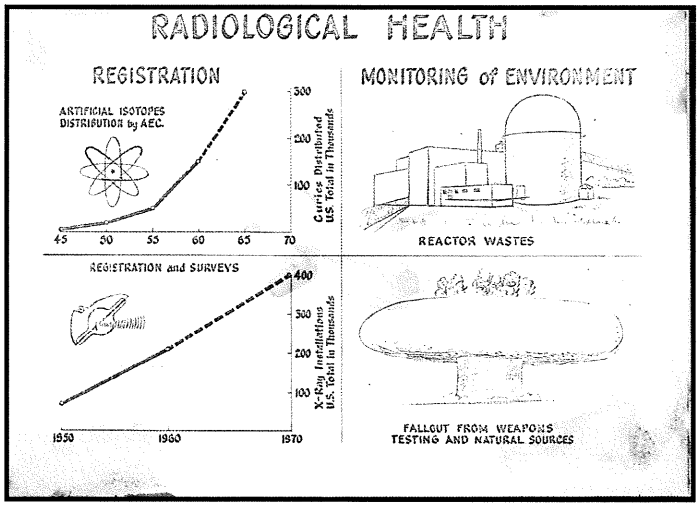
[776] MDH, *Minnesota's Health,* Vol. 14, No. 7, August-September 1960, p. 4.
[777] BOH, *Minutes,* January 22, 1963, MHS, pp. 31-32.
[778] BOH, *Minutes,* January 13, 1959, MHS, p. 13.
[779] BOH, *Minutes,* July 30, 1957, MHS, p. 125.

Surgery; George Michaelson, Minnesota Hospital Association; Dr. Tague Chisholm, Minnesota Academy of Medicine; Mrs. Richard Angevina, Minnesota Congress of Parents and Teachers, Inc.; Dr. Raymond Bieter, head of the pharmacology department at the University of Minnesota School of Medicine; and Dr. Harold Wright, pharmacology professor at the University of Minnesota.[780]

Outcomes of New Technologies: Air Pollution and Radiation

By 1949, the department was conducting surveillance for air pollution in the state. Continuous samplings taken from the roof of the Health Department building on the University campus in the 1950s found that peak concentrations of air pollution occurred in the winter months due to the increased use of fuel for heating. Weekend levels were lower than during the week, because of reduced industrial activity. Periods of low wind velocity, typically just before midnight and near sunrise, increased pollution.[781] In 1957, state legislation authorized the department to make regulations on air pollution in order to protect the public's health. No funds were allocated, however, and this limited the amount of work that could be done.[782]

A 1960 survey conducted by the department, with assistance from the U.S. Public Health Service, found that no serious air pollution problems existed in the 61 state counties surveyed. One out of three communities with populations larger than 1,000, however, reported receiving complaints about the air quality. Most of these problems in out-state Minnesota stemmed from agriculture-related industries.



In 1967 the department's role in air pollution was diminished. The Legislature created the Minnesota Pollution Control Agency, and the responsibility for water pollution, air pollution and solid waste control was placed in the new state agency.[783]

Radiation was another new concern of the population in the 1950s and 1960s. The public wondered about possible exposure and possible effects from a number of different sources. One area of concern in the late 1960s was the radiation levels from color TVs. E. R. Wykes, chief of the radiation control section, reported that only large screen television receivers are potential sources of radiation in harmful amounts.[784]

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[780] MDH, *Minnesota's Health,* Vol. 11, No.10, December 1957, pp. 1 and 4.
[781] MDH, *Minnesota's Health,* Vol. 15, No. 2, February 1961, p. 4.
[782] Ibid., pp. 3-4.
[783] MDH, *Minnesota's Health*, Vol. 22, No. 7, August-September 1968, p. 2.
[784] MDH, *Minnesota's Health,* Vol. 22, No. 5, May 1968, p. 2.

(Note: The department's history with radiation and nuclear power is also covered in Chapter 4.)

Environmental Health People

Throughout the years a large number of people have contributed to the improvement of environmental health in Minnesota. A few of those include:

Herbert Bosch, M.P.H., was director of environmental health (then called environmental sanitation) in 1949. He began working for the department in 1936 and left in 1950 to become the first chief of the environmental sanitation section of the World Health Organization. He became a member of the Board of Health in 1952.

Frank L. Woodward, B.E., was head of general sanitation in 1949. He became director of environmental health in 1950 and served to 1968.

Frederick Heisel, B.S.C.E., M.P.H., joined the department in 1939. He became assistant director of environmental health in 1967 and was director of environmental health from 1968 to 1976.

Roger DeRoos, Ph.D., was head of the environmental health division from 1979 to 1983.

Ray Thron was director of environmental health from 1983 to 1992.

Patricia Bloomgren became director of public health in 1992 and has continued through 1999.

O.E. Bronwell, C.E. was chief of the municipal water supply program. He began work at the department in 1920, retiring in 1955.

Harold Whittaker joined the department in 1907.[785] When the division was formed in 1914, he became the first director. He continued as director until 1946 when he retired and became a consultant to the World Health Organization from 1951 to 1961. In 1962 he began a history of environmental sanitation in Minnesota and continued working on it until his death May 1, 1967. He received the first Harvey G. Rogers Award in 1964 in recognition of his efforts to promote public health through the preservation of quality water resources in the state. He was also a champion of safe milk for children.

Myhren Peterson joined the department in 1936 and became supervisor of district sanitation in 1957.

George Raschka joined the department in 1940 and later became associate chief of the radiation and occupational health section.

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[785] MDH, *Minnesota's Health,* May 1967.

Harold S. Adams was head of the division of hotel and resort inspection in 1949.

Charles B. Schneider, M.P.H., joined the department in 1958. He became chief of the hotels, resorts and restaurants section in 1966, replacing Robert Hunt, who resigned.

Russell Frazier joined the department in 1942. He became the head of the combined sanitation and industrial health laboratories in 1951.

Elmer Huset joined the department in 1947. He was appointed chief of the municipal water supply section in 1956.

Paul Johnson, chief of the water supply and general engineering section, joined the department in 1950.

Lyle Smith, M.S., joined the department in 1941. He was chief of the water pollution control section from its beginning in 1961.

Harvey G. Rogers was head of the water pollution section for many years. An annual award for preserving Minnesota's water resources is given in his name.

Harvey G. Rogers Memorial Award

The Harvey G. Rogers Memorial Award was established in 1963. The award, in his memory, was presented by the MPHA to honor those persons who best exemplify the spirit of dedication and years of distinguished service toward promotion of public health through preservation of the quality of water resources of the State of Minnesota. The award, given annually, has been received by the following:

1964 – Harold Whittaker
1965 – Chester S. Wilson
1966 – Malcolm Hargraves
1967 – Lyle Smith
1968 – Theodore Olson
1969 – Gerald Briggs
1970 – Thomas Warner
1971 – William Poblete
1972 – Paul Johnson
1973 – Russell Frazier
1974 – John Moyle
1975 – Winston Larson
1976 – No award given
1977 – No award given
1978 – Elmer Huset
1979 – George Schoepfer
1980 – No award given
1981 – No award given
1982 – Richard Bond
1983 – David Peterson
1984 –
1985 – No award given
1986 – Judge Miles Lord
1987 – Richard Gray, Sr.
1988 – Stuart Hanson, M.D.
1989 – Conrad Straub
1990 –
1991 – Janet Green
1992 –
1993 –
1994 – Robert Mood
1995 – Bonnie Holz
1996 – Frank Steffenson
1997 – Gary Englund
1998 – Dale Schroeder
1999 –
2000 –
2001 -

The importance of environmental health was noted in a 1999 article in the Star Tribune when achievements of the last century were highlighted:

"Clearly, medical science has achieved phenomenal successes.

But the No. 1 reason why people are living longer and healthier lives?

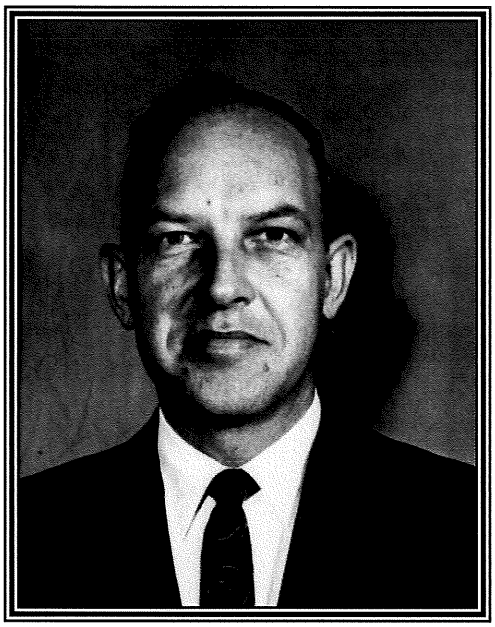
Better sanitation, say medical historians and epidemiologists. Contaminated water and dirty living conditions were (and still are in many places) the breeding grounds of disease."[786]

> ***"Without basic hygiene, the basic ideas of cleaning up the streets and sanitation and sewage removal, . . . none of the other advances would have been meaningful."***[787]
>
> **Dr. John Graner**
> **Associate Professor of Medicine & Medical Historian at Mayo Clinic**

[786] *Minneapolis Star Tribune*, "Living Longer, Living Healthier," May 16,1999, pp. A10 & A11.
[787] Ibid.

Chapter 9

The Health of Minnesota – 1970 to 1978



"The First Administrator": Dr. Warren Lawson
Secretary and Executive Officer of the Board of Health, 1970-1973
Commissioner, 1973-1978

"In summary then, the principal basic faults in the structure in state government in health matters are, in my view:

1) ***the lack of any clear state policy on health matters or for the organization of health services;***
2) ***lack of recognition that the only possibility of containing the spiraling costs of medical care and the consequences of illness and disease is prevention;***
3) ***the phenomenon of fragmentation which is disastrous to the maintenance and development of effective health programs and health services;***
4) ***a too narrow political view of the appropriate role and function of the state health agency especially at this critical time when traditional existing systems of health care and medical care delivery are undergoing rapid change;***
5) ***the almost total absence of competence and commitment and involvement of the state's subdivisions in health services and health programs."***[788]

Dr. Warren Lawson, Secretary and Executive Officer, April 17, 1972

[788] Dr. Warren Lawson's statement at the Joint Subcommittee Meeting Senate Committee On Health and Welfare, April 17, 1972, p. 31.

The country was in a state of turbulence in the late 1960s and into the 1970s. Similarly, the tenure of Dr. Warren Lawson was fraught with political challenges: the fluoridation of municipal drinking water in Brainerd, the Reserve Mining lawsuit regarding the disposal of taconite wastes into Lake Superior, the Health Department's association to a nursing home scandal. Through involvement with these and other issues, Dr. Lawson's years were dynamic and difficult. Opponents publicly challenged his ability to handle his position. The news media questioned the appropriateness of his relationship with a nursing home administrator who was also a Board of Health member, his decision on the risk of asbestos in Lake Superior, and other actions. Once he received an unsigned written threat. This he forwarded to the Bureau of Criminal Apprehension.

". . .government has become much more complicated and sophisticated over the years and all indications are that this trend will continue. This means that agencies must develop more management and administrative skills in support of the technical operations and responsibilities. Concepts such as management by objectives, program planning and budgeting systems, goals setting, etc. are reflections of this fact."

". . .the whole health field and the health services arrangements are undergoing rapid change and it is quite evident that the official health agencies must be prepared to assume new responsibilities and new roles as the political decisions which have yet to be made are incorporated into law. Highly-organized management skills are essential so that the State official agency is prepared to respond flexibly and effectively to the new demands that will be placed on it."

". . .the Department must begin to intensively assert its role of leadership in coordinating and integrating the public health services effort which has increasingly in recent years become seriously fragmented at every level of government. Where fragmentation may be the present-day fact of life, and may have many roots and causes, it is nonetheless inefficient, wasteful, and has had and is having serious consequences throughout the public health and health care services systems. If the process of fragmentation and the consequences of it are to be counteracted, strong leadership must be exerted at the State level and by the Department of health, and the focus of this leadership must be identified directly with the Executive Office."[789]

Dr. Warren Lawson
1972

Compared to earlier decades, the late 1960s and 1970s was a period of considerable change for the department. At the end of Lawson's tenure the department was a decidedly different agency than the one that existed at the beginning. Changes Dr. Lawson initiated and championed, as well as those over which he had little control, resulted in a new era for public health in Minnesota. Public health was taking on a different light, and a new generation of public health professionals was taking over.

The 1970s: A Time of Many Changes for the Health Department

The new and modern building at 717 Delaware Street S.E., constructed in 1969, was a big change for the Health

[789] MDH, "Staffing Plan for Executive Office" (internal memo), February 24, 1972.

Department. No longer housed in a building owned by the University, the department now had an autonomy that wasn't present when based on the University of Minnesota campus. The department was less likely to be confused as being part of the University. Another change brought about by the new building was the opportunity for a unified department. Prior to 1969, metropolitan department employees had been working in several locations in St. Paul and Minneapolis. Now all employees were in one location. For those in charge, it made possible greater control of the divisions' activities. The new building also created opportunities for growth, as the department now had the space to add new programs. It was possible to pursue additional funding opportunities.

The composition of the Board of Health, the nine-member governing entity of the department, was in transition during this period. Members were not serving for 10, or 20 or more years, as had been the case a few decades earlier. There was steady turnover. In 1972, less than two years after his death, none of the members who had served with Dr. Robert Barr as secretary and executive officer were still on the board. This meant all of them had less than two years' experience as board members. To further alter its makeup, 1973 legislation expanded the board to 15 members. Addressing a nationwide trend of community involvement, the new legislation mandated that six of the 15 board members be consumers. The new people came from different backgrounds, and some weren't very familiar with the traditional operations of the department. The inexperienced board depended more on guidance from the agency head, unlike the situation years earlier when the board was well seasoned.

A 1973 legislative change affected Dr. Lawson's title and carried with it symbolic significance. As the head of the agency, Dr. Lawson was no longer executive officer and secretary, the title that had been used since the agency was formed in 1872. Dr. Lawson was now commissioner of health.

During the 1970s, a large number of long-standing department employees retired. This departing generation took with them years of valuable experience, including a military perspective from their experiences in World War II, and public health training from an earlier time when infectious diseases were still predominant. Combined, the service years of three division directors, Dr. Bauer, Dr. Knudsen and Dr. Fleming, totaled more than 100 years. Each had headed one of the department's divisions for a period ranging from 14 to 27 years.

Beginning in 1972, and continuing for the next five years, a pillar of public health in Minnesota retired each year. Under state law, Dr. A. B. Rosenfield, director of special services, was forced to retire in 1972.[790] Dr. William Harrison, director of local health administration, retired from his position in 1973 after 17 years with the department.[791] Dr. Helen Knudsen, director of health facilities, retired in 1974, after 30 years. Dr. Dean Fleming, director of personal services (disease prevention and control) and a department employee since 1938, retired in 1975. Dr. Henry Bauer, director of medical laboratories, ended his 38-year career with the department in 1976.

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[790] Memo from John McKasy, administrative assistant, to Dr. Warren Lawson, October 31, 1972.
[791] Memo from Dr. William Harrison to Dr. Warren Lawson, June 21, 1973.

Many of the division directors' assistants and section leaders were also retiring. Elmer Slagle, assistant director of the hospital services division, retired in 1970 after 40 years of service. A few of the other long-term employees who left during this period were:

- Mabel Denny retired from the venereal disease section in November 1973 after 31 years of service.
- Emerson W. Storey, statistician, retired from the department in 1973, after 31 years of service.
- Nora Hoffman, clerk stenographer at the northeastern district office, retired in 1975 after 45 years of service to the department.
- Melvin Fossan, bacteriologist in the medical laboratory division, retired in 1975 after more than 35 years of service.
- Jim Bigham, accounting officer intermediate, celebrated 35 years with the department in 1976.
- Bernice Hendrickson, offset press operator, retired December 1976 after 38 years with the department.
- Marjorie Airgood, senior clerk typist, retired from the Mankato district office after nearly 40 years of service on March 1, 1977.
- Harold Anderson, district representative in Mankato, retired on March 29, 1977, after 28 years of service with the state.

Bertril Estlund, chief of the accounts and finance section since 1953 and a department employee for 37 years, submitted a letter of resignation in 1973:

> I have been feeling for sometime that this is a long enough time to serve behind a desk – and a pencil. I would now like to spend a few years, the early and most important ones of our retirement, out of doors – gardening, traveling, shop work, and of course a lot of fishing.[792]

The department was an aged organization in transition. After several decades with little change in division leadership, there were now openings and opportunities within medical laboratories, health facilities, disease prevention and control, local health administration, and special services.

Along with leadership, the department operational environment was also in transition. An important change was the relationship between the University of Minnesota School of Public Health and the department. A unique connection was lost when Dr. Barr, a close friend of Dr. Gaylord Anderson, director of the School of Public Health, died in 1970. Others from the University of Minnesota School of Public Health who had worked closely with the department for several decades, including Dr. Cecil Watson and Dr. Harold Diehl, were leaving the University. Long-time personal contacts were disappearing. Dr. Lawson made attempts to retain the connection with the School of Public Health, but he was a focused person who concentrated his energies on accomplishing goals in his priority areas. The demands of the position and public

[792] Memo from Bertril J. Estlund to Dr. Warren Lawson, June 19, 1973.

health challenges left little time for building relationships with others. The contacts with the University's School of Public Health became more of a formality.

The relationship between the Minnesota Public Health Association (MPHA) and the department temporarily weakened as well. MPHA was the child of the department, formed in 1907. For many years Dr. Dean Fleming, director of disease prevention and control/personal services, ensured the organization ran smoothly. The board supported MPHA and subsidized meetings. In these early years MPHA was a professional association where public health professionals could come together. The organization filled a special need for many local health units who didn't have public health centers. Policies and activities of MPHA seconded those of the Board of Health.

In the 1960s and early 1970s, Dr. Ellen Fifer and John Diley, both very active in MPHA, were working on the comprehensive state health plan at Minnesota State Planning. For a time Minnesota State Planning became the focal point for MPHA activities. When the state community health services plan was implemented in the mid-1970s, a slate of candidates that strongly represented the Health Department was presented to MPHA. These candidates won, and MPHA was again associated more closely with the department.

Minnesota Public Health Assoc.
Presidents, 1949 to 1999

1949 – Frederick Behmler, M.D.
1950 – Viktor Wilson, M.D.
1951 – Irene Donovan
1952 – Allan Stone
1953 – Allan Stone
1954 – S. A. Whitman, M.D.
1955 – Myhren Peterson
1956 – Clare Gates, Ph.D.
1957 – Clare Gates, Ph.D.
1958 – Robert Ragsdale
1959 – A. B. Rosenfeld, M.D.
1960 – Robert Anderson, V.M.
1961 – Henry Bauer, Ph.D.
1962 – Karl Lundberg, M.D.
1963 – Vivian Harriman, PHN
1964 – Robert Hohman
1965 – Earl Rubie
1966 – William Jordan, D.D.S.
1967 – Ruth Stief
1968 – Robert Schwanke
1969 – Charles Schneider
1970 – C. A. Smith, M.D.
1971 – Arvid Houglum, M.D.
1972 – Thomas Weber
1973 – Ellen Fifer, M.D.
1974 – Paul Schuster
1975 – Kenneth Taylor
1976 – Harold Leppink, M.D.
1977 – Donna Anderson
1978 – Ellen Aldon, M.D.
1979 – Margaret Sandberg
1980 – John Cushing, Jr.
1981 – Frances Decker
1982 – K. C. Spensley
1983 – Esther Tatley
1984 – Esther Tatley
1985 – Deborah Plumb
1986 – Ed Ehlinger, M.D.
1987 – Terry Hill
1988 – Gayle Hallin
1989 – Malcolm Mitchell
1990 – Charles Oberg
1991 – Stan Shanedling
1992 – Mary Sheehan
1993 – Ellen Benavides
1994 – Deborah Hendricks
1995 – Paul Terry
1996 – John Oswald
1997 – Larry Sundberg
1998 – Mary Sheehan
1999 – Marshall Shragg
President Elect – Tricia Todd

Changes Driven by Legislation

Arising out of President Johnson's efforts to build a "Great Society," the department was affected by a number of federal laws passed during the 1960s and 1970s. These included Medicare/Medicaid, Title XIX for Early Screening, OSHA, and Maternal and Child Health. The department was the designated administrator for several of these social programs, considerably expanding activities, while increasing the department's role as a regulatory body. The department began certification of health facilities for Medicare. Additional regulatory responsibilities were added as a result of environmental protection laws. Some of the federal programs were very large, resulting in noticeable expansion of the department. One of these was the new Supplemental Food Program for Women,

Infant and Children (WIC). Authorized by Public Law 92-433, and administered by the USDA's food and nutrition services, cash grants were provided to health departments to make supplemental food available for pregnant and lactating women, infants and children up to four years old.[793]

Changes in federal legislation altered the course of the department's efforts in promoting expansion of health facilities in the state. For nearly 30 years the department had been supporting the growth of health facilities, particularly those in rural areas, through federal funding from the Hill-Burton Act. Funding through Hill-Burton ended in 1974. By this time, many hospital patients were using Medicare to pay their bills. In order to participate in Title XVIII (Medicare), hospitals had to comply with standards set by the federal government. The cost to make the changes could be prohibitive. The 13-bed Community Memorial Hospital in Clarkfield was one that experienced such difficulties. It did not pass the 1967 edition of the Life Safety Code of the National Fire Protection Agency, as required by the federal government for participation in Medicare. The costs to comply were high, and the community pleaded their case to Sen. John Milton in 1974:

> ***"As you know, the goals and objectives of our society are in constant flux. Therefore, if agencies of government are to function with relevance and effectiveness, they must be able to translate social objectives into public policies."***[794]
>
> **Dr. Valentine O'Malley**
> **Vice President, State Board of Health**
> **January 1973**

> Dear Senator Milton:
>
> This letter is being written for the purpose of asking you for your help to keep our hospital open. Medicare restrictions are becoming so rigid, it is making it very difficult for small hospitals to survive. We feel we have an adequate hospital for our community. We have doctors that compare with city doctors, also a very efficient nursing staff. And we think it is important to have a hospital close at hand for emergencies such as heart cases and accident victims. Please help us keep our hospital open.[795]

An additional contention of health facilities was compliance with the Certificate of Need Act, passed by the Minnesota Legislature in 1971.[796] It required any health facility planning new construction that would increase the number of beds or substantially change service provided to undergo a review process, if the costs exceeded $50,000. A public hearing on the planned expansion was first held in the community, organized by the appropriate area-wide comprehensive health planning agency. The area planning agency made a recommendation on the proposed construction and submitted it to the Board of Health. The board made the final decision on whether or not the facility could move forward with the construction. Review, discussion and decision-making on these

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[793] U. S. Department of Agriculture, "Pilot Special Supplemental Food Program Starts for Women, Infants, and Children" (news release), USDA 2086-73, July 23, 1973, pp.1-2.
[794] Opening remarks by BOH Vice President Valentine O'Malley to Senate Finance Committee, January 31, 1973.
[795] Letter from Mrs. Oscar Barkeim, Clarkfield, to Sen. John Milton, St. Paul, April 8, 1974.
[796] The state certificate of need legislation was slightly different from the federal version, which was part of P.L. 92-603, passed in 1973. The federal law did not have power to prevent construction, it applied to some facilities not included in the state legislation, and it was administered by State Planning, creating a duplication of efforts.

certificates of need were complicated and time-consuming and took up a large portion of the board's meetings. During the first three years, from 1971 to 1974, the board reviewed only 74 applications, of which 67 certificates were approved.[797]

Passage of earlier federal legislation, the Civil Rights Act of 1964, made the department look more closely at possible discriminatory activities and its hiring practices. The department placed special emphasis on the recruitment of Native Americans, as indicated in this letter from Dr. Lawson on the affirmative action plan:

> We would certainly favor employment of native Americans in chemical and alcohol dependency programs, where they impact directly on native Americans—as well as in general program development and administration.
>
> The Department has been actively involved with several Native American health manpower development programs, including the Native Americans in Medicine program at the University of Minnesota, Duluth and the Health Care Administration Program of the School of Public Health, Minneapolis. Further, Mrs. Roberta Williamson, a Native American, was recently appointed to the Board of Health to represent the viewpoint of the native American community.
>
> Technical assistance and consultation continues to be provided by the Department to many Native American groups such as Indian Affairs Commission, Indian Health Board, tribal councils, etc.
>
> Your continued interest in the Department is appreciated, and be assured that we are actively seeking qualified members of minority groups at all levels of staffing.[798]

Dr. Lawson: Style and Background

The department was in a new place, new people were replacing experienced employees, and the new agency head, Dr. Warren Lawson, was different than Dr. Barr, Dr. Chesley and earlier executive officers. Dr. Lawson became acting executive officer in 1970 when Dr. Barr died. He was named executive officer in 1971 and became, as one of his assistants later reflected, "the first administrative type."[799] He didn't travel to the field as frequently as Dr. Barr or Dr. Chesley had done. He attended events in the district offices if asked, but he didn't make a habit of visiting the rural areas of Minnesota. Dr. Lawson's relationship with department staff was different as well. He didn't label employees as "my gang," the way Dr. Chesley had, or as "my family," the way Dr. Barr had. Yet, he was friendly and walked around the department building and knew employees by sight. He spent a lot of time focused on management and administrative issues from his new second floor office.

Dr. Lawson had a bachelor's degree in chemical engineering and first worked for the department in 1941 as an environmental health sanitarian and assistant public health engineer in environmental sanitation. During the next 15 years he continued to work at the department, while earning a master's of public health in 1945 and a medical doctor

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[797] MDH, *Services to Minnesotans: Biennial Report to the Legislature*, January 1975, p. 8.
[798] Letter from Dr. Warren Lawson, commissioner of health, to Sen. John Milton, St. Paul, May 21, 1974.
[799] Interview with MDH employee, February 1999.

degree in 1956, both from the University of Minnesota. From 1956 to 1966, Dr. Lawson was director of the state employees health service and director of the occupational health and radiation control program. In 1966 he was appointed deputy health officer, under Dr. Barr.

Dr. Lawson was serious, pragmatic, quantitative and goal-oriented. Overall, he didn't have the close working relationship with the board as Dr. Barr had had. This was partially due to the more frequent changeover of board members. There wasn't as much time to develop connections.

Dr. Lawson's did know what he wanted and went after it. Indicative of his orderly approach and engineering background, the department's first policy and procedure manual was issued under Dr. Lawson's administration. Produced in 1975, the manual addressed personnel issues, finance and accounting, administrative services, and general issues. Among these, the manual designated areas in the building where smoking was allowed. Personnel were not to make coffee if the cafeteria was open and it could be purchased there. Solicitation of funds for recognizing department employees was to be limited to the division in which the employee worked. Division directors were responsible for making sure their areas were decorated in good taste, and posters, pictures and other materials did not detract from the office décor. [800]

Under Dr. Lawson's administration, the department underwent a functional analysis, set up a system for planning and evaluation, added a controller for financing, established a systematic budget process, restructured organizational relationships within the central and district offices, created a new organizational chart, redesigned records management and printing services. Dr. Lawson's organizational skills were needed, as the department was undergoing a time of significant growth. The number of department employees increased by almost 55 percent during Dr. Lawson's eight-year administration.

To help maintain communication within this growing department, an internal employee newsletter was instituted in April 1973. *What In Health's New?* was published every other week and kept employees informed of administrative and program actions, as well as providing a forum for employee comments and questions and information sharing. The first editor of *What In Health's New?* was Mary Ann Doty of personnel. Russell Havir and Nancy Nachtsheim succeeded her. Newsletters published during this period are dominated by articles on affirmative action, announcements of training opportunities, and a log of new employees. Periodically, all-department social activities, such as ski parties, picnics, talent shows and evening entertainment events are announced. Names figuring predominantly in organizing these events were Jim Wigginton, Diane Johnson and Kent Peterson.

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[800] MDH, department policy and procedure manual, July 1975.

Dr. Lawson's Goals

Dr. Lawson set three main goals for himself as executive director. He wanted to defragment the system and consolidate health activities in the department. He wanted to improve local health services and make it possible for local units of government to take care of their own needs. And, third, he wanted to give more attention to chronic disease.

In his efforts to defragment the health system, Dr. Lawson felt that the agency responsible for the health of the population should rightly control more of the health dollar and more of the health functions of state government. Only about 15 percent of the state's budget for health activities went to the department. Dr. Lawson took on battles with Human Services and the Pollution Control Agency to try to gain control of activities.

Dr. Lawson wasn't very successful in his attempts to transfer programs from other agencies to the department. The only program that was transferred and remained permanently was the crippled children's services program, placed in the department in November 1973.[801]

Health professional licensing boards were transferred to the department, beginning with the nursing board in August 1974.[802] While several boards did relocate to the department, it was a temporary move for all. In 1972, prior to the transfer in, Dr. Lawson was asked by the Legislature how satisfied he was with the department's relationship with health licensing. He replied:

> I can say this. We currently have no direct relationship with any of the health professional licensing boards. We do have a regulatory agency in a variety of other fields and frequently have need to communicate with them about specific matters. We believe that as the state moves to developing a much more coordinated health information system that involves medical manpower of all kinds and varieties, and as we start identifying new kinds of professions and developing systems for certifying or licensing or whatever happens, that there is going to have to be a lot more central state involvement in these issues. One of the difficulties we have is trying to get the licensing boards to work together with us so that we can develop a good system in the state of collecting useful information about the professions and their distribution and qualifications, because we think this is needed in making many decisions that we are required to make. I think there would be some advantage for some closer tie-in between the state health agency and the health profession licensing group. I also suspect, as everyone else has indicated here, that there would be economies in this kind of legislation.[803]

Dr. Lawson continued trying to defragment, coordinate and integrate state health-related programs. Inter-agency contract arrangements were made with other state agencies to ensure the department conducted the health components. These included a contract with the Department of Public Welfare regarding the early and periodic screening programs for children, a contract with the Department of Labor and Industry

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[801] MDH, *"Services to Minnesotans, Biennial Report to the Legislature,"* January 1975, p. 7.
[802] Ibid.
[803] Joint Subcommittee Meeting, Senate Committee on Health and Welfare, April 17, 1972, pp. 37-38.

regarding the occupational health and safety program, and an agreement with the Department of Agriculture regarding food inspections.[804]

One of the challenges Dr. Lawson dealt with was the federal government's designation of some health-related activities to agencies other than the Health Department. The 1972 amendments to the federal Social Security Act, for example, designated state planning agencies as the sole agencies for carrying out the administration and health planning functions.[805] Dr. Lawson did not approve of this decision and wrote to the governor's office:

> In Minnesota and in the remaining states where the (a) agency is located elsewhere, however, the changing position of the Federal government will increasingly result in confusion and conflict since two separate agencies will be involved in 'regulating' in some areas. It is perhaps desirable therefore to raise with you at this time the larger consideration of the transfer of the (a) agency to the State Board of Health. . . .[806]

Not all new federal health-related programs were assigned to the department, but a significant number were. The department's total budget increased almost eightfold during Dr. Lawson's administration. Total annual department expenditures in 1970 were $4,876,825 compared to $41,192,282 in 1979.[807]

Dr. Lawson's second goal was to improve local health services. Since its beginnings in 1872, the department had been trying to develop a more effective system for providing public health services to all communities in the state. Impediments were the lack of resources and resistance by local units to consolidate. Dr. Lawson's top priority for the 1975 legislative session was expansion of efforts to assist local communities to improve their capacity for delivering local health services, and he designed the Community Health Services Act for this purpose..[808] Through its passage he was able to obtain the resources needed for local communities. Rep. Martin Sabo, then Speaker of the House, strongly supported a community health services system in combination with social services, but Dr. Lawson fought for a separate program.

In addition to defragmentation and an improved local health system, Dr. Lawson's third priority was reduction of chronic disease, focusing on wellness and health promotion. His lead person in this area was Dr. A. B. Rosenfield. Described as "20 or 30 years ahead of his time," Dr. Rosenfield was progressive and believed in the "Teddy Roosevelt can-do" style of government. Together, Dr. Lawson and Dr. Rosenfeld advocated for expansion of public health activities in the areas of alcoholism, mental illness, cancer, nutrition, tobacco control, and other chronic diseases and conditions related to lifestyles. As deaths from and cases of communicable diseases had dropped dramatically, they recognized more attention needed to be given to chronic disease. Though health promotion and attention to lifestyle factors had been advocated before, Dr. Lawson attacked them with new vigor.

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[804] MDH, *"Services to Minnesotans, Biennial Report to the Legislature,"* January 1975, p. 7.
[805] P.L. 92-603 Title 42.
[806] Memo from Dr. Warren Lawson to Mr. Thomas A. Kelm, governor's executive secretary, January 31, 1974.
[807] MDH (finance and administrative services division), "Expenditure Comparison for the Period 1954-1999."
[808] Memo from Dr. Lawson to executive office, division directors and district representatives, November 12, 1974.

Lawson's Support Team

The retirement of many long-time employees created openings. Lawson was always alert for new talent to bring into the department. He was looking for a new generation of dynamic public health professionals.

Dr. Lawson liked capable chameleons, people who could adapt to the various circumstances and get the job done. He was innovative and surrounded himself with creative individuals. His focus on health promotion gained much success because of the leadership of Dr. Rosenfield. His focus on local health services moved forward through the skills of Robert Hiller, Ph.D., who took a strong leadership role. Dr. Hiller had a background in biometry, and had been chief of the vital statistics section since 1962. Dr. Lawson recognized Dr. Hiller's abilities in planning and management and gave him "make-it-happen" assignments. One of the first of these was establishing the community health service system. Effective February 1, 1974, Dr. Hiller became assistant commissioner for development, responsible for establishing and implementing goals and objectives, analysis, evaluation, and priority setting. [809] At the same time, Ernest Kramer became director of the community services and development division, and Fred Goff became assistant to the director. [810]

Margaret Sandberg joined the department as a health planner in June 1972. Previously she was a comprehensive health planner with the Metropolitan Health Board of the Metropolitan Council.[811] Michael Moen began his career at the department in 1974 as Dr. Lawson's administrative assistant. Two others who began work in the executive office in 1974 were Wayne Arrowood, planner, and Paul Gunderson, analyst. In 1976, Pauline Bouchard began work in the executive office as a law clerk.

Another addition to Dr. Lawson's team was Ellen Fifer, M.D., who joined the department in 1973 as assistant commissioner for programs. Dr. Fifer had been the director of the comprehensive health planning program at the State Planning Agency from 1967 to 1973. A native of New York, she worked as a staff physician at the University of Minnesota and was health officer in the cities of St. Louis Park, Richfield and Bloomington. [812]

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[809] MDH, *What in Health's New?,* Vol. 2, No. 3, February 1, 1974, p. 1.
[810] Ibid.
[811] MDH, *What in Health's New?,* Vol. 2, No. 4, February 15, 1974, p. 1.
[812] MDH, *What in Health's New?,* Vol. 2, No. 2, January 18, 1974, pp. 1-2.

Dr. Lawson coveted talent, and it is charged that he even stole from within his own agency. While Dr. Helen Knudsen, director of health facilities, was on vacation, he transferred David Giese from her division to the executive office.

It was during this period that Michael Osterholm, Ph.D., joined the department. When he first came in 1975 he was a graduate student intern, working for the personal health services division. Dr. Osterholm has been described as "fortunate" for the department. Articulate, enthusiastic, and compelling, Dr. Osterholm used disease outbreaks to capture the interest of the people and spread the public health message.

"I see the Department undergoing rather massive change which is hard on everyone, the changers and the changees! These changes come in response to changes in our society: Health services are a right not a privilege. Demands are placed on the Department from the Governor's Office, the Department of Administration, Legislature, Federal Government and from the consumer public. We have added new programs in response to legislation. For example: the H.M.O. Unit, Health Manpower Program, Technical Consultation and Training Section of the Division of Health Facilities; and have added staff to strengthen others: Emergency Medical Services, Family Planning and Community Services Development. I think that change will continue to be with us but hopefully the rate of change will not be quite so overwhelming."[813]

Dr. Ellen Fifer
Assistant Commissioner for Programs, 1973

Internal Management

The great decentralization of department employees prior to construction of the new building in 1969 had resulted in a loose coalition of division directors who Dr. Lawson felt operated somewhat independently. Though division programs were operating successfully, Dr. Hiller and Dr. Lawson felt there was a need for greater sharing of information, with divisions working more closely together to produce interrelated goals and objectives linked to the agency's mission and vision. Dr. Lawson saw the current separateness of divisions as destructive for the agency. It was not a true agency, but a coalition of divisions.

Determined to get the power centralized in the executive office, Dr. Lawson took a new approach to bring the divisions together in closer synergy. When state government announced the Loaned Executive Action Program (LEAP) in 1972, Dr. Lawson actively sought a LEAP team for the department. The department was the smallest agency to have a team. While LEAP's recommendations were ones Lawson wanted, they were viewed as LEAP initiatives, not Lawson initiatives.

In 1973, through LEAP, the department was reorganized for the first time since 1957. The number of divisions was reduced from six to five. The disease prevention and control division was renamed personal health services and enlarged to become a super-division which included maternal and child health, dental health, poison control,

[813] MDH, *What in Health's New?,* Vol. 2, No. 2, January 18, 1974, pp. 1-2.

nutrition, adult health and mental health, in addition to the existing sections of disease prevention and control, and acute and chronic disease.

> ***"Changes in the public health and in the existing medical care delivery system are occurring and will continue. It might well be, however, that the really basic change that must occur is to reorganize our efforts more positively toward promotion of wellness and health instead of concentrating all of our efforts on illness and disease, and this is the real challenge of the years to come so that we may be the healthiest, as well as the wealthiest nation on earth."***[814]
>
> **Dr. Warren Lawson, 1972**

In 1973, Dr. Lawson instituted assistant executive officer positions, the precursors of bureaus and assistant commissioners. Reporting directly to the commissioner, each assistant executive officer had responsibility for two or more divisions.

Further organizational changes were made in 1976. Assistant executive officers became assistant commissioners, and the number was expanded to three. They covered one of three areas: programs, administration or community development. Along with other organizational changes at this time, a new division, health manpower, was added. This division had oversight of health providers and services and indicated the regulatory expansion that was under way.

One of Dr. Lawson's former assistants views the department as evolving to a united, powerful agency in the 1970s. The department was together in one building, working towards a shared mission. This lasted for more than a decade.

Health Care vs. Medical Care

Amid all the other changes that were occurring during the 1970s, there was a nationwide transition that made the distinction between public health and medical care more difficult. Often the word "health" was used instead of "medical" when referring to direct patient care. The new name of the University of Minnesota Medical School was the Health Science Center. The new usage sometimes confused persons who thought it represented public health. The use of the term "health maintenance organization" added to the confusion. Dr. Lawson felt the health maintenance organization title incorrectly implied preventative, when the preventive services at health maintenance organizations tended to be limited to periodical physical examinations and immunizations at this time.[815]

One of the recommendations from the LEAP team was to restate the purpose and duties of the Department of Health. The department's 100-year-old statement of powers and duties, as given in Minnesota State Statutes 144.05 through 144.12, was written to "protect and preserve" the health of the people of Minnesota. A mission

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[814] Dr. Warren Lawson's statement at the Joint Subcommittee meeting, Senate Committee on Health and Welfare, April 17, 1972, p. 34.

[815] Ibid.

statement and new duties, as adopted by the Legislature in 1973, aimed at protecting, maintaining and improving the health of the citizens. For some, the inclusion of the word "improving" implied treatment in the medical sense of the word and was viewed as part of the nationwide trend making the difference between health and medical more obscure.

> ***"I sometimes wonder what happened to the term medical care. It has almost fallen into total disuse and in its place we now have the term health care – thus, we talk about health insurance and the health delivery system, etc. Now, the facts are that health insurance is not health insurance at all, it is sickness insurance, and what most persons think of as the health delivery system is not a health delivery system, but it is almost totally concerned again with sickness and disease."***[816]
>
> **Dr. Warren Lawson, Commissioner of Health, January 1975**

Politics vs. Science

A 30-year department employee described the organization as leading with its head, not its heart. Historically, the department has waited to base decisions on facts, on scientific evidence. First and foremost in the minds of the "old school" of public health greats was the quantifiable effect any activity would have on the health of the population and its scientific rationale. Dr. Barr, for example, was very hesitant to deliver a message to the public in 1961 that might be interpreted as "smoking causes lung cancer."[817] He didn't want to have that message go out, unless it was clearly supported by fact. The department did not see itself as a political agency.

Dr. Lawson continued with this concrete decision-making approach. Decisions were to be based on facts, not political whims or expediency. This approach could be unpopular with legislators who needed to try to satisfy their constituents. There was an increase in activism and radicalism during this period, and citizens were becoming more and more vocal. This could sometimes make it difficult for the department to implement activities. One area where this was best exemplified was the resistance from the City of Brainerd to the department's efforts to fluoridate the municipal drinking water. While most communities readily accepted this addition, which brought with it the prospect of ending tooth decay, a few communities staunchly refused. The most resistant was Brainerd.

One letter which exemplifies the feeling of the times:

> What was the purpose of the Vietnam conflict, Korea, or any other war the United States has been involved in during its 200-year history? I was under the impression it was to protect our rights and freedoms. Forced fluoridation may not offend you, but it certainly does me, as it does many other veterans. Being a Vietnam veteran and father of a 3-month-old son, I feel that whether he gets fluoridated water should be my decision and not that of the State Legislature or the State Health Department.

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[816] Presentation by Commissioner Warren Lawson to the House Health and Welfare Committee, Minnesota Legislature, January 21, 1975, p. 1.
[817] BOH, *Minutes,* May 23, 1961, MHS, p. 215.

> Although my home town of Brainerd has voted fluoridation down three times by an overwhelming majority, we are still being forced into a seemingly endless struggle to keep fluoride out of our pure well water. This is most certainly an infringement on our constitutional rights. If I want my son to have fluoride, I will get a prescription from the doctor, and then I will know he gets the proper dosage and not amounts as variable as his daily intake of water.
>
> Mass medication is most un-American. We in Brainerd are trying to do something about decisions of this kind to the people. We are asking legislators to vote for House File 1055 and Senate File 1750, which would give the people of each municipality local option in the matter of water fluoridation. We lose more and more of our freedoms every day. Let's not lose the right to decide what medication we will take or give to our children.[818]

Citizens of Brainerd were strongly opposed to fluoridation. So much so that Dr. Lawson received a threat, indicating harm if he did not stop advocating fluoridation. The department took the unusual step of filing a lawsuit to try to implement fluoridation. Fluoridation of Brainerd's drinking water did not occur until 1983 and did not happen without scars that continue to this day.

(Note: The department's role in fluoridation is described in greater detail in Chapter 11.)

The Reserve Mining Case

An excellent example of the department's focus on scientific rationale as the basis for decision-making was the case with the Reserve Mining Company and asbestos in the drinking water of Duluth.

Malignant mesothelioma, a rare cancer that attacks the lining of the lung or stomach and for which there was no cure, had shown to be associated with asbestos exposure.[819] When it became known that the Reserve Mining Company had been discharging their asbestos-laden wastes into Lake Superior and contaminating the drinking water of Duluth, a lawsuit was filed against the company.

The Pollution Control Agency took a strong position against Reserve Mining and sought to have the discharge into the lake stopped. The department felt otherwise. It took the position that, with the limited information available, the asbestos fibers in the drinking water from tailings did not seem to constitute a major threat to the population. The department felt throwing the company's 3,000 employees out of work would create undue mental and health stress and cause a worse effect than that caused by the asbestos. The risk from the tailings was figured at one death per 100,000 persons, compared to a homicide rate in Duluth of three deaths per 100,000 persons.

The department made its first official statement on its position at a Pollution Control Agency board meeting on July 9, 1973. Citing analyses to-date on the water in the

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[818] *Minneapolis Tribune,* "Freedom From Fluoridation," (letter to editor by Bruce L. Kraemer, board member, Minnesotans Opposed to Forced Fluoridation, Brainerd, December 27, 1973.

[819] Letter from Harry Von Huben, water supply branch, to Henry Longest, water division director, both from the U.S. Environmental Protection Agency, September 12, 1975.

Lake Superior area, the department reported: "We cannot say that there is no risk, but the information that we have suggests that any risk that is present is very small."[820]

Information received and reviewed during the next year reinforced that decision. Death rates for both lung and gastrointestinal cancer in the state for the years 1955 to 1971 showed no significant difference in the Duluth area.[821]

Based on information available, the department reached the following official conclusions regarding the danger of asbestos in the drinking water of Duluth and surrounding areas:

- The situation in the Duluth area is comparable to other places in North America, and present information suggests the risk is small.
- Any risk present is low.
- The economic impact created by loss of employment could have real health consequences.
- The incremental risk from fiber exposure does not constitute an emergency.[822]

The department's position did not indicate the sense of danger and risk, as did the reports from the Minnesota Pollution Control Agency, the courts and the federal Environmental Protection Agency. While Judge Miles Lord described the discharge of taconite into Lake Superior as a "very substantial public health menace," Dr. Lawson wasn't so certain. He said "...little scientific data are available on the matter, and that realistically it may be years before definitive information is forthcoming."[823] The Environmental Protection Agency felt there were health risks and prohibited North Central Airlines from using water from Duluth's water supply, as the agency could not certify it for interstate use due to the presence of amphibole asbestos fibers.[824]

Duluth Mayor Ben Boo regarded reports by the Pollution Control Agency and the Environmental Protection Agency on the health risk as extravagant. In 1974 he was quoted as saying that he tried to counterbalance these fear-generating messages in the media. He said the statements he used to reduce concern came from the Department of Health at his request.[825] This raised questions about the department's involvement in the issue.

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[820] MDH, "Status Report on Lake Superior Asbestos Water Problem," (memo), July 11, 1973.
[821] Letter to Cecil Newman, editor of the *Minneapolis Spokesman*, from Dr. Warren Lawson, August 3, 1973.
[822] Memo from Dr. Warren Lawson to Gov. Wendell Anderson, "Documentation of the Minnesota Department of Health Position in Relation to the Water Supply Problems of the Western Lake Superior Area, April 5, 1974.
[823] *Minneapolis Tribune,* "Duluth Health Threat Said Not Downplayed," April 26, 1974.
[824] Letter to Duluth mayor Ben Boo from Francis Mayo, regional administrator, U.S. Environmental Protection Agency, April 23, 1974.
[825] *Minneapolis Tribune*, "Ben Boo 'Managed' News on Fiber Threat," March 23, 1974.

Dr. Lawson immediately sent letters to the newspapers clarifying that the department had not inappropriately provided information to Mayor Ben Boo; but the department's reputation was under fire. One letter writer expressed his feelings:

> How can we trust an institution—which many look upon to protect the public health—that has become politicized? What other policies or statements from this agency are based upon protecting powerful economic organizations or as a result of 'requests and prodding' from other political officials or groups?
>
> So that we can again have faith in the credibility of the Minnesota Health Department, Gov. Wendell Anderson – if he is at all concerned about honesty and integrity in government agencies – should immediately seek to remove from office all the agency officials who took part in this action.[826]

That spring, when the department reported that fish from Lake Superior were safe to eat "in-so-far as the possible presence of asbestos-like fibers is concerned," the analysis did not go without question.[827] A newspaper article reported that the conclusion was reached based on the analysis of one fish. It ended with:

> Evidently, we can conclude that there is at least one trout in Lake Superior that is safe to eat unless there were asbestos fibers present that were not detected by the testing equipment. And if there were fibers present it may or may not be dangerous to humans depending upon whether or not future scientists ever determine how much asbestos fiber in fish is bad for us."[828]

The department's position brought both it and the governor's office under attack. In a May 7, 1974 Minneapolis Tribune editorial, the former deputy director of the Pollution Control Agency lambasted the governor, the department and Dr. Lawson:

> Once again, in the April 26 Tribune, we have the governor making excuses for the Minnesota Health Department. If the Department did not 'downplay' the asbestos risk, what was it doing? Why did Dr. Warren Lawson write to the Red Wing paper pooh-poohing asbestos as only a relative risk like many others we must learn to live with.
>
> During my tenure in the Minnesota Pollution Control Agency, the Health Department never lost an opportunity to thump for a retrograde health policy. It was over the Health Department's objections that we established telemetric monitoring of Monticello and that the low-level radiation study was commenced, and the Department had done nothing on the health aspects of Reserve's tailings in all the years of the controversy. When finally asked by the court about asbestos, the Department appeared to downplay the threat as much as it could.
>
> There is a continual chorus in this country about risk-benefit. If we just take another risk, add another pollutant, then the benefits will be worth it. Dixy Lee Ray of the Atomic Energy Commission is the principal practitioner on the federal level, and in Minnesota it is Dr. Lawson. This view happens also to suit large corporations that are happy with a "survival of the fittest" philosophy as long as they are found among the fit. And so we have the Anderson administration continuing the support the Health Department. This is the most comfortable and apparently least risky position, and it is not about to leave it, as I learned during the MPCA years. At the crack of doom an Anderson spokesman will be saying the evidence lacks foundation.

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[826] *Minneapolis Tribune,* "Boo's New Management," letter to the editor from Don Ternes, Duluth, April 7, 1974.
[827] *Minneapolis Tribune,* "It Makes You Wonder," April 29, 1974.
[828] Ibid.

> We are now living in a world which demands prevention, not cures, and demands it for survival. But it is natural for bureaucracies to preside rather than prevent, or at most advocate cures after the fact. To do otherwise would remove the need for their existence. Such a luxury, and its encouragement or tolerance by spineless politicians, is wrecking this country, a Watergate by default. All the Health Department alarms and breast-beating over jack-o-lanterns and pinworms does not excuse it from the duty of preventing large-scale disasters instead of appearing at the autopsy with apologies or denials.[829]

An article in the *Minneapolis Spokesman* pointed out the Health Department's isolated role:

> The irony in the confrontation between the steel industry and the spokesman for society lay in the fact that the industry's one protagonist in this confrontation was the Minnesota State Health Department, which argued among other preposterous things that employment on the iron range was more important to the health of the region than the water pollution the Reserve operation was producing. Almost everybody else is holding otherwise, though Judge Lord did express grave concern about the 6,000-odd jobs that will be affected by the shutdown.[830]

Questions were being raised as to whether or not the department had the best interests of the citizens of Minnesota in mind. A May 9, 1974 WCCO-TV editorial was broadcast on "The Scene Tonight." The editorial read:

> Considering the performance of its officials in the Reserve Mining Company pollution case we're left wondering whether the Minnesota Health Department's purpose is to protect the public's health or the state's industries.
>
> Shortly after a federal warning that asbestos fibers from Reserve's discharge into Lake Superior might cause cancer among the Duluth residents who drink the lake water, a spokesman for the Health Department said the risk is very small, admitting that it isn't clear what the effects of the material in the water may be.
>
> And later, State Health Commissioner Dr. Warren Lawson wrote a public letter conceding that there were only 'rough, first-order estimates' of the risk to go on, yet he said they are 'well within the risks to which the population is normally faced...' such as heart attack, car wrecks, and suicide. And he said the asbestos risk must be weighed against the effects of illness and disease too. He concluded that emergency action did not seem warranted. Which seems to say that if an industry is important enough it should be allowed to take some liberties with the public's health and the public shouldn't worry.
>
> One might understand the line of reasoning from a Chamber of Commerce, but not from a State Health Official.
>
> After looking into the matter, the Governor's office has now decided the Health Department did not deliberately downplay the warnings. That seems very charitable, and we're not convinced.
>
> We suggest that State Health Officials use our tax money looking for present and future health perils and combating them....and that they stop muffling danger warnings before they know how great the danger may be.[831]

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[829] *Minneapolis Tribune,* editorial by Charles Carson, former deputy director of the Minnesota Pollution Control Agency, May 7, 1974.
[830] *Minneapolis Spokesman,* "The Iron Industry and the Judge," April 22, 1974.
[831] Letter from Ron Handberg, WCCO-TV news and public affairs director, to Dr. Warren Lawson, May 13, 1974.

The Reserve Mining case received national attention. Science magazine pointed out the question with which the department was struggling: "How clear must the scientific evidence be for a court to find that pollutants from an industrial plant represent a threat to public health?"[832] The Pollution Control Agency, the governor and public support seemed to feel the risk caused by taconite tailings was sufficient to stop the activity.

On March 15, 1975, the situation received even more attention when CBS-TV correspondent Dan Rather released a report on a case of mesothelioma in Duluth, suggesting it may have been caused by asbestos from mining wastes in the drinking water.[833]

The Reserve Mining situation case placed the department in a position at odds with other state agencies. In July 1975, James Coleman, former assistant director of the department's environmental health division, resigned from his position to enter consulting work and spoke to the media about his experience with the Reserve Mining case. He said he had been told by Byron Starns, chief deputy attorney general, not to publicize differences since the Pollution Control Agency and the Health Department were part of the same agency.[834]

Following a publicized nine-month trial, presided over by Federal District Court Judge Miles Lord, the taconite plant was shut down as it was deemed an imminent health threat. Three days later, following the orders of the U.S. Circuit Court of Appeals in St. Louis, it was reopened. While the department did not support the risk assessment of other agencies, it did take an active role in supporting the City of Duluth in obtaining a water filtration plant that could deal with the contaminated water. The Laws of Minnesota 1975, Chapter 437, Subd., provided for state assistance to build water treatment facilities. A total of $123,297.59 (less flagpole and plant sign) was provided in a grant to Duluth in 1976.[835] That same year Commissioner Lawson received an invitation from the Mayor of Duluth, Robert Beaudin, to attend the dedication of the city's water filtration plant. It read: "We are aware of your contribution to making this important facility possible for the benefit of our citizens, and will be very pleased to have you observe it become a reality."[836]

The dumping of taconite wastes by Reserve Mining into Lake Superior stopped permanently in 1980, but the issue of asbestos-induced mesothelioma on the Iron Range was far from over. It would resurface with several future Health Department administrations.

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[832] Luther J. Carter, "Pollution and Public Health: Taconite Case Poses Major Test," *Science*, October 4, 1974, pp. 31-34.
[833] Memo from Dr. Warren Lawson to Gov. Wendell Anderson, January 13, 1976.
[834] *Minneapolis Star Tribune,* "Reserve Case Dispute Aired," July 11, 1975, p. 51.
[835] Letter to Mayor Robert Beaudin from Dr. Warren Lawson, October 26, 1976.
[836] Letter to Dr. Warren Lawson from Mayor Robert Beaudin, November 5, 1976.

Power Line Controversy

Another high-profile issue that began during Dr. Lawson's administration was the power line controversy. Minnesota had the distinction of having the second and third high-voltage, direct-current transmission power lines in the country. The first was in Oregon and California between the Bonneville Dam and Los Angeles. The first power line in Minnesota ran from North Dakota to Duluth. The second, scheduled to run into the metro area from North Dakota, was met with much resistance. As the protestors were most concerned about the potential ill health effects, the Department of Health was involved in this political issue.

The Cooperative Power Association (CPA) and United Power Association (UPA) began discussion of this project in 1972. In 1976, the Environmental Quality Board, which approved environmental impact statements, issued a construction permit for the power line. Plans proceeded relatively smoothly until June 10, 1976, when the project confronted protestors on the field of the Virgil Fuchs farm. The center of the protest continued in Polk and Stearns counties, prompting Gov. Perpich to tour the area in January 1977.[837] Legislative hearings on power line issues took up much of the 1977 legislative session.

In 1977, the department produced a report, primarily a literature study, stating there were essentially no ill health effects from the power line.[838] Vandalism and obstruction continued at the construction sites. The protestors toppled 15 towers. The protestors formed the General Assembly to Stop the Powerline (GASP). [839]

When the power line was ready for testing in October 1978, the department looked at the potential hazards, conducted data collection where possible and reviewed what few studies on direct current power lines had been done. The department looked at the potential ill effects from ozone, air ions, and the shock hazard condition, with no definitive conclusions. The issue was one that Dr. Lawson eventually passed on to his successor, Dr. Pettersen.

Nursing Home Scandal

While engrossed in LEAP organizational changes, trying to convince Brainerd to comply with legislation which mandated fluoridation of their drinking water, trying to implement community health services and while trying to deal with power lines, asbestos in Lake Superior and numerous other issues, Dr. Lawson was confronted with his role in the River Villa Nursing Home scandal.

The River Villa Nursing Home was the largest privately owned nursing home in Minnesota. One of the owners, Bertram Strimling, had been appointed to the Board of

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[837] MDH, "Brief Chronology of CU-TR-1."
[838] *St. Paul Pioneer Press*, "Power Line Data Inconclusive," November 9, 1977, p. 13.
[839] MDH, presentation to Minnesota Academy of Medicine on "Powerline Ionization Hazards," December 1, 1981.

Health in 1971. As a member of the board, Mr. Strimling was one of the people who selected the executive officer and secretary, then Dr. Lawson.

As the regulator of nursing homes, the department conducted inspections and determined whether a facility met the requirements to receive Medicare payments. Questions arose about conflicts of interest, particularly when a letter was discovered in which Mr. Strimling had written to Dr. Lawson, "Anything you can do for me to speed the approvals needed will be greatly appreciated."[840]

A 1975 grand jury investigation of the nursing home's affairs uncovered conflicts of interest and political influence peddling on the part of several public officials; inadequate regulation by the Health and Welfare departments, informal kickbacks and other charges which led to the criminal prosecution and conviction of Mr. Strimling and his partner, George Hedlund. Prior to this, on April 4, 1974, Bert Strimling had resigned from the Board of Health.

Bertram Strimling and Dr. Lawson spoke at a legislative hearing on the subject on February 18, 1975. Dr. Lawson denied giving favored treatment to Mr. Strimling. [841] He said that it is almost impossible to avoid dual interests on the board.

Two months after the 1975 legislative hearing, additional information made the situation for the department worse. Anthony Kist, chief of health facilities standards and compliance, was transferred to another division when it was learned that he had borrowed $13,000 from the Washington Development Company, the eventual owners of River Villa. Mr. Kist had borrowed the money in 1968 when he was a nursing home inspector.[842]

The media raised concerns about alleged conflicts of interest, political influence, favored treatment and hidden profits between the department and Mr. Strimling, especially after two department employees spoke out. In February 1975, James Miles, the department's chief of inspections, resigned to accept another position. He reported that Dr. Lawson orally requested notices of when nursing home inspections would occur.[843] Two months later, Ellis Olson, another department employee who was in charge of nursing home licensure and certification, told the news media that, "Dr. Lawson has told us that any help that facility needs and wants, I want you to make sure that they get it in terms of meeting standards."[844]

On July 1, 1975, shortly before two legislative commissions began an investigation into the department's effectiveness in nursing home regulation, Dr. Lawson sent a directive to department employees not to talk with legislators unless it was cleared with the commissioner or one of his assistants. State Sen. John Milton, DFL-White Bear Lake, said the order was "frightening" and said "It's like the bloody Pentagon Papers."[845] Dr.

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[840] *Minneapolis Tribune,* "Nursing Homes – The Regulated May Also Regulate," February 4, 1975, p. 1.
[841] *Minneapolis Tribune,* "Health Commissioner Denies Favors," February 19, 1975.
[842] *Minneapolis Tribune,* "State Health Aide Shifted Because of River Villa Link," April 29, 1975.
[843] *Minneapolis Tribune,* "Nursing Homes – The Regulated May Also Regulate," February 4, 1975, p. 1.
[844] *Minneapolis Tribune,* "River Villa Nursing Homes Series/Owner used Health Board Seat," February 4, 1975, p. 6A.
[845] *St. Paul Pioneer Press Dispatch*, "Gag Order Seen in State Probe," July 31, 1976, p. 12.

Lawson explained that the purpose of the memo was to prevent everyone in the department from communicating with everyone else while he was responsible for the department. To some, like Sen. Milton, however, it raised questions as to what the department might be trying to hide.

In June 1975, Bert Strimling denied receiving kickbacks from his position as a member of the board. However, Robert Wernick, owner of the Pink Supply Company, told the court he had, at Mr. Strimling's suggestion, paid him $1,500 a month for information on state approval of nursing home proposals. As a member of the Board of Health, Mr. Strimling knew when certificates of need were issued to nursing homes to expand or build. Mr. Wernick consented to the arrangement in 1974 but stopped paying, as business did not come in. As a result of Robert Wernick's testimony, Mr. Strimling was put on trial in 1976 for perjury in Hennepin District Court.[846]

Under Media Attack

Perhaps more than ever before in the last 30 years, the department was under attack during Dr. Lawson's administration. State Sen. Winston Borden of Brainerd was most concerned about Dr. Lawson's insistence to fluoridate the drinking water of Brainerd, but in a letter to the Crow Wing County Review he referred to several other issues:

> The priorities of Commissioner Lawson are wrong and his employment contract with the State Board of Health should be terminated at the next meeting of the State Board of Health.
>
> Let me cite three examples. Nursing home scandals have been the subject of recent court actions in rural areas as well as in the metropolitan area. The scandals could have been prevented by proper nursing home regulations by the Department of Health. Instead, the scandals have included evidence of improper activities of health department personnel.
>
> The legislature has found it necessary to undertake a complex investigation of the nursing home industry. We have found that the sorry conditions that exist in some private nursing homes also exist in some state facilities. The Commissioner of Health should have led the fight for better nursing home regulations in Minnesota. Instead he has been silent.
>
> In addition we have had serious problems with venereal disease in Minnesota. In the last ten years the number of cases of venereal disease have increased by more than 500 percent. That's why the legislature in 1974 directed the Department of Health to adopt a vigorous program for the detection and treatment of venereal disease. In the last six months I have seen no real evidence that the Commissioner has attempted to move the bureaucracy to implement the program.
>
> When I say the Commissioner of Health has a wrong sense of priorities, I must refer to what he has done as well as to what he has not done. The Commissioner has spent a substantial amount of time and money to force the citizens of Brainerd to fluoridate their water supply pursuant to a 1967 law. For five years the Commissioner has tried to force fluoride down the throats of the citizens of Brainerd. The Commissioner has refused to consider any alternative to the fluoridation law such as a dental care program recommended by the Brainerd City Council. The Commissioner has not conducted studies to indicate the value as compared to the harm created by the state law. His high-handed bureaucratic attitude on this issue should not be tolerated. It

[846] *St. Paul Pioneer Press*, "Strimling Got Money for Health Board Ties – Wernick," January 29, 1976, p. 13.

has resulted in the spending of vast sums of taxpayers' dollars to force them to do something that they do not need or want.

The Board of Health should expect the Commissioner to set priorities for the Department. Let me respectfully suggest that the people of this state consider it far more important to have proper nursing home regulations and a good venereal disease treatment program than they do to have forced fluoridation.

The people are justifiably upset with the conduct of Commissioner Lawson and I urge that he not be reappointed. If he is reappointed, let me further suggest that pursuant to Chapter 310 of the 1975 Session Laws that the Senate will not confirm his reappointment," Borden concluded.[847]

Amid all the media and public turmoil, Dr. Lawson had a personal loss. His wife, Eleanor C. Lawson, who had served as the department's librarian for many years, died of cancer on November 5, 1974.

Community Health Services

Perhaps Dr. Lawson's single greatest achievement during his tenure was implementation of the Community Health Services Act. The foundation for this system was well laid and, unlike earlier attempts to improve the local health system in the 1940s and 1950s, the CHS system is strongly in place and working well more than 20 years later.

(Note: Implementation of the Community Health Services Act is described in greater detail in Chapter 10.)

Disease Prevention and Health Promotion

While health promotion did not capture the news media's attention in the same way as did fluoridation in Brainerd or the risk of asbestos, progress was being made within this third priority area of Dr. Lawson's. The emphasis of the administration was placed on health behavior modification, or restructuring one's life to increase the habits that lead to better health. One of the reasons given for emphasizing healthy lifestyles was the skyrocketing cost of health care costs. Given the rapid rate of increase, a growing segment of society was unable to afford proper care and treatment.[848]

One of the efforts to better educate the public was a telephone health-line set up by the department's health education unit. Pre-recorded messages were changed every two weeks. The public was encouraged to phone in for this information on understanding and protecting their health.[849]

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[847] *Crow Wing County Review*, "Borden Attacks Health Board," Vol. 75, No. 44, February 26, 1976, p. 1.
[848] *Capitol Reporter*, "Health Commissioner Hopes to Inject Good Health in Lifestyles," January 17, 1978, pp. 3-4.
[849] MDH, *What in Health's New?,* Vol. 2, No. 6, June 7, 1974, p. 2.

In 1975, the department instituted smoking policies, in order to comply with the Clean Indoor Air Act. If an employee had a private office, he or she could determine whether or not the office was to be smoke-free. A semi-private office was designated as a smoking area only if all employees occupying the office agreed. Division directors were responsible for designating their bay areas. They were required to ensure some areas were smoke-free. Conference rooms were to be smoke-free for public meetings. Internal meetings were smoke-free or not, at the discretion at the person in charge. Washrooms on the second and fourth floors permitted smoking. All others were smoke-free. Employees were free to smoke in the locker rooms, a designated area of the cafeteria, and the lounge off the boardroom.[850]

In 1977 Dr. Lawson demonstrated his personal commitment to support no-smoking initiatives, by joining with other public figures in signing a pledge not to smoke. The newspaper article describing this event was titled "State Bigwigs (Puff, Wheeze) Sign Pledges." Along with Minneapolis Mayor Al Hofstede, State American Cancer Society President John Brown, and Miss North Star 1977, Stephanie Harstad, Dr. Lawson signed a pledge not to smoke on January 19, 1977, D-Day. At this time he announced that on D-Day the department would begin holding smoking cessation clinics for employees.[852]

> ***"People do not change their behavior patterns alone, and just providing information is not nearly enough. (What will have to be done is to) . . .create an environment which is conducive to improved health behavior."***[851]
>
> **Dr. Warren Lawson, 1978**

In 1978, health promotion activities within the department intensified. It continued offering smoking cessation clinics. The department placed special attention on education, particularly for those who might be receptive. A bill that would support more health promotion activities was proposed during the 1978 legislative session.[853]

While there were many health challenges, as well as political problems, in Minnesota during Dr. Lawson's administration, the health status of the population was excellent. Minnesota had the distinction of being in second place, just behind Hawaii, as the state with the longest life expectancy.[854] Based on data from numerous sources, gathered for the Minnesota Medical Association's health care cost commission in 1979, the following statement was made:

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[850] MDH, *What in Health's New?,* Vol. 3, No. 18, August 29, 1975, p. 1.
[851] *Capitol Reporter*, "Health Commissioner Hopes to Inject Good Health in Lifestyles," January 17, 1978, p. 3.
[852] *St. Paul Pioneer Press,* "State Bigwigs (Puff, Wheese) Sign Pledges," January 10, 1978, p. 15.
[853] *Capitol Reporter,* "Health Commissioner Hopes to Inject Good Health in Lifestyles," January 17, 1978, p. 4.
[854] *St. Paul Pioneer Press,* "Quality of Health in Minnesota," January 24, 1979, p. 11.

"In general, it may be concluded that Minnesotans enjoy an almost unparalleled state of health in the United States."[855]

Tor Dahl, 1979

Significant Change: Board of Health

Perhaps the most significant change during Dr. Lawson's tenure was the demise of the Board of Health in 1977. The board historically served as a shield for political issues. Without the board, the department was forced to deal with these issues more directly.

(Note: The demise of the Board of Health is described in Chapter 12.)

While Dr. Lawson had been involved in political issues and was very willing to develop his skills in this area, he recognized he did not have this expertise and learned to depend on those who did. Department staff were somewhat naive in the area of politics to which they were now directly exposed, and it took awhile to gain this skill. In the meantime, some burns occurred. There were few attempts to gain the support of other organizations and build coalitions, as had been done in the past. Some organizations seemed less politically adept than the department at this time. As a former department employee reported, "At least we gave the same answer to the same question each time."

The board's demise was a factor in ending Dr. Lawson's career with the department. Up until 1977, the board selected the commissioner. Through the new legislation, he was selected by the governor and could be fired at will by the governor. In the fall of 1977, Gov. Perpich needed to make a decision as to whether or not he should reappoint Dr. Lawson for another year or whether he should select one of the five other candidates recommended by his screening committee. A large constituency, with a considerable number of votes, wanted to see Dr. Lawson removed. Gov. Perpich was a candidate for re-election in 1978, and he needed those votes.

"Seniors Want Health Commissioner Ousted"

Senior citizens were growing in numbers and becoming more organized. In October 1977, 1,000 delegates of the Metropolitan Senior Federation held its sixth annual convention in Minneapolis. Delegates passed 15 resolutions, one of which was to call for the appointment of a new health commissioner.[856] They were dissatisfied with Dr. Lawson and his failure to implement nursing home reform measures, specifically for his failure to activate an advisory council that had been mandated by the Legislature in 1976. Dr. Lawson's lack of commitment was indicated, they felt, in that only two

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[855] *St. Paul Pioneer Press,* "Quality of Health in Minnesota," January 24, 1979, p. 11.

[856] *St. Paul Pioneer Press*, "Seniors Want Health Commissioner Ousted," October 26, 1977, p. 17.

meetings of the advisory council had been held in 1½ years, and those were both orientation meetings. The seniors also charged that Dr. Lawson was not receptive to consumers and was not accessible to the public.

State Board of Health Meeting, 1971

Several people applied to the governor's appointment commission for the health commissioner position. By July 1977, applications had been received from Dr. Ellen Fifer, assistant commissioner for programs at the department; Sen. John Milton, DFL-White Bear Lake; Joan Campbell, Fifth District DFL chairperson and nurse; Larry Fredrickson, state senate lawyer; Robert Randle, director of state medical assistance payments; and Dr. Eunice Davis, child development director at St. Paul Ramsey Hospital.[857]

After screening potential candidates, the commission submitted six nominations to Gov. Perpich in October 1977. Of those who had applied, only the application of Dr. Eunice Davis was included. The other five nominations for commissioner were: Dr. Robert ten Bensel, professor and director of maternal and child health at the University of Minnesota; Allen Koplin, associate director of the Illinois Health Department; Theodore Marmor, who was with the Center for Health Administration at the University of Chicago; LuVerne Pearman, director of the Ebenezer Center for Aging; and Dr. Lawson.[858]

Gov. Perpich's brother, Sen. George Perpich, urged the governor to appoint Dr. Lawson for another year. Robert Goff, head of the governor's waste and management task force, also supported Dr. Lawson's appointment. Mr. Goff felt administration was Dr.

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[857] *St. Paul Pioneer Press,* "Six Challenge Minnesota Health Commissioner's Job," July 6, 1977, p. 41.
[858] *St. Paul Pioneer Press,* "Panel Nominates Six for Health Department Commissioner," October 6, 1977, p. 27.

Lawson's strong point, and he was most impressed with the excellent fiscal controls and administrative procedures put in place by Dr. Lawson.[859]

Gov. Perpich narrowed his choice to either LuVerne Pearman or Dr. Lawson, but by November 1 he had not made up his mind. He was leaning towards Dr. Lawson, but he wanted one issue resolved. Legislation had established an office of health facility complaints in 1976. This office was set up to handle complaints on the care given in nursing homes. Ernest Kramer was named the first head of the office in 1976 but later was fired. Gov. Perpich wanted to know why. Dr. Lawson explained that he felt Mr. Kramer was slow in setting up the office. The department was 80 to 100 reports behind in the handling of nursing home complaints, one of the concerns expressed by seniors. Dr. Lawson named Jean Donaldson to head the office, with the hope that the department would be caught up within a month, by January 1, 1978.[860]

Gov. Perpich decided to appoint Dr. Lawson for one more year to the $41,000-a-year post. The senior federation did not support his decision, but Gov. Perpich made the appointment with the promise that senior citizen leaders would be invited to assess Dr. Lawson's performance in six months. [861]

When the 140,000-member Minnesota Senior Federation met in Duluth in November 1978, they once again called for Dr. Lawson's removal. Dr. James McGinnis, federation president, said, "He's a man that's got to be removed and that's it. He's got to go now...His is a policy of minimal acceptance, and I don't think that's good enough."[862] In particular, delegates at the conference cited Dr. Lawson's handling of a controversy involving Med-A-Van versus Gold Cross Ambulance and his response to complaints on the conditions at the Park Point Manor Nursing Home.[863]

When Dr. Lawson told delegates that he found conditions at the Park Point Manor Nursing Home improved and said he thought the patients liked it there, he received boos from the audience. The conference vote to ask for his firing was unanimous.[864]

Gov. Perpich responded to the federation that Dr. Lawson's performance would be routinely evaluated, as would all state commissioners, after the following week's election. He also agreed to appoint a three-member committee, chaired by State Sen. Sam Solon of Duluth, to monitor conditions at the Park Point Manor Nursing Home.[865] Less than a week later, however, the election results were in and Gov. Perpich had not been re-elected.

According to Joseph Kiener, president of the Senior Coalition of Northeastern Minnesota, Gov.-elect Albert Quie had made a commitment to remove Dr. Lawson as

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[859] *St. Paul Pioneer Press,* "Perpich Thinks of Keeping Lawson Health Commissioner," November 1, 1977, p. 21.
[860] *St. Paul Pioneer Press,* "Perpich Will Appoint Lawson Health Chief," December 6, 1977, p. 1.
[861] Ibid.
[862] *St. Paul Pioneer Press*, "Seniors Demand Lawson's Ouster," November 2, 1978, p. 29.
[863] *Duluth News Tribune*, "Lawson Will Retire," November 25, 1978, p. 2A.
[864] *Duluth News Tribune*, "Lawson Post Part of Evaluation," November 4, 1978, p. 2A.
[865] Ibid.

health commissioner.[866] In any event, the representative of the seniors publicly stated he did not expect Dr. Lawson to be reappointed, as he felt Gov, Perpich had recognized the problem with the incumbent.[867] On November 25, 58-year-old Dr. Lawson notified Gov.-elect Albert Quie that he did not want to be reappointed as commissioner.[868]

Dr. Lawson completed his term on December 31, 1978, and in January 1979 Dr. George Pettersen, the new health commissioner, offered Dr. Lawson a civil service position as director of the personal health services division.[869] This division covered programs in maternal and child health, crippled children's services and chronic and communicable disease. Dr. Lawson retired at the end of 1979, after working 38 years for the department. He died of a heart attack in September 1988, at age 68.

Dr. Lawson has been described as one of the last department heads who was a true public health professional, both technically and administratively. Subsequent commissioners did not arrive with as strong backgrounds in these areas, but depended more on others. Dr. Lawson is different from all subsequent commissioners who, unlike Dr. Lawson, have come from outside the department. Becoming a department employee in his early 20s, Dr. Lawson is the last commissioner who made the department his lifelong career.

The Minnesota Public Health Association created the Warren L. Lawson Memorial Award in 1992. This award is given to recognize Dr. Lawson's creative leadership, energetic and thoughtful pursuit of public health goals, his interest in developing public health leadership capability and capacity, and his dedication to public health in Minnesota.[870]

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[866] *Duluth News Tribune*, "Lawson Will Retire," November 25, 1978, p. 2A.
[867] Ibid.
[868] *St. Paul Pioneer Press, "Lawson Will Retire Next Year,"* November 25, 1978, p. 3.
[869] *Minneapolis Tribune*, "Lawson Given Key Job in New Health Administration," January 7, 1979, p. 4B.
[870] Minnesota Public Health Association, brochure on Warren R. Lawson Memorial Award, Lawson Reflective Leadership Project, August 1993.

Chapter 10

Local Health Services

The system of public health – known in Minnesota as Community Health Services (CHS) – includes state and local governments and is designed to:

"...protect and promote the health of the general population...by emphasizing the prevention of disease, injury, disability, and preventable death through the promotion of effective coordination and use of community resources, and by extending health services into the community."

(Minn. Statute 145A.02)

Charles Hewitt, Edward Bracken and other early leaders in Minnesota's public health history advocated a strong local health system as the key to successful public health in the state. This approach, supported by more recent public health leaders as well, calls for a coordinated delivery of services and information through the local government, which also determines the needs of the community. The Department of Health can provide specialized services to local health units, but its main role should be that of giving consultation and advice. Though numerous attempts were made, it wasn't until the 1970s that such a local health services system was achieved in Minnesota.

The difficulties in establishing a strong local health system in Minnesota had their seeds in 1866 when the Legislature authorized township supervisors to become the boards of health.[871] Dr. Hewitt's early zeal to work with the local health services might have also contributed to the later difficulties. He supported legislation, passed into law in 1873, which provided for boards of health in all incorporated towns, villages, boroughs and cities. Health officers, preferably physicians, were to be appointed.[872]

An outgrowth of the 1866 and 1873 laws was the formation of a multitude of local health units. In 1952 there were 2,828 health jurisdictions and 674 full or part-time health officers in the state. Seven hundred physicians served 1,800 townships, and 646 villages had health offices.[873] While such disbursement of units might have been appropriate in the 1800s when transportation limited access, it did not fit the mid-20th century.

The small health units lacked the resources to provide full services, and there weren't enough physicians and nurses to fill the positions. The system was large and

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[871] Harold S. Diehl, M.D., *Public Health in Minnesota: An Overview of the Past and a Glance Toward the Future,* Minnesota Medicine, Volume 42, January 1959, p. 33.
[872] Philip Jordan, *The People's Health,* 1953, p. 116.
[873] BOH, *Minutes,* February 5, 1952, MHS, p. 43.

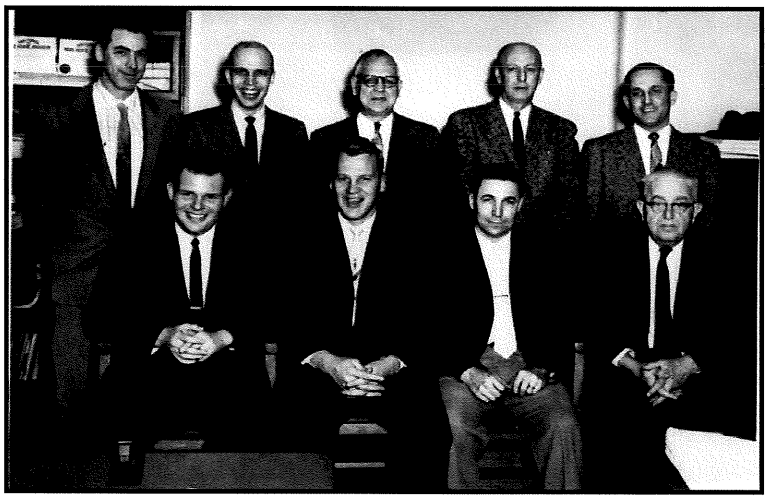
disorganized, but there was a resistance to consolidation. Communities wanted to retain their own health units, no matter how small.

The large number of health units was especially challenging for department employees, who had to contact each local health unit when they tried to assess public health needs, provide health education information, or offer any services and forms of assistance.

Three factors were necessary to develop a strong local health system: a coordinated and centralized system, delivery of services at the local level, and adequate funding to make this possible. By 1949 substantial progress had been made in coordinating public health services for local units of government. By 1980, all areas would be addressed.

Establishing District Offices/Field Offices

In an effort to better coordinate local health services, the department established district offices throughout the state. The first two district offices, in Mankato and Bemidji, were set up in 1936 under the Social Security Act of 1935. These offices provided federal aid to areas particularly hard hit from the Depression. Offices were established in Duluth and Rochester in 1936, Worthington and Minneapolis in 1947 and Fergus Falls and Little Falls in 1948.[874] By 1949 there were eight district offices.



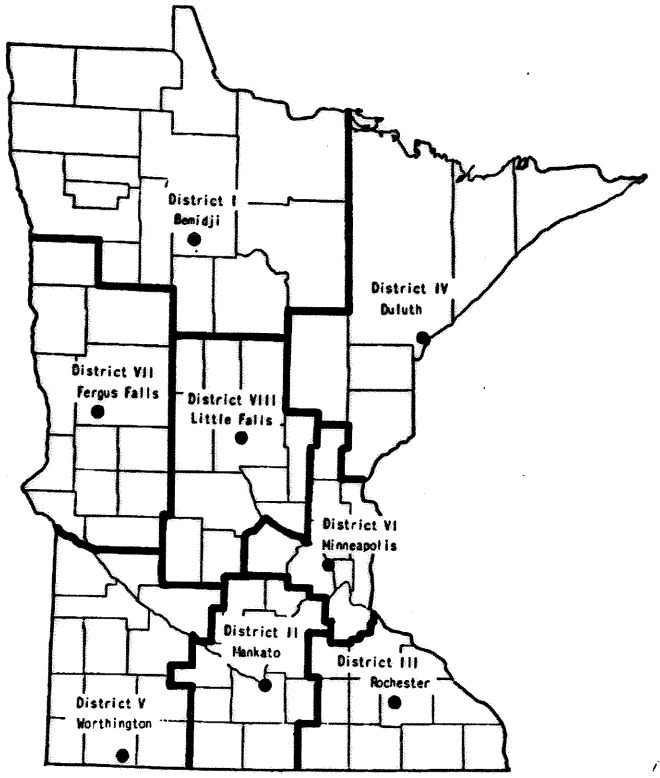
District Engineers – 1959
Standing (l to r): H. A. Starin, L. S. Sku, M.C. Peterson, F. Heisel, P. B. Johnson
Sitting: G. Goldschmidt, D. Hahn, E. Jourdan, A. C. Larson

District offices had a core staff that provided health services at the local level. This decentralized service included expert technical advice, supervision of statewide programs, collection and compilation of vital statistics, laboratory diagnosis for communicable disease control, water pollution control, services of licensing bureaus, health education and industrial health.[875]

In 1949 each district office had a public health engineer or sanitarian, one or more public health nurses, and clerical personnel. In some instances, the district office provided the only health service available for people in a locality.

[874] MDH, Departmental chart titled, "Minnesota Department of Health – District Health Units," December 1948.
[875] MDH, Report by MDH titled *"Public Health in Minnesota is Going Forward Step by Step,"* 1949, p. 1.

District offices provided a number of advantages for the Health Department. The medical director, engineer and nurse in the district office were able to provide consultations and supervision of local activities that would otherwise have to be done by someone from the central office. Being geographically closer to the people in the district, district office staff were in a better position to observe, assess and understand the community and its needs, as well as to establish personal contacts and develop relationships with the people in the community.



District Offices, 1949

The district offices were, and continue to serve as, intermediaries between the central office and local units of government. The district offices play an important role in that they are often the first contact many people have with the department. Requests for assistance from local representatives are channeled through the district offices. When necessary, consultants from the central office travel to the district to help with problems, such as outbreaks, case finding, and surveillance.[876]

The heads of the district offices are listed in the following chart. The first woman to be appointed district health officer was Dr. Helen Wolff in 1949 in District 5, Worthington.

[876] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, pp. 2-3.

Heads of District Offices/Field Offices (through 1999)[877]

Bemidji – District One-Northwestern
Dr. J.R. Kingston, 1936-38, 1939-42
Dr. D.S. Fleming, 1938-39
Dr. Percy T. Watson, 1942-46
M.D. Peterson, 1947-48
Dr. G.A. Miners, 1948-52
R.H. Pinther, 1952-53
Dr. Mary Ghostly, 1953-57
Dr. Sidney Finkelstein, 1957-67 at least
William Heisenfelt, 1972-89 at least

Mankato – District Two-South Central
Dr. Floyd Feldman, 1936-38
Dr. F.G. Gunlaugson, 1938-40
Dr. F.W. Engdahl, 1941-44
Dr. A. G. Liedloff, 1944-56
Dr. H.J. Nilson, 1956
Dr. Otto Fesenmaier, 1956-67 at least
Harold Anderson, 1972
Rodney Church, 1981-89
Ward Bisping, 1998-99

Rochester – District Three-Southeastern
Dr. Floyd Feldman, 1938-41, 1943-48
Dr. Lester Breslow, 1942-43
Dr. Viktor O. Wilson, 1948-67 at least
Dr. Raymond Jackman, 1972
Eric Anderson, 1975
Eric D. Anderson, 1978-89

Duluth – District Four-Northeastern
Dr. C.A. Scherer, 1937-44
Dr. Mario Fischer, 1944-58, 1963
Dr. C.A.E. Lund, 1958
Dr. Arvid Houglum, 1967
Dr. Harold B. Leppink, 1972
Bruce T. Rowe, 1975
Lamar J. First, 1981-83 at least
Marie Margitan, 1989

Worthington/Marshall (as of 1971) – District Five-Southwestern

Dr. Byron O. Mork, Jr., 1947-49
Dr. Helen Wolff, 1949-51
Amandus Larson, 1951-53
Dr. John Stam, 1953-67 at least
Gary L. Otnes, 1972
John Blohm, 1981-89

Minneapolis – District Six
Dr. A.B. Rosenfield, 1947-50
Dr. John Smiley, 1950-52
Dr. Percy Watson, 1952-56
Dr. W.C. Harrison, 1956-72 at least

Fergus Falls – District Seven-West Central
Frederick Heisel, 1948-66
Robert Poyzer, 1972-89 at least

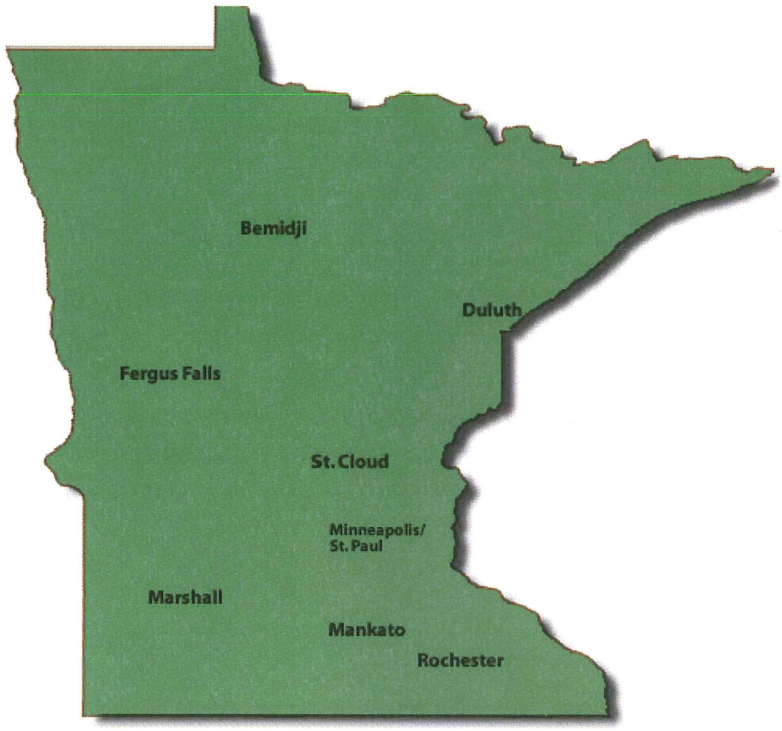
Little Falls – District Eight
Dr. Edward J. Simons, 1948-50
Dr. A.M. Watson, 1950-
Donald Seifert, 1963-67 at least
Andrew Starin, 1972

St. Cloud – Central District
LeMar "Jack" First, 1981-99

While the district offices weren't true local health services, they did demonstrate what could be accomplished with more coordinated and consolidated efforts in rural Minnesota. In 1951 Mr. Frank Woodward, chief of environmental services, commented: "The thing is that you will notice if you check back over several years, it has only been since the completion of the districts in the state that we have been able to get to all the water supplies...."[878]

[877] MDH, *Minnesota's Health,* Vol. 13, No. 3, March 1959, p. 2.
[878] BOH, *Minutes,* January 25, 1951, MHS, p. 46.

In 1999, the district offices numbered seven, not eight, and had been renamed field offices to better reflect their role, no longer confined to one area of the state. In 1999, field offices ranged in size from eight to 28 employees and were located in St. Cloud, Bemidji, Mankato, Duluth, Marshall, Rochester, and Fergus Falls. Each office covered environmental health, family health, disease prevention and control, and administration. Minnesota has been unique having an epidemiologist in each field office.



Department of Health District Offices in 1999

Many department employees in the field offices have worked as inspectors. In that role they educate and inform, providing the advisory function advocated by early public health leaders in Minnesota. Some offices have had special programs. For example, Fergus Falls had a one-year program studying arsenic.

The field offices have been successfully used to strengthen the relationships between the Health Department and other state agencies. A closer working relationship has ensured a unified approach to problems and in many instances, improved efficiency. The Rochester field office has shared a building with the Pollution Control Agency, making it much easier for the two agencies to coordinate and support one another on environmental issues.

Strengthening Local Health Services in the 1940s and 1950s

The importance of transferring public health activities from the state Health Department to local government was emphasized when the governor's "Little Hoover" Commission released its report in 1950. It made a strong recommendation for improved local health services, recognizing a trend for centralization in the department and recommending decentralization to improve the local health service system:

> ***"Establish single- or multiple-county Health Districts having adequate financial resources to assure necessary local public health services by the respective local health units. Authority and responsibility for public health administration should be transferred to the local health districts as rapidly as possible and the State Department of Health should increasingly limit its activities to educational consultative and supervisory services, except where local health units have not been established."***[879]
>
> **Governor's Efficiency in Government Commission, December 1950**

The commission also recommended reorganization, so that the department could better serve local health administration:

> Reorganize the Department of Health on a functional basis by the establishment of four divisions, namely, the Division of Environmental Sanitation, the Division of Local Health Services, the Division of Departmental Administration and the Division of Disease Prevention and Control. The Division of Local Health Services should be under the immediate direction of the Deputy Commissioner of Health and should serve as a central operating division from which all services should be channeled to the district health officers and to the local health units.[880]

Following the release of the commission's report and recommendations in 1950, a citizen's committee met with all division directors and some section chiefs from the department to discuss the report's findings. The committee's recommendations on local health services were fully supportive of the commission's report: They supported the policy of increased local control and recommended strengthening the administration of local health services to facilitate the transfer of more control to local government.

To make it possible for more local units to operate, they recommended a policy of hiring non-medical doctors as district directors, when medical doctors were not available:

- First, establish a policy of local health services with the local people assuming more responsibility both in carrying out the policies and the programs and in supporting them financially. We feel that the closer you can get to the people who are directly involved, the more responsible will be the work and the more effective for the local conditions.

- Second, take steps to recruit a well-qualified person to fill the position of Chief to the Section of Local Health Administration. Dr. Barr's duties take so much of his time that we have felt that probably we will need a Chief under him for that Section, rather than for just part of the work.

- Third, establish a policy on Health Department districts to include the naming of full-time professional persons other than medical as district directors, making provision for adequate

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[879] J. L. Jacobs & Company, "How to Achieve Greater Efficiency and Economy in Minnesota's Government. "Recommendations of the Minnesota Efficiency in Government Commission. December 1950, Chapter VIII, pp. 98-99.

[880] J. L. Jacobs & Company. "How to Achieve Greater Efficiency and Economy in Minnesota's Government. " Recommendations of the Minnesota Efficiency in Government Commission. December 1950, Chapter VIII , pp. 99.

> medical consultation for each of these districts. It has been found impossible to get full-time medical directors for these different district health units and in order to get continuity and effective action we may need to take some person in the district who knows the circumstances there to take over the function of the District Office.[881]

An improved local health system, better coordinated and with increasing local control, was a constant focus of health board members and leaders in the department during the 1940s and 1950s. Like Hewitt and Bracken, Dr. Albert Chesley, executive officer and board secretary, was a strong advocate for a better local system but disappointed at the pace it was making. During one discussion he commented, "The establishment of local health services is proceeding about as fast as it can under present circumstances. Nobody can grant what you want most." [882] The difficulty of accomplishing this was recognized when Dr. Robert Barr, deputy executive officer, introduced Dr. John Smiley as the person who would work with Dr. Percy Watson, chief of the local health services section, on the development of local health services in the state, and he added, "which is a tough job."[883]

The department viewed the eight district offices as only "a partial remedy" for developing a strong local health system.[884] It supported the belief that, "Basic public health policy is developed in local communities which should be able to set up and control their own public health programs."[885] This was one of the factors behind departmental support of the 1949 County Board of Health Act, whereby the state legislature authorized the establishment of county and multi-county health departments.[886] This act encouraged local units to consolidate so full-time health departments would be accessible to all citizens. Counties could levy a tax, not to exceed one mill, to finance the county health department.

While the County Board of Health Act was a good idea in theory, it was not practical economically or politically. It was costly to consolidate, and small communities wanted to retain their autonomy. The law's effect was minimal, resulting in only one health department, the Olmsted County Health Department, which was established July 14, 1953.[887] Mr. Jerome Brower, chief of departmental administration, explained to the board, "The problem is to get counties to line up. There just isn't any experience of counties working together on a project of this kind. It is going to take quite a little bit of time."[888]

While the department was unsuccessful in its efforts to establish county health departments, health councils were forming and working. The first health council was established in Lake County in 1947. The purpose of these councils was to coordinate health activities and expand public health programs, through cooperation with

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[881] BOH, *Minutes,* January 12, 1954.
[882] BOH, *Minutes,* July 14, 1949.
[883] BOH, *Minutes,* February 14, 1950, MHC, p. 33.
[884] MDH, report titled *"Public Health in Minnesota Is Going Forward Step By Step,"* 1949, p. 9.
[885] Ibid.
[886] County Board of Health Act of 1949 (M.S. 145.47-145.54)
[887] BOH, *New Dimensions for Minnesota,* p. 21.
[888] BOH, *Minutes,* November 14, 1950. MHC, p. 464.

community agencies. The Lake County Council sponsored a mobile chest x-ray unit, established a county-wide nursing service by transferring school nursing to this broader field, held county-wide immunization programs and adult vaccination clinics, and joined together with the American Cancer Society to sponsor a cancer detection clinic. The Lake County Council met four times a year, and those in attendance included representatives from the hospital, welfare board, Red Cross, sanatorium board, 4-H Club, Farm Bureau, Grange, local tuberculosis, cancer and poliomyelitis associations, county superintendent of schools, school nurses, county commissioners and dentists.[889] By 1951, the counties of Nobles, Cottonwood, Itasca, and South Koochiching also had councils.

Other initiatives to improve the local health services system were made in response to the recommendations by the Governor's Efficiency in Government Commission. The board reorganized the department giving greater importance to local health services. In 1953, local health services became a separate division with these sections: local health administration, public health nursing, dental health, maternal and child health, public health education, and hospital services. Dr. Robert Barr, deputy executive officer, headed the local health services division. Dr. Hilbert Mark was chief of local health administration, which included the district offices.

While the board had a policy of supporting local health services, there seemed to be very little it could do to transfer more responsibility to the local units of government. The board did try. In 1956, when Duluth prepared to enact an ordinance accepting hotel and restaurant inspections by the state's health department in lieu of inspections by its own department, the board didn't approve. Members felt it was contrary to their philosophy and policy of assigning the responsibility to local authorities[890]

Concerns about state vs. local delegation of duties were voiced by long-time board member Dr. Ruth Boynton when the board discussed a bill introduced to the Legislature one year later, in 1957. The bill provided for a tuberculosis control officer, appointed by the sanatorium commission. Dr. Boynton wondered if the bill wasn't "a bit dangerous in view of the fact that we are trying to get a county health officer who will have all of the public health problems in the county." She also wondered if it might deter the establishment of a county health department.

> Mr. President, I hate to pursue this TB control officer matter, but I do want to go on record as expressing a good deal of question as to whether this Board should support that. If this had been suggested 20 years ago when our cases of tuberculosis were ten times what they are now I think there would have been much more logic to it.
>
> What bothers me about this whole thing is that you are turning over a public health function to an institution, according to the present wording of the bill, apparently without any necessary relation to the State Health Department or the city and county health department. I think it is a matter of principle. I think if the bill says this person should be employed by, or some arrangements made

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[889] MDH, *Minnesota's Health,* Vol. IV, No. 4, April 1950, p. 3.
[890] BOH, *Minutes,* April 19, 1956, MHC, p. 70.

> with the local health department, that would strengthen it, but to have a tuberculosis officer who has no legal responsibility except this general law, it seems to me is bad.[891]

In 1958, when the board reviewed a proposal to add 11 new employees to the district offices, members questioned the appropriateness of supporting local health services in this way. Vice President Herbert Bosch didn't feel the staffing was excessive, but he pointed out it still wasn't local health services in the sense of actual work at the local level:

> I think this is a matter which the board should give a considerable amount of thought to because very obviously budgets are going to be pared along the line one place or the other. Our subcommittee actually felt the staffing they are talking about here is not excessive for districts. We don't want any implications here of a feeling that this is excessive staffing, but we do want the board to appreciate that what is being discussed in the preliminary stage here is a step-up of appropriations for that single time of about $253,000, which still isn't local health services in the sense or actual work at the local level. It is really decentralized state service.[892]

The cost of a county health department, plus resistance by towns, villages and cities to move health work to the county level, continued to prevent consolidation of local health agencies, leaving many operating part-time and with limited services. Again trying to encourage centralization, the Legislature amended the County Board of Health Act in 1957.[893] The permissible tax levy for a health department was raised from one mill to two mills, with the expectation this would make it possible for more communities to establish county or multi-county health departments, as had been done in Olmsted County.

The amended legislation had minimal effect with only one more county health department. St. Louis County commissioners voted to organize a county board of health in 1959.[894] The state's local health system remained fragmented and without adequate leadership. In June 1960 there were 2,738 units of government in Minnesota with health jurisdictions.[895] Only five had full-time health officers. A total of 1,324 units had no duly appointed health officers.[896]

Local communities were short on resources, not just to support consolidation, but for public health activities in general. While public health authorities had indicated that communities needed about $1.50 per person to provide minimum public health services, few areas of the state spent amounts even close to that figure.[897] To compound the problem, federal funding for local health services decreased in the 1940s, as more federal funds were directed to hospital construction. Up until 1976 there was no specific state legislation that provided funding for community health services in Minnesota, except for a small amount designated for public health nursing.

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[891] BOH, *Minutes,* January 31, 1957, MHC, p. 7.
[892] BOH, *Minutes,* August 13, 1958, MHC, p. 211.
[893] Laws 1957, Ch. 470.
[894] *BOH,* Minutes, January 13, 1959, MHC, p. 10.
[895] BOH, *New Dimensions for Minnesota*, p. 20.
[896] Ibid.
[897] State of Minnesota, "Organization and Management of Public Health Agencies: Summary and Report for Efficiency in Government Commission," 1950, p. 5.

Only $1,500 a year per county had been available from 1947 to 1965 for public health nursing services.[898]

Efforts to Strengthen Local Health Services in the 1960s

By 1961, the situation with local health services had changed little. Most counties were not able to raise enough funds to support a county health department. Minneapolis, St. Paul, Duluth, Rochester, St. Louis Park and Bloomington were the only counties that had full-time health officers. The lack of resources for local health services continued to be an impediment in most counties. Therefore, when an opportunity to expand county nursing services appeared in 1961, the department was most interested, even though the amount was relatively small.[899]

The opportunity came in the form of proposed federal legislation and was in response to the challenges all states were facing in trying to strengthen their local public health systems. Responding to this national need, in 1961 the federal government proposed legislation that would remove the ceiling for annual assistance to states and increase community health service grants, special project grants, nursing home construction grants and hospital research grants. Eager for any opportunity to receive increased funding for the state, Dr. Robert Barr, executive officer and secretary, testified before the Interstate and Foreign Commerce Committee in support of the Federal Community Health Services and Facilities Act (H.R. 4998) on May 3, 1961:

> There are some of us who are so provincial as to believe that if such an individual simply wants unnecessary special care, such as a pretty nurse to wait on him and hold his hand during his illness, it is hardly society's responsibility to provide for this kind of care. But, we also would add that if there are not enough nurses, either pretty or otherwise, to provide basic care to all who need it, then perhaps even the individual who has resources sufficient to pay for such attention is doing a disservice to society if he demands it and as a result deprives some other less fortunate individual of nursing service that is critically needed.
>
> It has been demonstrated that the provision of good home nursing services as well as homemaker's services may not only reduce to some extent the need to provide nursing home beds but will also retain the individual in a family setting in his own community which, in properly selected cases, is best for the individual and is most economic. Unfortunately, such services, which were once provided by neighbors and friends, and are now provided through visiting nursing services in the larger cities, are not available in most areas.
>
> There are substantial numbers of trained personnel residing in most communities, particularly nurses, whose children are grown or who, because of other reasons, could give part-time services either in this field of home care or to the hospital or nursing home. The development of local rosters of such individuals would also be of tremendous value in case of a community disaster. Health departments are advocating the development of such for Civil Defense purposes. Several state, like Minnesota, have provisions for the development of home nursing services under the direction of the county public health nursing service and for the payments for

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[898] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,"* 1976, p. 1.
[899] BOH, *Minutes,* May 23, 1961, MHC, p. 218.

> care from public welfare funds as well as for the acceptance of private fees from those who are able to pay. [900]

The Community Health Services and Facilities Act of 1961 (PL 87-395) did pass, and it authorized the surgeon general of the U.S. Public Health Services to make one-time project grants to public or non-profit private agencies in counties. The grants were to be used to develop out-of-hospital health services, with particular emphasis on home nursing care and homemaker services. There was an increased amount of funding to improve the quality of care for the chronically ill and aged and for outpatient care. Dr. Barr was disappointed that projects were submitted to the U.S. Public Health Service, not the state Board of Health. Local health units that participated included Morrison County, Minneapolis Health Department and the St. Paul Bureau of Health. [901] [902] The grants awarded totaled $82,000.[903]

Strengthening Local Health Services in the 1970s

In the 1970s the environment changed, and legislative and constituent support for community-based services increased. This could be seen in legislation affecting other state agencies. The Human Services Act of 1973 made it possible for counties to create a single board for the coordination of human services, court services, public health services, public assistance, social services, mental retardation and mental health services.[904] The 1973 Community Corrections Act made it possible for counties to develop and plan community-based correctional programs.[905]

The department had long supported community-based services, and Dr. Warren Lawson, executive officer and secretary of the board, had selected this need as one of his top three priorities. In the early 1970s he described his vision to legislators:

> Chairman Kirchner: (Chair of Joint Subcommittee of Senate Comm. On Health and Welfare) "Dr. Lawson, you made some allusions to the direction of health services from the State level, and then a moment later discussed something about the county agency. I wasn't quite sure what your concept was of the administration of health services as between the State and the local and county levels. Do you feel that the State should be the structurally mechanical unit that directs the activities in each of the various levels, or how would you coordinate between the State level and the community or county level in handling these?"
>
> Dr. Lawson: "With the long tradition of home rule in the State, I think it is probably necessary to give local communities some range of option, but I think that we have passed the time when we can afford to have each municipality or each township or each county be markedly different from each other in terms of health programs, whether you are talking about staffing, the kind of program, and what not, that might be involved. Does that answer your question?"

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[900] BOH, *Minutes,* May 23, 1961, MHC, pp. 223-226.
[901] BOH, *Minutes,* October 31, 1961, MHC, p. 375.
[902] BOH, *Minutes,* May 23, 1962, MHC, pp. 213, 240-242.
[903] MDH, *Minnesota's Health,* Vol. 16, No. 1, January 1962, p. 1.
[904] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,"* 1976, p. 2
[905] Ibid.

> Chairman Kirchner: "It still leaves me with some thoughts of just how you project that down the line. How do you allow them latitude and still in a sense make many of the decisions for them? Would you do this through regulation or through selection of staff or – "
>
> Dr. Lawson: "It seems to me the State has got to lay some kind of a baseline that would have to be met by local agencies and the local agencies then could proceed to elaborate upon this as long as it did not get completely out of bounds, and here I'm thinking in terms of specific regulations. One of the difficulties that has existed is there sometimes tends to be competition in seeing how high standards can be gotten at the local level, and I think this kind of thing is relatively destructive and should be controlled within limits."[906]

Demonstrating his support, in 1973 he renamed the local health administration division as the community services and development division. Headed by Robert Hiller, Ph.D., this division took the lead in getting legislation passed to strengthen local health service.

Key persons who supported Dr. Hiller in his work were Ernie Kramer, head of local health administration; Fred Goff, supervisor of district offices; and Emil Angelica. They realized that a lot of federal funding through categorical grants was available, but many local units were not qualified to receive these funds, as they didn't meet personnel requirements. By combining the federal money in one pot and distributing it throughout the state, the local units might have the resources they needed.[907]

In August 1974 the first planning meeting for the proposed legislation on community health services was held in the department's Chesley Room. Robert Hiller led the meeting, writing ideas on the board. Attendance was large and included representatives from the Regional Development Division, the federal Health Systems Agency, the State Emergency Medical Services, the counties and the department.

The department worked at gaining support for the community health services plan, but it did not always go smoothly. From time to time there were setbacks, as reported on this meeting in St. Cloud in September 1974:

> ....The State Health Department was not present on the panel and Mr. Broeker proceeded to elaborate on this absence, speaking in terms of past bad attitude, indifference towards cooperation and involvement and saying that we had no commitment to the act and because of reorganization and confusion so far had made no attempts to firm up a position. He ended the comment by in effect saying that one could see the lack of interest in Human Services by the Department was quite evident because as all could see the Health Department had not sent a representative. He then called upon Dr. Bond of the U of M School of Public Health to comment and Bond became quite concerned saying he didn't represent the Department but thought Dr. Lawson's plans and the Comprehensive Community Health Services Bill were consistent with and would fit very nicely with the Human Services Act. At any rate, feelings by the crowd toward the Department were very negative.
>
> All of the District Representatives agreed that had we been advised of the Health Department's inability to attend and been briefed on the Department's wishes we could have and would have filled in. As it was, everything happened so fast that we were unable to respond, nor were we able to sit on the panel. We fully expected someone to appear from Minneapolis, so we were not prepared.

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[906] Senate Committee on Health and Welfare, Joint Subcommittee meeting, April 17, 1972, pp. 35-36.
[907] Conversation with Robert Hiller, January 29, 1999.

> In our estimation, this was another black day for the Health Department. We also believe that it will now be tougher than ever to enlist support from local government for the Community Health Services Bill.
>
> I was asked to prepare this memo so that Community Services and Development can in the future be better prepared. Much, much closer communication between the Metro Office and the districts must occur if we are to perform in a creditable manner.[908]

Significant support was gained, and the proposed community health services bill that was presented to the 1975 Legislature was influenced by department policies that included:

- Prevention of illness, disability and premature death must be the cornerstone of the state effort to protect, maintain and improve the health of the people.
- Preventive health services must be delivered through a system with extensive local administration and fiscal control, within state guidelines and standards.
- The proper role of state government is long-range planning, standard setting, and provision of technical support, while the proper role of local government is to plan, develop, administer and deliver preventive and personal health services within an integrated local system.
- The existing fragmented health services system requires communication, coordination and cooperation in planning and delivery of health services to be effective.[909]

Passage of the Community Health Services Act of 1976

Politically, the Community Health Services Act was non-partisan. It had the backing of both parties, with a sprinkling of support from very liberal Democrats and a sprinkling of support from far-right Republicans. Most of the support came from somewhere in between. Much of the testimony in support of the bill was given by local representatives. There was general agreement on the bill's focus on prevention, state-local partnership and need for an integrated approach. Disagreement arose related to the roles of county and municipal government, compatibility with existing tax policies and sexuality-related issues of family planning and abortion.[910] One obstacle to the bill's passage was Gov. Wendell Anderson's support of a Community Health and Social Services Act, which would have combined the activities of the departments of Health and Human Services.[911]

The Minnesota House and Senate approved the community health services bill during the 1975 legislative session. The conference committee report that reconciled differences, however, was not approved by the end of the session. During the next six

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[908] Memo from R. Poyzer, district representative, to E. Kramer, community services and development, October 1, 1974.
[909] MDH, *"New Life for Public Health: The Politics of Prevention in Minnesota,,"* Presented at 104th Annual Meeting of the American Public Health Association in Miami Beach, Florida, October 17-21, 1976, p.p. 2-4.
[910] Ibid., p. 5.
[911] Conversation with Robert Hiller, January 29, 1999.

months support for the bill grew, and was strengthened when Gov. Anderson stated in a press release that, "There has been too little activity in the area of preventive medicine. We would be better off spending much more money on preventive care."[912]

Early in 1976 both houses of the Legislature passed the bill, and it was enacted into law on February 6, 1976. The initial appropriation was $2.75 million for the period February 6, 1976, through June 30, 1977.[913]

The purpose of the Community Health Services Act, stated in Section 1, is "the development and maintenance of an integrated system of community health services under local administration with a system of state guidelines and standards." State statute defined "community health services" as:

> "...those services designed to protect and improve the people's health within a geographically defined community by emphasizing services to prevent illness, disease, and disability, by promoting effective coordination and use of community resources, and by extending health services into the community. These services include community nursing services, home health services, disease prevention and control services, family planning services, nutritional services, dental public health services, emergency medical services, health education and environmental health services.[914]

> ***The CHS Legislation..."is the most significant legislation in public health since the Minnesota Board of Health was established in 1872."***[915]
>
> **Commissioner of Health Warren Lawson, 1977**

Unlike other legislative efforts to improve the local health system in Minnesota, the Community Health Services Act of 1976 (the "CHS Act") offered attractive subsidy funding. To be eligible, the community must have a local board of health and the community's population must exceed 30,000. This population requirement was an incentive to consolidate for those counties with populations under 30,000. This requirement addressed the long-term problem of multiple health units throughout the state.

The CHS Act stressed local control and options, and there was flexibility in such legislative requirements as having a local board of health. This board could be the county board of commissioners, the human services board, or an administrative board of elected officials, health care providers and laypersons, depending on the community's choice.

In addition to having a local board of health and a population in excess of 30,000, in order to receive funding the community must create a community health services plan, approved by both the county board of commissioners and the state Board of Health.

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[912] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, p.5.
[913] Ibid., pp. 2-4.
[914] Ibid., p. 5.
[915] *St. Paul Pioneer Press*, "Two Minnesota Counties Get First Health Service Grants," January 13, 1977, p. 7.

The community must also comply with state rules and must provide local matching funds.

Each community health service plan submitted to the department for approval was required to include the following:

- A community participation process that will assure involvement of all interested citizens. This includes establishing broadly representative advisory committees and task forces, public notices, media involvement, public forums and hearings, and plan review and comment.
- A quarterly work outline defining the steps and process within a specified time frame.
- Demographic data and health services inventory, including descriptions of existing programs that can serve as a base for future planning and services delivery.
- Identification of needs using a community participation process.
- Identification of priorities using a community participation process. This will become the basis for determining the priority health needs of the community that should have first attention for subsidy and in delivery of services.
- An administrative structure for fiscal control, developing the plan, and delivery of services and evaluation of impact.[916]

Implementation of the Community Health Services Act of 1976

Since its formation in 1872, the department had been fighting to strengthen its local health services. With the passage of the CHS Act, this could become a reality – if the law was successfully implemented. Designated for this formidable task was Robert Hiller, department employee since 1962.

Robert Hiller determined that in order to successfully implement the CHS Act, a CHS representative and nurse to help with the process was needed for each district office. The district CHS representative was charged with getting the system organized and operating. This was a political role in that each CHS district representative had to mobilize community leaders.

Mankato was the first location to have a district representative, Bemidji was second, and soon all districts had a representative. Robert Hiller planned that once the system was operating successfully at the local level, there would be no need for district representatives. The position would be eliminated, and the territory of nurses expanded. When Dr. Petterson became commissioner, however, he decided to retain the district office representatives. The CHS district representatives remained until the 1990s when they were gradually phased out.

The first CHS district representatives were: Bob Poyzer, Fergus Falls and Little Falls; Bill Hiesenfelt, Bemidji and Duluth; and Harold Anderson, Mankato, Worthington and Rochester.

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[916] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, pp. 7-8.

Nursing consultants played a major role in implementing the CHS Act. Speaking with county public health nurses, they gave advice on what to say to get their commissioner's interest. Some county commissioners resisted implementing the act due to recent experiences with federal seed money. Federal funding for a program might be provided for a short while and then cut, leaving the commissioners with an unfunded program and no available funding to continue activities.[917]

However, through the efforts of department representatives, more than half of the state's counties agreed to participate in the statewide Community Health Services system that first year. By October 1976, the board had received 26 planning grant applications, representing 46 of the 87 Minnesota counties and over 75 percent of the state's population.[918]

The first CHS plan reviews, held in the Chesley Room of 717 Delaware Street, were called "The Inquisition" by participants. Representatives of the community responded to questions regarding their plans to spend a portion of the $2.75 million in grant money from the state that was available through fiscal year June 30. The first two awards, totaling $420,110.50, were made in January 1977.[919] St. Louis County received $322,500, and Olmsted County received $97,610.50.

After the first group of counties had agreed to participate, department representatives had to work harder to get other counties involved. Department employees became salespersons. They talked with Lions Clubs, Kiwanis Clubs and other community groups; they primed these people to talk with their county commissioners in support of the CHS Act.

Seemingly minor actions sometimes made the difference between whether or not a county chose to participate in the CHS system. For example, Benton County requested maps to distribute at their county fair. The state was unable to provide the maps. If they had, one department employee believes they would have joined a year sooner.[920]

Sometimes conflict occurred when communities were asked to designate a primary hospital and a secondary hospital as part of the CHS plan. Federal legislation had established seven health systems agencies in Minnesota for the purpose of monitoring and preventing unnecessary health expenses. These did not always match well with the CHS areas.

Another challenge was clarification of the different roles the district offices and CHS system each played. The district offices were originally established to help coordinate the local health services. The CHS Act added one more player with whom they would need to consult. While activities were overlapping and could be confusing, Robert

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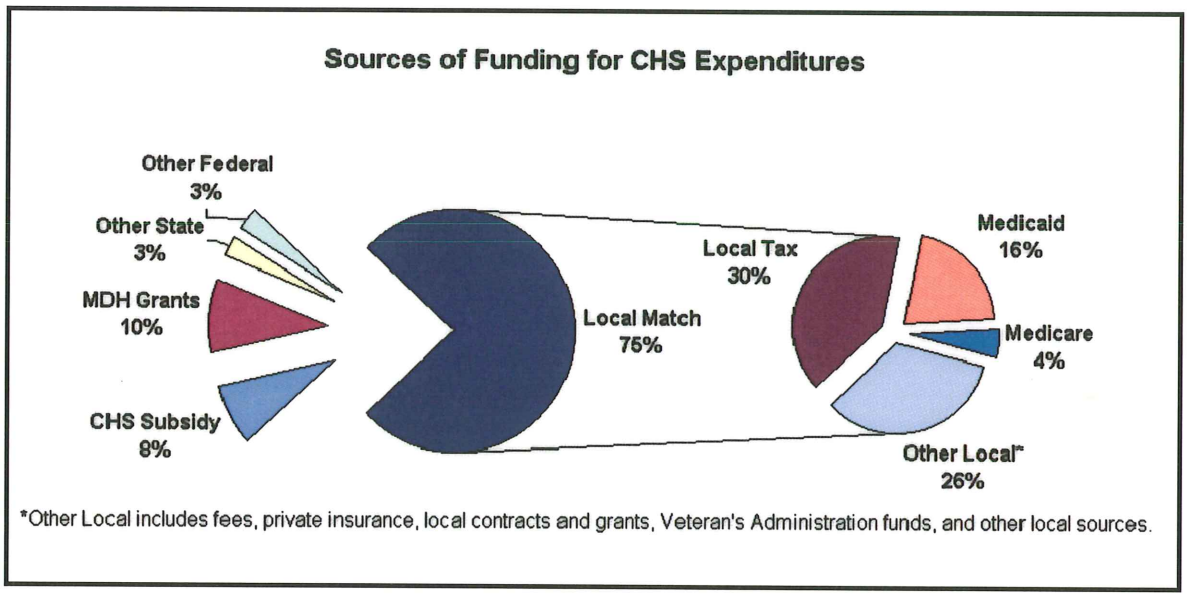
[917] Conversation with Robert Hiller, January 29, 1999.
[918] MDH, "New Life for Public Health: The Politics of Prevention in Minnesota," presented at 104th annual meeting of the American Public Health Association, Miami Beach, Florida, October 17-21, 1976, p. 9.
[919] *St. Paul Pioneer Press*, "Two Minnesota Counties Get First Health Service Grants," January 13, 1977, p. 7.
[920] Conversation with MDH employee, 1999.

Hiller's original decision to place CHS representatives in each district office helped prevent misunderstandings.

While many people were involved with the implementation of the CHS Act, there were several key individuals. One was Margaret Sandberg, a planner from the Metropolitan Council Health Board, who understood politics.[921] Others were Dr. Valentine O'Malley, member of the State Board of Health; Fred Goff; Ernie Kramer, Jack First and Robert Hiller. They traveled throughout the state, introducing the CHS program to communities.

Implementation of the CHS Act required commitment, dedication and hard work. One of the department's older employees, who played an active role in the process, questioned whether it would be possible to do the same in 1999, as he felt the "zealots" who pushed through the CHS Act would, by then, have become a dying breed. Would it be possible to gather the momentum to undertake such an initiative today? With changes in the social structure, the employee wondered if the commitment and time needed would still be present.



In the formation of CHS areas, several unique arrangements developed. The first multi-county CHS area was Carleton/St. Louis/Lake. Bruce Rowe, district representative from Duluth, helped put the CHS system in place in Lake County, and then he worked as the CHS administrator. One multi-county area hired the regional development commission to help with the administrative work, and the public health nursing director from each of the four counties took turns acting as the CHS administrator.

The CHS Act was originally skewed with the greatest benefit being received by poor counties that had been trying to implement public health activities. This was changed through legislation in 1986. The year 1985 was used as a base for future funding, and

[921] Conversation with Robert Hiller, January 29, 1999.

any new money was distributed on a per capita basis. This was most advantageous to cities and rapidly growing areas.

In 1987 the Community Health Services Act became the Local Public Health Act. This change was made following a review of all state statutes related to local public health by the State Community Health Services Advisory Committee (SCHSAC). This review was made to clarify the relationships between statutory, departmental and local authorities.

The committee was formed to provide consultation and make recommendations to the health commissioner. Comprised of representatives from each community health board in Minnesota, SCHSAC has worked with the commissioner to develop public health policy and address legislative and other issues impacting state and local public health agencies. Meetings have often been active and loud, as issues were discussed and decisions made. Those in attendance might not have agreed, but they usually left with a clear understanding of the policy.

Work by the SCHSAC has been accomplished through task forces, committees and groups. In addition to regular planning and administrative committees, SCHSAC addresses issues of concern, often producing reports and recommendations. Special task forces and work groups that have existed since 1979 include the following and are indicative of the public health areas of concern in the local community:

- Home Care Task Force, 1979-81
- Environmental Health Policy Study, 1979
- Long Term Care Task Force, 1982-83
- Emergency Medical Services Task Force, 1982-84
- Fellowship for Physicians in Community Health Planning Task Force, 1985
- Environmental Health Task Force, 1986
- Environmental Health Work Group, 1987, 1992
- Health Promotion Work Group, 1987
- Community Emergency Medical Care Work Group, 1987-88
- HIV Subcommittee, 1988
- Home Care Subcommittee, 1989
- Disease Prevention and Control Agreements Subcommittee, 1989
- Water Well Attachment Review Group, 1990-91
- Interagency Community Health and Social Services Subcommittee, 1990-93
- Chemical Health Promotion Work Group, 1991
- Public Health Nuisance Control Work Group, 1991
- Immunization Review Group, 1992
- Health Care Reform Work Group, 1992
- Health Care Reform Implementation Work Group, 1993-94
- Violence Prevention Work Group, 1993-94
- Well Moratorium Work Group, 1994
- Capacity Building Action Team, 1994-95
- Assurance Work Group, 1994
- Assurance Under Managed Care Work Group, 1995
- Disease Prevention and Control Work Group, 1996
- Environmental Health Services Review Group, 1996
- Correctional Health Work Group, 1997
- Local Public Health and Hospital Coordination Work Group, 1997
- Clarifying Roles in a Changing Health System Review Group, 1997
- Public Health Governance/Education Work Group, 1998
- Local Public Health Accreditation Work Group, 1998
- Information Management/Integration Review Group, 1998
- Disaster and Emergency Preparedness Work Group, 1999
- Assessing Organizational Capacity Work Group, 1999
- Educational Strategies Discussion Group, 1999
- Youth Risk Behavior Endowment Review Group, 1999 [923]

The SCHSAC meets four times a year at the department in Minneapolis. Meetings are led by a chairperson who is elected for a one-year term. Chairpersons of SCHSAC have been:

1976 – Ellen Alkon
1977 – Ellen Alkon
1978 – Ray Cink
1979 – Cal Condon
1980 – Ray Eckes
1981 – Ray Eckes
1982 – Harold Trende
1983 – Vernon "Bob" Haglund
1984 – Arvid Thompson
1985 – Frank Jungas
1986 – Lee Luebbe
1987 – Richard Jacobson
1988 – Arlyn Nelson
1989 – Bill Brakke
1990 – Kal Michels
1991 – Howard Warnberg
1992 – Warren Rodning
1993 – Delores Baumhofer
1994 – Jean Michels
1995 – Mary Haug
1996 – Donald Peterson
1997 – Dean Massett
1998 – Harlan Madsen
1999 – Audrey Richardson[922]

Community health services conferences are scheduled annually. These two-day meetings, usually held in conference centers near Brainerd, are for the purpose of improving the administration and delivery of community health services in Minnesota. Conference themes vary each year, and the themes for the last years have been:

1985 – Decision Making in Community Health
1986 – Ethics and Leadership in Community Health
1987 – Collaboration for Quality
1988 – Mobilizing the Community to Promote Health
1989 – Assembling the Public Health Puzzle in the 90s
1990 – Community Health: Mission and Vision
1991 – Translating Vision into Action: Leadership in Changing Times
1992 – Public Health – Health Investment
1993 – Public Health in a Changing World
1994 – Community Health: Moving Ahead in a Competitive Environment
1995 – Today's Challenges, Tomorrow's Solutions: Shaping Policy and Practice
1996 – Twenty Years of Partnership: A Rich Heritage, A Vibrant Future
1997 – Tradition and Change: Working Together to Improve the Health of Communities
1998 – Reaching our Goals, Building our Future
1999 – A Century of Progress[923]

Implementation of the CHS Act was relatively quick and soon reached the maintenance mode. Activities were first located within the department's community development bureau. When it was eliminated in 1979, CHS activities were placed in the community services division. That division was eliminated in 1982, but replaced two years later with the community health services division. Commissioner Mary Madonna Ashton named James Parker the director of the division in 1984. When Mr. Parker died of leukemia in 1991, Ryan Church, a section chief from the division, became director.

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[922] Information from community health services division through department's library.
[923] Ibid.

In 1999 no area of Minnesota was without a locally administered board of health. Minnesota's 49 community health boards provide direction and coordination for local public health departments.

The 1976 Community Health Services Act has had its intended effect of emphasizing local government's role and responsibility in the delivery of health services. Concurrently, the department's role in delivering services to communities has been replaced with increasing focus on regulation and technical assistance. Communities are much more involved in planning, implementing and operating their public health system.

As a result of the field offices and the CHS program, Minnesota has a strong public health program at the local level – something the early formers of the department would find most pleasing.

A 1999 Minnesota Department of Health report reads:

> *"A Partnership that Works*
>
> ***The community health services partnership of state and local governments has been over twenty years in the making. The partnership works! It works because it reflects an ongoing commitment to effective public health services, and because of a shared mission of improving the health of all people in Minnesota."***[924]

Public Health Nurses: A Public Health Cornerstone

The public health nurse is one of the cornerstones of local public health services. They have not, however, always been supported by local or state government. Prior to 1916, public health nursing services in Minnesota communities were financed by voluntary and insurance agencies. This changed in 1916 when the county commissioners of Ramsey, Renville and St. Louis counties established public health nursing services.[925] Public health nursing positions were reduced during the Depression years, but federal funds in 1936 reactivated county nursing services.

> ***"WHAT SPARKS public health in Minnesota? From top state officials to families in remote rural areas, the reply is the same --- 'public health nursing.' "***[926]
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> ***Minnesota's Health*, 1953**

[924] MDH, http://www.health.state.mn.us/divs/chs/comdev.htm, 2000.
[925] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December, 1956.
[926] MDH, *Minnesota's Health,* Vol. 7, No. 6, June 1953, p. 1.

Through much of the period from 1949 to 1999 there was a shortage of county public health nurses. Several initiatives were attempted to increase the supply. On March 5, 1947, Gov. Luther Youngdahl signed a bill that set aside $130,500 annually for state aid to counties wishing to employ public health nurses.[927] Eligible counties could receive $1,500 a year, which covered about half the cost of nursing services in 1947.[928] In 1962, counties could still receive the $1,500 stipend from the state for nursing services, but at that time the amount covered only about a fourth the cost.[929] The stipend remained available through 1965.

District Public Health Nurses, 1958
(l to r) Mary Johnson, Helen O'Dair, Dagmar Johnson, Alberta Wilson, Ruth Abbott, Jane Sheehan, Evi Altschuler, Helen Farrington, Marion Nielsen

In 1950, 64 counties in Minnesota had organized public health nursing services. By December 1952, there were 83 public health nurses serving 57 counties. Other public health nurses served schools and industrial plants.[930] The recommended ratio of public health nurse to population was 1 to 5,000, but in Minnesota there was only one public health nurse for every 15,000 people.[931] In order to meet the demand, counties sometimes had to seek help from volunteers, such as from nursing auxiliaries and laypersons.

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[927] MDH, *Minnesota's Health,* Vol. I., No. 1, March 1947, p. 1.
[928] BOH, *Minutes,* May 23, 1962, MHC, p. 213.
[929] MDH, *Minnesota's Health,* Vol. VI, No. 11, December 1952, p. 4.
[930] Ibid.
[931] MDH, *Minnesota's Health,* Vol. 8, No. 1, January 1954, p. 4.

By 1956 there was a total of 724 public health nursing positions in Minnesota. Of these, 165 were public health nursing positions in rural cities and schools; 431 were positions within health agencies, schools and industries in Rochester, Minneapolis and St. Paul; and 128 were positions in 70 Minnesota counties.[932]

In 1962, most counties had at least one public health nurse. Thirteen had two, one had three, Ramsey had eight, St. Louis had 13, Hennepin had 14 and Olmsted had 15. Fourteen counties, however, still did not have nursing services.[933] Only one county in Minnesota, Olmsted, had the recommended ratio of one public health nurse per 5,000 people in 1962.[934]

While there was a need for public health nurses in general, there was a particular need in the areas of rehabilitative nursing for patients with chronic illness, maternal and child health, school health and accident prevention. A rapidly growing need existed in home nursing care for the aged. To address this need, in 1955 the Legislature passed the Public Health Nursing Law.[935] This law authorized county health boards to hire licensed practical nurses and registered nurses to assist public health nurses with home care. Legislation also made it possible for the county board to accept fees for these services. In 1955 the Board of Health was empowered to set standards and to certify public health nurses.[936]

Later, in 1963, an amendment to the law permitted counties to employ home health aides to help public health nurses.[937] It allowed counties to collect fees for the services of home aides. The Board of Health, charged with setting the fees, in 1963 determined that a county could charge users of this service $1.50 per hour.[938]

Nursing Newsletters

One method public health nurses used to spread their message was through newsletters. In the late 1940s and early 1950s, there were three different newsletters related to nursing produced at the department.

From 1948 to 1952 the department's public health nursing section published a bi-monthly newsletter, *What's Going On*, filled with information on resources for public health nurses and updates on relevant policies. This newsletter was also a means of information exchange, sharing reports from district offices. The newsletter was originally intended for rural public health nurses, but requests were received from directors of urban public health nursing agencies and schools of nursing in Minnesota.

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[932] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December, 1956.
[933] BOH, *Minutes*, May 23, 1962, MHC, p. 213.
[934] BOH, *New Dimensions for Minnesota: Planning Guide for 1963-1973*, p. 22.
[935] Minnesota State Statute 144.08.
[936] MDH (local health administration division), "Growth of Local Health Services in Minnesota," December 1956.
[937] MDH, *Minnesota's Health,* Vol. 17, No. 5, May 1963, p. 3.
[938] BOH, *Minutes,* May 20, 1963, MHC, p. 379.

In 1952 a decision was made to discontinue the newsletter and absorb its contents into an enlarged *Minnesota's Health*, the department's official newsletter.[939]

Another nursing newsletter, *Nursing Home News*, was sent out every other month to chronic and convalescent homes, county welfare boards, public health nurses, and other individuals and agencies interested in improving care of aged and chronically ill. It was intended as a medium for the exchange of ideas and to bring attention to the work being done in these facilities. [940] Published from 1948 through 1951, the newsletter was produced by the department's hospital licensing unit. Publication ended when the Minnesota Association of Nursing Homes voted to begin publishing *The Nursing Home Voice*. Existing information and reports would be included in this new publication.

Nursing in Industry was a third newsletter targeted at nurses, this one for those who worked in the field of industrial health. Like the other newsletters, this publication provided a forum for exchanging ideas, as well as providing information.[941] Produced monthly by Heide L. Henriksen, R.N. and industrial nursing consultant, the newsletter was published until February 1952. All recipients were then placed on the mailing list of *Minnesota's Health*, in an effort to reduce duplication.

Public Health Nursing Section

Public health nursing is one of a few department sections that has been located in more than one division. Between 1949 and 1999 the section has been part of five different divisions.

In 1949, it was located within the special services division, and in 1956 was moved to the newly created local health administration division. It remained there until 1963 when it was transferred to the administrative services division. The move was made to emphasize the broader role public health nursing had, its activities considered departmental, rather than confined to one division.[942] When the community services and development division replaced the local health administration division in 1973, community nursing was included as one of the sections. In 1982, the community services division was eliminated, and public health nursing was placed in the disease prevention and control division where it remained until 1984. At that time it was placed in the recreated community health services division and has remained there.

Public health nursing has had five different directors between 1949 and 1999. Ann Nyquist was director through 1954, and Alberta Wilson followed her, serving from 1955 to 1971. After Alberta Wilson came Francis Decker, LaVohn Josten and Mary Rippke, who assumed the position as chief in 1992.

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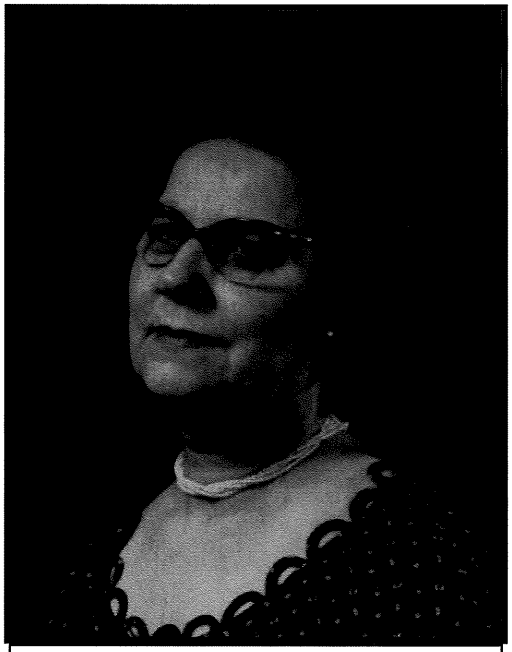
[939] MDH, *What's Going On*, March 1952, PHN-479.2.
[940] MDH, *Nursing Home News,* Volume III, No. 4, October, November and December 1951, p. 1.
[941] MDH, *Nursing in Industry,* Vol. 1, No. 1, October 10, 1944, PHN-95-1, p. 1.
[942] BOH, *Minutes,* January 22, 1963, MHC, p. 19.

Notable Public Health Nurses

Throughout the years, there have been many public health nurse greats. One of the pioneer public health nurses was Caroline G. Walz. She resigned in 1951 after serving the people of Crow Wing for more than 23 years. Regardless of blizzards or other bad conditions, she provided services to families and she "set a goal for others to duplicate."[943]



Ann Nyquist

Ann S. Nyquist joined the department in 1925 and was director of the public health nursing program from 1941 until her death in 1954. According to department files, she was "well known...as a type of person who never seeks publicity for herself but who has done a marvelous job and deserves the highest commendation."[944] A film about public health nursing, "Your Friend in Blue," was produced by the department and two other voluntary organizations in 1949. Ann Nyquist had a major role in producing the film, and it was dedicated to her.[945]

In 1966, Mary Johnson, a public health nurse for more than 35 years, retired from the department. Dr. Robert Barr first knew Miss Johnson when she was a county public health nurse in Traverse County. He was athletic coach at Wheaton, and they ate at the same boarding house.

Miss Johnson began with the department in 1929, a time when the Depression caused a large load of relief work to be added to the public health nurse's duties. She also worked during World War II, another time when the demands on the public health nurse increased. As a public health nurse into the 1960s, Miss Johnson was faced with providing home nursing care for the aged, the sick, the disabled, the mentally ill and the mentally retarded. Traditional duties, including pre- and postnatal visits, tuberculosis case finding and follow-up, and immunizations were part of her duties.[946]

Laura Hegstad joined the department in 1931. A 33-year veteran of public health, she received the Board of Health's certificate for meritorious service when she retired on July 14, 1964. Later, in 1965, she was awarded the Albert Justus Chesley Award by the Minnesota Public Health Association..

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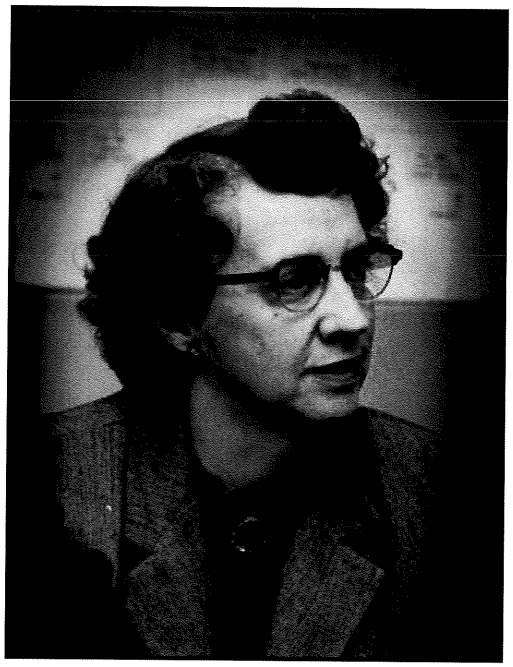
[943] MDH, *Minnesota's Health,* Vol. VI, No. 1, January 1952, p. 2.
[944] MDH files kept at the Minnesota Historical Center.
[945] MDH, *Minnesota's Health,* Vol. 9, No. 1, January 1955, p. 2.
[946] MDH, *Minnesota's Health,* Vol. 20, No. 1, January 1966, pp. 1 and 4.



Alberta Wilson

Alberta Wilson, R.N., M.S., active in many organizations, worked at the department from 1953[947] until her retirement in 1971. Named chief of the public health nursing section at the beginning of 1955, Ms. Wilson was known to tug at her belt, and say, "I have to go work with the boys." Alberta Wilson had the distinction of being the department's first female employee to wear slacks to work

Eleanor Conrad was a public health nurse from St. Cloud. She worked on developing home health services statewide. Ann Moorhous joined the department as a public health nursing advisor in community services in 1974. Some of the many other public health nurses who worked at the department from 1949 to 1999 include:

Ruth Abbott
Ev. Altschuler
Helen Farrington
Dagmar Johnson
Linda Keller
Sara Mullett
Roxanne Newland
Marion Nielsen
Helen O'Dair
Mary Rippke
Jane Sheehan
Cheryl Smoot
Terry Tange from Bemidji
Lorene Wedeking

[947] MDH employee records.

Chapter 11

Chronic Disease, Health Promotion

In 1973 the department's mission, as stated in Minnesota statutes, was changed by the Legislature. The charge to "protect and preserve" was replaced with a mandate for "protecting, maintaining and improving" the health of Minnesota citizens. This area was not a new one for the department but it was now formalized and emphasized.

Early efforts in health promotion and the prevention of chronic disease were often limited due to lack of funds. Dr. A. B. Rosenfield, special services director, was a strong proponent of health promotion and disease prevention. Despite the funding limitations, he was influential in initiating programs in nutrition, poison control, school health, family life education, mental retardation, emergency medical care services, human genetics, family life education, and maternal and infant mortality. In addition to these, in the 1950s the department already had programs addressing mental health, tobacco use, alcoholism, cancer, heart disease and dental health.

In 1951 the department sponsored a program "Exhibits on Tour," which focused on chronic disease, its prevalence and the need for early action. A truck with the exhibits traveled throughout Minnesota, stopping at communities. Exhibits were free and open to the public. Exhibits were created for heart disease, the seven warning signs of cancer, a baby's mental health, community preparedness for civil defense, suggestions for fire and accident prevention in the home, reminders of the need for safe water supplies and drainage systems, industrial health hazards and services for correcting them, and fluoride in the drinking water. During the first 10 months of 1951, the truck visited 42 communities in the state.[948]

Mental Health

One of the areas outside of non-communicable disease where the department tried to take an active role early on was mental health. Mental health had begun to receive greater recognition as a public health problem nationwide with the passage of the 1946 federal Mental Health Act.[949] Federal funds for preventive mental hygiene were received, and in December 1947 the Board of Health created the mental health unit.[950] It was placed in the preventable diseases division (later to become disease prevention and control).

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[948] BOH, *Minutes,* October 16, 1951, MHS, pp. 319-321.
[949] P.L. 487, 79th Congress, app. 3 July 1946.
[950] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, p. 4.

Gov. Luther W. Youngdahl supported mental health efforts, and the state's new mental health law was inaugurated July 1, 1949. Conditions for mental patients in institutions were improved. Restraints were removed; the number of staff increased, and there was a single standard diet for both staff and patients.

The board felt it should be involved in mental health. It felt this sent an important message, emphasizing the prevention aspects. The governor, however, directed U.S. Public Health Service funds for mental health to Social Welfare where Dr. Ralph Rossen was appointed commissioner of mental health. The board was not pleased with this decision and discussed it at its May 5, 1949, meeting:

> Dr. Thomas Magath, President of the Board of Health: "The Governor, of course, has his troubles and I am sympathetic toward them, just as we have ours, but I think the thing that I find most difficult to understand is why he didn't call in the only agency in the State who has done anything about mental health for at least an expression of opinion. He was under moral obligation to give the State Board of Health an opportunity to express an opinion as to whether they thought the bill was good, bad or indifferent. He didn't' do that, and that is my chief complaint."
>
> Dr. Albert Chesley, Executive Officer: "You must remember that he was bedeviled from all points of view. If there was any attempt to change it, he was afraid he might lose the whole thing."
>
> Magath: "He should have thought of that before he put himself out on a limb."[951]

Dr. Chesley wrote a respectful letter to Gov. Youngdahl, sent May 9, 1949, asking for the active participation of the board in the preventive aspects of the state's mental health program under Chapter 512, Laws 1949. He specifically requested that the board be delegated to carry out the program. On May 19, Carl Jackson, director of public institutions at Social Welfare, sent a copy of an administrative order to the board. The order delegated Dr. Chesley as special assistant in the public institutions division with full power and authority to act for Mr. Jackson in the administration of the federal funds allotted under the 1946 Mental Health Act. [952]

The board was offered $29,667 for mental health programs within the department. The board wasn't certain it wanted to accept the funds, however, as they would be administered through the department. Dr. Boynton spoke on the matter at a board meeting on June 30, 1950:

> The thinking of the Board in times past is that the Board has never been in a position where any other State Department has dictated to it what it shall do. I am sure the Board does not want to be in that position, and I don't mean to infer that it wants to be. But I want some assurance of non-interference and cooperation and my feeling is that Dr. Rossen's reaction is that he wants cooperation. If we were to ask another agency for permission to expend money, that would be intolerable. As to continuity, again I got the impression that the opportunity of cooperation and continuity was good and was there. We must have Board action on accepting these funds and then after that, if we should continue the division as such.[953]

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[951] BOH, *Minutes,* May 5, 1949.
[952] Ibid.
[953] BOH, *Minutes,* June 30, 1950, MHS, p. 249.

The board voted to accept the funds, and during the next year the department continued activities and initiatives in mental health. The prevention of mental illness was the theme of the department's exhibit at the State Fair in 1949.[954] Dr. Barr spoke on "Minnesota's Mental Health Needs" on KUOM radio in 1949.[955] The department recommended mental health policy, sponsored lectures on mental health, and provided the services of a mental health consultant to public health nurses. "Mental Health Day" was held in Albert Lea in 1949, with 500 to 600 people in attendance.[956]

On December 16, 1949, the board changed and upgraded the status of mental health within the organizational structure. They created the preventive mental health services section, superseding the mental health unit created in 1947. William Griffiths, M.A., was acting chief of this new section.[957] During the existence of this section through 1962, it had four other heads: Francis Gamelin, M.A.; Anne Marks, R. N., M.P.H.; William Ferguson, M.A.; and Genevieve Damkroger.

Though the department hoped to have greater involvement in mental health and fought for more participation, interactions with the public institutions division were not entirely satisfactory. The department had control over a very small percentage of the mental health funding and was limited in what could be done.

Eventually, the main programs for mental health were kept in Public Welfare/Human Services. On July 1, 1962, all funds for preventive mental health programs were transferred from the Board of Health to the Department of Public Welfare, and designated the Mental Health Authority in Minnesota. The Health Department's section of preventive mental health services, by this time located in the special services division, was eliminated. After July 1962, all requests for mental health speakers, films, pamphlets, etc. were directed to Public Welfare. [958]

Alcoholism

The Board of Health also had tried to be actively involved in the prevention of alcoholism. This effort was as old as the agency, in fact. In 1872, Dr. Hewitt, first executive officer of the board, recognized alcoholism as a public health problem. He produced a report on "The Duty of the State in the Care and Cure of Inebriates."[959]

In 1953, the Legislature made the department responsible for preventive work in the area of alcohol abuse. This activity was located in the mental health section. When this section was eliminated in 1962, the alcoholism unit operated as an independent unit under the leadership of Genevieve Damkroger, M.A. By 1966, activities related to

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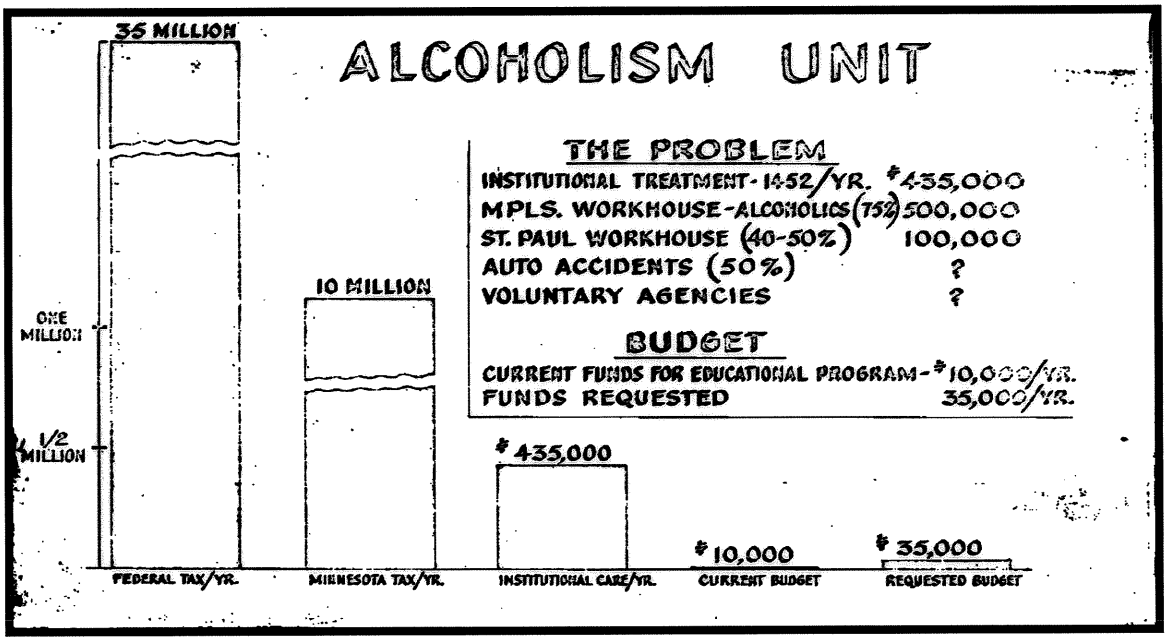
[954] MDH, *Minnesota's Health,* Vol. III, No. 8, August 1949, p. 3.
[955] MDH, *Minnesota's Health,* Vol. III, No. 2, February 1949.
[956] BOH, *Minutes,* June 13, 1950, MHS, pp. 249-250.
[957] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, p. 4.
[958] BOH, *Minutes,* May 23, 1962, MHS, p. 217.
[959] MDH, *Minnesota's Health,* Vol. 9, No. 2, February 1955, p. 1.

alcoholism were included in the family life education section in the department's special services division.

The High Cost of Alcoholism -- Part of presentation to Legislature in 1961



A conference on the prevention of alcohol in Minnesota was held in Worthington in October 1953. Sponsored by the department, this daylong meeting was attended by doctors, nurses, judges, clergy, and representatives of voluntary groups.[960] Conferences were later held in Mankato, Thief River Falls and Fergus Falls. A three-day institute on alcoholism was held at the University of Minnesota in April 1954.[961]

The department's role in the prevention of alcohol abuse was largely educational. In addition to the conferences, the department provided the public with pamphlets on alcoholism and used films and radio to spread public health messages on this topic. A coordinating council on alcoholism was established.

As with mental health, the costs of alcoholism treatment, as well as other societal costs created, were high. The department used this reasoning in 1961 when trying to convince the Legislature to provide cost-effective funding for prevention.

The 1961 Legislature granted the board a small amount of funds ($14,000) for the prevention of alcoholism. A much larger portion of funds (approximately $500,000) for programs related to alcoholism was directed to the Department of Welfare. The issue was discussed at the board's January 1962 meeting:

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[960] MDH, *Minnesota's Health,* Vol. 7, No. 11, December 1953, p. 3.
[961] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 7.

Dr. Frank Krusen: "It seems obvious that alcoholism is a medical problem and a psychiatric problem as well. It happens that psychiatry comes under the Department of Welfare in this state."

Dr. Arnie Rosenfield: "The law itself is a little peculiar in that there is an Advisory Board set up to tell the Health Department how to run a program with $14,000 whereas the bulk of the program in alcoholism is in the Department of Welfare where they spend half a million dollars, and the board has no authority over Welfare. The Board's authority is limited to the Health Department, but what they talk about at a meeting is not what we are doing but what Welfare is doing. We are concerned with the educational part of it, but they are not interested in that.

Prof. Herbert Bosch: "I have felt all the way through that we have been in a rather poor position when we carry on alcoholism and mental health programs without psychiatric consultation. I think this is doing everyone a disservice."[962]

Dr. Barr felt the question was whether the issue was important enough to make a real effort to develop a good program. He wondered if there should be an effort to transfer some of the federal money from other sources to this program.

Dr. Frank Krusen: "It would seem to me, from the discussion we have heard so far, that it is considered to be very important. I think the major question is whether this is likely to fall in the middle between the Department of Welfare and the Department of Health, and I think it is apparent that it should be explored and developed further."

Dr. Edgar Huenekens: "I agree that we either ought to have a very good program or none at all. What we have been doing is little bits of things that don't amount to anything."

Mrs. Katharine Densford Dreves: "$14,000 would hardly provide even one man. If you want a program, you have to have some way to support it."

Bosch: "This is a program that needs real pepping up because this is truly a health program, and I think that some way or other, if we can get any kind of Federal funds or divert other funds, we ought to beef up this program to where it is a good program."

Mr. Arnold Delger: "It appears, from personal observation, that the alcoholism problem first comes to the attention of the general practitioner. I would feel that if we don't do something to back these people up, we are letting them down. It certainly is a health problem in the beginning, the way the problem is brought to the attention of the medical people."

Dr. Arnold Swenson: "Forty per cent of the people who are chronically on welfare are there because of alcoholism. It is a tremendously high percentage."

The board agreed to approach the governor with the suggestion he expand or modify his advisory committee to include representatives of strong industrial groups like Minnesota Mining and Honeywell.[963] Despite its efforts, the department's alcoholism program did not expand as the board had hoped.

In the 1990s the department, under the leadership of Dr. Carolyn McKay, director of the division of maternal and child health; placed renewed emphasis on protecting children from the effects of alcohol and drugs, such as crack cocaine. In 1989, as a

[962] BOH, *Minutes,* January 16, 1962, MHS, p. 18.
[963] Ibid., pp. 18-20.

result of legislation initiated by the department, warning signs on the dangers of alcohol use during pregnancy were sent to eating and drinking establishments throughout the state for posting.

> ***"All known patches of marijuana in Minnesota will have been destroyed within the next two years. Progress of the eradication program plus efforts of law enforcement officers have already greatly reduced the use of marijuana."*** [964]
>
> **Thor L. Aamodt, State Entomologist, Minnesota Department of Agriculture, 1954**

In 1997 Minnesota ranked fourth in the nation in the percentage of women of childbearing age who drank frequently.[965] Fetal alcohol syndrome (FAS) was considered the number one cause of mental retardation in the state.[966] Minnesota spent only $500,000 to protect children from birth defects but spent an estimated $45 million a year on residential and medical treatment for children with FAS.[967]

In the late 1990s the effort to prevent fetal alcoholism began moving forward rapidly when Susan Carlson, the governor's wife, took this issue on as a personal crusade. A juvenile court referee at Hennepin County Detention Center, Susan Carlson saw first hand the lifelong and irreversible effects on children from alcohol use during pregnancy.

In 1997 Susan Carlson promoted a bill that would provide $4 million to combat fetal alcohol syndrome in Minnesota. The bill, sponsored by Rep. Barb Sykora, called for increased education and public service announcements about the dangers of alcohol consumption during pregnancy. It also included a controversial section allowing the involuntary commitment of women who drank heavily during pregnancy. Health care providers were to report drinking during pregnancy as child abuse. Concern was expressed that such a law might lead some women, afraid of being locked up, to avoid contact with health providers and not receive prenatal care. [968]

The 1997 Legislature funded a portion of the bill, $1.25 million, for chemical dependency treatment and public awareness of FAS. Susan Carlson vowed to continue her campaign in the next legislative session and formed a task force to collect testimony and information for educating the Legislature on the impact of FAS and fetal alcohol effect.[969] In 1998, this 47-person task force produced a report, "Suffer the Children: The Preventable Tragedy of FAS." Among other recommendations it called for greater education on the dangers of alcohol use during pregnancy and the commitment of heavy drinkers to force them to quit drinking during pregnancy.[970]

The initiative to reduce fetal alcohol syndrome received support from many areas, including newspaper editorials, in the late 1990s.[971] By the end of the session, the 1998

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[964] MDH, *Minnesota's Health,* Vol. 8, No. 5, May 1954, p. 4.
[965] *St. Paul Pioneer Press*, "FAS," April 28, 1997, p. 6A.
[966] *St. Paul Pioneer Press,* "Initiative to Battle FAS Begins," March 12, 1997.
[967] Ibid.
[968] Ibid.
[969] *St. Paul Pioneer Press*, "Start Toward Sainthood?", June 13, 1977, p. 10a.
[970] *St. Paul Pioneer Press*, "Report Outlines Measures for Pregnant Drinkers," February 5, 1998, pp. 1A and 12A.
[971] *St. Paul Pioneer Press,* "Proposal to Combat FAS Deserves Support," February 10, 1998, p. 10A.

Legislature appropriated $5 million for fetal alcohol syndrome. The initiative was included as part of the education bill, and funds were to be used for public awareness, clinical costs, intervention, and treatment programs. [972]

Fluoridation: A Long Battle

In 1949, the board knew it had to take a position on one non-communicable disease issue – the fluoridation of drinking water. It was being pressured from various groups for its recommendation: Was it okay? Was it safe? Should it be done? Like many other decisions the board made, it wasn't certain of the answer. Herbert Bosch, then head of environmental sanitation, said he was personally opposed to it: "...we went through the whole thing in the '20s on the subject of adding iodine."[973]

The board's decision on fluoridation was influenced by the actions of the national dental and public health groups. By November 1950, the American Dental Association and the American Public Health Association had gone on record in support of large-scale fluoridation of water supplies.[974] One month later all major organizations had given formal approval of fluoridation in drinking water supplies.

At its December 21, 1950, meeting, the board passed a resolution in support of fluoridation:

> WHEREAS the United Stated Public Heath Service has seen fit to alter its basic policy concerning the fluoridation of public water supplies,
>
> BE IT RESOLVED, that the Minnesota State Board of Health recommends the fluoridation of public water supplies within the State of Minnesota for the partial control of dental caries where such a program can meet and maintain the standards recommended by the state health authority.[975]

Though its decision was backed by the major public health associations, in 1952 the board still wrestled over the message it was giving the public. It didn't want to inaccurately present fluoride as a panacea for all dental problems. It was also concerned about the safety of fluoride, as this discussion at one board meeting indicates:

> Dr. Lester Webb: "I think it is important to warn people and to warn the professional people on its usage and to warn them in thinking that it isn't going to solve all our dental ills."
>
> Dr. H. Z. Giffin: "One of the things we don't know is what it is going to do over a long period of years."
>
> Barr: "I think the answer to that is that there are many places where fluorides occur normally in water supplies in higher concentration than they are being placed in water right now. There are some fluorides normally in almost all water supplies, so that the addition of up to one part per

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[972] *St. Paul Pioneer Press*, editorial, April 5, 1998.
[973] BOH, *Minutes,* July 14, 1949.
[974] BOH, *Minutes,* November 14, 1950, MHS, pp. 498-499.
[975] BOH, *Minutes,* December 21, 1959, MHS, pp. 563-567.

> million to 1.2 parts per million of fluorides is not going beyond the experience that we have had in many water supplies through the country, and there is no evidence ever demonstrated that even up to 3 and 4 and 5 parts of fluoride does any harm at all to the population using it, except that where over two parts per million there developed some mottling of the enamel. We know that that is about the level were that begins to occur so that the 1.2 parts being put in water supplies is not going to cause any mottling and certainly it is very much less than normally occurs in many places. If it was going to cause any harm you would think there would be some evidence in those communities who have had it throughout their lifetimes."[976]

Although no one knew for certain, the potential savings in dental costs from fluoridation seemed to be high. The cost to find out was relatively low. At about $0.10 per person per year in any community, the lifetime cost was estimated at $7.50.[977] This could, and did, become one of the public health investments with a big payback for the population.

The board made a public announcement that communities could begin fluoridation of their water supply once plans for installing equipment were approved by Dr. William A. Jordan, director of the department's dental health division. Almost immediately, Dr. Jordan began receiving daily calls and letters from communities interested in fluoridating their water supplies. [978]

The first community in Minnesota to begin adding fluoride to its drinking water supply was Red Lake Falls. Fluoride, at a ratio of one part per million, was added to their drinking water on April 25, 1951.[979]

By 1952, 21 communities had fluoridated their drinking water supplies: Red Lake Falls, Winnebago, West Concord, Thief River Falls, Montevideo, Fairmont, Fergus Falls, Granite Falls, Hallock, Ely, Arlington, Benson, Hutchinson, Staples, Mora, Austin, Appleton, New York Mills, St. Paul, International Falls and Mapleton.[980]

While these communities readily supported fluoridation, strong resistance existed in some parts of Minnesota and the nation. Board members discussed this opposition at their July 10, 1952, meeting:

> Barr: "There has been, as you know, considerable agitation against fluoridation of water supplies raised in Minnesota. Raised by a group of people who are anti to any community effort. Their claims vary all the way from medical treatment to rat poison in the water supply. There is no basis for the claims, but I think they were wise in Minneapolis to delay any action until the people themselves were convinced that it was something they wanted and insisted on having it irregardless of objections by groups in the city. This program has been backed by the State Dental Association. You will remember that some two years ago you had a large meeting in the Nicollet Hotel to which we brought in people from Wisconsin, the Public Health Service, to go over the pros and cons of the use of fluorides in the water supplies. Attendance of people who were operating water supplies throughout the state as well as others who were interested, and your own dental group."

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[976] BOH, *Minutes,* July 10,1952.
[977] MDH, *Minnesota's Health,* Vol. VI, No. 2, February 1952, p. 1.
[978] MDH, *Minnesota's Health,* Vol. V., No. 3, March 1951, p. 3.
[979] MDH, *Minnesota's Health,* Vol. V., No. 5, May 1951, p. 4.
[980] MDH, *Minnesota's Health,* Vol. VI, No. 10, November 1952.

> Giffin: "Is there any organization which is propagandizing against this thing? It seems to be a national thing."
>
> Barr: "I don't think there is any particular organization you can put your finger on. But there are a whole group of the antis who are against everything--vaccination, all that type of stuff. It is the same general group of people that are against this."
>
> Webb: "They take all their data--all are the same from all the states--state who said so, who he was, and what he said--and it seems to be a combined effort throughout the United States because they are using the same terminology and the same objectives."[981]

By 1954, 34 Minnesota communities had fluoridated their drinking water supplies. An estimated 460,000 persons were regularly drinking fluoridated water. [982] By 1960, 60 municipal drinking water supplies, serving one-third of the state's population, were fluoridated. [983] The net savings to the public that resulted were estimated at $1,455,046 over a 10-year period.[984] The savings would be greater still if fluoride treatments could reach the 90,000 urban children and 145,266 rural children who were not covered.

Fluoridation of drinking waters was challenged in 1954 by a federal bill submitted by Rep. Roy Wier of Minneapolis. H.R. 2341 would prohibit federal, state or municipal agencies from treating public water with any fluoride compound. Dr. Chesley wrote a letter to Rep. Charles A. Wolverton, chairman of the Interstate and Foreign Commerce Committee, in the U.S. House of Representatives:

> I am sure your committee is interested in presenting the best of health practices to all people of this nation. By the passage of such a bill as H.R. 2341 your committee and Congress would be retarding the health benefits to our people. The fluoridation of water is a health measure that should be adopted on the local level. I suggest very strongly that this bill be defeated in your committee.[985]

Thorough studies had indicated there was no statistical difference in deaths in cities with high fluoride content in their water and cities with low fluoride content. At the June 1, 1954, board meeting Dr. Chesley commented on H.R. 2341: "It is necessary to have bills of this kind to bring out the truth about things."[986]

By the 1960s, fluoridation was showing results. A survey of Red Lake Falls, fluoridated since 1951, indicated cavities were reduced by 70 percent.[987] Long-term studies were also done in Fergus Falls, Ely and St. Paul. All indicated that fluoridation reduced decay significantly.[988]

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[981] BOH, *Minutes,* July 10, 1952.
[982] MDH, *Minnesota's Health,* Vol. 8, No. 3, March 1954, p. 2.
[983] MDH, *Minnesota's Health,* Vol. 14, No. 7, August-September 1960, p. 2.
[984] MDH, *Minnesota's Health,* Vol. 15, No. 1, January 1961, p. 5.
[985] BOH, *Minutes,* May 11, 1954.
[986] BOH, *Minutes,* June 1, 1954.
[987] MDH, *Minnesota's Health,* Vol. 15, No. 9, November 1961, p. 1.
[988] MDH, *Minnesota's Health,* Vol. 17, No. 5, May 1963, p. 4.

By 1962, public health dentists were stating that half of all tooth decay could be prevented by adding fluoride to the community drinking water or by topically applying fluoride to teeth.

While many communities in Minnesota readily installed fluoridation equipment, there was considerable resistance in other communities. At the November 10, 1959, board meeting, Dr. Litman, a dentist, said he felt the failures in the fluoridation program were due to the negative publicity about fluoride on the radio and television and the approach taken by some dentists. Trying to understand how to convince the population of the benefits of fluoridation, the board approved an application for a grant to study the behavior and action of a community that had defeated the fluoridation program by a referendum.[989]

Fluoridation of municipal water supplies was optional through the 1960s. That changed in 1967 when the Legislature passed a bill, M. S. 144.145, requiring fluoridation of municipal drinking water in Minnesota by 1970.

Several communities resisted the legislation mandating fluoridation, but the town that drew the most attention was Brainerd. Brainerd fought fluoridation into the 1980s. Interestingly, in 1910, Brainerd was one of the first six towns in Minnesota to chlorinate their drinking water.[990] In the early 1900s, Brainerd was one of the most progressive towns as far as sewage disposal, being one of the first to establish a sewerage system.[991]

Brainerd held several referendums on whether or not to fluoridate their drinking water. Each one was defeated. A 1961 referendum, prior to the state legislation, was defeated by a vote of 2,846 to 1,427.

Brainerd had not fluoridated its water by the deadline set by the Legislature, and in September 1971 the state asked Brainerd to fluoridate its drinking water. Equipment was installed in September 1972. The department tried to convince the Brainerd community to move forward with fluoridation. Department staff prepared and distributed an estimate of the cost savings, approximately $548,636, which would result from 1970 to 1979 savings due to fluoridation in Brainerd.[992] The department tried to identify supporters and allies. Russell Havir, the department's central district representative, met with people in Brainerd in late 1973 to try to find those who would actively support the fluoridation law.[993]

Brainerd filed a suit, attempting to prevent enforcement of MS144.145. The case was decided in favor of the state on August 30, 1973, and Brainerd was instructed to add fluoride to its drinking water. On January 23, 1974, Health Commissioner Dr. Warren Lawson sent a letter to the Brainerd city council, asking what steps it had taken to

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[989] BOH, *Minutes,* November 10, 1959, MHS, p. 257.
[990] Philip Jordan, *The People's Health*, p. 113.
[991] Ibid., p. 143.
[992] MDH, "Estimated Cost to Brainerd Area Citizens for Not Fluoridating their Water Supply," November 30, 1973.
[993] MDH, report on Brainerd community support for compliance with the 1970 fluoridation law, December 28, 1973.

commence the process of adding fluoride to the municipal water supply and offering technical assistance.[994]

> ***"Fluoride is harmful to some people; a national conspiracy of some kind is aimed at getting the substance into water and such action amounts to giving people medicine against their will. Every town has its fluoride pusher assigned by the American Dental Association.***[995]
>
> **Opponent of Fluoridation, Brainerd, 1974**

Brainerd's water and light department wrote back to Dr. Lawson, informing him that the necessary equipment for fluoridation was installed but not currently in operation. Attached to the response were memos indicating the Brainerd city council's intent to pursue other options before complying with the law. It requested a delay in enforcement from Attorney General Warren Spannaus and indicated its support for proposed legislation that would permit local options.[996]

By 1974, Dr. Lawson was running out of patience. He sent a letter to Brainerd city officials:

> It is the city council's duty, as a duly constituted public body, to comply with the laws of this State regardless of personal opinions which may be held concerning a particular law's merit. We expect the city of Brainerd to fulfill its obligation to proceed as soon as practical to commence fluoridation of the municipal water supply.[997]

In May 1974, Dr. Lawson received a copy of a news articles on the Brainerd fluoridation issue. Scrawled at the top of the article, in squiggly handwriting, was: "Lay off Brainerd Lawson or you will be sorry." At the bottom was written "Warning." Part of the article was underlined in red ink: "The anti-fluoridation forces are very powerful in this town."[998] One leader of the anti-fluoridation movement in Brainerd said that Brainerd could "become another Wounded Knee if the State forces fluoridation."[999]

About the same time, Dr. Lawson received the letter featured on the next page.

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[994] Letter from Dr. Warren Lawson to Brainerd City Council, January 23, 1974.
[995] *Minneapolis Tribune,* "Fluoridation foe is latter-day Carrie Nation," July 15, 1974.
[996] Letter to Dr Warren Lawson from Richard Johnson, secretary, Brainerd Water and Light Board, February 1, 1974.
[997] *Minneapolis Star Tribune,* "Brainerd and State Near Showdown on Fluoride," May 1974.
[998] Ibid.
[999] Ibid.

Nearly five years after the law requiring fluoridation was to go into effect, Brainerd was still without fluoride in its drinking water. Dr. Lawson wrote, "I do not, and the Department and Board do not derive any satisfaction or benefit from the continuation of the controversy or from carrying out the duties laid upon us by State law."[1001]

In the summer of 1974, the board took the somewhat unusual step of attempting to file a lawsuit to force fluoridation in Brainerd.[1002] District Judge John Spellacy dismissed the board's petition, but some other positive events were occurring. In the summer of 1974, several Brainerd dentists and physicians made a statement in full support of fluoridation.[1003] In August 1974 the Brainerd city council indicated it wanted to meet and work out a compromise.[1004]

Sen. Borden of Brainerd was very opposed to the state's position. He wrote the department through the newspaper:

> Neither your department nor the proponents of fluoridation were willing to discuss the merits of the issue and the recent election in Brainerd. Rather you chose to refer to the election as a sham. It seems to me if you really believe

Example of Letter Dr. Lawson Received from Opponent of Fluoridation in 1974

Dear Sir,

I'm taking this pleasure to write you to let you know how I feel on this damible "florida poison" which you big shots are so determined to put in our water supply here in Brainerd Now I for one have several hundred dollars which I will fight this to the last cent. Why are you so sure its good for a few kids teeth when all it does is rotten them? I have a book that the most famous Doctors are agenst this dam Poison and that's all it is Now here is a Dr's name, "Dr. Kaj Ronholm. Foremost athority on "floride" also. When it kills house plants and gold fish it will kill human beings, and another thing why don't the small towns have to put it in? I'll tell you why because there isn't enough money involved, and another thing if this goes thru I'll put a well in my home also why are you down there so al fired concerned about what we drink. If you would take care of your own water supply and leave our pure water alone you would have all you could do No if our water is so polluted that this da florida has to be put in OK go ahead but I don't think it is so Why pullute it we are told to clean up our lakes and rivers than you want to pullute our water supply and how dumb can someone be. I may not be the smartest one on this subject but one thing I do know some big Jackass is making a lot of money somewhere. Now if you want this book I have on this subject go by the June Prevention. On Page 70 it says "Floridation: Waiting for the disastor" I dare you or anyone else to read this then try and force us here in Brainerd to allow this to be put in our water system. Thank for my pleasure."[1000]

[1000] Letter from Mrs. Zelma Wickham to Dr. Warren Lawson, May 30, 1974.
[1001] Letter to Sen. Winston W. Borden from Dr. Warren Lawson, July 17, 1974.
[1002] Memo from Richard Wexler, special assistant to the attorney general, to Dr. Warren Lawson, August 5, 1974.
[1003] Statement given to Dr. Warren Lawson from Dr. Echternacht, June 17, 1974.
[1004] Letter to Dr. Warren Lawson from Sen. Winston Borden, August 12, 1974.

> in the merits of fluoride and really believe that the process of an informed citizenry making the right decision through the Democratic process, you would have chosen to persuade the citizens of the merits of your position.[1005]

A peremptory writ of mandamus was issued on December 4, 1974, directing Brainerd to begin fluoridation immediately pursuant to MS144.145 and regulation MHD112(b). The city appealed to the Minnesota Supreme Court, which affirmed an earlier order of the District Court.[1006]

Brainerd tried for exemption from the law, but in March 1976 the Minnesota Supreme Court ruled that Brainerd must abide by the state law and fluoridate its drinking water. The decision angered Mrs. Nordahl Johnson, head of Minnesotans Opposed to Forced Fluoridation. She stated to the press, "We're simply not going to put fluoride in our water. If we have to fight in the streets of Brainerd, then we'll fight in the streets of Brainerd. If the governor wants to send troops to Brainerd in this Bicentennial year, then let him."[1007]

Opponents of the legislation felt the court's decision was wrong, as it went against the rights of the people. Associate Justice MacLaughlin elaborated on the right-to-privacy issue: "While forced fluoridation does intrude on an individual's decision whether or not to ingest fluoride, the impact of this intrusion on an individual's life is negligible."[1008]

Opponents of fluoridation in Brainerd took the case to the U.S. Supreme Court who dismissed the case for lack of a substantial federal question.[1009] Following this decision, on October 16, 1976, the Health Department ordered fluoridation of Brainerd's municipal drinking water. Brainerd asked for a delay of the state order so that they could present new evidence showing a causal relationship between fluoridation and cancer. Assistant Attorney General Dick Wexler argued that there is a large body of opinion to the contrary.[1010]

In 1979, Brainerd was still fighting fluoridation. The 1979 Legislature enacted a provision requiring a three-member panel, appointed by the governor, to review health aspects of fluoridation. Municipalities that had not yet fluoridated did not need to do so until July 1, 1979, at which time the writ of mandamus would take effect.[1011] Facing a contempt citation, on October 24, 1979, five Brainerd City Council members changed their position and agreed to fluoridate the city's drinking water.[1012]

In early 1980 the FBI and the Justice Department became involved with the fluoridation issue in Minnesota, but they found no grounds for criminal prosecution. According to a Twin Cities newspaper, John Graham, Brainerd's attorney to stop fluoridation, said he

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[1005] *Brainerd Daily Dispatch,* "Officials Discuss Fluoride Compromise," August 20, 1974.
[1006] Memo from Richard Wexler, assistant attorney general, to Dr. George R. Pettersen, June 4, 1979.
[1007] *Brainerd Daily Dispatch,* "High Court Says Brainerd Must Fluoridate," Vol. 99C, No. 19B, March 26, 1976, p. 1.
[1008] Ibid.
[1009] Memo from Richard Wexler, assistant attorney general, to Dr. George R. Pettersen, June 4, 1979.
[1010] *St. Paul Pioneer Press,* "Brainerd Battles Fluoride With Cancer," December 10, 1976, p. 16.
[1011] Memo from Richard Wexler, assistant attorney general, to Dr. George R. Pettersen, June 4, 1979.
[1012] *St. Paul Pioneer Press*, "Lawsuit Challenging Fluorides Dismissed," January 4, 1985, p. 3D.

thought a pro-fluoridation group called "Graham's Crackers" was out to discredit him. Mr. Graham went to the FBI and alleged that Dr. Bernhard Flavhan, chief of the dental health section at the Minnesota Department of Health, might have accepted $5,000 from an association to alter a report critical of fluoridation. According to the news account, both Dr. Flavhan and Mr. Graham agreed that Mr. Graham had called Dr. Flavhan at home one evening. They differed, however, on what was said. Dr. Flavhan said Mr. Graham asked him what he took from the dental association. When Dr. Flavhan responded that it was five golf balls, Mr. Graham asked him if he was sure it wasn't "five big ones." According to Mr. Graham, Dr. Flavhan told him he had been given five big ones for favors rendered.[1013]

Despite the October 1979 vote by the city council to fluoridate Brainerd's drinking water, the water was not yet fluoridated more than three months later. On February 5, 1980, a letter from Dr. George Pettersen, commissioner of health, was hand delivered to Brainerd City Attorney D. A. Larson. The letter ordered Brainerd to fluoridate the municipal drinking water, as required by law, within 48 hours. The letter stated: "Should you not commence fluoridation of Brainerd's water supply within 48 hours of receipts of this letter, I will have no choice but to seek appropriate remedies in court."[1014]

The Brainerd City Council met and decided to ask Dr. Pettersen for a three- to five-week extension. Dr. Pettersen agreed to think about a two-week extension and promised an answer by 9:00 a.m., February 7.[1015] The extension was not given, and Brainerd began putting fluoride in its drinking water on February 7, 1980. An un-fluoridated tap was provided for those wishing to use it.[1016]

Three years later the issue was in the forefront again. On March 28, 1983, the Brainerd City Council voted to terminate funding for fluoridation as a cost-saving measure.[1017] The supply of fluoride was expected to run out about May 9. The city sought the support of Gov. Perpich, but he informed them the matter would be handled by the state Department of Health.[1018] Brainerd City Attorney John Graham argued that the health commissioner had discretion in carrying out the 1967 legislation requiring fluoridation, but Gov. Perpich said no.[1019]

The new health commissioner, Sister Mary Madonna Ashton, sent the Brainerd city clerk's office a letter stating that they had until April 20, 1983, to restore funds for fluoridation. Sister Mary Madonna said the city council's decision was a disappointment, and she urged them not to proceed in contempt of court orders but to work for change through the Legislature. She said her position was the same as that of

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[1013] *St. Paul Pioneer Press,* "Brainerd Has Till Thursday to Fluoridate Water," February 6, 1980, p. 22.
[1014] Ibid.
[1015] *St. Paul Pioneer Press,* "Brainerd Council Seeks Extension in Minnesota's Fluoridation Order," February 7, 1980.
[1016] *St. Paul Pioneer Press,* "Lawsuit Challenging Fluorides Dismissed," January 4, 1985, p. 3D.
[1017] *St. Paul Pioneer Press,* "Deadline Set for Brainerd," April 20, 1983, p. 4C.
[1018] *St. Paul Pioneer Press,* "Brainerd is Told Again to Fluoridate Its Drinking Water," April 8, 1983, p. 2B.
[1019] *St. Paul Pioneer Press,* "Brainerd Quits Fluoridation Fight," April 22, 1983, p. 1C.

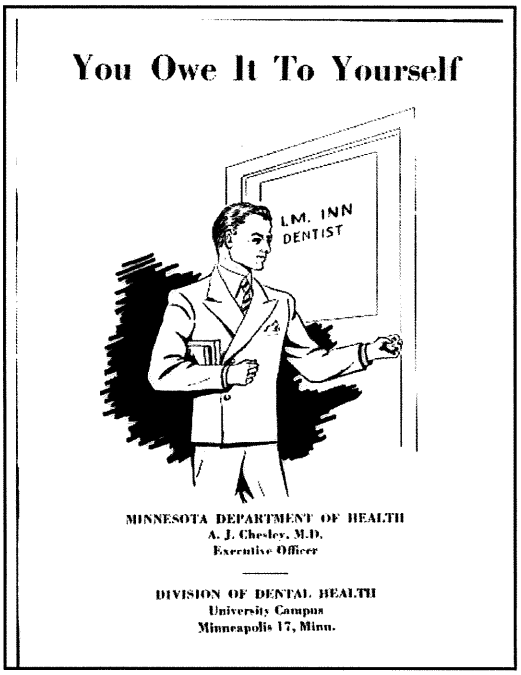
her predecessor, Dr. George Pettersen; and to stress the point she enclosed a letter he had sent to Brainerd earlier.[1020]

John Graham, special counsel for the city, was not pleased with the department's actions. He said, "What they want to do is force the hand of the city. The politics in that department must be crazy."[1021]

A special meeting of the Brainerd City Council was held April 21, and it voted 6-0 to rescind its March 28 decision to end funding for fluoridation. The legal battle could cost up to $30,000, when the fluoridation would cost $3,000. [1022]

Fifteen years had passed since the 1967 legislation requiring fluoridation of municipal drinking water was enacted. Thirteen years had passed since the 1970 deadline for fluoridation, set by the Legislature. Brainerd's battle to prevent fluoridation lasted through four executive officers/commissioners: Dr. Barr, Dr. Lawson, Dr. Pettersen and Sister Mary Madonna Ashton. By 1983 it appeared as if Brainerd was accepting fluoridation permanently. Upon hearing the news, Sister Mary Madonna said: "I'm delighted. I'm very happy. I felt that was important for our relationship. I'm sure the Governor will be delighted also."[1023]

The issue wasn't completely over, however. Anti-fluoridation Brainerd activist Irene Johnson brought the case to court and requested that sanctions be imposed on Sister Mary Madonna. On January 2, 1985, Hennepin District Judge Patrick Fitzgerald denied Irene Johnson's request and dismissed the case.[1024] The issue had been almost continuously in the courts since 1972.



In addition to promoting fluoridation of drinking water supplies, the department has had a strong dental health program. In the 1950s the department's dental health unit recommended topical fluoridation, banning the sale of candy and soft drinks in schools, and brushing or rinsing teeth immediately after eating and timely dental care.[1025] Working with the Minnesota Dental Association, they took an aggressive approach to better dental health.

[1020] *St. Paul Pioneer Press,* "Brainerd Given Week to Restore Fluoride Funds or Face Lawsuit," April 14, 1983, p. 7C.
[1021] Ibid.
[1022] *St. Paul Pioneer Press,* "Brainerd Quits Fluoridation Fight," April 22, 1983, p. 1C.
[1023] Ibid.
[1024] *St. Paul Pioneer Press,* "Lawsuit Challenging Fluorides Dismissed," January 4, 1985, p. 3D.
[1025] MDH, M*innesota's Health,* Vol. VI, No. 1, January 1952, p. 3.

One activity, a topical fluoridation program, was part of a study that attracted attention from around the world. From 1948 to 1958, 2,513 children took part in the Askov dental demonstration project in Askov, Minnesota.[1026] Participants were children, aged three through 17 years. These children received topical fluoridation, twice-daily tooth brushing drills, regular dental care with x-rays, and were urged to reduce the amount of sweets they ate. The project was sponsored by the Health Department, the Minnesota Dental Association, the federal Children's Bureau and the citizens of Askov. The Askov Dental Health Council was the governing body.[1027]

With the use of dental x-rays, an additional 2.87 caries were found in children through the Askov program. The study also showed what seemed to be a direct correlation between lactobacilus and caries.[1028] As Askov water was not fluoridated until March 1960, the study was able to measure the effect of topical fluoride and other methods of reducing decay. Based on the Askov study, it was felt the fluoridation of drinking water would reduce more cavities at less cost and less effort.

Education was part of the Askov 10-year dental health project. Four rats were used to teach nutrition. "Abercrombie" and "Darwin" received well balanced diets, the "basic seven," and thrived. "Bartholomew" ate the food typical of most Askov school children. He got too much sugar and starches and too little milk, fruits and vegetable. "Caeser" received the diet the children dreamed about – candy, cake, cookies, jam and soft drinks. The four rats were shown to the Askov school children, hoping weak and scrawny "Caeser" would encourage a better diet among the children.[1029]

A community-wide topical fluoridation program was held in Isanti County in 1951. The Parent Teachers Association sponsored the event, five local dentists took part, and the Department of Health provided equipment and the services of two dental hygienists. Topical fluoridation programs were also held in Braham and Cambridge.[1030]

The first countywide dental health education program in Minnesota was organized in Pope County in 1954.[1031] The county's health service committee sponsored the program. Members included F. S. Stone, D.D.S.; H. J. Talle, county superintendent of schools; Mrs. Sigurd Bjerke, Mrs. John Morton; Mrs. Ernest Peper and Miss Olivia Peterson, public health nurse. Every one of the 36 schools in Pope County participated. More than 2,000 children received instruction in dental health during the week of February 14, 1955.[1032]

School children in Bloomington played an important part in launching a well-known toothpaste. In 1955, the Department of Health, the Lions Club, the public and private schools of Bloomington, and Bloomington

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1026 MDH, *Minnesota's Health,* Vol. 14, No. 4, April 1960, p. 3.
1027 MDH, *Minnesota's Health,* Vol. 8, No. 2, February 1954, p. 1.
1028 BOH, *Minutes,* February 14, 1950, MHS, p. 30.
1029 MDH, *Minnesota's Health,* Vol. III, No. 3, pp. 1-2.
1030 MDH, *Minnesota's Health,* Vol. V, No. 2, February 1952, p. 2.
1031 MDH, *Minnesota's Health,* Vol. 9, No. 1, January 1955, p. 3.
1032 MDH, *Minnesota's Health,* Vol. 9, No. 3, March 1955, p. 3.

dentists sponsored a study to test dentifrice with fluoride. Third and fourth grade students participated.[1033] After one year there was a 35 percent reduction in decay among the students in Bloomington's "Operation Toothpaste" study.[1034]

The results of the study of stannous fluoride in Bloomington led to the announcement, on August 1, 1960, by Proctor & Gamble that the American Dental Association recognized Crest toothpaste as an effective anti-decay dentifrice. It was the first dentifrice to be recognized as effective in reducing decay.[1035]

Another first for Minnesota was the statewide dental card program. It was first introduced on a statewide basis during 1942-943. Each pupil was given a dental card to take to the family dentist for an exam. There was usually no charge for this exam. If no defects were found, the card was signed and returned to school. If defects were found, the normal procedure was to have the dental work completed, after which the card would be returned to the school.

In 1956, 2,913 schools, including more than 450,000 students, were participating in this program. The dental card program found that slightly less than half of elementary school children were not receiving needed dental treatment. The reasons were due to a shortage of dentists, indifference, and insufficient family funds.[1036]

Heart Disease and Cancer

Two additional areas of non-communicable disease where the department took an active role were cancer and heart disease. The department focused on education, detection and surveillance. Heart disease and cancer were the leading causes of deaths among Minnesotans in 1949. Heart disease had been the leading cause of death in Minnesota since 1914, except for 1918 when more persons died of influenza.

In the 1950s the department sponsored several activities aimed to improve health professionals' understanding of both cancer and heart disease. At the request of Robert Hohman, executive secretary of the Minnesota Heart Association, the department established a course for physicians, covering the areas of cancer, heart disease and rehabilitation. A series of clinical conferences, evaluating case studies, were first held in Litchfield, Owatonna, Montevideo, Glencoe and Hutchinson in 1954.[1037]

In 1956 the department, the University of Minnesota School of Public Health, and the U.S. Public Health Service worked together on a pilot training program in cardiovascular disease for nurses. The three-month course was designed to give practical working experience in cardiovascular disease at hospitals and health agencies in the Twin

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[1033] MDH, *Minnesota's Health,* Vol. 9, No. 4, April 1955, p. 4.
[1034] MDH, *Minnesota's Health,* Vol. 10, No. 6, June-July 1956, p. 4.
[1035] BOH, *Minutes,* September 13, 1960, MHS, pp. 335-336.
[1036] MDH, *Minnesota's Health,* Vol.11, No. 5, May 1957, pp.1-3.
[1037] MDH, *Minnesota's Health,* Vol. 8, No. 3, March 1954, p. 2.

Cities. One reason the Twin Cities were selected as the location of this pilot project was the excellent working relationships between agencies in the area. [1038]

Annual deaths from rheumatic fever numbered 500 to 600 in Minnesota in the 1950s, becoming one of the leading causes of death and disability among children.[1039] The department began conducting a study of rheumatic fever in 1955. Control was difficult, because the exact cause was not known and its symptoms resembled less serious conditions. [1040] The 1955 study was followed by similar studies in 1958 and 1962. [1041]

In 1959, Dr. Dean Fleming worked with the Minnesota Pharmaceutical Association and the heart and medical associations to establish a rheumatic fever prevention program.[1042] This included a registry on rheumatic fever patients and the provision of necessary drugs to ensure adequate treatment was received. [1043] The program began in January 1960. Using the forms provided, physicians submitted cases to the department, establishing a registry of rheumatic fever patients. By 1961, the department had established a case registry of 4,119 rheumatic fever patients. Registered patients were able to get prophylactic drugs for long-term treatment at reduced costs from participating pharmacists.[1044]

The department also started a cancer control program in 1947. Grants from the U.S. Public Health Service made it possible to establish a section of cancer and heart disease control in the department in 1949. The section was one of four within the division of preventable disease. The section, directed by Dr. N. O. Pearce, worked closely with the Minnesota division of the American Cancer Society, formed in 1938, and the Minnesota Heart Association, started in 1948.[1045] In 1953, the section was renamed chronic disease and geriatrics.

The department's program focused on increasing informational facilities for the benefit of physicians, nurses, dentists, pharmacists and other professional groups. Refresher courses and programs were offered. [1046] In 1949, Dr. Pearce and Dean Fleming, M.D., M.P.H., completed a cancer statistical study of Minnesota that was published in Minnesota Medicine magazine in August 1950.[1047]

A challenge in dealing with cancer at this time was the stigma associated with it. Like tuberculosis and other diseases in earlier years, people often wanted to conceal the fact that they had cancer. The population's perception of cancer was pointed out when the board discussed the possibility of a creating a cancer statistical center in 1949:

[1038] MDH, *Minnesota's Health,* Vol. 9, No. 10, December 1955, p. 2.
[1039] MDH, *Minnesota's Health,* Vol. VI, No. 1, January 1952, pp.1-2.
[1040] MDH, *Minnesota's Health,* Vol. III, No. 9, September 1949, pp. 1-2.
[1041] BOH, *Minutes,* May 23, 1962, MHS, pp. 232-233.
[1042] BOH, *Minutes,* January 12, 1960, MHS, p. 9.
[1043] BOH, *Minutes,* May 26, 1959, MHS, p. 120.
[1044] MDH, *Minnesota's Health,* Vol. 15, No. 5, May 1961, p. 4.
[1045] MDH, *Minnesota's Health,* Vol. III, No. 9, September 1949, pp. 1-2.
[1046] Ibid.
[1047] BOH, *Minutes,* December 21, 1950, MHS, p. 542.

President Thomas Magath: "But we certainly can anticipate that in ten or fifteen years this feeling that people have about anyone knowing that they have cancer will be broken down."

Dr. Robert Barr: "I think it might be very much less than that."

Magath: "I don't think doctors would object if their patients were willing. I think it is an educational process that you have to go through here."

Dr. Albert Chesley: "That is exactly what we had to do in tuberculosis." [1048]

Early on chemotherapy was not yet available, and the mode of treatment for cancer was either surgery or radiation. Survival rates were low. Early detection was advocated as one way to reduce the likelihood of death. The Minnesota Medical Association, the Minnesota division of the American Cancer Society, and the Board of Health promoted annual physical examinations and breast self-examinations. In addition to early diagnosis, they stressed treatment and education to reduce mortality.

The Minnesota Cancer Society asked for the Board of Health's support in a campaign to increase detection at doctors' offices. The cancer society hoped to increase early detection through a brief history form that doctors would give patients to complete when they came to the office for an examination. The slogan of the campaign was: "Every physician's office a cancer detection center."[1049]

The board wasn't sure if it should sponsor this program. Board members discussed it at a meeting in 1950:

Dr. Ruth Boynton: "Would the examination be required to include x-ray, G.I. and rectal?"

Dr. Dean Fleming: "No. Laboratory studies and x-ray and gastric, microscopic examination, biopsy, would be outside of the cancer examination."

Boynton: "How do they call that a cancer examination? It seems to me you are fooling the public awfully. I am not sure that I believe in selling the public that kind of examination is sufficient to detect cancer."

Fleming: "I think there is some danger of that in it. It is one way, perhaps, to get people to come in for a periodic examination. If that is behind their thinking another publicity thing that will get people to come in for examination...trying in follow-up twelve months later and tabulation of the cards."

Dr. Frederick Behmler: "I think you are fooling the public there."

Charles Netz: "There is no complete examination where you can say a person does not have cancer. It seems to me that the thing they propose is wholly inadequate. They are going to give some of these people confidence that would not be on a basis of fact."[1050]

The state reported 151.8 deaths per 100,000 from cancer in 1953, an increase from the 128.3 deaths per 100,000 population reported in 1940. Especially noted were the

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[1048] BOH, *Minutes,* January 20, 1949.
[1049] MDH, *Minnesota's Health,* Vol. 10, No. 4, April 1956, pp. 2-3.
[1050] BOH, *Minutes,* February 14, 1950, MHS, pp. 46-48.

increases in cancers of the respiratory system.[1051] The possible link between cancer and tobacco use began receiving greater attention.

Tobacco Use

In 1952, the American Cancer Society began a study in Minnesota to try to determine whether there was a relationship between smoking and cancer of the lungs.[1052] In June 1954, the study reported that men who smoked cigarettes were found to have 75 percent higher death rates from all causes, and heavy smokers had a cancer death rate and a heart death rate nearly twice that of non-smokers in Minnesota. Lung cancer deaths were three times as common among men with a history of cigarette smoking.[1053]

The Health Department began initiatives to alert the population to the potential dangers of smoking. A new employee in the department's public health education section developed an educational program for Minnesota students showing the relationship of cancer and cigarette smoking. Facts were presented so students had a base of information from which to make their decision on smoking. [1054] The program was adopted in the Minneapolis Public Schools where it was used in junior high schools. Dr. Fleming commented at the board meeting that while he thought this new field of cancer education held great promise, he thought junior high was a little late, as many school children begin smoking in sixth grade.[1055]

In 1962 the department supported the production of a filmstrip about the risks of smoking. The filmstrip, created for 11- and 12-year-olds, was titled "I'll Choose the High Road." It noted there is a possible relationship between smoking and respiratory conditions, including lung cancer. The filmstrip was available to all schools in the state, without cost.[1056]

While the department had begun educational campaigns about tobacco use, there was some hesitancy regarding the message they might be sending out. This was discussed at the May 23, 1961, board meeting. Dr. Barr questioned how far the board should go in recommending that children not smoke without clear scientific evidence. He felt there was a relationship between smoking and lung cancer, but he hesitated to condemn the use of tobacco. He felt it would be interpreted by the public that the Board of Health had endorsed a program in the schools that is against smoking because smoking causes cancer. He didn't know if that was true. Dr. Frank Krusen, board president, felt the department should go ahead with the program.[1057]

[1051] MDH, *Minnesota's Health,* Vol. 9, No. 3, March 1955, p. 2.
[1052] MDH, *Minnesota's Health,* Vol. VI, No. 4, April 1952, p. 1.
[1053] MDH, *Minnesota's Health,* Vol. 8, No. 8, September 1954, p.4.
[1054] BOH, *Minutes,* May 23, 1961, MHS, p. 167.
[1055] BOH, *Minutes,* December 19, 1960, MHS, p. 421.
[1056] MDH, *Minnesota's Health,* Vol. 16, No. 5, May 1962, p. 3.
[1057] BOH, *Minutes,* May 23, 1961, MHS, p. 215.

Dr. Barr's outlook on smoking was typical of that shared by many Minnesotans. Public support for no-smoking initiatives was not strong. A December 1963 poll conducted by the Minneapolis Star and Tribune found that 69 percent of the people believed cigarette smoking "had proved to be a health hazard." Half of the people interviewed did not want a national campaign to discourage people from smoking. Their objections were based on the grounds that "the individual should decide for himself whether he will smoke."[1058]

Any reluctance by Dr. Barr or the board to openly oppose cigarette smoking changed on January 11, 1964. The U.S. Surgeon General issued a warning that "cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action.[1059] On January 14, 1964, the board issued its own resolution on smoking and health. It resolved that the department would increase its educational efforts in this area and resolved to take leadership in implementing the recommendations in the surgeon general's report.[1060]

The board's resolution on smoking and health noted that it was "more prudent from the public health viewpoint to assume that the established association between cigarette smoking and deaths from coronary disease and many other cardiovascular diseases has causative meaning than to suspend judgment until no uncertainty remains." The resolution noted the increased association between cigarette smoking and lung cancer, chronic bronchitis and emphysema.[1061]

"TAKE A DAY OFF FROM SMOKING. MAYBE YOU'LL EVEN LIKE IT."

D-Day, October 21, 1975

At this time, in the 1960s, many department employees and board members still smoked. Dr. Barr smoked two packs a day. This began to change. In 1975, the department instituted smoking policies, in order to comply with the Minnesota Clean Indoor Air Act. Under certain conditions, smoking was still allowed in some work areas. On Monday, March 3, 1986, smoking was no longer allowed in any work areas of the department building. Smoking was still permitted in the third and fifth floor lounges and a designated part of the cafeteria. Before Sister Mary Madonna ended her administration in 1991, the department building had become completely smoke-free.

Under the leadership of Kathy Harty, the small departmental unit created to curb tobacco use, became very visible. Among other initiatives, this unit was responsible for creating the popular posters designed to discourage cigarette smoking.

[1058] MDH, *Minnesota's Health,* Vol. 18, No. 2, February 1964, p. 2.
[1059] MDH, *Minnesota's Health,* Vol. 18, No. 1, January 1964, p. 2.
[1060] MDH, *Minnesota's Health,* Vol. 18, No. 2, February 1964, p. 2.
[1061] Ibid.

Survey and Screening as Prevention

Throughout its history, case finding and surveillance have been critical aspects of the department's activities. This has been especially true with chronic diseases and conditions that may not be easily identified until they have caused irreparable damage. Therefore, early case finding is extremely important.

Many screening programs existed at the department between 1949 and 1999. Some of them are listed below:

- **Cancer and Heart Disease** - Screenings for cancer and heart disease were an outgrowth of the tuberculosis screenings that were offered to the public for several years beginning in 1948. Thoracic surgeons and cardiologists thought early signs of pulmonary cancer or cardiac disease might appear on the x-rays taken for tuberculosis case finding. Not feeling any symptoms, people would otherwise not be reporting to the doctors. By the time they did, it might be too late.[1062] A pilot study was done to determine whether mass x-ray survey findings would help be of value through early case finding. The pilot study, the first of its kind in Minnesota, was done in Rice and Goodhue counties in 1951. Chest x-rays showed 22 of every 1,000 x-rayed had conditions requiring further medical attention. Of these, 15 suggested heart or other chest abnormalities and seven indicated tuberculosis.[1063]

- **Vision and Hearing** - In 1963 the department began a vision and screening program for school-age children. During the first year, 17,000 children were screened, and by 1967 more than 66,000 had had their vision and hearing screened. During the 1967-1968 school year, 5,111 children were identified as having problems, and referrals were made to professionals.[1064]

- **Diabetes** - In 1967 the State Department of Health, the Minneapolis Department of Health, the Twin Cities Diabetes Association and the University of Minnesota jointly sponsored a screening program to identify diabetics in Minnesota. Diabetes was the eighth leading cause of death in the state at this time.[1065]

- **Blood Pressure** - Nationwide, the population was becoming better aware of the importance of monitoring one's blood pressure. Minnesota had a unique approach to emphasize the value of blood pressure testing in preventing chronic disease. In 1973 the department asked each member of the state Legislature to allow a nurse to take the legislator's blood pressure. The department wanted to prove that one of every 10 legislators had, like the rest of the adult population, high blood pressure. The memo to the 134 House of Representative members from Dr. Lawson announcing this plan began with this line: "What does a pretty

[1062] BOH, *Minutes,* August 1, 1950.
[1063] MDH, *Minnesota's Health,* Vol. V, No. 3, March 1951, pp. 3-4.
[1064] MDH, *Minnesota's Health,* Vol. 22, No. 1, January 1968, pp. 2-3.
[1065] MDH, *Minnesota's Health,* Vol. 21, No. 5, May 1967, p. 1.

nurse measuring your blood pressure have to do with control of medical care costs?"[1066]

Injury and Safety

In 1953, one out of every three deaths among Minnesota children, aged one to 14 years, was caused by an accident. There were three times as many deaths from accidents as there were from cancer, the second most frequent cause of death in this age group.[1067]

Despite the large number of children injured, it was difficult to get legislative support to address this health problem. At a 1950 board meeting, Dr. Robert Barr, deputy executive officer, reported:

> We have some difficulty in getting legislative groups to recognize that here is something of prime importance so far as children are concerned and we can do something about it, if we had some funds. Last time we did request a small amount of funds but they didn't earmark any amount for doing home accident work.[1068]

In 1956 the Minnesota Medical Association, the Minnesota Hospital Association, the Minnesota Highway Patrol and the Minnesota Department of Health jointly conducted a two-year study on the causes of accidents.[1069]

In 1961, it was estimated one-third of automobile accidents could have been prevented if seat belts were used. Public demand was not high, but the belts were equipped in all state-owned vehicles, and department employees were instructed to wear them at all times.[1070]

The first comprehensive accident survey in Minnesota was done in Brown County beginning in 1962. The survey, conducted to measure the number, type and cause of all accidental injuries and deaths, was under the direction of O.B. Fesenmaier, M.D., of District II in Mankato, and A. B. Rosenfield, M.D., director of the department's division of special services. [1071]

Violence and Suicide

In 1950, for the first time, suicide became one of the top 10 leading causes of death in Minnesota The death rate was 11.4 per 100,000 in 1950, compared to 17.5 in 1932, the highest recorded rate in the previous 40 years. During the war years of 1942 to

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[1066] Letter from Dr. Warren Lawson to 134 Minnesota State Representatives, March 30, 1973.
[1067] MDH, *Minnesota's Health,* Vol. 8, No. 5, May 1954, p. 1.
[1068] BOH, *Minutes,* December 21, 1950, MHS, p. 560.
[1069] MDH, *Minnesota's Health,* Vol. 10, No. 6, June-July 1956, p. 1.
[1070] MDH, *Minnesota's Health,* Vol. 15, No. 9, November 1961, p. 3.
[1071] MDH, *Minnesota's Health,* Vol. 16, No 10, December 1962, p. 1.

1945 the suicide rates were the lowest on record. Dr. Dean S. Fleming, chief of the department's preventable disease section, commented on the increase in suicides:

> Modern life has become extremely complex, and some people are not too well equipped to face it. We cannot say for certain that a good start in life will prevent the kind of emotional breakdown that sometimes causes people to take their own lives. But, we do know that emotional stability is generally greater in people who enjoyed a healthy and happy childhood. A solid foundation for good mental health, laid down in the early years, is the best insurance a person can have against the onslaughts of trouble that he may experience later in life. [1072]

By 1998, suicide ranked ninth among the leading causes of death in the Minnesota.

Healthy Life Styles

A study by the Metropolitan Life Insurance Company in 1952 indicated that weight control appeared to be the most practical means of preventing or retarding the degenerative diseases of middle and later life.[1073]

In 1954, the department sponsored a film, "Cheers for Chubby," about weight control. Originally produced and distributed by the Metropolitan Life Insurance Company, it was seen by 180,000 Minnesotans within a few months. Later it was renamed "Losing to Win" and was distributed by the department.[1074]

[1072] MDH, *Minnesota's Health,* Vol. V, No. 2, February 1951, p. 2.
[1073] MDH, *Minnesota's Health,* Vol. VI, No. 6, June 1952, p. 3.
[1074] MDH, *Minnesota's Health,* Vol. 8, No. 2, February 1954, p. 3.

Chapter 12

Organizational Changes – The Board Dissolves

"Nowhere in the world -- not in Kansas or Korea, not in Michigan or Mexico, not in Washington or West Germany -- does the family of man have more or better medical care available than in the state of Minnesota. There is a sad and never-ending procession of stricken humanity from throughout the nation and throughout the world crowding the great medical centers at Rochester and the University in Minneapolis. . .

In addition to these considerations, Minnesota has a century old public health program which is perhaps without equal in the world. The work and standards of Minnesota Board of Health are unique in the United States and they are the undisputed model for every other state.

All this is background for a startling proposal introduced suddenly in the chronically chaotic and frenzied final days of the legislative session and already scheduled for action on the Senate floor after cursory consideration in the Senate's Civil Administration committee. The proposal would erase the existing and model organization of an appointive state board with staggered terms which names an executive director and would substitute for it a state commissioner of health and a deputy commissioner appointed by the governor for terms which coincide with the governor's term.

It would make the office of the chief public health officer in the state a political football and it would make the officer himself a political creature.

This is an outrageous and totally undeserved affront to the existing board of health and its respected executive officer, Dr. Robert Barr. It also reflects a calloused disregard for the welfare of every citizen for this sake of creating (for a still obscure reason) a new political plum.

As a matter of self-interest and even self-protection, citizens ought to urge their senators and representatives to oppose this proposal. Protests would also be appropriately addressed to the chief author, Sen. Gordon Rosenmeier, conservative of Little Falls.

If this proposal had any merit it would properly have been introduced at least in the first 90 days of the session when hearings and general discussion were still possible. Lawmakers ought to be advised that public patience with high-handed, undemocratic legislative dealings is exhausted. The introduction of "midnight legislation" has become habitual in the Minnesota legislature. As the case in point illustrates once again, proposals nearly become laws (and in some instances do become laws) before the public and the groups concerned are even aware that a proposal exists."[1075]

Worthington Daily Globe, 1963

[1075] *Worthington Daily Globe*, "New Bill Would Put State Health Service in Politics", May 2, 1963.

Established through legislation in 1872, Minnesota was the third state in the nation (after California and Massachusetts) to have a state Board of Health. The Minnesota Board of Health first consisted of seven persons, including a secretary. The governor appointed the secretary who administered the functions of the board, including supervising quarantine matters, devising a scheme to collect health statistics and acting as an advisor for hygienic and medical matters.[1076]

Dr. Charles N. Hewitt, credited with establishing Minnesota's Board of Health, was the state's first health officer. The governor dismissed him suddenly in 1897, after 25 years of service. Some months earlier he had been asked by Tamas Bixby, the governor's private secretary, to contribute to the governor's political campaign. Dr. Hewitt declined because he did not want to mix his work with politics, and Mr. Bixby suggested he change his mind as a matter of policy.[1077]

William Watts Folwell, first president of the University of Minnesota, described Hewitt's dismissal in a memorial he wrote:

> After a quarter century of devoted service to his state, that service came to an abrupt termination. Dr. Hewitt had never needed to ask for reappointment to membership of the State Board of Health, nor to reelections as its executive secretary. He had kept the office absolutely clear of political complications. At work in his office on a certain afternoon in January in 1897, word came to him that the Governor had omitted his name from the list of appointments to membership of the State Board. It was the work of a few minutes for him to gather up the few articles belonging to him personally and say a word of parting to his faithful assistants. In his last report, for the preceding year (1896), in a concluding paragraph he expressed, as follows, the feelings of the hour.
>
> 'The best of my life and effort have gone into this work. I have spared neither time, labor, nor thought, to make it what it ought to be. Such as it is, the record is made and closed. I resume tomorrow the active practice of my profession with the sincere wish that the public health service of Minnesota may maintain and advance the position which it has won among the similar organizations in other states. I am still more anxious that it continue to serve the whole people of Minnesota in the future as in the past.' [1078]

Following Dr. Hewitt's sudden dismissal, legislation was passed giving the Board of Health, not the governor, the power to appoint the executive secretary. This would prevent the rapid discharge, at the discretion of one person, experienced by Dr. Hewitt. The board was the decision-making body, and the governor appointed each member for a four-year term. The secretary and executive officer, a paid position, was the administrative head of the department, enforcing health laws and directing departmental activities. The secretary and executive officer reported to the board. Members of this board were unpaid.

This arrangement did not go without challenge. As early as 1917 a bill was presented to the Legislature proposing a commissioner of health to be appointed by the

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[1076] Philip Jordan, *The People's Health*, 1953, p. 42.
[1077] Ibid., p. 74.
[1078] BOH, *Minutes,* attachment, October 13, 1964, MHC, p. 537.

governor.[1079] The bill failed, but some form of it continued to appear throughout the years.

In 1949 the board's legal mandate, written in Minnesota Statute 144.03, was to "see that all lawful rules and orders of the board of health, and all duties laid upon it by law are enforced and performed, and that every law enacted in the interests of human health is obeyed." Minnesota Statute 144.05 further described the board's role:

> The board shall exercise general supervision over all health officers and boards, take cognizance of the interests of health and life among the people, investigate sanitary conditions, learn the cause and source of diseases and epidemics, observe the effect upon human health of localities and employment and gather and diffuse proper information upon all subjects to which its duties relate. It shall gather, collate and publish medical and vital statistics of general value and advise all state officials and boards in hygienic and medical matters, especially those involved in the proper location, construction, sewage, and administration of prisons, hospitals, asylums and other public institutions. It shall report its doings and discoveries to the legislature at each regular session thereof, with such information and recommendations as it shall deem useful.[1080]

Department employees accomplished specific tasks, but ultimate responsibility fell to the board.

Efforts to Eliminate the Board of Health

In the early 1950s, the board's existence came under attack with the release of recommendations by Gov. Luther Youngdahl's commission on efficiency in government, better known as the "Little Hoover" commission. This commission, established in 1950 to improve the operations of state government, used three outside consultants to evaluate state agencies. The J. L. Jacobs Company of Chicago was hired to survey the Health Department. They focused their attention on all ramifications of health in the state, not just within the department. [1081]

The governor's commission made 143 recommendations that affected the department, based on the findings of the J. L. Jacobs Company.[1082] Of these recommendations, the Board of Health judged 25 as duplications, 35 as requiring legislation and 52 as administrative action items.

The consultant's appraisal of the department's existing structure was unfavorable:

> The State Board of Health is headed by an administrative board of nine members appointed by the Governor with customary (not required by law) Senate confirmation for three-year overlapping terms. Boards are useful where the collective judgment of a number of persons is required, but they are recognized as having distinct disadvantages when heading administrative organizations. They diffuse both responsibility and authority which confuses the public and

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[1079] Jordan, pp. 96 and 97.
[1080] M.S. 144.03 was repealed in 1977.
[1081] BOH, *Minutes,* August 1, 1950, MHC, pp. 307-310.
[1082] BOH, *Minutes,* February 5, 1952, MHC, p. 58.

> employees, they provide almost unlimited opportunity for 'buck-passing,' they delay decision making, and are generally cumbersome and undesirable for getting administrative work done.[1083]

Further, the commission directly challenged the board by making a recommendation to "establish a Department of Health under a single official entitled the Commissioner of Health, who should be appointed by and removable by the Governor and whose term shall be co-terminus with that of the Governor."[1084] This would revert to a structure similar to the one in effect when Dr. Hewitt was suddenly relieved of his duties. Board members were unanimously concerned that the possible outcome would be detrimental to the health of the people of the state.

> ***". . .I think of all the boards in the State we should be most independent of politics and that if it isn't, the health of the State will suffer."***[1085]
>
> **Dr. Theodore Sweetser, Member of the State Board of Health, 1952**

The commission's recommendations so concerned board members that a letter was written to Dr. Donald J. Cowling, president of Carleton College.[1086] Dr. Cowling headed a citizens committee formed to study the commission's recommendations and make a report to the governor. The committee was evaluating the 143 recommendations pertaining to the Health Department, but the board addressed only one, the one that would change the board's role. An excerpt from the letter to Dr. Donald Cowling follows:

> The general principle of increased efficiency of government with its corollaries of fixed responsibility and avoidance of duplicated efforts is of course commendable. The State Department of Health has tried to keep its progress abreast of the best efforts in its field and has welcomed suggestions for improvement. It has cooperated with other departments and has already put into effect many of the recommendations of the 'Little Hoover' Commission...
>
> There is one fundamental change which is advocated by the Interim Commission which would in our opinion be most unfortunate, basically wrong, and possibly disastrous. The proposal is that the Commissioner of Health be appointed by the Governor, that his term of office coincide with that to the Governor, and that the State Board of Health be only an advisory body. Probably we would have nothing to fear from the present state administration, but in the past we have several times been fortunate in the ability of the Board of Health and the Health Department to resist political pressure from one or another Governor and his administration. This has been possible because the Health Officer is responsible only to the State Board of Health whose members are appointed by the Governor, but in a manner and over such a spread of time that no one Governor has been able to dictate its policies and actions. The importance and the nature of public health work require a continuity of program, a professional skill, and an independence from political pressures. Minnesota, in its official health activities and accomplishments has for many decades held a preeminent position. We hope that the future health and well-being of our people will not be jeopardized by adoption of the suggested change.[1087]

[1083] BOH, *Minutes,* February 5, 1952, MHC, p. 58.
[1084] Ibid.
[1085] Ibid., p. 61.
[1086] Letter from Dr. Theodore H. Sweetser to Donald J. Cowling, chairman of the Citizen's Committee for the Governor's Efficiency in Government Commission Report, December 30, 1952.
[1087] Ibid.

In addition to the letter to Dr. Donald Cowling, the board prepared and distributed a more detailed report, dated January 9, 1953, as to its opinion on the recommendation to abolish the board:

1. As to the public health, the advantages of a concentration of authority in the Chief Executive are speculative and theoretical and as a concept of public administration, it is yet untested by experience in this field. In the field of health, the concept that a concentration of responsibility and authority in a popularly elected official makes for greater economy, brings about better coordination, supervision and control of programs and provides the opportunity for insuring increased benefits and more efficient services is largely untried and presently remains in the realm of pure political theory. As a theory it is deceptive in that such centralization of control is to be placed in the hands of a chief executive who, under our scheme of things, will rarely have the essential training in the medical sciences to oversee the performance of a health job. In its kinship with preventive medicine, public health administration is an extremely technical and exacting task and the top administrator should be technically and scientifically equipped for policy formulation and execution and free to act in the public interest discharging his public health duties and responsibilities.

2. Minnesota's public health record is enviable; hence why jeopardize it by basic change in the organization of the agency. It can be said candidly and unequivocally that the State of Minnesota has been singularly favored by the high level of development of its medical institutions, by the excellent training and research achievements of its medical personnel, and the effective adaptation of existing medical facilities to the health needs of its citizens. All these advantages have combined to make Minnesota's record in advancing and preserving the public health an enviable one. Yet its accomplishments could be even greater if, services, as noted approvingly in the 'Little Hoover' Report, could be activated. The practical conclusion to be stressed in summary is that Minnesota's experience measures up so favorably as to achievements that there can be no sound or compelling reason why any basic change in the organization of the official public health agency of the State should be affected.

3. The present board form has strengthened and intensified public health pursuits in Minnesota. A long period of highly efficient service has been given by the past and present members of the State Board of Health, all of whom have been men and women distinguished in their specialized pursuits. They have adequately met their responsibilities as the Board's record of accomplishments amply demonstrates. The general criticism made by the 'Little Hoover' group that administrative boards are timid, weak and ineffective can have no application to the Board of Health, as its official proceedings will strongly reflect. They have administered firmly and wisely, but have been careful to give their Executive Officer sufficient latitude to enable him to supply essential flexibility in his execution of policies. On the other hand the Governor-Advisory Board-health commissioner combination for public health administration could well develop very readily through diffusion of views into a vacillating and ineffective team because of the inter-play of forces stemming from a mixture of too little or no technical knowledge on the part of the Governor, who rarely has public health training, a complete lack of responsibility in the board for delineating policy, and the resulting inability in the health officer to perceive a clearly sanctioned approach to a particular course of action.

4. Competent people will be unavailable, but if available for service out of a sense of duty, such members will tend to become disinterested, have less time to devote to serious thought on problems and will be more inclined to give hasty opinions where their collective thinking lacks binding force on questions of significance. The State Board of Health now relies on 10 advisory boards and committees. These function very effectively but they are ad hoc bodies, which give attention on request to questions which may arise in single areas of health activities are focused upon problems which require expert informed opinion for solution. The 'Little Hoover' Report recommends that the State Board of Health be an advisory body whose decisions on topics put before it shall have no binding effect on the health commissioner. For extensive practical

observations in the public health field it is difficult to see how such a body, which would be asked to devote valuable personal time and direct its energies to a wide range of specialized problems involved in public health planning, could be of any real aid to the commissioner or to the programs. Men and women with the highest qualifications, interested in the State's public health needs and having the broadest experience in and knowledge of technical public health administrative practices and procedures, will not be attracted to such service, will be unwilling to serve or to give generously of their time under circumstances where their collective judgment may not, and need not, be heeded at all by the commissioner. Less qualified members who might accept service on such a body to enhance their reputations and prestige would certainly be of no great assistance to a busy and harassed health commissioner.

5. Amenability to political control will deprive public health programs of proper planning, make them more costly, less productive and effective. Public health activities are costly and become productive in terms of benefits only when carried on in a consistent manner over a period of time. They must be assured for politics. This is because the undramatic nature of the work does not always win the enthusiastic response and continuous public support which other endeavors of government may enjoy. Consequently, any interference, whether it arises from ill-advised shifts in policy through political disturbances or upheavals, for the imposition of political or special-interest pressure or favoritism in any form, makes precarious the chances of reaping the greatest benefits from the investment of public funds in the programs. And where political interference stands as an ever-present threat of work interruptions will discourage even the more callused of them from attempting to carry on the many projects and research tasks which require continuity. Staff initiative will diminish, and the department my find itself failing to measure up to its responsibilities at a time like the present when the prospects for increased gains on the public health front have never been brighter and its objectives so close to realization in many areas of public concern." [1088]

Members of the board in 1953 were an experienced and distinguished group: Dr. Ruth Boynton, Dr. Frederick Behmler, Mr. Leo Thompson, Dr. Theodore Sweetser, Dr. Lester Webb, Professor Herbert Bosch, Dr. James Halvorson, Dr. Charles Netz and Mrs. Inez Madsen. The average number of years anyone had served on the board was almost seven, and three had been members for 13 years or more.

The J. L. Jacobs Company assessment and subsequent report by the governor's commission caused the board to reflect. Had it become a "rubber stamp" committee, approving, without question, the recommendations of their advisory groups and top management in the department? Was it "weak, timid and ineffective," as the Jacobs report described most administrative boards?

More sensitive to its role, the board clearly wanted to make policy decisions, to be involved. When the board was asked to approve the budget for July 1, 1952 to June 30, 1953 during the last few minutes of the May 27, 1952, meeting, board members were not ready to quickly endorse it, as had been typical in the past. When the possibility of scheduling another meeting to make decisions on the still-to-be discussed budget was raised, Mr. Jerome Brower, departmental administration director, responded: "I don't think so. I think it can be taken care of in a few minutes."[1089]

Board members spoke out:

[1088] BOH, *Minutes,* January 9, 1953, MHC, pp. 11-12.
[1089] BOH, *Minutes,* May 27, 1952, MHC, p. 158.

Boynton: "It seems to me the Board should have more than five minutes."

Sweetser: "I haven't seen it at all until now."

Netz: "It seems to me that we should give adequate time to the consideration of the budget."

Bosch: "Probably the budget is more important than most of the items that are on the agenda today."

Webb: "How much have we ever changed the budget? We have usually approved it as presented. I am not saying that that is a good practice."

Boynton: "I don't think so either. That is a responsibility of the Board as I see it."

Sweetser: "I would like to hear something about it before the meeting, except just the figures."

Bosch: "It seems to me that very obviously we can't go over the detailed figures. We don't want to. But I think that the budget is actually a policy-making document in many respects. You are dropping some position and you are adding some others. It seems to me that it behooves us as members of the Board to know what those changes are and approve or disapprove them, or at least discuss the matters. Going though the budget hurriedly the other day I saw some things in there that I think are policy making which I think this Board should discuss. It would seem to me that either we should have a separate meeting to discuss the matter, or in line with Dr. Sweetser's comments, a notation of the changes contemplated.[1090]

The board's insistence on examining the budget before approval created a problem, as the required submission to the U.S. Public Health Service was already 12 days overdue. The board did not want to submit the budget without review, but neither did it want to hurt its relations with the Public Health Service. Dr. Sweetser suggested: "Why can't he write them a letter that the grand total is about this, and not give any sub-totals at all. He could say he is very sorry that the Board is so cantankerous and that it is not his fault."[1091]

In the end, a motion was made that the budget be submitted with the understanding that revisions could be made in the future.

During the next few months, board members continued to analyze the board's role with respect to the budget but also in a broader perspective. Their thoughts were expressed in these comments, taken from the June and September board meetings:

Sweetser: "After spending I don't know how many hours in going through this thing I realized that the Board ought to spend its time in determining the general policy of whether we want to spend more money on training personnel or on public health education or in carrying out the administrative jobs of public health...epidemiology, cancer work, and all that kind of thing, and I think there are three or four of those policies we ought to determine and not spend too much time on details."[1092]

Boynton: "It is an extremely important thing for this Board, not only in our relationship as to what kind of a program we are going to have, but in our even longer range planning – before the next

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[1090] BOH, *Minutes,* May 21, 1952 MHC, pp. 158-159.
[1091] Ibid., p. 162.
[1092] BOH, *Minutes,* June 3, 1952, MHC, p. 188.

> legislative session – as to what our needs are, what we may expect to ask of the legislature. I do think that as a policy board it probably is our duty and responsibility to study this on the recommendation of these people in charge and make decisions as to whether we should thin out and keep the programs we have or whether we should chop off some directly and limit our activity in that way. I don't think we should wait until we come up to the next budget meeting."[1093]

Recognizing the necessity of studying the needs of the population and the department's programs in order to make sound budget decisions, the board formed a committee to review department programs. Members appointed to this committee to study existing and future programs were Dr. Theodore Sweetser, chairman; Prof. Herbert Bosch, co-chairman; Dr. Ruth Boynton; Dr. W. W. White and Dr. Charles Netz.[1094] The committee not only studied the budget, but it met with all division directors and two of the section chiefs at least once.

The committee's end product was a list of written policies and directives. These were referred to and used in decision making for many years, not just for the budget, but for other decisions. The recommendations stressed health education, better local government services, less reliance on federal funds, a new building, improved regulatory functions, and better care for the aged. The board also emphasized a stronger role for itself with greater involvement in budget decisions and hiring decisions. It also wanted the board to have an expanded role in its public relations activities. The board wanted to ensure that it survived.

Approved by the board, the committee's recommendations were distributed throughout the public health community. Ten of the key recommendations are listed on the following pages, and all 32 are provided in the appendix.

Since release of the report by the Governor's Efficiency in Government Commission, the board seemed more willing to challenge the executive officer, his deputy, and other department employees. It also became more involved in department internal issues; it was not going to blindly approve a decision or idea. An example occurred in 1954 when Deputy Executive Officer Dr. Robert Barr proposed that a proportion of top-level personnel be removed from civil service classification:

> Boynton: "I don't see how the Board can act on anything unless we have a specific recommendation on which to act."
>
> Barr: "Would you like to have something drawn up and circulated to the Board before the next meeting?"
>
> Netz: "The specific positions, I think, too."
>
> Boynton: "And I think the reason in back of it. I agree there are many advantages and at the same time many disadvantages, too. And I think we should be clear why we are in back of this

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[1093] BOH, *Minutes,* September 23, 1952, MHC, p. 31.
[1094] Ibid., pp. 31-31½.

RECOMMENDATIONS OF THE COMMITTEE REVIEWING HEALTH DEPARTMENT PROGRAMS 1954
(Committee Members: Dr. Sweetser, Prof. Bosch, Dr. Boynton, Dr. White, and Mr. Netz)

LOCAL HEALTH SERVICES

"First, establish a policy of local health services with the local people assuming more responsibility both in carrying out the policies and the programs and in supporting them financially. We feel that the closer you can get to the people who are directly involved, the more responsible will be the work and the more effective for the local conditions.

"Second, take steps to recruit a well-qualified person to fill the position of Chief to the Section of Local Health Administration. Dr. Barr's duties take so much of his time that we have felt that probably we will need a Chief under him for that Section, rather than for just part of the work.

"Third, establish a policy on Health Department districts to include the naming of full-time professional persons other than medical as district directors, making provision for adequate medical consultation for each of these districts. It has been found impossible to get full-time medical directors for these different district health units and in order to get continuity and effective action we may need to take some person in the district who knows the circumstances there to take over the function of the district office.

PUBLIC RELATIONS/MARKETING

"Fourth, Make further efforts to have the activities of the Health Department known to the medical profession and to the populace. It has been suggested that a page in 'Minnesota Medicine' devoted to Health Department business and activities would be desirable. There has been further discussion of other means of making the activities of the Health Department a little less cut and dried and abstract so that people could understand them better and cooperate better, not only with people in medicine but in other professional and non-professional groups.

FUNDING

"Fifth, work out a plan making it possible to utilize State funds for continuing the main programs which you have to keep up, and then use the Federal funds, which may be discontinued at any time, for the programs which are being used only temporarily.

INTERAGENCY COOPERATION

"Sixth, encourage Board members to attend meetings and hearings of the Water Pollution Control Commission and other Commissions with which the Board of Health is trying to work.

PUBLIC HEALTH NURSES

"Seventh, take steps to effect legislation to extend the present $1500 aid for public health nurses in counties so that they could have more than one public health nurse covered by that aid in counties which have more than 5,000 population.

DENTAL HEALTH

"Eighth, plan ways and means of getting State appropriations for the Sections of Dental Health and Industrial Health. The Dental Health Section is supported only by Federal money, which may be discontinued at any time, and that is one of the things that we had in mind having State funds for the activities, which you have to keep up continually.

BUILDING
"Ninth, secure State appropriations for the construction of a new State Health Department building. That State Health Department building has been under study for a long time and we don't seem to be getting very far with the accomplishment of it. The State Board of Health is working under a handicap with its headquarters separated and scattered around, and the University has set aside a location, which would be very satisfactory for a State Health Department building. Some aggressive campaign should be carried out to bring that program to completion and get the Department into satisfactory headquarters, which will allow efficient work.

PERSONNEL, RECORDS
"Tenth, encourage a study of ways to decrease the amount of clerical work in connection with the record keeping in the various sections of the Health Department. This is just under study."

State Board of Health, 1954

thing---what positions and the reasons why it would be to the advantage of the State not to have certain positions under Civil Service."

Bosch: "I fully believe there are certain positions that should be taken out, but I believe before taking official action the top level staff people should be canvassed, because I wonder whether the Board would like to sign away Civil Service rights on certain jobs if the person in that job had certain reservations. That would take certain protection away from the employee, too, as far as tenure of position is concerned. I don't think we should do that until the people affected by it would have a chance to comment on it."

Barr: "If it is for the efficiency and improvement of services of the Department, then the weight of the opinion of the individual would not be worth very much."

Bosch: "I'm not sure I agree with that. That was a part of the contractual agreement when he went in and his wishes should be given a considerable amount of consideration."[1095]

Despite board members' efforts, several years later the board was still concerned over its lack of involvement in department affairs. At the October 3, 1956, board meeting the budget for the next biennium was again presented with little time for board review:

Bosch: "Undoubtedly we are going to have to follow the procedure Mr. Brower has outlined here, but I would bring up the point that we have brought up every time when these budgets have come up and that is that eventually the Board is responsible, and if the Board is to function as it should we must have the explanations in advance. Too often we place a 'rubber stamp' on the budget without having had adequate opportunity to study it. I would hope that eventually we would get to the point where we could have the budget plus explanation far enough in advance so that we could study it." [1096]

Boynton: "We as a Board have a responsibility for the over-all budget requests--almost a 50% increase for the Department – and I think as a matter of policy we want to be sure that that is a wise thing to do at this time. I do think that when we ask for a 50% increase in funds from the State we should be very sure that we can justify the expenditure of the money and present the need for it. I am quite sure the needs are there, and probably more than that, but I don't think we

[1095] BOH, *Minutes,* June 1, 1954, MHC, pp. 123-124.
[1096] BOH, *Minutes,* October 3, 1956, MHC, p. 189.

have had quite time enough, perhaps, as a Board, to look at the over-all picture and needs of the Department."[1097]

By 1960, the board's involvement with staff relative to the budget had changed. At the board meeting on May 24, 1960, Deputy Executive Officer Henry Bauer suggested that a committee of board members work with division directors in preparing the biennial budget. Dr. Boynton, Dr. Wente and Prof. Bosch served on this special budget committee.[1098] The committee worked with the division directors through the summer and at the September 13, 1960, board meeting jointly presented the upcoming budget for approval.

Efforts to Eliminate the Board

The board's role and its value seemed settled, and then, suddenly, late in the 1963 legislative session, the board learned that Sen. Gordon Rosenmeier of Little Falls had introduced a bill that had potential for dramatically changing the department. This bill, S.F. 1711, was called "A Bill for an Act, Relating to the Organization and Administration of the State Government in Respect of the Department of Health, the State Board of Health, and the Water Pollution Control Commission; Amending Minnesota Statutes 1961, Sections 144.02, 144.03, 144.04, 115.02, and 144.38, Subdivision 2." It proposed the creation of a Department of Water Pollution Control and transferred all powers and duties of the Board of Health directly or indirectly related to water pollution to the commission. It called for a change of powers of the Board of Health related to water pollution, but what really concerned the board was the proposed change in the leadership of the department.[1099]

The bill called for a commissioner of health who would be appointed by the governor at intervals of four years. As of the first Monday in January 1964, the head of the agency was to become a political post. The deputy commissioner's position was to be filled by the present secretary and executive officer, Dr. Robert Barr. The board was to become an advisory board only. The bill included a statement that the commissioner would be subject to removal by the governor for cause after notice of charges.

Upon learning of this last-minute legislation, the board called a special meeting on Monday, April 22, 1963. Dr. Frank Krusen, board president, contacted Lt. Gov. Sandy Keith who told him William Shovell, the governor's executive assistant, felt Gov. Rolvaag was in favor of the bill. The governor, according to Mr. Shovell, wanted the department in closer liaison with the governor's office.[1100]

The board considered Sen. Rosenmeier's proposed bill, and Dr. Jackman said that if this bill became law it would be possible to have a new commissioner every time a new governor was elected. The board did not feel the qualifications given for a

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[1097] BOH, *Minutes,* October 3, 1956, MHC, p. 189.
[1098] BOH, *Minutes,* May 24, 1960, MHC, p. 141.
[1099] BOH, *Minutes,* April 22, 1963.
[1100] Ibid.

commissioner "trained and experienced in the field of public health" were acceptable. Members felt the head of the agency should be a physician specifically trained and experienced in public health. The board was also concerned with the effects such a bill, if passed into law, would have on its established relationships with other organizations, such as the Minnesota Medical Association and the Mayo Clinic. It thought these relationships would deteriorate, if the head of the agency became a political appointment. It noted that under the proposed legislation, the commissioner would be free to carry out a program against the wishes of the board.

The board had no doubt it wanted to oppose Rosenmeier's bill. The only question was the strategy to use. The board passed a resolution that it did not support the bill on the grounds that the executive officer should not be politically involved and the board should not become an advisory board. The board agreed to write a letter and distribute copies to all organizations concerned with the problem and ask for their support.[1101] The letter to Sen. Rosenmeier read:

> The Minnesota State Board of Health at a special meeting on Monday, April 22, 1963, considered the provisions of S.F. 1711.
>
> It is very concerned with the problems of water pollution and especially those created by urban expansion and the two accidental oil spills into the Minnesota and Mississippi Rivers during the past winter.
>
> The Board is most appreciative of the excellent work that you and your committee are doing in the legislature in the planning, drafting, and support of S.F. 243, to which the Board gives its most earnest support.
>
> The Board, however, is at a loss in interpreting the intent of S.F. 1711, since it fails to find language in the proposed bill that will resolve or prevent water pollution problems related to storage and accidental spills of oils and other liquids and chemicals, etc.
>
> It appears to the Board that S.F. 1711 only provides political control of the program and activities of the State Board of Health and the Water Pollution Control Commission.
>
> This, as you know, does not necessarily improve or strengthen the total health program and activities of the State Board of Health, which has been free of politics since its inception in 1872.
>
> The Board is of the opinion that the many accomplishments in preventive medicine and public health, of which it and the citizens of Minnesota are justly proud, can be in part at least attributed to continuous uninterrupted programs that are free of political pressures and, as such, have the support and cooperation of the many voluntary and professional organizations interested in health.
>
> It is also of the opinion that the political appointment of a Commissioner of Health, who is also chief executive of the Water Pollution Control Commission, will not improve its programs and activities or the execution of the authority provided in S. F. 243.
>
> Moreover, financial support for the employment of competent personnel and the purchase of supplies and adequate facilities are as much a part of the successful execution of a program as is a legislative authority.

[1101] BOH, *Minutes,* April 22, 1963, MHC, pp. 264-267.

> We solicit your support in the development of a total health and a total water pollution control program which will have the backing of the many professional and voluntary organizations, which in the final analysis have considerable influence on the course and the effectiveness of any program.
>
> The Board is in accord with the proposal for establishment of an interim commission to study health and related matters during the 1963-1965 biennium. The Board of Health will extend its complete cooperation in any study which such a commission wishes to undertake.
>
> We respectfully solicit the opportunity to discuss with you S.F. 1711 and any other problems related to the Board of Health and its department. [1102]

Rosenmeier's bill elicited strong negative reactions, as well as support. The bill didn't pass in 1963, but one year later, in September 1964, Sen. Rosenmeier challenged the board in a different manner. As chairman of the state departments subcommittee of the Senate Civil Administration Committee, he sent a letter to Board President Dr. Raymond Jackman, asking him and any other board members to appear at a sub-committee hearing on September 14, 1964. The short letter stated the committee would like to "discuss with the group the operations of the State Board of Health and the staff services being provided the Board by the Department of Health." [1103]

Dr. Jackman didn't receive the letter until only a few days before the hearing. Despite the short notice, six of the nine board members rearranged their schedules to attend the hearing. Dr. Jackman, however, wasn't expecting and wasn't prepared for the challenging questions he received. He reflected on the meeting at the next board meeting:

> I would like to say that having given this hearing considerable thought, it looked to me as if the entire purpose of this was to downgrade the image of the Board of Health. This was not stated in the letter that I received from Senator Rosenmeier requesting us to appear before the Senate Sub-Committee. The Senator for the most part refused to let me direct his questions to the staff members who would be much more knowledgeable of these different areas and details than I was. Consequently, in the press, I particularly had a very bad picture painted. But my shoulders are broad and my skin is thick, and this doesn't bother me, and I sincerely feel, as pointed out in the letters that I wrote to the senators, there are many advantages to our current system over that where the Governor of a state appoints the health administrator.[1104]

Following the hearing, Dr. Jackman wrote a letter to Sen. Rosenmeier with a five-page report containing arguments for keeping the board. He noted:

> ...where the state health officer has been appointed because of his political affiliation, it has been to the detriment of the people's health and the disorganization of the state health department. Texas is a prime example. The same thing happened in Ohio and in a recent turnover there, almost all key personnel left that state health department."[1105]

[1102] Letter from Dr. Frank H. Krusen, BOH president, to Sen. Gordon Rosenmeier, 53rd District, April 23, 1963.
[1103] Letter from Sen. Gordon Rosenmeier to Dr. Raymond Jackman, September 8, 1964.
[1104] BOH, *Minutes,* October 13, 1964, MHC, p. 540
[1105] BOH, *Minutes,* attachment: letter (10/9/64) from Dr. Raymond Jackman to Sen. Gordon Rosenmeier, October 13, 1964, MHC, pp. 529-534.

In his report to Sen. Rosenmeier, Dr. Jackman pointed out that several programs currently in the department, such as the Hill-Burton hospital construction program and studies of oral polio vaccine, would be particularly endangered by political pressure. He noted the statewide studies of oral polio vaccine would never have been done in Minnesota, if the authority for participation had been vested in a public official:

> No governor nor party would have dared take this much responsibility in view of the fact that some health authorities elsewhere had indicated there was a considerable hazard. Minnesota dared take this calculated risk because of the recommendations of an advisory committee on poliomyelitis, representing as it did the key persons in medicine and public health in Minnesota.
>
> By the same token, Minnesota, among all states, held out against the use of Salk vaccine until its use was placed under proper controls and thorough studies were developed. So great was the national pressure to use this vaccine freely prior to the development of proper controls that no elected government official could have withstood it. The soundness of the judgment made here in Minnesota was borne out when the Cutter vaccine was found to have caused cases of polio.
>
> At the national level, the Cutter episode created a national crisis that resulted in the resignation of the Secretary of Health, Education and Welfare; the complete upheaval of the National Institutes of Health; and the resignation of the Surgeon General of the United State Public Health Service. None of these people was personally to blame for the episode and all of them had been subjected to political pressures that were beyond their powers to withstand. These examples are the most critical ones, but the development of services in all the divisions with a lot of public contact could well be skewed as a result of pressures." [1106]

In his report, Dr. Jackman mentioned the existing rapport the board had with the medical profession and voluntary health agencies. He felt much of the department's success depended on these relationships, and this might be lost if new commissioners were appointed with every change in governor.

> We here in Minnesota have every reason to have faith in our governors. We do not feel that under the type of able leadership provided by our chief executives that a new governor of whatever party would necessarily appoint a new commissioner of health. However, this has occurred in a very large proportion of the states where the commissioner of health is appointed by the governor. This same thing has even happened in the State of Minnesota in many of the departments when there have been changes in the political party in power.[1107]

Dr. Jackman thought the present system with the governor appointing members of a board of health that is the policy-making body helped ensure the continuity and stability in programs, freedom from unreasonable political pressures, and the development of long-standing relationships with the medical profession and the related health professions and organizations. [1108]

Dr. Jackman's well-planned report probably didn't reach many people, but reports on the hearing did. News articles weren't very favorable for the Board of Health. The Virginia Mesabi Daily News, in an article titled "Rosenmeier Brings Out New Facts About State Health Board," suggested inappropriate activities by the board:

[1106] BOH, *Minutes,* attachment, October 13, 1964, MHC, pp. 529-534.
[1107] BOH, *Minutes,* attachment: letter (10/9/64) from Dr. Raymond Jackman to Sen. Gordon Rosenmeier, October 13, 1964, MHC, pp. 529-534.
[1108] Ibid.

> Veteran State Senator Gordon Rosenmeier of Little Falls, exponent of sound government practices where it acts, will press hard in the upcoming 1965 session for reorganization of the state board of health, which he regards as failing to perform its function as befitting an important state body. Senator Rosenmeier, heading an interim commission sub-committee studying state departments, won admission from Dr. R. J. Jackman of Rochester, a board member, that only seven meetings have been held since January, 1963, and that members often "vote" by mail on matters. Dr. Jackman also admitted that secret sessions are held by this public body and that no minutes are kept of the proceedings. Sen. Rosenmeier also brought out that much of the Board's work is left to Dr. Robert N. Barr, its secretary, who is an employee supposed to do the board's work, according to the statutes, although 'they are general'.
>
> The senator won an admission from Dr. Jackman that the board's consideration of the water pollution control law, adopted by the 1963 Legislature, had been held in secret because it 'was a rather hot issue, so we took it into executive session.'[1109]

Sen. Rosenmeier promised to continue to press for reorganization of the board, and such a bill was introduced by then Sen. Rudy Perpich in 1965. The proposed bill called for a department with a commissioner appointed by the governor. The 1965 bill didn't pass, and neither did a similar bill, S.F. 1577, introduced in 1967. [1110]

By the early 1970s, Rosenmeier was no longer a legislator, but several other factors made the change he desired more likely. It was a time of transformation and shifts in the health sector. Health care and public health were redefining themselves. Implementation of Medicare and other federal programs created challenges and changes. Within the department, significant transitions occurred. Dr. Barr died in December 1970. His successor, Dr. Warren Lawson, did not have the same relationship with the board that his predecessors had had. He didn't profess strong support for the continued existence of the board. In addition, the nursing home industry came under close scrutiny in the 1970s, and one nursing home scandal involved a member of the board.[1111] When it was discovered that the department was forewarning nursing homes of upcoming inspections, the board came under strong criticism. This gave fuel to critics of the board. A further challenge was that Rudy Perpich, one of the authors of the earlier bill to abolish the board, had been elected lieutenant governor.

The Legislature continued to discuss whether or not the board should be abolished and replaced with a commissioner appointed by the governor, as was done in other agencies. Dr. Warren Lawson was asked this question at a joint subcommittee meeting on health and welfare in 1972. He replied:

> I think that's the $64 question, and I don't know whether I, as the Secretary of the Board, really ought to comment on that. I have several basic feelings about this, and I've thought about this problem a good deal. I think the first thing the Legislature ought to look at if it's going to examine this thing is, considering the investment that the Legislature has made in the Board in terms of

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[1109] BOH, *Minutes,* attachment: *Virginia Mesabi Daily News* (9/22/64), "Rosenmeier Brings out New Facts About State Health Board", October 13, 1964, MHC, p. 539.

[1110] BOH, *Minutes,* April 11, 1967, MHC, p. 102.

[1111] 1975 grand jury investigation of the River Villa Convalescent Medicenter nursing home in Minneapolis and subsequent criminal prosecution of its owners, Bertram M. Strimling and P. George Hedlund.

funding and in the law, whether they've gotten a good product under this existing system. It seems to me that that would be the first thing one would look at in this regard. I think it is certainly true that with a Board you get a certain amount of insulation from day-to-day politics. I always wondered about that because I don't really believe that's true. I really believe that there really isn't that much politics that goes on. I think most agencies operate on the basis of logic and common sense and are really not swayed in their day-to-day decisions. So I don't really see the advantage.

> ***"The entire system of delivery of government service, at least in the health field, is becoming so complex that one hardly knows who is responsible for what."***[1113]
>
> **Dr. Warren Lawson, June 1972**

The other aspect of this problem is that public health probably will, like a number of other departments do, have to set their objectives in terms of generations and that maybe this long-term kind of continuity, if you are going to really raise the health standards of the population, requires some kind of reasonable protection from politics if politics interferes with a government agency operation, and since I've never worked for an agency that has a commissioner, I wouldn't know if that's true or not.

Also I think that we are talking nowadays more and more about more and more public involvement, and it would seem to me that a Board like this provides a lot more opportunity for people that are knowledgeable in the health care system to have an input into State health policies.

So these basically are the considerations that I think are involved. I have a basic additional belief, and that is that almost anything works if you've go the funds and the authority to do it, and almost nothing does if you don't.[1112]

LEAP Helps to Finally Abolish the Board of Health

The mechanism that effectively contributed to the abolishment of the board was Gov. Wendell Anderson's Loaned Executives Action Program (LEAP). Just as Gov. Youngdahl initiated the "Little Hoover" commission, in 1972 Gov. Anderson introduced LEAP as his plan for improving efficiency and management in state government.

Gov. Anderson appointed a 29-member management advisory committee to LEAP.[1114] Headed by Douglas Dayton, former vice president of Dayton Hudson Corporation, business executives were lent to the state for three to six months to help streamline procedures, reorganize the structure, and emphasize better management.[1115] Three loaned executives, Roger W. Berg, Harold Engelhaupt and James R. Klum were assigned to the Health Department. They were committed to serve three to six months. Their charge was to "assist the state organization to become more viable on its own."[1116]

[1112] Dr. Warren Lawson presentation at Joint Subcommittee meeting of Senate Committee on Health and Welfare, April 17, 1952, pp. 41-42.
[1113] BOH, *Minutes,* June 19, 1972, MHC, p. 7.
[1114] News release from the office of Gov. Wendell R. Anderson, May 21, 1972.
[1115] *Minneapolis Star Tribune*, "The LEAP Program So Far," October 4, 1972.
[1116] Office of the Governor, "News From Leap," June 13, 1972.

Working with the loaned executives, the department's LEAP planning committee identified several areas to review and study over the next few months. They were:

- Establish and write department statement of purpose.
- Develop proper organization of department, including the board, internal structure and regional offices. Develop proposal for organization of statewide health function including distribution of responsibility among levels of government, those health functions not currently in the Health Department and consideration of a human services function.
- Establish position of department controller.
- Redesign the process for budget responsibility and control.
- Develop department-wide system of fees and licensing.
- Establish department personnel and training functions.
- Develop model for communications in department.
- Evaluate and establish procedures for placement and utilization of department personnel, including M.D.s.
- Develop system of 1) planning and 2) evaluating department programs.
- Redesign records management and printing services.
- Redesign system of public education marketing of services and public relations.[1117]

The two projects that had the most impact in changing the department were the first two, revision of the 100-year-old department statement of purpose and the development of a new organizational structure.

The LEAP team thought the department's purpose was not clear and that there were different opinions regarding its proper role. The LEAP team "discovered that until we have some general agreement on the purpose of a State Board of Health/Department of Health, it is difficult, if not impossible, to develop opportunities for improvement in the Department which are meaningful in light of the stated purpose." [1118]

The LEAP team sent out copies of the existing mission in Minnesota Statute 144.05 to 21 "key people in the State" for review. Those selected were: Dr. Warren Lawson, Linda Sutherland, Dr. Ellen Fifer, Dennis Pederson, John Westerman, Dr. Valentine O'Malley, Mrs. Alyce Clay, Arnold Delger, Hibbert Hill, Dr. John W. Lawrow, Maurice McCollar, Dr. William Nienaber, Bertram Strimling, Frederick Heisel, Dr. Dean Fleming, Dr. Helen Knudsen, Dr. William Harrison, Dr. Henry Bauer, Dr. A. B. Rosenfield, Ernest Kramer and Margaret Tanna.[1119]

The letter requesting input was sent August 9, with a response requested by August 14.[1120] Arnold Delger's response represented those who felt the mission needed no changing:

[1117] MDH, internal report: "LEAP Task Force Project Planning Schedule," 1972.
[1118] Letter to Mr. Arthur D. Delger from Roger Berg, LEAP at State Department of Health, August 9, 1972.
[1119] Letter from Dr. Warren Lawson to 21 persons who participated in mission statement revision, October 26, 1972.
[1120] Letter from Roger Berg to Arnold D. Delger, August 9, 1972.

"Outside of the Preamble to the U.S. Constitution, where also are you likely to find a statement that has stood the test of 100 years any better than the one broad statement you ask me to 'revise' - ??"[1121]

> ***"...Its (a Health Department's) ultimate success depends on the availability of dedicated people – Board members – Executive Officers – Division Heads – Civil Service Employees, etc. In this respect we have been exceptionally fortunate in Minnesota at all levels. Lines of authority and little boxes on a chart make for ease of operation; but effort expended in development of existing staff and recruitment of new personnel will be repaid with interest for years to come."[1123]***
>
> **Arnold D. Delger, Member, Board of Health, 1972**

The second area that most affected the department's structure was the reorganization project. Dr. Warren Lawson, assisted by Robert Hiller, assumed responsibility for this area. Though the number of employees had almost doubled from 1956 to 1972, the department's structure had remained virtually unchanged. By 1972, 20 persons were reporting directly to the executive officer. The department had expanded to 50 different programs, creating challenges for coordination, cooperation and integration of activities. In addition, there were hazy lines of authority, and a large number of leaders were nearing retirement age without preparation for and development of successors. The LEAP team proposed a "major restructuring of the Health Agency, with appropriate lines and designation of accountability, authority, and responsibility."[1122]

Together, Dr. Lawson and Robert Hiller recommended reducing the seven existing divisions to three: community and health services, (two units: health services and health hazards), labs, and health facilities. They recommended establishing deputy positions for administration and departmental programs.[1124]

These recommendations were not well received by many of the people within the department. Dr. Dean Fleming, who had worked at the department since 1938, expressed his feelings in a memo to Dr. Lawson:

> My first reaction was that I never had seen or heard presented in a convincing manner any reason or evidence pointing to the need for a reorganization of the Department. Without any intent to be critical, it is my feeling that the existing organization of the Department and its relationship to the Board and to the Governor has been simple, direct, effective, and economical, provided the administration of the department conformed to the organization patter and to accepted basic principles of administration. By that I refer to the line of authority and responsibility which must be adhered to if the division directors who have responsibility, are to work effectively with the Executive in executing policies. When other persons are brought in and exercise authority but without responsibility, working administration breaks down. If the Executive wishes to have additional staff services, there would be no problem provided the line personnel are adequately informed and communications maintained.

[1121] Letter from Arnold D. Delger to Roger Berg, chairman of LEAP, August 16, 1972.
[1122] MDH, "Re-organization of the Department of Health," (LEAP project report), November 10, 1972, p. 2.
[1123] Letter from Arnold D. Delger to Roger Berg, chairman of LEAP, August 16, 1972.
[1124] Memo from Dr. Warren Lawson to Commissioner Richard Brubacher, Department of Administration, on "Re-organization of Department of Health," November 28, 1972.

> The existing organization pattern is one that has functioned successfully over the years, is similar to that of other effective health departments, and maintains the number of persons reporting directly to the next higher level at a reasonable number.[1125]

Both the mission and the organizational structure were changed, as a result of LEAP recommendations, indirectly affecting the board. The department was reorganized in 1973, although the changes were not quite as drastic as originally proposed. The organization went from seven to five, not three, divisions. Bureaus were added, creating an additional line between the head of the agency and the divisions.

The department's mission and duties of the agency head were also changed. The following includes changes made by the Legislature in 1977 and 1986:

DEPARTMENT OF HEALTH
Section: 144.05 General duties

> Subdivision 1. General duties. The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens. This authority shall include but not be limited to the following:
>
> (a) Promote personal health by conducting general health education programs and disseminating health information;
>
> (b) Coordinate and integrate local, state and federal programs and services affecting the public's health;
>
> (c) Conduct public health and general health care services by providing consultation and technical training for health professionals and paraprofessionals;
>
> (d) Continually assess and evaluate the effectiveness and efficiency of health service systems and public health programming efforts in the state; and
>
> (e) Advise the governor and legislature on matters relating to the public's health. [1126]
>
> HIST: (5339) RL s 2130; 1973 c 356 s 2; 1977 c 305 s 45; 1986 c 444;

Included in the list of recommendations made by the LEAP team in 1972 were several directly affecting the board:

- a minimum of three board members should be from outside the metropolitan area;
- the board should be expanded from nine to 11 members;
- "Enlightened consumers," as well as providers and professionals should be included on the board; and
- Board members should be compensated for meetings, in addition to expenses.[1127]

[1125] Memo from D. S. Fleming, M.D., to Warren R. Lawson, M.D., November 14, 1972.
[1126] Minnesota State Statute 144.05, 1977.

Minnesota Board of Health, 1971

Like the recommendations related to the department's mission and organizational structure, the recommendations directly affecting the board were implemented with modifications. Legislation in 1973 increased the board membership to 15. Nine board members were to be licensed health professionals and six were to be public members. For the first time, board members would receive compensation, $35.00 per meeting, plus travel expenses. Another change that came with this legislation was the title of the agency head: the executive officer and secretary was now to be called the commissioner of health.[1128]

The Board of Health Is Abolished

Unlike the boards of the 1950s and 1960s, the Board of Health in the mid-1970s was not in a strong position to respond and react to legislation that threatened its demise. In 1974, when the board increased from nine to 15 members, most board members were new to the job. Eight of the 15 board members were serving their first term. Two members had served one year, three had served two years, and the two most senior members had been on the board for three years. Compared to the average number of

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[1127] Memo from Dr. Warren Lawson to Commissioner Richard Brubacher, Department of Administration, on "Re-organization of Department of Health," November 28, 1972, p. 13.

[1128] Statement by Minnesota Department of Health presented to the Senate Committee on Governmental Operations, September 19, 1973, p. 1.

years of service board members had in earlier years, the 1974 board was inexperienced. A large portion of each meeting was spent in orientation. In addition, much of each meeting was spent reviewing certificate of need requests, and there was little time for anything else.

Persons Observing State Board of Health Meeting, 1970s

The bill to abolish the board was introduced quietly. An April 1976 news article in the Pioneer Press reported the event:

> On Monday, the Senate, Health, Welfare and Corrections Committee considered a seemingly innocuous department 'housekeeping' bill and quietly tacked on an amendment to abolish the Board and replace it with an advisory body before unanimously approving the measure.[1129]

There was no drastic protest, as board members had made in earlier years to such a challenge to the board's existence. On hearing of the proposed legislation, the 1976 Board of Health adopted a quiet resolution stating the amendments were made without previous notice, without testimony from parties involved, and represented a significant change to the health system of Minnesota.[1130] The bill, however, passed into law and the board was abolished by the 1976 Legislature.

[1129] *St. Paul Pioneer Press,* "Health Unit Hits Terminal Legislation," April 11, 1976.
[1130] Ibid.

When the board was abolished, new legislation gave the commissioner of health authority to establish a state health advisory task force.[1131] A few meetings were held, but regular meetings were not sustained.

Robert Willmarth, a board member since 1973, resigned when he learned of the plan to make the board advisory rather than administrative. He noted that the Education Board was remaining administrative and explained why: "Of course the reason they aren't is that the teachers' groups showed they have more muscle in the legislature than the groups that felt we should remain administrative."[1132]

Reflections on Board of Health vs. Commissioner

Some of the predictions made by board members in the 1950s and 1960s have come to pass. There has been a greater turnover of commissioners since the board was abolished in 1977. From 1872 to 1977, a period of 105 years, there were five heads of the department. From 1977 to the present, 22 years, there have been eight, almost twice as many in one-fourth of the time

There are differing opinions as to whether or not the department became more or less political. Many strongly believe that, as the board predicted in the 1950s, politics has taken precedence over public health. One example was the situation experienced by Dr. Bert Hirschhorn, director of the family health division, in 1998. An internist who had spent much of his career in maternal and child health, Dr. Hirschhorn joined the department in 1995. The division he headed, family health, included health promotion programs, as well as those specifically targeting maternal and child health.

In 1997, Susan Carlson, Gov. Arne Carlson's wife, began a campaign against fetal alcohol syndrome (FAS), one of the public health problems being addressed by the family health division.[1133] When the division staff objected to what they perceived as a punitive approach to FAS by Mrs. Carlson, and when they felt demoralized by what appeared to be directives coming to them from Mrs. Carlson through her staff assistant, Dr. Hirschhorn supported his staff. About the same time, Dr. Hirschhorn spoke out in another area, tobacco. At the direction of Gov. Carlson, Commissioner Anne Barry testified at the U.S. Senate Commerce Committee hearings on the tobacco bill. Dr. Hirschhorn felt the testimony given was at great variance with what both his staff and department colleagues in the Smokefree 2000 Coalition believed was in the best interests of the public's health. Professionally, he could not accept it and stated this. Despite a glowing personnel review by his supervisor, Dr. Hirschhorn was fired.[1134] Later he reflected on what happened: "I was asked to step down as division director and then fired for insubordination when I refused. I was seen as an irritant; I heard

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[1131] Minnesota State Statute 144.011, Subd. 2, 1977.

[1132] *St. Paul Pioneer Press*, "Health Officer Quits, Hits Advisory Plan," May 19, 1977, p. 40.

[1133] FAS is covered in Chapter 11.

[1134] Prior to 1977, Dr. Hirschhorn would have been responsible to the commissioner, who would have been directly responsible to the Board of Health, not the governor. Prior to 1977, the governor would not have had the power to remove a commissioner or a board member.

through the grapevine that the Governor said, 'Get rid of that doctor over there.' And so it happened."[1135]

Dr. Hirschhorn spoke to the department's division directors at an agency management team meeting, just prior to his leave-taking in 1998:

> First, though we like to think of public health as non-partisan and science-based, we know realistically that politics often intrudes, recently and painfully around tobacco and fetal alcohol syndrome. How do we then protect the integrity and morale of our professional staff when politics seem to override? We need to discuss this recurrent problem, openly and honestly.[1136]

He closed his statements and ended his time at the department with a final note:

> On a personal note, my two and a half years at the Minnesota Department of Health have been a wonderful crowning to a happy career in public health – I've been privileged to work on some of the most important public health issues of our time, with thoughtful and highly skilled colleagues (and I appreciate the courage many have showed in carrying out their mission). I have no regrets – these are the memories that will prevail, and these are the memories that count.[1137]

Other Challenges to the Department's Organization

Throughout the department's history, proposed legislation and studies commissioned by the governor have challenged not only the existence of a board but also the make-up of the organization and the manner in which it is run. As early as 1914, an efficiency and economy commission, appointed by Gov. Eberhart, made a recommendation to move the activities of the department to the Department of Public Welfare.[1138] This proposal has resurfaced several times since, as have proposals to transfer the environmental health division to another agency.

Beginning in 1972, and again in 1974, state agencies were directed to complete thorough analyses of their agencies.[1139] Like the "Little Hoover" study of 1950, the intent was a better understanding of agency activities. A thorough functional analysis of state agencies was produced.

In 1975, Gov. Anderson surprised the department when he announced his plans to establish a mega-agency. His office proposed to create a human services coordinating office that would include corrections, health, employment services, welfare and vocational rehabilitation. Dr. Lawson circulated to the staff a memo from the governor's office announcing the plans and proposed legislation. On the routing memo was written, "Wow!"[1140]

[1135] Communication with Dr. Bert Hirschhorn, October 20, 2000.
[1136] Statement by Dr. Bert Hirschhorn, 1998.
[1137] Ibid.
[1138] Philip Jordan, T*he People's Health,* pp. 95 and 96.
[1139] Memo to department heads and activity managers from Gov. Wendell Anderson, May 29, 1974.
[1140] Routing memo from Dr. Lawson to staff on January 21, 1975, attached to proposed legislative bill and memo from Linda Sutherland, governor's office, to Dr. Lawson, January 21, 1975.

A 1984 study by Minnesota Planning did not support the merger of Health, Human Services, and Economic Security. The report cited the lack of support by key constituencies and the probability that existing networks and relationships would be weakened. The report did recommend improved coordination, reduced duplication in such areas as inspections, and noted there was potential for merging the environmental health division with another state agency.[1141]

Between 1949 and 1999, the three main studies that challenged the organization of all government agencies were the Governor's Efficiency in Government Commission ("Little Hoover Commission"), established in 1950; the Loaned Executive Action Program (LEAP) established in 1972; and the Commission on Reform and Efficiency in Government (CORE) formed in 1991. Other surveys and studies have made recommendations affecting the department. They include:

1955-58 – Self-Survey Task Force Report
1956 – The Legislative Research Committee Report
1959 – Self-Survey Task Force Report
1961 – Legislative Building Commission Report

While the department has never been consolidated with another agency, several units have been transferred to other agencies.

During the 50-year period from 1949 to 1999, the following movements occurred:

- In the 1950s all mental health activities were moved to the Department of Human Services (at that time called the Department of Public Welfare).
- In 1967 water pollution control activities became a separate state agency.
- In the 1970s services for children with handicaps was transferred from the Department of Public Welfare to the Health Department.
- Emergency health services were transferred to the Health Department.
- In the 1990s, the children's unit was transferred to the new Department of Children, Family and Learning

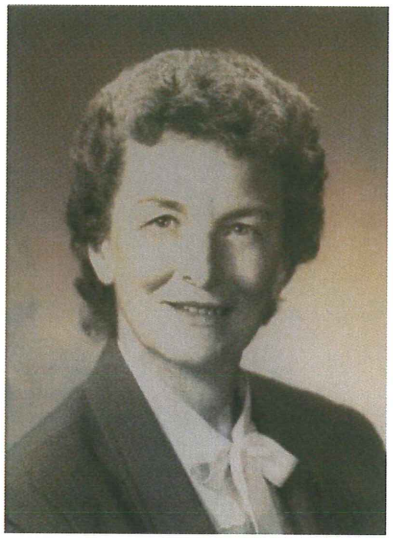
[1141] *Minneapolis Star and Tribune,* "Support Lacking for Merger of 3 State Agencies," August 1, 1984, pp. 3B & 4B.

Minnesota Board of Health Meeting – Board increased from 9 to 15 members in 1974

Chapter 13

The Health of Minnesota – 1979 to 1991

Commissioner, 1979 to 1983
George Pettersen, M.D.



Commissioner, 1983 to 1991
Sister Mary Madonna Ashton

Dr. George Pettersen of Rochester had a unique 55th birthday. On that day, January 1, 1979, he accepted, with honor, Gov.-elect Albert Quie's invitation to become the commissioner of health, the seventh person to head the agency. Acceptance meant giving up his position as director of Olmsted County's health department, and it also meant a drop in salary. Instead of the $47,000 he received at the county, he would receive an annual salary of $41,000 at the state. He noted that he hoped he could persuade legislators to raise it to where it should be to be competitive, $55,000 or $60,000.[1142]

Dr. Pettersen had been county health department director since July 1974. A native of St. Paul, he attended the University of Minnesota Medical School and worked as a general practitioner in Mabel from 1952 to 1956. After a surgical residency in St. Paul, Dr. Pettersen returned to general practice in Aitkin in 1957. From 1971 to 1972 he worked for Project Hope in Jamaica and Brazil. After receiving a master's of public

[1142] *Rochester Post-Bulletin,* "Dr. Pettersen 'Honored' by State Position," January 1, 1979, p. 21.

health degree from the University of California in 1974, he returned to Minnesota and accepted the position in Olmsted County.[1143]

> ***"I have no pat solutions to all problems, because some don't have solutions and we just have to live with them..."***[1144]
>
> **Dr. George Pettersen, Commissioner of Health, 1979**

When Dr. Pettersen learned in December 1978 that he and another physician were finalists for the health commissioner position, he stated his thoughts on public health: "Public health offers a different feel for medicine because it involves providing services for people who don't have or can't afford it."[1145] He added that he would like to change the negative image public health had within the medical profession.

Gov.-elect Quie selected Dr. Pettersen for health commissioner for several reasons: he had county public health experience; he had been working near the greatest medical facility in the world, Mayo Clinic; peers held Dr. Pettersen in high regard and groups that were previously critical of the former state health administration supported him. The relationship of some groups with the previous health administration had been referred to as somewhat "stormy," and Dr. Pettersen showed promise of quelling the controversy.[1146]

His appointment especially pleased local health agencies, as Dr. Pettersen was a strong supporter of the 1976 Community Health Services Act. He emphasized local control for public health versus directives from the state. He felt community public health in Rochester was good and hoped to be able to support the development of similar systems in other parts of Minnesota.[1147]

Local health agencies were so pleased when Dr. Pettersen was named commissioner, that they gave him a framed photo of a paddleboat, which hung on his wall during his administration. To people in out-state Minnesota, he was one of their own.

The Transition

Unlike his predecessors, Dr. Pettersen had not previously worked within the Department of Health. Being new to the department, he did not have the advantage of a close understanding of the organization's operations and its staff. Initially, Dr. Pettersen was also somewhat limited in what he could do. The biennial budget for 1979-1981 had already been determined and approved by his predecessor, Dr. Lawson. In addition, five-year goals and two-year goals for the department had been established.

[1143] Ibid.
[1144] *Rochester Post-Bulletin,* "Pettersen Retaining Dr. Lawson in State Health Department," January 6, 1979, p. 8.
[1145] *Rochester Post-Bulletin,* "Pettersen 'Honored' By Health Department Bid," December 20, 1978, p. 34.
[1146] *Rochester Post-Bulletin,* "Pettersen Retaining Dr. Lawson in State Health Department," January 6, 1979, p. 1.
[1147] *Rochester Post-Bulletin,* "Pettersen 'Honored' by State Position," January 1, 1979, p. 21.

Minnesota Department of Health Goals for the 1980s

1. To promote personal responsibility for a state of well-being by motivating behavioral changes that reduce the risk of disease or injury.

2. To support and assist local government in developing effective, high-quality community health services in all 87 counties by providing state level leadership in support of local efforts to encourage individual, family and community responsibility for health promotion and the prevention of disease, disability and premature death.

3. To evaluate the potential and actual toxicity of substances and harmful effects of radiation sources; to minimize exposures in the home, work place and community environments.

4. All children and young adults should have the information and encouragement necessary for long term health through development of positive health attitudes and behavior that will maintain health and reduce risks.

5. To facilitate further development of opportunities for the handicapped, ill and disabled to achieve their optimum level of wellness and individual/family independence in their own home and community environment through the expansion of locally and administered home care and community services.

6. To develop and maintain an organized and coordinated system of quality assurance which is effective in protecting the health and safety of the public and which appropriately recognizes the economic, social and political considerations associated with regulation.

7. To improve decision making and health related planning and research at all levels of government and in the private sector by collecting, analyzing, and distributing clear and up-to-date information on deaths (mortality), illness and injury (morbidity), medical costs, personal risk factor prevalence and health care resources by state and local jurisdiction on a regular basis.[1148]

Within his first year, Dr. Pettersen began changing the structure and management of the department. Organizationally, he elevated community services from a bureau to division status. He divided the programs bureau in two: health services (disease prevention and control, medical laboratories, environmental health, and community services) and health resources (health systems and health manpower). During his

[1148] MDH, "Goals for the 80s," August 1980, pp. 1-16.

entire tenure, however, he never filled the position of assistant commissioner in the new bureau of health services.

The management team who supported Dr. Pettersen in the executive office during much of his administration included Duane Johnson, James Brunsgaard, Thomas Maloy, and Wayne Carlson. Duane Johnson had been assistant commissioner of administration for the last five years of Dr. Lawson's tenure, and he was appointed Dr. Pettersen's deputy commissioner. He remained in that position throughout Dr. Pettersen's administration.

In 1980 Thomas Maloy filled the assistant commissioner of administration position vacated by Duane Johnson. He kept the position until 1982 when he temporarily left the department to become acting director of budget, planning and control at the Department of Finance. Thomas Maloy started state service in 1968, working for the Pollution Control Agency. He transferred to the Health Department in 1970 and was promoted to accounting director in 1973.[1149]

In October 1979, Dr. Pettersen appointed James Brunsgaard, former office manager for a Rochester insurance firm, to fill the newly created position of assistant commissioner for health resources, the bureau primarily concerned with the regulation of facilities and providers.[1150] Mr. Brunsgaard left the department in 1981.

Wayne Carlson served as Dr. Pettersen's assistant. He accepted this post in 1979 and held it throughout the administration.

Many long-term employees had reached retirement during Dr. Lawson's administration, but a few from this "old guard" were still working. One was Dr. C. Barton Nelson, assistant division director of disease prevention and control. He retired in 1982 after many years with the department.

Attention to Seniors

Gov. Quie supported "open government," with agencies accessible to the citizens of the state. One of the reasons he selected Dr. Pettersen as health commissioner was that Dr. Pettersen was viewed by an aide as "an easily approachable and readily accessible person."[1151] It was particularly important that relationships improved with groups representing the senior population. They had repeatedly charged that the previous health administration had been inaccessible and indifferent to the needs of others.

[1149] MDH, *What in Health's New?* Vol. 5, No. 7, April 8, 1977, p. 2.
[1150] *Minneapolis Tribune*, "James Brunsgaard Appointed Asst Comm for Health Resources," October 20, 1979, p. 8A.
[1151] *Rochester Post-Bulletin,* "Pettersen Retaining Dr. Lawson in State Health Department," January 6, 1979, p. 1.

> ***"We (the Department) and the seniors may not always agree on our positions, but it is our concern that we maintain an ongoing liaison where we can keep abreast of the situation and render assistance to the seniors when it is needed and not wait until a major problem mushrooms."***[1152]
>
> ***Wayne Carlson, Assistant to Commissioner, 1979***

Therefore, one of Dr. Pettersen's first goals was establishing a good relationship with seniors. During the first few months of his administration, he met twice with representatives of the Minnesota Senior Federation and the Senior Citizens Coalition. Among other topics, they discussed nursing home inspections, legislation and health maintenance organizations. The seniors reported that Dr. Pettersen was receptive to their needs.[1153] The one point of contention they had with Dr. Pettersen was retaining Dr. Lawson, who was appointed as the personal health services division director. Bruno Aijala, vice president of the Minnesota Senior Federation, commented on Lawson's new assignment, "I didn't expect it. I thought we were through with Lawson. I do hope Lawson has changed and Petterson carries a whip over him."[1154]

Dr. Pettersen had an open door policy, and he sought input from citizens. At the beginning of his administration he emphasized that he "wants to be available to any people who have health problems of a nature that we can help solve."[1155] Dr. Pettersen regularly attended the state community health advisory committee meetings. In 1981 he invited public involvement by sponsoring a legislative forum, providing an opportunity to discuss public health issues and proposed legislation. The department had held similar forums in the late 1960s and early 1970s.

Power Line Controversy

Dr. Pettersen inherited a number of challenges that the previous health administration had been addressing. One of these was the power line controversy that had emerged in 1972. Dr. Pettersen was the second commissioner and Gov. Quie was the third governor to deal with the power line issue.

Soon after Gov. Quie was elected, opponents of the high-voltage power line running from North Dakota to Delano, Minnesota, sent a Mailgram to Gov. Quie requesting assistance. Gov. Quie was responsive and told them, "I want to work with these people regarding health issues raised in the Mailgram."[1156] While Gov. Quie didn't give support for the science court requested in the Mailgram, he agreed to talk with the protestors.[1157]

[1152] *Duluth Herald,* "Coalition Optimistic Over New Health Head," March 14, 1979, p.1B.
[1153] Ibid.
[1154] *Rochester Post-Bulletin,* "Elderly Group Unhappy At Dr. Lawson's Retention," January 8, 1979, p. 3.
[1155] *Rochester Post-Bulletin,* "Pettersen Retaining Dr. Lawson in State Health Department," January 6, 1979, p. 1.
[1156] *Rochester Post-Bulletin,* "Quie to Probe Power Line Health Factor," January 8, 1979, p. 8.
[1157] *Rochester Post-Bulletin,* "Too Late to Convene 'Science Count' On Power Line Health Issue: Quie," January 11, 1979, p. 14.

By the summer of 1979 the department had begun electrical environment monitoring of the situation, and in the fall of 1979 Commissioner Pettersen visited a power line in the Lowry area to speak with residents. Responding to his questions, people described unbearable headaches, dermatitis, nausea, inflamed throats, difficulty in breathing, nosebleeds and blurred vision. One woman said that if she walked under a fluorescent light in her basement after spending time under the power line, the light would often glow.[1158]

In January 1980 Dr. Pettersen held a meeting with about 20 of the power line opponents, who were members of the General Assembly to Stop the Power Line (GASP). The meeting became heated at times. GASP wanted the Cooperative Power Association of Edina and the United Power Association of Elk River to prove there were no health hazards. If they couldn't, they wanted the line shut down. Dr. Pettersen said he didn't have authority to shut down the line, and one representative fired back, "You can order us to stop using some pesticides."[1159] Protestors said they were tired of studies. One representative said, "We have had studies and studies and studies, but now the line is there and we're human guinea pigs."[1160]

The following week, protestors approached Dr. Pettersen about an earlier idea, a citizen's jury. They wanted a group of 25 Minnesota voters, selected at random, to review the literature on the power line, listen to testimony and determine if it was safe. Dr. Pettersen agreed to discuss the idea with the governor's office, the Minnesota Pollution Control Agency, the Environmental Quality Board, and the Minnesota Planning Agency.[1161]

The protestors worried about possible health effects and wondered why they should be at risk for something that benefits others in the state.[1162] The power line issue emphasized some of the challenges of the new areas of public health. With no definitive scientific data and conclusions, it was difficult for the department to make a statement one way or another. Public opinion and emotionally laden approaches could be very effective in the decision-making process. The department's view of this situation was captured in a 1981 report:

> In the past scientists, industry and government have been the decision-makers but with the onset of the protest movement all three have had their reputations tarnished. Maybe it has something to do with the fact that we have now largely conquered the problems of infectious diseases. Or maybe it has something to do with the fact that people have more money and more spare time. Or maybe it is because our values have changed and the human organism cannot adjust to the rapid changes that are occurring in our society thereby desiring a return to a more simple life. At times the courts have been asked to make decisions regarding scientific opinion and by and large fail to emulate Solomon and his wisdom.
>
> On the other hand, legislatures have attempted to deal with these issues and more often than not those deliberative bodies do not provide the best forum for objective scientific discussion.

[1158] Transcription of visit by Dr. Pettersen to Lowry, Minnesota, November 16, 1979.
[1159] *St. Paul Pioneer Press,* "Probe is Possible on Line Complaints," January 5, 1980, p. 3.
[1160] Ibid.
[1161] *St. Paul Pioneer Press,* "Power Line Foes Seek 'Jury' to Determine Health Hazard," January 15, 1980, p. 22.
[1162] MDH, presentation to Minnesota Academy of Medicine on "Powerline Ionization Hazards," December 1, 1981.

> Scientists themselves are sometimes prone to minimize risks in order not to sensitize a public's emotional response. We all feel frustration in dealing with the protestors because there does not seem to be any process at the present time for resolving these differences. In our open society, it is difficult for government to impose its will through force. Public opinion is the thing that carries the day. The public's support of the President in the air controllers strike which made the President's action justifiable. People are somewhat noncommittal to the large wage increase demands that public school teachers are making and Don Hill, the MEA President, is losing credibility.
>
> These things are important as we consider the protestors and by the use of scientific information and list the aid of public opinion to reach resolution for these types of disputes. What we are trying to do is define the nature of the risk of the power line. It amounts to describing the electrical environment under the line and then relating that environment to the people who live nearby. If any of the forces of electricity or the air ions that are produced can bring about ill effects, what is the nature of these ill effects, how far do they extend from the line, how many people are affected, does it affect the economy such as influences on farm animals or crops.
>
> These types of questions are raised by protestors because their land and their work are precious to them. They want everyone to understand what risks are involved in order to bring the electricity into Minnesota through the DC line. The people want to be part of the decision-making process in that they want to understand what the risks are and then determine themselves whether or not they wish to take those risks.[1163]

The department's power line environmental monitoring studies were conducted at the Dickinson converter station in Wright County in 1981. This was a period of economic recession and government cutbacks. An epidemiological study on the effects of the CPA/UPA high voltage DC power line was limited due to lack of funds.

Nursing Home – Bethel Care Center

Though relationships with the senior population were improving, Dr. Pettersen, like Dr. Lawson, had to spend a considerable amount of his time embroiled in nursing home controversies. The Bethel Care Center case received the most attention during his administration. Allegations of improper care, disappearance of prescription medications, prescriptions being filled for a deceased patient and other charges were reported, and the case received considerable media attention.

The owner of Bethel Care Center, Harold Mordh, had connections with political figures. When his case was tried in Ramsey County, St. Paul Mayor Laurence Cohen sent a letter of support to Ramsey District Court Judge Joseph Summers who was to give sentencing.[1164] After making a plea bargain, Mr. Mordh, pled guilty to and was sentenced to six months in the county workhouse for the less serious charges of: 1) possession of a sawed-off shotgun; 2) possession of a controlled substance; 3) diversion of corporate funds; and 4) the filing of false income tax returns. The department was assumed responsible for determining whether or not the more serious

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[1163] MDH, Presentation to Minnesota Academy of Medicine on "Powerline Ionization Hazards," December 1, 1981, pp. 11-12.

[1164] *St. Paul Pioneer Press,* "Mordh a Case of Fact Versus Image," January 14, 1981, pp. 1 and 4.

charges were substantiated and whether Mr. Mordh's license could be revoked, placing a heavy responsibility on the department.[1165]

New Health Problems

While Dr. Pettersen had to address long-standing public health issues such as power lines, fluoridation in Brainerd and nursing homes, several new and especially challenging problems emerged or were identified during his tenure. Four diseases, all new and unknown, received substantial attention.

- **Reye's Syndrome (1979)**
  A viral disease that affected children resulted in the deaths of an 11-year-old boy and a 10-year-old boy in Minnesota in February 1979. Termed Reye's syndrome, a swelling on the brain developed, following a flu-like illness or chickenpox.[1166]

- **Toxic Shock Syndrome (1980)**
  A flu-like illness, affecting women, sometimes resulting in death, emerged in the 1970s. The link between tampon use and toxic shock syndrome was established in the spring of 1980.[1167] By that time, Michael Osterholm, then chief of acute disease epidemiology, had begun directing a three-state study of toxic shock syndrome, and it was followed by a second study beginning July 1981.[1168] At least 10 Minnesota women had died of toxic shock syndrome by 1981.[1169]

- **Lyme Disease**
  Although cases of Lyme disease probably occurred in Minnesota several years earlier, it wasn't until the early 1980s that it became widely known. Carried by the deer or bear tick, Lyme disease tended to affect people who hiked in woodland areas. There were 27-29 cases of Lyme disease in Minnesota in 1981.[1170]

- **AIDS (1981)**
  AIDS was first identified in the United States in 1981. Minnesota's first case was identified in 1982 and the state's first AIDS death was confirmed the same year.

Identification of Needs

More than midway through his administration, Dr. Pettersen wrote and sent a series of letters addressed to "People Concerned with Public Health in Minnesota." In his first letter, dated March 11, 1982, he announced a three-phase process for biennial planning and budget setting. First, key public health problems would be identified. Second,

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[1165] Ibid.
[1166] *St. Paul Pioneer Press,* "2 Children Die of Rare Disease," February 15, 1979, p. 9.
[1167] *St. Paul Pioneer Press*, "Absorbency Linked to TSS," January 14, 1981, pp. 1 and 6.
[1168] *St. Paul Pioneer Press,* "2nd 3-State Study to Survey Toxic Shock," June 15, 1981, pp. 21-22.
[1169] *St. Paul Pioneer Press*, "Absorbency Linked to TSS," January 14, 1981, pp. 1 and 6.
[1170] *St. Paul Pioneer Press*, "Tick-Borne Disease Reported in State," July 6, 1983, p. 6C.

solutions to these problems would be identified. And finally, goal setting and budget development for the department would be set.[1171]

To identify the major public health needs, Dr. Pettersen appointed a blue ribbon work group. Members were Professor Richard Bond, Grand Marais; Tor Dahl, Ph.D., St. Paul; Richard Frey, M.D., Minnesota Coalition on Health Care Costs; Leonard Kurland, M.D., Mayo Clinic; Leonard Schuman, M.D., University of Minnesota, epidemiology division; Robert ten Bensel, M.D., University of Minnesota School of Public Health; Andrew Dean, M.D., disease prevention and control division director; Roger DeRoos, Ph.D., environmental health division director; Paul Gunderson, Ph.D., director of Minnesota Center for Health Statistics; and Jerry Nida, M.D., community services division director. This group identified the following areas as ones where the health of Minnesotans could be improved substantially:[1172]

1. **Cigarette Smoking**. Data indicated 30 percent of Minnesotans still smoked, resulting in a huge impact on death, disability and medical costs. In the first month of Dr. Pettersen's administration, U.S. Surgeon General Julius Richmond strengthened earlier reports on the dangers of smoking by releasing a large document that provided overwhelming evidence linking mortality and morbidity to smoking.[1173]

2. **Alcohol and Drug Misuse**. Data indicated alcohol was a factor in more than 10 percent of all deaths in Minnesota. Of particular concern was the increased use among young people.

3. **Injuries**. In 1980, accidents, poisonings and violence accounted for 44 percent of deaths before age 65 in Minnesota.

4. **Nutrition.** While earlier attention to nutrition had focused on under-nutrition and deficiency disease, the focus of the 1980s was the promotion of healthy eating styles that decreased one's risk for heart disease.

5. **Environment.** Of particular concern, was the contamination of municipal well water by potentially dangerous organic compounds.

6. **Stress**. It was believed that stress was a significant health problem for many Minnesotans.

7. **Activity Level**. It was believed many Minnesotans got too little exercise.

[1171] Letter from Commissioner George Pettersen to People Concerned with Public Health in Minnesota, March 11, 1982.
[1172] MDH, "Major Health Problems in Minnesota – 1982," May 11, 1982.
[1173] *Rochester Post-Bulletin,* "Government Study: Smoking More Dangerous Than Supposed," January 11, 1979, pp. 1 and 13.

8. **Hypertension**. Data indicated four-fifths of Minnesotans with hypertension know of their condition but only about half are properly controlled.

9. **Maintenance of Existing Gains.** In order not to lose ground with gains made through traditional public health programs such as immunization and sanitation, continuing attention must be given these areas.

As part of the second phase of the planning process, Commissioner Pettersen scheduled meetings in Thief River Falls, Fergus Falls, Duluth, St. Cloud, Mankato, Marshall, Rochester and Minneapolis to gather advice on addressing the identified public health priorities.[1175] Community meetings were held in July 1982.

Some of the input received from outside the department addressed the make-up of this blue ribbon work group itself – there were no female members. Dr. Pettersen acknowledged this as an error and responded that he would do better in the future.

In October 1982, "Healthy People – The Minnesota Experience" was produced. One month later, the DFL gubernatorial candidate was elected. Dr. Pettersen had been appointed by a governor belonging to the IR party. Dr. Pettersen and the Department of Natural Resources commissioner were the only two agency heads who indicated they were interested in retaining their positions.[1176] Within a

Assumptions for the 1980s

1. A greater percentage of the total population will be in the older age groups.

2. Changes in lifestyle and family living will be influenced by energy availability.

3. Continuing cooperation will exist between public and private institutions.

4. Health and medical care costs will continue to rise, prompting changes in financing and delivery of services.

5. As sickness care costs increase, there should be increasing emphasis on preventive services.

6. Health attitudes will increasingly be developed at an early age through good health education programs within the community.

7. Toxic or hazardous materials as well as sources of harmful radiation in the home, workplace or outdoor environment will be identified and dealt with in an objective manner.

8. The family will retain basic responsibility for the health and wealth of its members, but family services will be redirected to encourage independence.

9. Local public health programs will be provided by Community Health Services agencies with continuing state subsidies.

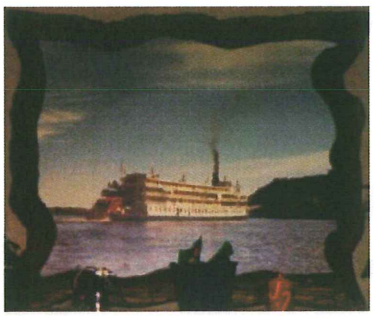
10. There will continue to be a need for certain ongoing public health programs such as infectious disease control.

11. Contamination of the ground water by wastes of all kinds will pose increasing problems and require greater efforts to contain them.[1174]

[1174] MDH, "Goals for the 80's," pp. 1-16.
[1175] Letter from Commissioner Pettersen to People Concerned with Public Health in Minnesota, July 6, 1972.
[1176] *St. Paul Pioneer Press*, "Keefe, Tschida Earn Spots on Perpich Team," November 9, 1982, p. 1C.

month after the election, however, Gov.-elect Rudy Perpich had selected a new health commissioner.

When Dr. Pettersen left the department in 1983, he left behind the framed picture of a paddleboat he had received when he became commissioner. The picture first rotated from the executive office supply room to someone's office until it became a department tradition. In 1992 the picture became a traveling department award, with attached rules for its care. It has been transferred throughout the department, and recipients have included Diane Jordan, Mary Rippke, Elisabeth Emerson, Steve Schletty, Rebecca Tholen, Ron Olson, Norman Hanson, Arnie Rosenthal, Carol Schreiber and Sally Sabathier.



"First Woman, First Non-M.D., First Nun"

Soon after the 1982 election, Gov. Perpich began interviewing candidates for top agency posts. He interviewed Sister Mary Madonna Ashton, former head of St. Mary's Hospital in Minneapolis, for the position of health commissioner, even though he knew hiring her would cause some political controversy. Running late, he came to the meeting missing a necktie. Holding out two virtually identical ties to Sister Mary Madonna, he asked her to select one. She quickly did. Unbeknownst to her, she had passed Gov. Perpich's test. He found out she could make decisions quickly.[1177]

A Controversial Appointment

On December 9, 1982, front-page news announced that Gov. Perpich had selected Sister Mary Madonna Ashton as the person to fill the $47,000-a-year health commissioner post.[1178] Sister Mary Madonna broke new ground in that she was the first woman, the first non-medical doctor and the first Catholic nun to serve as head of this 110-year-old agency. Sister Mary Madonna was immediately one of the most controversial of Perpich's appointments. Pro-life organizations had campaigned to have Gov. Perpich select candidates who supported their position, and concern was expressed that the appointment of Sister Mary Madonna represented the takeover of a special interest group. Gov. Perpich, however, said the efforts of the anti-abortion groups were not a factor in his decision.[1179] Sister Mary Madonna was admittedly pro-life, but she wasn't a participant in any pro-life movements.

A member of the order of the Sisters of St. Joseph, Sister Mary Madonna had bachelor's degrees in sociology and psychology and master's degrees in social work and hospital administration. She worked from 1949 to 1956 as medical social services

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[1177] *The Catholic Bulletin,* "No Ordinary Work for This Extraordinary Sister," Vol. 5, No. 22, June 8, 2000, p. 17.
[1178] *St. Paul Pioneer Press,* "Nun to Fill Perpich's Health Post," December 9, 1982, p. A1.
[1179] *St. Paul Pioneer Press,* "Health Commissioner Breaking New Ground," February 6, 1983, p. A1.

director at St. Joseph's Hospital, and was an administrative resident at the University of Minnesota Hospitals from 1956 until she joined St. Mary's in 1958. St. Mary's was one of the largest hospitals in Minnesota, and Sister Mary Madonna became chief executive officer in 1962.

When she accepted the health commissioner position, Sister Mary Madonna was 59 years old and had more than 30 years of experience in managing large health facilities. She was well qualified to make a complex organization like the Health Department run smoothly, and she did. She expected and received high caliber performance by employees. Her desk and files were, like her organization, kept in good order.

On the appointment of Sister Mary Madonna Ashton as Commissioner of Health:

"I can say without any fear of contradiction that she is a woman who was never known to compromise on the highest ideals of the health care profession. We have in our new Commissioner of Health an administrator who is known nationally and ranks among her peers as outstanding for her service and dedication. I am convinced that the quotation – 'Sometimes the best man for a job is...a woman' – is true."[1180]

Sr. M. Sarah Voss, O. S. B., Letter to the Editor, 1982

Sister Mary Madonna saw her job as coordinating activities between and among the departmental divisions for the benefit of all Minnesotans.[1181] She wanted to focus on programs for high-risk mothers and on child nutrition. She also wanted to promote statewide public health education in such areas as drug abuse, smoking, and chemical dependency. She hoped the public would become more involved in their overall health concerns and take personal responsibility for staying physically fit and healthy.[1182]

As commissioner of health, Sister Mary Madonna would administer family planning grants. Questions arose as to whether or not her vows to the church would conflict with her oath to the state. She quelled them with assurances that she would uphold the state's laws and the policies of the Perpich administration. Sister Mary Madonna said she had no problems with the concept of family planning. Still, a number of persons questioned her allegiance. Marianne Christianson, from the Minnesota chapter of the National Organization of Women, said, "Sister Ashton is under the authority of the pope. If the laws of the State and the nation conflict with the laws of the church, which will she uphold?"[1183] In addition to concerns by the National Organization of Women, opposition to the appointment also came from the Minnesota Abortion Rights Council, the Minnesota Women's Political Caucus and the DFL Feminist Caucus.[1184]

At her confirmation hearings on April 21, 1983, Sister Mary Madonna assured the senators that she would support Health Department spending for birth control. Much of

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[1180] *St. Paul Pioneer Press,* "Good Appointment," letter to editor by Sr. M. Sarah Voss, December 17, 1982, p. 12A.
[1181] *St. Paul Pioneer Press,* "Health Commissioner Breaking New Ground," February 6, 1983, p. A1.
[1182] Ibid.
[1183] *St. Paul Pioneer Press*, "Ashton Gains Approval as Health Chief," April 22, 1983, p. 1B.
[1184] *St. Paul Pioneer Press*, "Controversy Over Nun in State Office Fades," June 22, 1983, p. 8G.

the 2-½ hour hearing was devoted to a discussion of potential conflicts of interest between church and state. In her support, Archbishop John Roach of St. Paul sent a letter to the state Senate endorsing her appointment. There was only one dissenting vote at the hearing. This was from Sen. Donald Moe, DFL-St. Paul, who voted to oppose the "oppressive influence" of an anti-abortion group in the Legislature.[1185]

On May 10, 1983, the Minnesota Senate voted to confirm Sister Mary Madonna as commissioner of Health by a vote of 62 to 5. The dissenting votes came from Linda Berglin, DFL-Minneapolis; Donald Moe, DFL-St. Paul; Allan Spear, DFL-Minneapolis; Tom Nelson, DFL-Austin; and Mel Frederick, I-R Owatonna.[1186] [Note: Four years later, Sr. Mary Madonna's appointment at a second confirmation hearing was approved unanimously.]

Sister Mary Madonna's appointment attracted additional news coverage because of its similarity to a case in Michigan. Sister Agnes Mansour was appointed head of Michigan's welfare agency, but a representative of Pope John Paul II told her that she would be dismissed from her order unless she took a public stand against her agency's payment of abortion funding for Medicaid patients. [1187] Unlike Sister Mary Madonna, Sister Mansour was head of the state agency that handled Medicaid. In Minnesota, Medicaid was handled by Human Services, not Health. The day after Sister Mary Madonna received her Senate confirmation in Minnesota, Sister Mansour resigned from her religious order so that she could remain head of the welfare agency in Michigan.

Within six months after her appointment, the controversy over Sister Mary Madonna had faded. People who earlier had questions about her support of family planning were satisfied there was not going to be a conflict. Jeri Rasmussen of Planned Parenthood was one who had been concerned at first. Planned Parenthood received about $30,000 annually from the Health Department. Ms. Rasmussen reported Sister Mary Madonna had been very cooperative with her group: "She's made friendly overtures that she didn't have to make. One has to take those gestures at face value."[1188]

Sister Mary Madonna's Management Team

Three weeks after her appointment was announced, Sister Mary Madonna began naming her management team. Dr. Valentine O'Malley, appointed as deputy commissioner, was her first addition. Dr. O'Malley was well liked, diplomatic and understood the state's political environment. Committed to public health in Minnesota, for seven years he had volunteered his services as a member of the Board of Health. He served as vice president in 1971 and 1972 and was board president in 1977. Dr. O'Malley was 63 years old when he was appointed deputy commissioner. He had had

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[1185] *St. Paul Pioneer Press,* "Ashton Gains Approval as Health Chief," April 22, 1983, p. 1B.
[1186] *St. Paul Pioneer Press,* "Sister Ashton OK'd," May 11, 1983, p. 7C.
[1187] *St. Paul Pioneer Press*, "Mansour Resigns From Order," May 12, 1983, p. 1.
[1188] *St. Paul Pioneer Press*, "Controversy Over Nun in State Office Fades," June 22, 1983, p. 8G.

a private internal medicine practice in the Twin Cities since 1955. From 1967 to 1969 he had been chief of staff at St. Joseph's Hospital.[1189]

Daniel McInerney, a bright lawyer with a public health background, was named assistant commissioner of health delivery systems in 1984. He had worked at the department since the early 1970s and understood the agency. During the school year he taught public health law at the University of Minnesota School of Public Health. In 1986, Sister Mary Madonna appointed Daniel McInerney as deputy commissioner.

Other assistant commissioners named were Nancy Feldman, health delivery systems from 1986 to 1991; Michael Finn, health promotion and protection from 1986 to 1991; and Thomas Maloy, administration. Thomas Maloy, a long-time veteran of Minnesota state government, had worked as assistant commissioner for Dr. Pettersen and was appointed by Sister Mary Madonna in 1983. Mark Skubic was named legislative liaison in December 1983, and he remained with the department until 1989 when Estell Brouwer was named to this position.

With the exception of Dr. O'Malley and Michael Finn, all of Sister Mary Madonna's appointments came from within the department or from within state government. She relied on and used her assistants for information. Her deputy and three assistant commissioners had strong influencing roles in the decisions of the department.

Sister Mary Madonna named several new division directors during her administration. In 1984 Michael Moen became head of the newly named disease prevention and health promotion division, succeeding Dr. Andrew Dean, who accepted a position with the Centers for Disease Control. When health promotion became a separate division in 1987, Richard Welch was named head. Dr. Carolyn McKay, a pediatrician, became maternal and child health director in 1986. Kathleen Burek, who had begun working in health systems in 1985, was named the director of the new health systems development division in 1987. Also in 1987 Michael Tripple was named acting division director of health facilities; later, Linda Sutherland succeeded him.

Sister Mary Madonna was new to the department, and appropriately sought out and depended on employees for information. While she demanded a well-run organization, she encouraged employees to take the lead in their areas. Perhaps nowhere was it more apparent than with Dr. Michael Osterholm, who was named state epidemiologist in 1984. As state epidemiologist, Dr. Osterholm communicated and coordinated with the national Centers for Disease Control to address disease outbreaks in Minnesota. One of his strongest points was his ability to interest and motivate the general population. He attracted attention to public health and to the Minnesota Department of Health. He was soon quoted in the news more frequently than the commissioner.

The department decreased in size in the early 1980s, but it began increasing again during Sister Mary Madonna's administration. In 1983, when Sister Mary Madonna became commissioner, there were 550 full-time employees, more than twice as many

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[1189] *St. Paul Pioneer Press,* "St. Paul Physician Gets State Health Post," December 31, 1982, p. 7C.

as there were in 1955. By the time she left her position, the number of employees had increased to more than 800, a 50 percent increase. Sister Mary Madonna's salary increased, as well. By 1984 it was $57, 475.[1190] Effective January 1, 1989, it had risen to $65,903, comparative to $88,540 in 1999 dollars.[1191]

Employees were kept informed of department policies, employee events, and other activities through the newsletter "In Common." Buddy Ferguson and Mari Mitchell wrote and edited the four-page publication every four weeks.

Mosquito Militia

During her first year in office, Sister Mary Madonna was responsible for the single largest preventive mosquito spraying effort in the country to date. It started when laboratory tests confirmed the presence of the western equine encephalitis virus in a horse in Clay County. State health officials were concerned, as there was a bumper crop of Culex tarsalis mosquitoes in the state. These mosquitoes transmit western equine encephalitis, also called "sleeping sickness." [1192]

While no cases had been confirmed in humans, there were 30 suspected cases in humans and five suspected cases in horses. The department decided it had to act quickly to prevent an outbreak of this mosquito-borne encephalitis. Under the leadership of Michael Osterholm, then chief of acute disease epidemiology, plans were made to begin spraying 18 small towns in western Minnesota counties on August 23, 1983. The effort would involve seven airplanes and seven semi-trailers full of Malathion. The cost, estimated at $750,000 to $800,000 a week, would come from a $3 million state contingency fund.[1193]

> ***"By doing the spraying program as we are now doing it we hope to completely avoid human case problems."***
>
> ***Michael Osterholm, Chief of Acute Disease Epidemiology, 1983***[1194]

Spraying began in 12 communities, but then the department was forced to ground its fleet, now totaling 13 planes. Otter Tail County Judge Harlan Nelson issued a temporary restraining order at noon on August 24, at the request of the Minnesota Honey Producers Association and two beekeepers who were concerned about the effect of the spray on bees. Minnesota was a large honey-producing state, and Otter Tail County produced one-fourth of the state's honey. Michael Osterholm suggested covering the hives, and the beekeepers suggested spraying from sunset to sunrise.[1195]

[1190] *St. Paul Pioneer Press*, "43 State Officials Get Heft Salary Increases," July 18, 1984, pp. 1C and 2C.
[1191] *St. Paul Pioneer Press,* "State Agency Heads Given 5% Pay Boosts," December 21, 1988, p. 3C.
[1192] *St. Paul Pioneer Press*, "Aerial Mosquito Spraying to Begin," August 23, 1983, pp. 1A and 4A.
[1193] Ibid.
[1194] Ibid.
[1195] *St. Paul Pioneer Press,* "Encephalitis Spray Halted in Legal Snag," August 25, 1983, pp. 1A and 4A.

At 11:30 p.m. on August 24, Supreme Court Chief Justice Douglas Amdahl convened a three-judge panel to consider Otter Tail's restraining order. Spraying resumed, with restrictions placed on any spraying between the hours of 10 a.m. and 5 p.m.[1196]

Spraying resumed but not without problems. There were delays due to high winds, and then, on August 26, a hose broke on one of the airplanes from Environmental Aviation Service Inc., spilling 400 gallons of Malathion near the Willmar airport. Another 50 gallons leaked out, damaging cars below, while the plane flew to the airport. In addition, one of the planes flew during the restricted time period. The Health Department ordered them to stop flying.[1197]

Complaints began arising from environmentalists, who were concerned about the risks from the spray. Janet Keyes, a spokesperson for Citizens for a Better Environment, charged that the department misled the public about the risks. She felt more research was needed on the effects of Malathion on children before such spraying was undertaken.[1198]

A second spraying was begun on August 29, and a western encephalitis expert from the Centers for Disease Control came to Minnesota.[1199] No cases of encephalitis in humans had been confirmed, but there were 22 suspected cases and four probable cases. The number of counties to be sprayed was increased to 40. This included 286 towns and included nearly half the population of the state.[1200]

What resulted was the biggest spraying effort ever of the chemical Malathion in the country. Forty counties in western Minnesota were included. The total cost for the spraying was $1.7 million dollars.[1201]

After it was all over, the department was left with a lawsuit and 100 damage claims. By February 6, 1984, the state had paid out $58,987 in damages. Environmental Aviation Service Inc. filed a $691,000 lawsuit alleging that the state owed them that much for breach of contract. The state filed a counter suit of $50,000 for the loss of Malathion and clean-up costs.[1202]

Some questions were raised about whether or not the spraying was safe and if it had been an appropriate use of funds. The news media reported that few people were non-supportive of the effort.[1203] There were no confirmed cases of human encephalitis in the state. State Epidemiologist Michael Osterholm said that under the same circumstances he would support doing it over again.[1204]

[1196] Ibid.
[1197] *St. Paul Pioneer Press,* "400 Gallons of Malathion Spilled on Ground," August 26, 1983, pp. 1D and 2D.
[1198] Ibid.
[1199] *St. Paul Pioneer Press*, "Mosquito Offensive Goes Into 2nd Phase," August 30, 1983, p. 4A.
[1200] *St. Paul Pioneer Press,* "6 More Counties to Get Encephalitis Spray," August 31, 1983, p. 1C.
[1201] *St. Paul Pioneer Press,* "Mosquito Militia's Success Measured," February 6, 1984, pp. 1B and 2B.
[1202] Ibid.
[1203] *St. Paul Pioneer Press*, "Few People Bugged by Spray Campaign," September 7, 1983, p. 1C.
[1204] *St. Paul Pioneer Press,* "Mosquito Militia's Success Measured," February 6, 1984, pp. 1B and 2B.

Though the beekeepers lost many bees, the department received support for their efforts from the Minnesota Honey Producers. Dwight Hull, association president, said "I would have to say the spraying was necessary because there was potential for health problems there."[1205] The Centers for Disease Control sent a memo: "The program for containment of the western equine encephalitis threat in Minnesota was excellent....At the point when the risk of encephalitis occurrence in humans was considered to be significant...the spray program was implemented with minimal delay."[1206]

Changing Focus of Public Health

The most critical health problems of the 1980s were heart disease, cancer, smoking and traumatic injuries, the new term for accidents, as these injuries were believed to be predictable and preventable. For several decades chronic disease had been causing more deaths and illness than acute diseases. In trying to reduce mortality and morbidity, human behavior began to take on an importance as great as or more than disease organisms, and health promotion became the recognized intervention.

Sister Mary Madonna cemented this movement in Minnesota, emphasizing the roles of lifestyle behaviors, social problems and environmental factors in reduced mortality and morbidity. She addressed four areas in particular: cigarette smoking, poverty and malnutrition; care of the elderly and indoor air quality.[1207]

A department study in the spring of 1984 cited the high economic costs due to tobacco use. The health care costs, attributable to smoking, were estimated at $405 million a year in Minnesota.[1208] According to the author of the study, James Schultz, each pack of cigarettes sold resulted in $0.89 worth of health care costs for the following conditions:

$0.12 – cancer treatment
$0.23 – heart attack and circulatory problems
$0.30 – emphysema and respiratory problems
$0.23 – other illnesses, such as ulcers
$0.01 – injuries resulting from fires caused by smoking[1209]

[1205] Ibid.
[1206] Ibid.
[1207] *St. Paul Pioneer Press,* "We are our WORST Enemy in Health Matters," March 13, 1984, p. 1C.
[1208] *St. Paul Pioneer Press,* "Smoking Illnesses Costing 89 Cents a Cigarette Pack," May 14, 1984, p. 7A.
[1209] Ibid.

The department's first priority became helping people quit smoking or preventing them from starting to smoke. To do this Sister Mary Madonna established an advisory panel to come up with a statewide strategy to reduce tobacco use. The panel was comprised of 20 leaders in the community, representing business, labor, school administrators, medicine, and health promotion. With this committee, as with similar ones, Sister Mary Madonna demonstrated one of her strongest assets: a recognition that the right people have to be involved early on in order for successful implementation later.

> ***"In this new age, tuberculosis is replaced by tobacco smoke. The microbe that once killed thousands through our drinking water has been replaced by noxious vapors passing out of factories. 'Typhoid Mary' has been replaced by a drunk driver...In this new age, we face ourselves – our own decisions, our actions, our inaction – as the chief causes of death and disability."***[1210]
>
> **Sister Mary Madonna Ashton, Quoted in St. Paul Pioneer Press, March 1984**

> ***"Whether you smoke or not, we all pay for this one way or another."***
>
> ***Andrew Dean, M.D., Director, Disease Prevention and Control, 1984***

The advisory panel made a number of recommendations in 1984.[1211] Its key recommendation was to triple the cigarette excise tax, which was currently $0.18 per pack and hadn't been changed in six years. Other recommendations by this panel included a marketing campaign for a non-smoking lifestyle, education on tobacco use in junior high schools, encouraging sponsors of public events to not accept sponsorship by tobacco companies and improving compliance with the Minnesota Clean Indoor Air Act. Rather than take a strong regulatory approach that mandated change, the panel urged the department to try to promote change through a friendly, consultative manner.

Explaining the advisory panel's focus on prevention, Kathleen Harty, staff to the panel, noted that a recent study indicated 5 percent of smokers first begin as adults. In addition to more education for students, the panel recommended increased efforts to reduce smoking among students and teachers in schools.[1212]

Sister Mary Madonna's was the first administration to begin working with private industry in trying to protect the public from the health effects of tobacco. In 1985 she wrote the president of Republic Airlines, asking that he designate certain flights as smoke free. She received a reply from A. B. Magary, senior vice president of marketing at Republic Airlines:

> ...While I am personally sympathetic to your request, I must regretfully refuse it on economic grounds.

[1210] *St. Paul Pioneer Press,* "We are our WORST Enemy in Health Matters," March 13, 1984, p. 1C.
[1211] *St. Paul Pioneer Press,* "Tripling Cigarette Taxes Proposed," September 17, 1984, pp.1A and 4A.
[1212] Ibid.

> As you know, a low fare carrier in the southwest, Muse Air, recently very nearly went bankrupt by adopting a smoke-free policy. The facts of life are that a substantial number of our passengers continue to smoke, and many nonsmokers are accompanying them in their travels. When we consider a smoke-free environment, we must take into account not only driving away smokers but those who travel with them.
>
> The only viable solution to this problem, in my opinion, is an industry-wide ban on smoking enforced at the Federal level. I am sorry I am not able to be as positive on this issue as I have been on others we have shared; but hopefully, more favorable circumstances will arise in the future.[1213]

Northwest Airlines, however, did inaugurate a no-smoking policy on flights over two hours in length. A news conference was held to publicize this breakthrough.

The department changed its organizational structure in response to Sister Mary Madonna's focus on health promotion. In 1987 the areas of nutrition, injury prevention, and smoking prevention, currently part of the disease prevention and health promotion division, were placed in the new health promotion division.[1214]

The department building became smoke-free during Sister Mary Madonna's administration, and she supported other health promotion initiatives. In 1988, along with seven persons from other organizations, Sister Mary Madonna was appointed by Gov. Perpich to serve on the newly created Minnesota Institute for Addiction to Stress Research.[1215] In 1990, the department emphasized the dangers of alcohol use by developing legislation aimed at increasing awareness of fetal alcohol syndrome and other dangers to the fetus. As a result of this legislation, 4,300 bars, liquor stores and restaurants were sent posters to display. The poster was designed to be understood by persons who could not read English.[1216]

AIDS

By June 1983, five cases of acquired immune deficiency syndrome (AIDS) had been confirmed in Minnesota. Two of the five cases had died. In addition to these, at least 50 people had been reported as having the symptoms of AIDS.

Like polio in the early 1950s, there were unanswered questions about the potential methods of transmission of AIDS. As with other devastating diseases, where little is known, the public expressed fear. Worried about how they might contract AIDS, people looked at different causes, such as the mosquito. Similar to polio 30 years earlier, the department did not have clear scientific information with which to advise the public.

[1213] Letter from A.B. Magary, Republic Airlines senior vice president of marketing, to Sister Mary Madonna Ashton, December 2, 1985.

[1214] *St. Paul Pioneer Press,* "Moen Heads New Health Program," November 24, 1984, p. 10C.

[1215] *St. Paul Pioneer Press,* "Perpich Announces Appointments," August 10, 1988, p. 6D.

[1216] *St. Paul Pioneer Press,* "Minnesota Poster Warns of Alcohol Danger to Unborn," September 28, 1990, pp. 1B and 3B.

By January 1984, the Centers for Disease Control had documented a link between blood transfusions and AIDS.[1217] As the majority of those affected with AIDS at this time were gay or drug users, concerns were raised as to how this announcement would be interpreted.

> ***"Our concern with this is the same as it has been all along. It has to do with how easy it is for the public to start thinking gay blood is bad blood. That's kind of legitimatising some real nasty behavior towards gays."***[1]
>
> **Morris Floyd, 1984**

(Note: For more coverage of AIDS, please see Chapter 14.)

Measles

In 1957 there were 8,087 cases and 14 deaths attributed to measles. In 1961 there were 729 cases and four deaths; in 1962 there were 1,675 cases and 11 deaths.[1218] The same year measles vaccine was licensed, 1963, there were 3,368 cases with eight deaths. Then the number of cases began changing. Except for outbreaks in 1976 (2,650 cases), 1979 (1,219 cases) and 1980 (1,104 cases) the number of reported cases was small.

On November 10, 1982, an article in the St. Paul Pioneer Press read "Measles Believed Eradicated." [1219] There had been no new measles cases for 13 months, and there had been only two cases in 1982. The 1979 Legislature had passed a law, effective 1980, that required all elementary and high school students to receive measles immunization prior to entrance. The law did not, however, cover college students, and this age group was therefore considered the most vulnerable.[1220] Other vulnerable groups included the Amish and Hmong populations who were not adequately immunized against this contagious disease.

It appeared as though Sister Mary Madonna's administration would be the first in which there was not one reported death in Minnesota from measles, typhoid, tuberculosis, polio, whooping cough or diphtheria. The disease which had been most difficult to control was measles, but it now seemed as that, too, was under control.

Then, in 1990, a major measles outbreak occurred. Seventeen Amish children in Fillmore County were affected in January.[1221] By the middle of February, seven children had been hospitalized, most of them from St. Paul.[1222]. Responding to the unseasonable outbreak, the department urged the population to check their immunization records and receive the necessary protection. The outbreak continued.

[1217] *St. Paul Pioneer Press,* "Experts Accept Link, Seek to Calm Fears," January 12, 1984, p. 8A.
[1218] MDH, *Minnesota's Health,* Vol. 17, No. 5, May 1963, p. 2.
[1219] *St. Paul Pioneer Press,* "Measles Believed Eradicated," November 10, 1982, p. 2D.
[1220] *St. Paul Pioneer Press,* "Indiana Measles Outbreak Watched," March 9, 1983, p. 10A.
[1221] *St. Paul Pioneer Press,* "Measles Hits Amish Community," January 14, 1990.
[1222] *St. Paul Pioneer Press,* "Measles Outbreak Reported in St. Paul," February 16, 1990.

In May 1990 a 14-month-old Hmong boy in St. Paul died from complications of measles, marking the first such death in the state in 10 years.[1223] Three days later, a second death occurred. This time it was a 10-month-old child.[1224] A third child died from complications of measles within the next week.[1225] Three Minnesota children, none of them immunized, had died from a preventable disease.

Department efforts to reach all population groups were intensified. On May 10 the department issued an advisory targeting St. Paul residents and the Hmong population throughout the state. The advisory called for immunization of all children six months old and above. The normal recommended age was 15 months and above. By July the outbreak was winding down, and the advisory was lifted.[1226] By the end of the outbreak, more than 450 people in the state had contracted measles.

Similar to a 1988 legislative response to an outbreak of 700 cases of mumps in 1987, stricter immunization laws were enacted. [1227] Students entering Minnesota colleges in the fall of 1990 now had to show proof of immunization to gain entrance. [1228]

Salmonella: Cheese, Tomatoes

There were a number of food-related disease outbreaks during Sister Mary Madonna's administration, and the department responded quickly and strongly to all of them. At times this approach was not popular with Minnesota industry. One case was that of suspected salmonella poisoning caused by cheese during the spring of 1989. More than 100 cases of salmonella poisoning were reported, and the department suspected uncooked mozzarella and processed cheese as the source. A five-week warning on cheese was issued through July 6.[1229]

Minnesota and Wisconsin provided half the nation's cheese supply, and the department's warning resulted in high costs – an estimated $20 to $30 million in losses to the industry. Gov. Perpich told the press he was dissatisfied with the way the department had handled the case, as he felt there was no adequate evidence that the cheese caused the illnesses. While he was unhappy with the department's actions, he emphasized he was not going to interfere and would support the department's decisions: "They make the decisions, otherwise we'd have chaos in the whole operation. I never get involved in that; I really stay away from that, all right?"[1230]

[1223] *St. Paul Pioneer Press,* "St. Paul Toddler Dies From Measles Infection," May 3, 1990.
[1224] *St. Paul Pioneer Press,* "Measles Outbreak Claims 2nd Victim," May 5, 1990.
[1225] *St. Paul Pioneer Press,* "Child Dies of Measles in Minneapolis/ 3rd Death Comes as 25 More Cases are Reported in Area," May 8, 1990.
[1226] *St. Paul Pioneer Press,* "Measles Advisory for St. Paul, Hmong Throughout Minnesota Lifted," July 13, 1990.
[1227] *St. Paul Pioneer Press,* "Tougher Immunization Law Due January 1," December 8, 1988.
[1228] *St. Paul Pioneer Press*, "Minnesota College Students Reminded of New Immunization Requirements," May 16, 1990.
[1229] *St. Paul Pioneer Press,* "Perpich Unhappy with Handling of Salmonella Scare," July 13, 1989, pp. 1A and 6A.
[1230] Ibid.

Ultimately, the source of the outbreak was traced. The mozzarella cheese was shredded at four Wisconsin processing plants and was responsible for the multi-state outbreak.[1231]

Environmental Concerns

In 1985 news reporters called attention to the "fishiness" of reports issued by Minnesota and Wisconsin: it appeared fish caught on one side of the Mississippi were safe to eat, while fish caught on the other side were not.

The confusion resulted from the state fish advisories that were published by both states. The Minnesota Health Department issued warnings against eating certain kinds of fish from several areas. Restricted areas included the Mississippi River south of Sauk Rapids and lower St. Croix. In the "Summary of Wisconsin Fishing Regulations for 1985," there was no health warning for fish from the Mississippi River below Lake Pepin or the St. Croix.[1232]

Though the activism of the 1960s and 1970s had tempered, the population was still concerned about environmental issues. Members of Greenpeace once held a "toxic fish fry" in Chambers Grove Park in Duluth to publicize their concerns. They felt the Health Department should place a warning sign at this location.[1233]

Another environmental issue which began during this administration and would resurface several years later was related to the potential damage to lungs caused by asbestos in northern Minnesota. On the review of routine x-rays taken in his office, Dr. Ronald Seningen of Virginia noted abnormalities on about 30 percent of them. He contacted the Health Department, and outside experts were brought in. It appeared as if there was asbestos-related lung damage, and the news media wondered if this was caused by the taconite industry.[1234] Gov. Perpich appointed a panel of international experts to look more closely at this potential problem. After reviewing the x-rays, they were most concerned about those of about 50 men and felt a thorough investigation was needed. They urged the state to try to pinpoint the source.[1235]

The department unsuccessfully tried to get funds for such a study. One agency which refused to provide funds was the Iron Range Resources and Rehabilitation Board, which received much of its funding from the taxes of mining companies.[1236]

In a memo to Gov. Perpich, Sister Mary Madonna pleaded for funds for this study. She wrote that she was "convinced this issue will come up again in the future and, without

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[1231] *St. Paul Pioneer Press,* "Salmonella Source was Cheese Plant," January 23, 1990.
[1232] *St. Paul Pioneer Press,* "Two Diverse Reports Seem Rather Fishy," May 20, 1985, p. 1C.
[1233] *St. Paul Pioneer Press,* "Toxic Fish Fry to Publicize Polluted River," p. 5B.
[1234] *St. Paul Pioneer Press,* "Shaken by Asbestos Reports, Range Waits for Facts," March 4, 1985, p. 7A.
[1235] *St. Paul Pioneer Press,* "Cancer Mystery Ignored," December 21, 1997, pp. 1A and 10A.
[1236] Ibid.

additional funding, we will not have resolved this matter."[1237] When the problem escalated and received media attention about 10 years later, Sister Mary Madonna commented, "It's tragic and we predicted it."[1238]

Nursing Homes

Like commissioners before her, Sister Mary Madonna had to deal with problems in nursing homes. The quality of nursing homes had been improving steadily, and with Sister Mary Madonna's leadership, the department took a strong position against poor care in nursing homes. In 1988, the department revoked the license of Beverly Homes. Gov. Perpich supported the department's actions but many others didn't. When criticized, Sister Mary Madonna responded with a letter to the editor in the Pioneer Press. She emphasized that Minnesota did not tolerate inadequate care and invited people to submit recommendations for alternative solutions to the department. She emphasized that the bottom line was that the elderly in Minnesota nursing homes were not going to suffer from poor care. [1239]

In 1989 a nursing home abuse task force was established. It reported that the cases of fatal neglect in Minnesota nursing homes increased from 11 in 1987 to 35 in 1989. The number of suspected cases increased from 15 to 81. The number of complaints of deadly falls went from two to 21, and complaints of failure to provide prompt medical attention went from six to 24. The task force reported that mistakes had been responsible for the deaths of at least 63 elderly people in Minnesota nursing homes during the last three years. The task force identified a need for training and better supervision of staff working in homes. [1240] As a result of these recommendations, increased training standards were placed on nursing home personnel.

Minnesota – A Great State of Health

A 1987 radio ad for hospitals in Florida stated, "You don't need to go to Minnesota to find the best health care."[1241]

Gov. Perpich, always trying to develop the Minnesota economy, saw the potential for converting the state's international recognition for health care into a business. He formed the Governor's Commission on Promoting Minnesota Health Care Resources. With $7,000 in state funds and $306,000 in private funds, the commission's first project was a 16-page advertising supplement in the May 4, 1987, *Time* magazine. The

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[1237] Ibid.
[1238] Ibid.
[1239] *St. Paul Pioneer Press,* "Nursing Home Regulation," letter to editor, September 9, 1988, p. 14A.
[1240] *St. Paul Pioneer Press,* "Nursing Home Abuse Task Force Targets Better Staffing Supervision," September 28, 1990, p. 4B.
[1241] *St. Paul Pioneer Press,* "Governor's Commission on Promoting Minnesota Health Care Resources," April 29, 1987, p. 2B.

magazine was sent to 600,000 national corporate executives and 89,000 Minnesota subscribers.[1242]

In the *Time* magazine advertisement, Minnesota was described as a place "where people live longer and better."[1243] Sister Mary Madonna said that state health officials envisioned the promotion of health care and tourism, combining vacations with outpatient activities relating to wellness. [1244] The effort was reminiscent of the marketing of Minnesota to immigrants in the 1850s when they were urged to come to Minnesota because of the state's healthy climate.[1245]

While Minnesota received international recognition for its health services, some members of the population did not have access to those services. Increasing attention was placed on obtaining health care access for all Minnesotans. The state had already developed the Children's Health Plan. For $25.00 a year, children without health coverage were eligible for preventive care. In 1990 Daniel McInerney served on the State Health Care Access Commission. The department played an active role in developing a plan to ensure all Minnesotans had health care. However, this plan never reached the implementation stage.

When Gov. Perpich lost the November election, Sister Mary Madonna left her position as health commissioner and became chief executive officer of Carondelet Life Care Ministries. She continued to promote programs ensuring health care access for the population. In 1998, when asked who newly elected Gov. Ventura should invite to the governor's mansion to get needed advice for the next four years, Karen Gervais, director of the Minnesota Center for Health Care Ethics, suggested Sister Mary Madonna Ashton. Ms. Gervais explained: "She's now the leader of a model project for extending health care coverage to those who are uninsured and uncovered."[1246]

When Sister Mary Madonna left the department, a good-bye party was held in the Chesley Room. The lines of employees wishing to say good-bye extended far into the hall. It was clear she had gained the respect of employees. She had proved the Health Department could be successfully led by a nun, by a non-physician and by a woman.

[1242] Ibid.
[1243] Special Advertising Supplement, *Time*, May 4, 1987.
[1244] *St. Paul Pioneer Press,* "Governor's Commission on Promoting Minnesota Health Care Resources," April 29, 1987, p. 2B.
[1245] Philip Jordan, *The People's Health,* p. 1.
[1246] *St. Paul Pioneer Press,* "Whom Should Ventura Invite to Dinner at the Governor's Mansion for a Long Talk?," November 16, 1998, p. 3A.

Chapter 14

AIDS/STDs

Acquired Immune Deficiency Syndrome/Sexually Transmitted Diseases

The headline of the February 1959 agency newsletter, *Minnesota's Health,* read, "Minnesota Eliminates Syphilis as Serious Public Health Problem." [1247] Nine years earlier, in 1950, Minnesota had been the first state in the nation to report no cases of syphilis in newborns for the entire year. [1248]

The number of cases of syphilis had begun a downward trend by 1949. In 1949, 717 cases of syphilis were reported to the Health Department. This compared with 926 in 1948.[1249] The peak year for syphilis in Minnesota had been 1925 when 4,300 cases, a rate of 73.3 per 100,000 people, were reported. The number of cases in their latent stage was declining significantly by 1949. Late active and congenital syphilis cases occurred at a rate of 3.5 per 100,000 in 1952 compared to 32.0 per 100,000 in 1940. Congenital syphilis was becoming nearly non-existent.

In 1951, Minnesota had the lowest incidence of syphilis of any state in the nation.[1250] Unfortunately, Minnesota's success in controlling sexually transmitted disease created the same challenge as experienced with the control of tuberculosis. It became more difficult to obtain funding, and the Board of Health thought the lack of sufficient funding for continued control efforts was a serious problem. At a board meeting on December 21, 1950, the following interchange took place:

> Dr. Ruth Boynton, Member of Board of Health: "When you tell people that we have the lowest VD rate of any state, it is hard to convince the Legislature that we need money."
>
> Dr. Henry Bauer: "Why have a fire department when you just have a fire once in awhile? Why keep them sitting around?"[1251]

Much of the credit for the department's successful efforts to control syphilis and other sexually transmitted diseases goes to Dr. H.G. Irvine, a key figure in Minnesota's fight against venereal disease for more than 40 years. In 1916, as a University of Minnesota instructor, he read a paper before the Minnesota State Medical Association advocating the establishment of a venereal disease control program at the Department of Health. In 1918 he became head of the department's newly created division of venereal disease control. It was the first in the nation. Dr. Irvine was head of the division until 1929 when

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[1247] MDH, *Minnesota's Health,* Vol. 13, No. 2, February 1959, p. 1.
[1248] MDH, July 23, 1951.
[1249] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, pp. 3-4.
[1250] BOH, *Minutes,* October 16, 1951, MHS, pp. 318-319.
[1251] BOH, *Minutes,* December 21, 1951.

it became part of the disease prevention and control division. He served the department on a voluntary basis from 1930 to 1936, and then became a part-time consultant. One year he refused his salary because he said he hadn't earned it.[1252]

Dr. Irvine contributed to the drastic reduction of syphilis in Minnesota by strengthening relationships between the department and physicians and increasing the reporting of syphilis. Physicians were encouraged to use the department's laboratory services for serological tests on syphilis on blood and spinal fluid specimens, dark field examinations for spirochetes and smears and cultures for gonococci.[1253] Dr. Irvine helped establish regulations requiring physicians to report all cases of venereal disease to the department.

In 1949, the department's laboratory examined 240,388 blood samples and 4,857 spinal fluid samples for the presence of syphilis. Multiple testing was done to ensure an accurate diagnosis. The department kept files and advised physicians when re-testing was needed. Efforts were made to secure data as to contacts. These contacts were investigated and treated. The drug used was penicillin, with auxiliary treatment of bismuth or arsenic.[1254] The department provided drugs to ensure treatment was available. In 1957, 99 million units of penicillin were distributed to 14 physicians and one hospital for 48 cases. In comparison, the number of cases receiving drugs in 1947 was 591.[1255]

The program started by Dr. Irvine took a pragmatic approach to the control of venereal disease. It concentrated on case finding, follow-up and technical assistance. But it kept diagnosis, treatment, and as much follow-up and investigation as possible, in the hands of private practitioners. In 1957, the department investigated 500 persons, and provided consultation to 745 physicians. Sometimes special investigations were made. In 1951, when the 47th Viking Division of the National Guard was activated, for example, the department laboratory examined blood samples from 7,213 men. One new case was found.[1256]

One issue the department had to address was who should be tested for syphilis? What was reasonable? In 1955, to better target resources, the department advised hospitals and medical professionals to limit testing for syphilis to persons with these characteristics: 40 years of age and over, single, divorced, separated, widowed, and any persons other than white of any age. The workload was reduced, but the number of cases found remained the same.[1257]

One of the persons who followed up on syphilis cases was Lucy Clare Finley, a medical social worker. She began working for the department in 1936, conducting follow-up investigations of actual and suspected cases of venereal diseases. Prior to penicillin,

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[1252] MDH, *Minnesota's Health,* Vol. 13, No. 2, February 1959.
[1253] MDH, *Minnesota's Health,* Vol. 15, No. 5, May 1961, p. 4.
[1254] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, pp. 3-4.
[1255] MDH, *Minnesota's Health,* Vol. 13, No. 2, February 1959, p. 3.
[1256] BOH, *Minutes,* May 28, 1952, MHS, p. 169.
[1257] BOH, *Minutes,* April 24, 1961, MHS, p. 110.

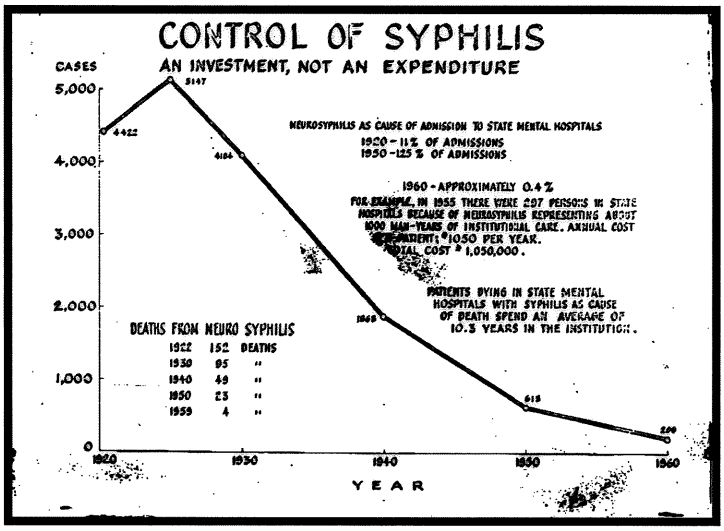
this required that she watch the calendar to note which patients were scheduled for treatment. If they didn't come, she found the patient and gave him/her a choice of being escorted to the doctor's office or the police station.

Miss Finley conducted follow-up investigations in all but one of the 87 counties in Minnesota. Once she went to a follow-up investigation, which necessitated she crawl through a barbed wire fence to get to the house. Undaunted, she ignored a large herd of cattle until halfway across the pasture she noticed the bulls charging at her. By a slim margin, she ran safely back to the other side of the fence. Eventually, Miss Finley found the patient and put her under medical care.

Miss Finley was dedicated. A former department employee recalls traveling with her in a car from Minneapolis to St. Paul for a meeting. Suddenly Miss Finley yelled: "Stop the car!" She saw one of her clients who was not supposed to be in town. Returning to the car, after speaking sternly with her client, Miss Finley said, "I told her to get out of town and stay out!"[1258] A poem read at Miss Finley's retirement in 1959 ended with these lines: "Jack or Jill…who now will put you sizzling on the grill?"[1259]

There were a number of cases of syphilis in mental hospitals, and the resulting costs incurred by the state were high. The estimated annual cost of caring for these patients while institutionalized was $780,000, almost the same as the total amount appropriated to the department for its venereal disease program since its inception in 1918 through 1951. Fortunately, the numbers were dropping. While nearly 11 percent of mental hospital admissions in 1920 had syphilis, only 1.25 percent was affected in 1950. This fell to 0.4 percent in 1959.[1260]

The cost of syphilis was high for the federal government, as well as for the state. In 1950 the Veteran's Administration asked all states to follow up on cases to help prevent central nervous system syphilis. A case of general paralysis could cost the government $40,000 per year. There were 1,400 cases from World War I, and with proper control, savings of approximately $1.0 billion for the federal government would result. Records were received, and the division of disease prevention and control did the requested follow up. There were some challenges, however.



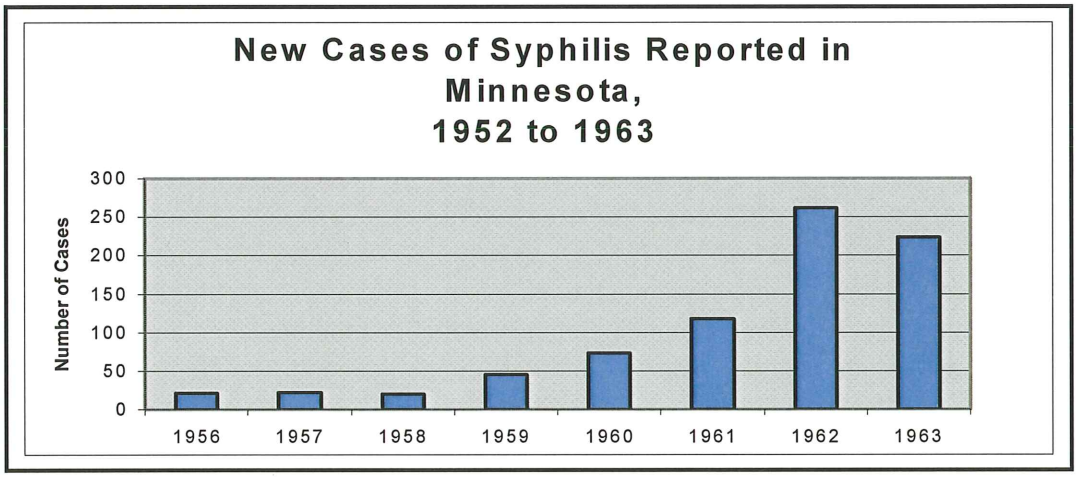
[1258] Interview with former MDH employee, February 1999.
[1259] MDH, *Minnesota's Health,* Vol. 13, No. 10, December 1959, p. 4.
[1260]

Dr. Dean Fleming, disease prevention and control director, said, "There must be considerable error in the way they assembled their records because they have a complete clinical record on a person who absolutely denies he has ever had such."[1261]

Fewer syphilis cases were reported throughout the state, and in 1958 the all-time low of four cases per 100,000 people was reached.[1262] It appeared as though syphilis would, like smallpox and other diseases, become history.

While the article in the department newsletter celebrated the conquest of syphilis as a serious public health problem in 1959, the department itself remained cautious. The end of the article mentioned that the opening of the St. Lawrence Seaway, with the creation of an international seaport in the state, could easily introduce new cases.[1263]

Though probably not due entirely to the St. Lawrence Seaway, syphilis began increasing in 1959 and 1960. The total number of primary and secondary syphilis cases reported in 1961 was the highest in over 10 years. To some extent, the reported increase in syphilis cases in 1960 could have been the result of improved reporting and data collection. The Public Health Service had assigned two trained employees to work in Minnesota for the purpose of syphilis case finding and improvement of educational concepts of venereal diseases.[1264] The increase in syphilis, however, was occurring all over the world.



In 1963, Minnesota was one of only nine states in the country that did not have a law requiring persons who planned to marry to be tested for syphilis. When a bill requiring premarital testing had been introduced in the Legislature in 1947, the Board of Health opposed it. One reason was that the laboratory test results might not be accurate and would cause unnecessary suffering.[1265]

[1261] BOH, *Minutes,* April 25, 1950, MHS, pp. 108-109.
[1262] MDH, *Minnesota's Health,* Vol. 17, No. 2, February 1963, p. 1.
[1263] MDH, *Minnesota's Health,* Vol. 13, No. 2, February 1959, p. 4.
[1264] BOH, *Minutes,* May 24, 1960, MHS, p. 74.
[1265] MDH, handout titled "What About State Syphilis?" January 29, 1947.

A bill requesting premarital serology testing for syphilis was again introduced in the Legislature in 1963, and again the board opposed it. Dr. Henry Bauer, deputy executive officer and medical laboratory division director, advocated against the legislation. At a meeting of state laboratory directors, he pointed out that syphilis is rarely discovered in persons who never suspected they had it. He estimated the rate was about one out of every 10,000.[1266]

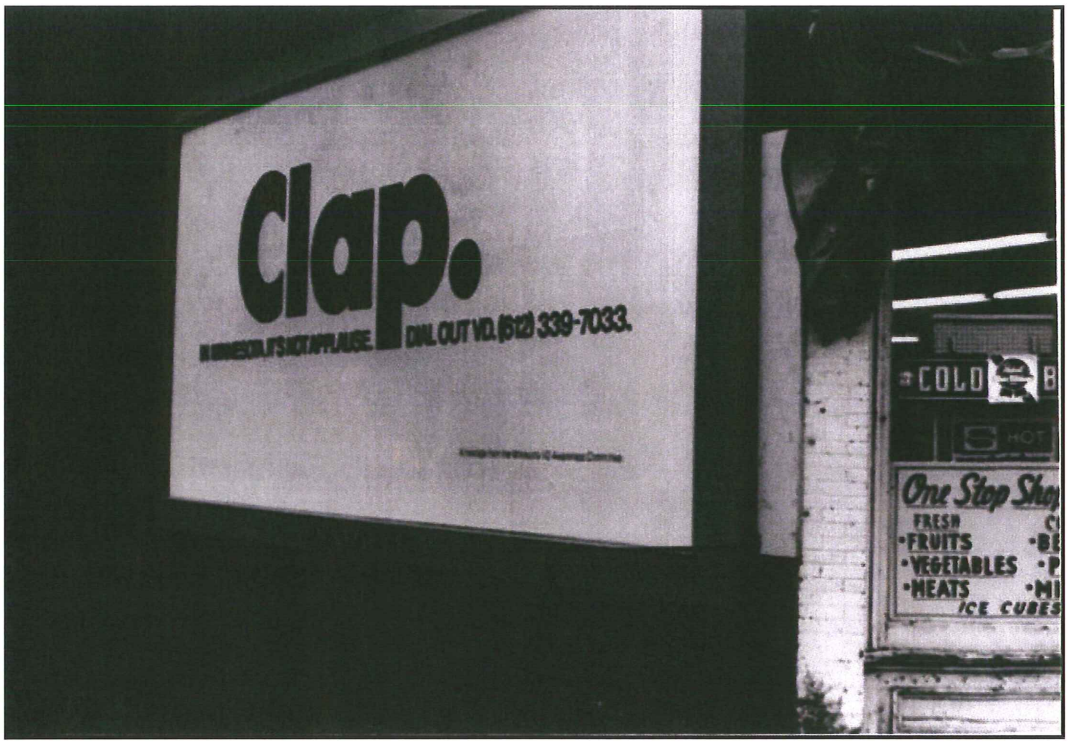
Dr. Bauer argued against premarital testing on the basis of cost. He thought the cost of testing could be better used for more serious public health problems. In 1963, the department's annual cost for conducting syphilis tests was estimated at $48,000. In addition, each bride and groom would need to pay about $5.00 to a physician for drawing the blood. In a 1955 study of serology tests done on 2,700 marriage license applicants, two syphilis cases were found. While the legislator introducing the bill was commended for his attention to public health problems, Dr. Bauer thought the program wasn't cost effective in Minnesota. One reason was effective case finding, due to the state's unique relationship between practicing physicians and the Board of Health.[1267]

Legislation calling for premarital testing for syphilis was proposed in 1956 but did not pass. Similar bills were regularly introduced during the 1960s. In the 1973 Legislature, a bill calling for mandatory testing of marriage license applicants for syphilis and gonorrhea was again proposed. Again, Dr. Bauer opposed the bill on the basis of cost and ineffectiveness. The board supported Dr. Bauer. In a news article titled "VD test proposal opposed by state health officials," board member Arnold Delger was quoted: "We'd be checking the wrong people."[1268]

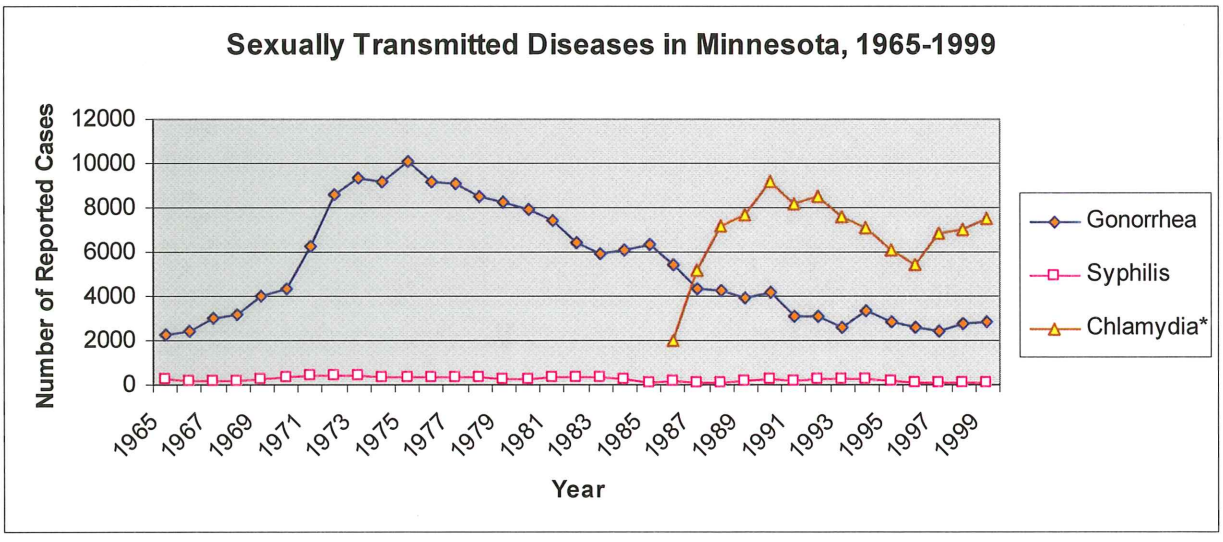
Following a national trend, sexually transmitted diseases began increasing in the late 1950s. After declining for several years, the first increase in gonorrhea occurred in 1953. Gonorrhea cases increased from 778 in 1956 to 1,423 in 1960. Most of the cases occurred in teenagers and young adults. The upward trend continued, with 1,900 cases of gonorrhea in 1961, 1,994 cases in 1962, and 1,967 cases in 1963.[1269]

Spurred by an increase in cases in the early 1970s, the department made a strong effort to bring the silent epidemic of sexually transmitted disease out to the public. The results were an awareness and education campaign that included hot lines, mass advertising, a speaker's bureau and training.[1270] The somewhat controversial award-winning "Clap, Clap" posters and billboards attracted a great deal of interest. This message was a significant change from earlier years when venereal diseases were not discussed openly, along with other communicable diseases. In 1918, the media substituted the term "the blood scourge" when referring to venereal disease.[1271]

[1266] *Minneapolis Star,* "Doctor Advises Against Pre-Marriage Blood Test," October 29, 1956, p. 9B.
[1267] BOH, *Minutes,* January 22, 1963, MHS, p. 32.
[1268] *Minneapolis Star,* "VD Test Proposal Opposed by State Health Officials," December 1972.
[1269] MDH, *Minnesota's Health,* Vol. 18, No. 8, October 1964, pp. 2-3.
[1270] MDH, *Program Performance Report FY 1975,* pp. 72-73.
[1271] MDH, *Minnesota's Health,* Vol. 21, No. 4, April 1967, pp. 1-4.



Unfortunately, the 1959 headline announcing the end of syphilis proved incorrect. Sexually transmitted diseases remained a concern of the department in 1999, warranting the continued existence of the section of AIDS/STDS.



Acquired Immune Deficiency Syndrome (AIDS)

In 1981 a 34-year-old Minnesota man read about a new illness, acquired immune deficiency syndrome (AIDS), a condition that attacked the victim's immune system. Some of the symptoms, such as swollen tissue around the neck, matched what he was

experiencing. One year later, his worst fears were confirmed. He was diagnosed as Minnesota's first case of AIDS.[1272]

Several new diseases and conditions had surfaced in the early 1980s, but the one that generated the most fear and concern among the population was AIDS. Little was known about the disease, and rumors abounded. In February 1983 the St. Paul Dispatch newspaper ran a full-page spread on this new and unknown disease. In one article the disease was described: "It is a disease that is baffling doctors while it kills. No one is sure what causes AIDS, what transmits it, what cures it."[1273] In the same newspaper the cause was postulated:

> It may be linked to poor hygiene and could be spread through such oral-fecal contacts as food handling. During the past two months, however, evidence has been pointing to the very real possibility that the nation's emergency blood supplies are being contaminated by whatever causes AIDS.[1274]

Within the same article, it was noted that some non-CDC researchers thought AIDS could be the result of biological warfare run amok. There was even a suggestion that it was a CIA plot to wipe out gays.[1275]

AIDS was most commonly reported in homosexual men, Haitian immigrants, IV drug users and hemophiliacs. There was increasing support for the theory that AIDS was transmitted through frequent sexual contact. The message the public health community sent was similar to the one the gay community had been receiving from political or moral arenas – they should avoid a promiscuous lifestyle. This seemed to create difficulties in interpretation of the message. Dr. John Whyte, a Minneapolis doctor, explained the public health approach: "We're not talking about sex, we're not talking about sin; we're talking about hygiene."[1276]

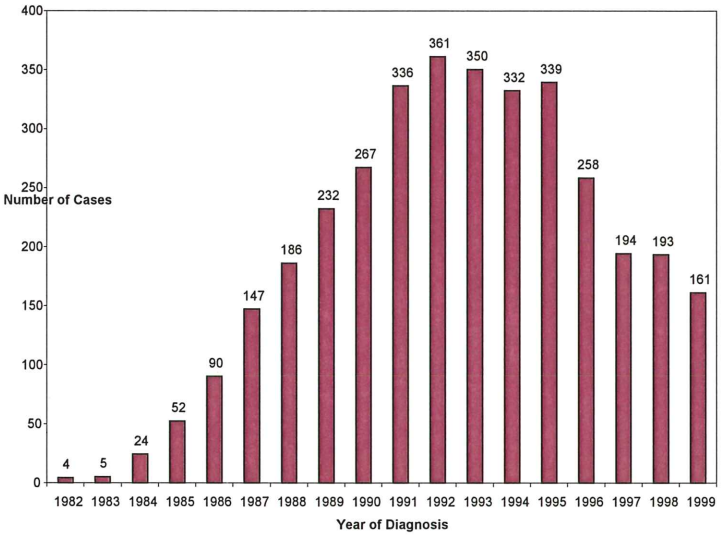
Gay leaders formed the Minnesota AIDS Project in 1983. This project offered support and information to persons diagnosed with AIDS and those who were potential victims of AIDS. The department supported this project, as well as others, with annual funding grants.

The first death of an AIDS victim occurred in October 1982 at St. Paul Ramsey Medical Center.[1277] The second Minnesota victim of AIDS died May 27, 1983.[1278] By August 1983 there were six confirmed cases of AIDS in Minnesota. Three of the victims had died.[1279] One month later Dr. Joel Kurtisky, the department's AIDS program director, reported there were now four confirmed deaths from AIDS in the state.[1280]

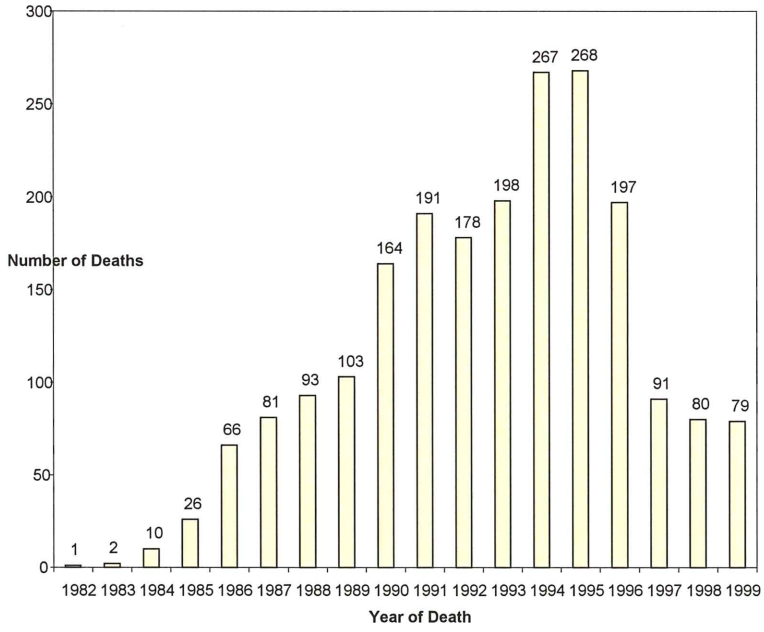
[1272] *St. Paul Dispatch*, "Gay Plague Stirs Growing Concern," February 17, 1983, p. 1A.
[1273] Ibid.
[1274] *St. Paul Dispatch,* "AIDS Emerges as Deadly Epidemic," February 17, 1983, p. 8A.
[1275] Ibid.
[1276] *St. Paul Dispatch,* "Syndrome: Gay Leaders Form Local Task Force," February 17, 1983, p. 8A.
[1277] *St. Paul Dispatch,* "Gay Plague Stirs Growing Concern," February 17, 1983, pp. 1A and 4A.
[1278] *St. Paul Pioneer Press,* "Second AIDS Fatality Reported in Minnesota," June 3, 1983, p. 12A.
[1279] *St. Paul Dispatch,* "Man's Death is Probed for AIDS Link," August 3, 1983, pp. 1A and 4A.
[1280] *St. Paul Dispatch*, "AIDS Victim Suffer Affliction and Misunderstanding," September 20, 1983, pp. 1C and 5C.

The cause of AIDS was still unknown, but the accepted theory was that AIDS was caused by an unknown virus. In 1983, in France's Pasteur Institute, the AIDS virus was isolated. In September 1983 Michael Osterholm, chief of the acute disease epidemiology section, said there was no way of knowing what would happen with a virus. It was possible that cases could drop off tomorrow, as viral diseases tend to peak.[1281] Unfortunately, that didn't happen in this case. AIDS continued to increase. By 1999, 161 confirmed cases and 79 deaths had been reported in Minnesota.

AIDS Cases Diagnosed in Minnesota, 1982 - 1999



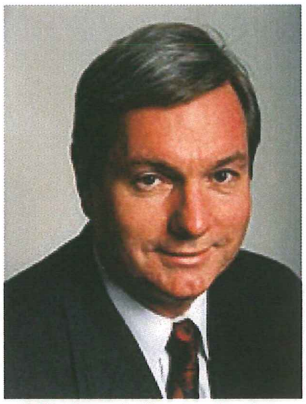
Deaths Among People Living with HIV/AIDS in Minnesota



[1281] *St. Paul Pioneer Press,* "Four Minnesota AIDS Victims Die," September 14, 1998.

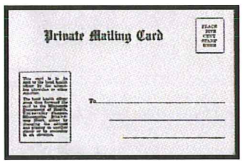
Chapter 15

Epidemiology



Michael Osterholm

The Minnesota Health Department has traditionally had a strong epidemiological program. Hibbert Winslow Hill, M.D., D.P.H., LL.D., a pioneer in his field, was the first official epidemiologist in the United States when the Minnesota Board of Health gave him that title on August 1, 1909.[1282]



From its beginnings in 1872, the Health Department has depended on reports from health professionals throughout the state to monitor disease activity. These data have been used to assess trends, identify affected populations, prioritize disease control efforts, evaluate prevention strategies, and recognize outbreaks. Reportable diseases were submitted to the department on cards such as these in the 1950s:

1-48 10M

As Required by Public Health Law I Report to the Health Officer a Case

Of..... In.....
Name of Disease — Township — Village — City — County

At.....
Street and house number, farm, camp, section number, name and location of hospital, etc.

Patient's name.....
Give full name, and for child, parent's initials or guardian's name. — Sex — Age — Race

Date of first symptoms.....19....; of diagnosis.....19....; of report.....19....

Dr..... of..... Minn.

Send a card for each case of each disease listed in Reg. 10795 of the Minnesota State Health Laws & Regulations. Diseases on list marked by an asterisk shall also be reported directly to the

Minnesota Department of Health, University Campus, Minneapolis, Minnesota 55440.

The H. O. or C. B. S. should fill out the blanks below and mail this report to Minnesota Department of Health, University Campus, Minneapolis, Minn. 55440.

I received this report.....19.... month—day

*Quarantined / Isolated / Placarded.....19.... month—day

Please send me.....
Name what supplies are needed.

Signed..... *M. D. Health Officer. / Chairman Board of Supervisors

For..... *Township / Village, P. O. Address..... / City

*Strike out words which do not apply.

[1282] MDH, *Minnesota's Health,* Vol. 1, No. 7, July 1947, p. 2.

State law has required the reporting of designated diseases. In the 1950s that list included the following, shown below.

REPORTABLE DISEASES

MINNESOTA STATE HEALTH REGULATION (a synopsis) – When called to a case, suspected case, or death from any of the diseases (listed below), the attending physician, within 24 hours, shall notify the local health officer (or local health department) by means of this reporting card or by phone. The local health officer (or local health department) shall mail this card to the Minnesota Department of Health, Disease Prevention and Control Section, 717 Delaware Street SE, Minneapolis, MN 55440.

Immunizable Diseases
Diphtheria
Influenza
Measles (Rubeola)
Pertussis (Whooping Cough)
Poliomyelitis
Rubella (German Measles) and Congenital Rubella Syndrome
*Smallpox
*Tetanus

Acute Viral Hepatitis
Type A ("Infectious Hepatitis")
Type B ("Serum Hepatitis")

Meningitis and Encephalitis

Venereal Disease
All Types (Use VD Report card)

Enteric Diseases, including Suspect Foodborne Illness
Epidemic Diarrhea (including Salmonellosis)
Shigellosis (Bacillary Dysentery)
Amebic Dysentery
Typhoid Fever
Paratyphoid Fever
*Cholera)Cases and Suspect
*Botulism) Cases

Tuberculosis

Occupationally-Related Diseases

Diseases Possibly Related to Environmental Health Problems

Not Reportable by Law, but Reports of Such Diseases Are Encouraged.

OTHERS

*Actinomycosis
*Anthrax
Brucellosis
Chickenpox (if patient over 16 years of age)
Conjunctivitis, Epidemic
*Glanders
*Leprosy
Leptospirosis
Malaria
Mononucleosis, Infectious
*Ophthalmia Neonatorum
*Plague
Pneumonia
*Psittacosis
*Rabies (animal and human cases and human exposures)
Rheumatic Fever
Ringworm of the Scalp
*Rocky Mountain Spotted Fever
Scarlet Fever
Trachoma
*Trichinosis
Tularemia
*Typhus Fever
Yellow Fever

Note: Any cluster of cases or increased incidence of any illness should be reported.

*Diseases marked with an asterisk shall be reported to the Minnesota Department of Health by phone (612-296-5200, -5201, or -5202).

Both additions and deletions have occurred to this list in the last 50 years. Some of the deletions include chicken pox, conjunctivitis, glanders, mononucleosis, pneumonia, ringworm, scarlet fever, smallpox, and trachoma. Additions include babesiosis, blastomycosis, campylobacteriosis, cat scratch disease, cryptosporidiosis, dengue virus, diphyllobothrium latum infection, ehrlichiosis, giardiasis, hemolytic uremic syndrome, hepatitis C, D, and E, histoplasmosis, human immunodeficiency virus, legionellosis, Kawasaki disease, listeriosis, Lyme disease, mumps, Reye syndrome, streptococcal disease, toxic shock syndrome, toxoplasmosis and yersiniosis.

Since 1995, the department has participated in the national Emerging Infections Program (EIP) funded by the U.S. Centers for Disease Control and Prevention in Atlanta, Georgia. EIP focuses on the identification and control of new or previously unrecognized disease problems. Through EIP, the department's public health laboratory has expanded surveillance and testing for a number of bacterial infections, and used molecular subtyping – or "fingerprinting" – to detect and find the source of food-borne and water-borne disease outbreaks.

Outbreaks and Interagency Cooperation

It has not always been clear where public health responsibilities in disease prevention and control begin and end. This has sometimes led to challenging relationships, particularly with other state agencies. A classic example of the difficulties encountered was the relationship between the Department of Agriculture and the Board of Health in their attempts to address food-borne and milk-related illnesses in the 1940s and 1950s.

In the 1940s the Legislature passed a bill that assigned Agriculture, rather than Health, as the agency responsible for milk supplies. Health board members thought this was an unsatisfactory split of responsibility. The department had pioneered the control of milk and thought it was its domain. The board also thought the department was placed in a difficult position by having responsibility for milk-borne disease with little or no authority to act.

It was particularly galling when the media depicted Agriculture as the lead agency during the investigation of an outbreak of food poisoning at the Fridley/New Brighton school district in 1949. The Department of Agriculture appeared on the scene to take control. Soon after, Dr. Dean Fleming, head of the disease prevention division at Health discussed the situation with board members:

> Dr. Dean Fleming: "As near as we could determine, they had not been asked to come by the people in charge. They apparently had heard about it and rushed to do their bit. After that the papers looked to them for their reports. They were the ones in the paper and on the radio."
>
> President Thomas Magath: "It seems to me that this calls for some communication from our Board to the Agriculture Department in which we should be very specific and tell them that is none of their business and that they should keep out of it."[1283]

The board clearly thought that Agriculture was stepping on toes and possibly endangering the health of the population by being untrained to handle infectious disease cases.

> Magath: "You have a wonderful chance to get into a very difficult position. Suppose this fellow from Agriculture had found something."
>
> Fleming: "We were wishing he would." [1284]

The board felt an employee from Agriculture, who was called "state bacteriologist," did not have the skills and education needed to properly deal with outbreaks of illness:

> Magath: "I don't doubt that he is pushing himself. I think we could say that by training or experience we do not consider him competent to investigate those outbreaks of human illness."[1285]
>
> Charles Netz, Board Member: "After all, Dr. V is nothing more than a bacteriologist. He was from the Farm Campus."
>
> Magath: "Yes, and he is not 'Dr.' V at all. I think we should state that he has limited educational qualifications and that he is not capable of stating an opinion."
>
> Dr. Frederic Bass, Board Member: "That would settle that case, but sometime they might have someone who would be qualified."[1286]

[1283] BOH, *Minutes,* January 20, 1949.
[1284] Ibid.
[1285] Ibid.
[1286] Ibid.

Dr. Ruth Boynton, Vice President of the Board: "I wonder if maybe we aren't a little at fault in not supplying a little information to the press on a thing of this kind which has been of public interest and which we have investigated. Don't you think we have a public relations duty here?"[1287]

After the board meeting, Dr. Albert Chesley wrote a letter to the Agriculture commissioner and sent a copy to the governor. The letter, dated February 1, 1949, read in part:

A report was also made to the Board on the investigation made by our Department on the food poisoning outbreak at Independent School District No.23, New Brighton, Ramsey County. The report included some discussion of the newspaper accounts of the investigation work carried on by your Department on this outbreak. The Board expressed great concern over the entrance of your Department into a matter which is strictly a problem of human communicable disease control, and it instructed me, by unanimous vote, to inform you that it takes the position that the law very clearly intends that the State Department of Health shall have complete jurisdiction in matters involving epidemics and the transmission of human disease.[1288]

A reply from Agriculture was received March 30:

Your letter of February 1st, 1949, relative to an investigation conducted by this department into the food poisoning outbreak at Independent School District Number 23, New Brighton, was received at my office during the time I was confined to the hospital.

I have discussed this matter with Dr. V and he informs me that it was simply a case of food poisoning and not a case of communicable disease.

You may rest assured that it shall continue to be the policy of this Department to leave all matters relating to contagious or communicable disease to the State Board of Health.

Dr. V or other representatives of this Department will be glad to discuss this matter with the State Board of Health at any time.[1289]

The letter was not a satisfactory response to Board President Magath: "Well, I was much disturbed by that letter and I personally am not satisfied to leave the matter at that point. If we are going to give ground in the protection of the public health we might as well quit."[1290]

The board continued to discuss the appropriate role of Health and Agriculture and whether or not the state bacteriologist from Agriculture had the appropriate qualifications to investigate food poisoning:

Netz: "It seems to me it is more important for that Department to check up on food before its consumption."

H. M. Bosch, Chief of Environmental Sanitation: "Enforcement of the pure food and drug laws."

Magath: "But in specific instances where the public is made sick, that is our business."[1291]

[1287] BOH, *Minutes,* January 20, 1949.
[1288] Letter from Dr. Chesley to Dr. Berg, February 1, 1949.
[1289] Letter from Dr. Berg to Dr. Chesley, March 30, 1949.
[1290] BOH, *Minutes.*
[1291] BOH, *Minutes.*

The board members weren't sure whether food poisoning was considered a communicable disease. Dr. Magath said, "I don't think you will ever get any two people to agree on a definition of communicable disease. It used to be termed contagious disease."[1292]

Though the discussion centered around one man and one incident, Dr. Chesley captured the larger issue when he said, "Everything in public health is spreading out so that there is no twilight zone."[1293]

In 1957, after continued discussions about the role of Agriculture and Health in milk supplies, executive officer Dr. Robert Barr sent a letter to Gov. Orville Freeman, outlining the Health Department's responsibilities related to milk supplies. Dr. Barr wrote that the department's responsibilities were limited to: 1) investigation and control of communicable and milk-borne disease outbreaks or of situations posing a definite threat of such outbreaks; 2) advisory services to and promotion of local milk control programs; and 3) investigation activities delegated by the U.S. Public Health Service related to enforcement of interstate quarantine regulations, such as the certification of milk supplies for use on interstate carriers.[1294]

Salmonellosis

In the 1950s an increasing number of cases of salmonellosis was reported. There were 23 reported cases of salmonellosis in Minnesota in 1950. In 1952 there were 186 cases and one death. Two deaths occurred in 1953.

> ***"Keeping salmonella-infected feces out of food, water, and pharmaceuticals may seem an oversimplification to the solution of the problem, but therein lies the key to prevention."***[1295]
>
> **Dr. Henry Bauer, Ph.D., Director of Laboratory, 1973**

The apparent increase in salmonellosis may have been due to improved laboratory techniques for identifying the organism or increased reporting. Changes in eating habits of the population may have contributed to a real increase, as well. People ate out more frequently, and they consumed more mass-produced foods. The mass-produced foods often contained multiple ingredients provided by different suppliers. The equipment used for production was sometimes poorly designed for sanitary maintenance. Mass-produced foods for pets and domesticated animals also contributed to the problem, as it might be contaminated with salmonella-infected ingredients.[1296]

[1292] BOH, *Minutes*.
[1293] BOH, *Minutes*.
[1294] Letter from Dr. Robert Barr to Gov. Orville Freeman, December 12, 1957.
[1295] Henry Bauer, "Growing Problem of Salmonellosis in Modern Society," *Medicine*, Vol. 52, No. 4, p. 329.
[1296] Ibid., p. 323.

While different reasons for the increase were suggested, department professionals agreed on one solution: better food-handling methods were needed to reduce the cases of salmonellosis.[1297]

Concerned about the increase in salmonella infections nationwide, in 1961 the Association of State Laboratory Directors and the Association of State Epidemiologists banded together and, with the Centers for Disease Control (CDC) in Atlanta, started a national surveillance program. Each state reported weekly to the CDC on the serotypes isolated during the week.[1298] After analyzing these data, it was learned that poultry and poultry products were an important source of infection. Eggs, particularly powdered and cracked ones, were a common source of infection. Patients in nursing homes who drank eggnog were often infected.[1299] Poultry as a source of salmonella infection was again emphasized in 1987.[1300] State Epidemiologist Michael Osterholm said, "If you are going to drink eggnogs with raw eggs, it is not if you will get sick, it is when you will get sick."

Poultry had already been identified as the source of an outbreak of salmonellosis in Minnesota. In 1954, 12 children in 11 different households were affected after receiving Easter chicks.[1301] The cases were traced to two grocery stores that gave out 1,000 chicks to customers. The chicks had been obtained from a hatchery that showed no signs of infection, but the chicks had been kept in crowded conditions.[1302]

"Much of prevention can be told with 'five Fs' – feces, fingers, flies, food and filth. The link in the chain of events which permits fecal matter to get into food must be broken if we ever hope to prevent salmonellosis."[1303]

Henry Bauer, Ph.D., Director of Laboratories, 1973

Outbreaks of salmonellosis continued through the 1960s. In 1963, an outbreak of salmonellosis occurred in a Minneapolis nursing home. Twenty-one out of 96 patients were affected.[1304]

In 1966, Salmonella New Brunswick contamination was discovered in a milk-drying plant in Plainview. The production of powdered milk did not require pasteurization, so in 1966 the Board of Health decided to recommend to Agriculture that pasteurization be the first step in the powdering of milk.[1305]

Other outbreaks of salmonella included:

[1297] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 4.
[1298] Henry Bauer, "Growing Problem of Salmonellosis in Modern Society," *Medicine*, Vol. 52, No. 4, 1973, pp. 323-330.
[1299] BOH, *Minutes,* May 18, 1964, MHS, pp. 327-328.
[1300] *St. Paul Pioneer Press*, "MHD Reports on Chicken as Salmonella Source," February 18, 1987.
[1301] MDH, *Minnesota's Health,* Vol. 8, No. 6, June 1954, p. 2.
[1302] MDH, *Minnesota's Health,* Vol. 10, No. 3, March 1956, p. 1.
[1303] Henry Bauer, "Growing Problem of Salmonellosis in Modern Society," *Medicine*, Vol. 52, No. 4, pp. 329-330.
[1304]
[1305] BOH, *Minutes,* May 16, 1966, MHS, p. 242.

1980 – Sausages were the source of an outbreak in New Hope.[1306]

1989 – A salmonella outbreak was attributed to cheese.[1307]

1990 – Tomatoes, imported from out of state, were the suspected source of a Salmonella javiana outbreak. [1308]

1991 – Cantaloupe was the source of salmonella infection.

1994 – The contamination of Schwan's ice cream led to an outbreak of salmonella enterititis.

1994 – Toasted Oats cereal were contaminated.

Food Poisoning

Between 1950 and 1960, more than 3,000 cases of food poisoning were reported to the department. Eleven were fatal. In May 1959, a custard-filled pastry that contained staphylococcus organisms caused an outbreak of 14 cases of food poisoning. In 1960, the department tried to get necessary legislation to develop an effective food sanitation program. The department had authority to regulate food establishments, but it didn't have enough funds to adequately run the program. More inspectors and inspections were needed.[1309]

Botulism Poisoning

In the summer of 1960, two deaths in Minneapolis were attributed to fish vacuum-packed in cellophane. The severe hot weather contributed to this food spoilage. The Minneapolis Health Department conferred with the state departments of Health and Agriculture and the federal Food and Drug Administration, which thought botulism was the cause. Wholesale and retail distributors were directed to pull the fish from the shelves, and the public was told to destroy any they had purchased.[1310]

Hepatitis

Cases of hepatitis, previously called jaundice, began increasing in Minnesota in the 1950s. There were more than twice as many cases of infectious hepatitis in 1954 as in 1953, and the numbers continued to rise:

[1306] *St. Paul Pioneer Press,* "More Salmonella Victims Reported," August 6, 1980, p. 18.
[1307] *St. Paul Pioneer Press,* "Perpich Unhappy with Handling of Salmonella Scare," July 13, 1989, pp. 1A and 6A.
[1308] *St. Paul Pioneer Press,* "Confirmed Salmonella Cases Stands at 83," November 28, 1990, p. 2B.
[1309] MDH, *Minnesota's Health,* Vol. 14, No. 8, October 1960, p. 2.
[1310] BOH, *Minutes,* September 13, 1960, MHS, pp. 330-331.

Infectious Hepatitis Cases and Deaths in Minnesota		
Time Period	**Number of Cases**	**Number of Deaths**
1934 - 1938	72	6
1939 - 1943	380	5
1944 - 1948	610	33
1949 - 1953	2,071	45[1311]
1954[1312]		7
1953 – 1955.[1313]	5,072	
1960[1314]	163	
Jan to June 1961[1315]	998	

In the summer and fall of 1960, there was an outbreak of hepatitis in the Faribault School and Colony, introduced to the institution through one employee. From July 1960 to January 1961, 205 cases and two deaths were reported at the school. The outbreak received considerable media coverage, reporting 30 deaths. Dr. Dean Fleming thought the media might have exaggerated the situation. By January 1961 he thought the outbreak was fairly well under control, and there was no justification for the publicity it continued receiving.[1316]

Another disagreement with the media over the reporting of hepatitis outbreaks occurred in 1978 and raised questions about how much information the department should supply the public. In August, 95 people who had eaten at the Edina Country Club contracted hepatitis A.[1317] The following October, five employees and four customers of Mama Rosa's restaurant in Minneapolis became ill, leading to the closing of this restaurant. At first the department did not name the restaurants.

The department was criticized in a St. Paul Pioneer Press editorial for failing to name the restaurants in question early and thereby alerting the public to danger. The editorial commented on the department's decision: "The officials based their asinine action on, of all things, the State privacy act."[1318] The editorial further charged that to "...play games with a disease as serious as infectious hepatitis is outrageous."[1319]

Dr. Andrew Dean, the new state epidemiologist, responded that releasing the names of restaurants could be injurious to the health of the public, believing restaurants would report fewer cases if names were routinely released.[1320] The department decided not to

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[1311] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 4.
[1312] MDH, *Minnesota's Health,* Vol. 9, No. 2, February 1955, p. 4.
[1313] MDH, *Minnesota's Health,* Vol. 20, No. 3, March 1966, pp. 2-3.
[1314] BOH, *Minutes,* July 11, 1961, MHS, p. 319.
[1315] Ibid.
[1316] BOH, *Minutes,* January 31, 1961, MHS, p. 35.
[1317]
[1318] *St. Paul Pioneer Press*, "Failing to Protect the Public," editorial, November 11, 1978, p. 14.
[1319] Ibid.
[1320] *St. Paul Pioneer Press,* "Hepatitis List Seen as Health Threat," November 25, 1978, p. 4.

release names and not to request a legal opinion on releasing names unless required to do so.[1321]

Other hepatitis outbreaks in Minnesota included:

1982 – Seven cases traced to a restaurant in Cook.[1322]

1982 – Hepatitis closes O' Gara's in West St. Paul.[1323] .[1324] [1325]

From 1949 through 1999, the department pressed for good personal and community hygiene to protect individuals from hepatitis. [1326] In explaining the cause of one outbreak in 1978, Dr. Michael Osterholm said he wasn't certain how it was being transmitted but added, "Basically, it's caused by poor hygienic habits."[1327]

Encephalitis

In September 1960 a four-year-old girl from Winona died of unknown causes. Four years later, frozen tissue from the girl was taken from the department's freezer and examined. California encephalitis was identified as the cause of the girl's death. This was the first known case of California encephalitis in Minnesota.[1328]

In 1966 there were 13 confirmed cases of encephalitis in Minnesota. Most occurred in Fillmore, Houston or Winona counties. All three counties are located in the southeastern portion of the state. In 1967 there were eight confirmed cases of encephalitis, with occurrences in Carver, Hennepin and Sibley counties. In 1969, there were seven cases, with reports now coming from Dakota and Ramsey counties.[1329]

In 1968 a second fatality from California encephalitis occurred. A six-year-old girl from Gilmore Valley, an area west of Winona, died. Because of these deaths, in 1969 the department began taking blood samples from persons in Winona and the surrounding area. The department expected to find California encephalitis antibodies in the blood of a small percentage of people, indicating they had contracted the disease. The department had not expected the high number of positive test results as it found. In Gilmore Valley nearly one out of every three people over 10 years old had California encephalitis antibodies in their blood.[1330] Based on these findings, the department worked with physicians in Winona to try to identify more cases.

[1321] *St. Paul Pioneer Press,* "Health Officials Won't Seek Opinion on Hepatitis," November 28, 1978, p. 32.
[1322] *St. Paul Pioneer Press,* "7 Cases of Hepatitis Traced to Former Restaurant in Cook," June 9, 1982, p. 11.
[1323] *St. Paul Pioneer Press,* "Hepatitis Cases Linked to Cook, O' Gara's West Closes," June 9, 1982, p. 11.
[1324] *St. Paul Pioneer Press,* "5 More Cases of Infectious Hepatitis Diagnosed," June 10, 1982, p. 1.
[1325] *St. Paul Pioneer Press*, "6 More Cases of Infectious Hepatitis Reported," June 10, 1982, p. 1.
[1326] MDH, *Minnesota's Health,* Vol. VI, No. 4, April 1952, p. 2.
[1327] *St. Paul Pioneer Press,* "Hepatitis Among Food Handlers Rises," November 2, 1978, p. 1.
[1328] *Minneapolis Tribune,* "Sleep Disease Find Startles Health Aides," July 10, 1969, pp. 1A and 4A.
[1329] Ibid.
[1330] *Minneapolis Tribune,* "Sleep Disease Find Startles Health Aides," July 10, 1969, pp. 1A and 4A.

The high number of mosquitoes in Minnesota places the state at greater risk for encephalitis. In the 1960s it was considered endemic in certain areas of the state. To help reduce the risk of encephalitis, areas were sometimes sprayed to eliminate mosquitoes. In the fall of 1975, the Red River Valley was sprayed extensively with Malathion in populated areas by the state and federal governments. Areas that could not be sprayed were provided with information on mosquito management. Health Commissioner Dr. Warren Lawson wrote, "However, it is not possible to determine for certain if the spraying decreased the number of human cases of mosquito-borne encephalitis that might have otherwise occurred.[1331]

In 1978, encephalitis cases continued to be reported in Minnesota and Wisconsin. [1332] [1333] Surveillance for evidence of the California encephalitis group virus continued in the southeastern portion of the state.[1334]

In August 1983 the department became very concerned that conditions in western Minnesota were conducive to a large number of western equine encephalitis cases. As a result, the largest spraying effort in the nation occurred in Minnesota in August 1983.

(Note: This mosquito spraying effort is described in Chapter 13.)

Meningitis

An outbreak of bacterial meningitis occurred in Mankato in 1995.[1335]

Other Outbreaks in the State

Some of the other outbreaks in Minnesota are listed below.

Year	Disease	Description
1951	Shigellosis	An outbreak occurred at the Institution for the Mentally Retarded. About 150 patients were affected; most were bedridden and fed by other patients.[1336]
1952	Ringworm	An outbreak of at least 30 cases occurred in the East Grand Forks schools.[1337] Dr. C.B. Nelson and other personnel from the department investigated. Working with the community nurse, local health officer, and family physicians, they set up control measures. The community nurse used a wood lamp to check children. Suspected cases were referred to family physicians. When it became apparent that the outbreak was extensive, treatment centers were set up in two schools and personnel were employed

[1331] Letter from Dr. Warren Lawson to Sen. Hubert Humphrey, October 31, 1975.
[1332] *St. Paul Pioneer Press,* "Four Sick Because of Mosquito – Encephalitis," August 10, 1978, p. 41.
[1333] *St. Paul Pioneer Press,* "New Cases of Encephalitis Studied – Dr. Hall," August 12, 1978, p. 18.
[1334] E.S. Hurwitz et al., "Surveillance for California Encephalitis Group Virus Illness in Wisconsin and Minnesota, 1978," *American Journal of Tropical Medicine Hygiene*, Vol. 32, No. 3, May 1983, pp. 595-601.
[1335] B. Siegel, "Meningitis Outbreak: Mother Nature Sends a Scary Message," *Medical Economist*, Vol. 72, No. 16, August 21, 1995, pp. 173-186.
[1336] BOH, *Minutes,* July 23, 1951, MHS, pp. 218-219.
[1337] MDH, *Minnesota's Health,* Vol. VI, No. 10, November 1952.

		to run them. The local health officer deputized the clinic physician to manage the epidemic and to see all infected children. Children in grades 1-9 were checked at the detection center once a month.[1338]
1953	Trichinosis	An outbreak of at least eight cases occurred in St. Charles. Persons became ill after eating homemade pork sausage.[1339]
1957	ECHO-9	Between August 1 and October 14, more than 600 people were affected by a similar ailment. The laboratory ran numerous tests and identified the illness as ECHO-9 virus. The cause of the outbreak was identified by the tissue culture method for isolating viruses. It wasn't until 1954 that the laboratory was able to isolate viruses.[1340]
1957	Legionnaire's Disease	Minnesota was the first state to document an outbreak of Legionellosis.[1341] It occurred at a meat packing plant in Mankato.[1342]
1957	Influenza	One of the most devastating outbreaks occurred in 1957. A total of 18,100 cases of "Asian flu" were reported.[1343] [1344]
1963	Reye's Syndrome	A case occurred in Olmsted County.
1963 and 1964	Influenza	In 1963, there were 795 cases and 89 deaths from influenza. In 1964, there were 356 cases and 88 deaths.[1345]
1968	Influenza	"Listening posts" were activated at Worthington, Rochester, St. Cloud, Thief River Falls, Fergus Falls, Duluth and Crookston.[1346]
1975	Lyme Disease	A case was reported in Olmsted County.[1347]
1976	Influenza	The possibility of holding swine flu clinics was discussed.[1348] The department agreed to provide the vaccine.[1349] Later, a vaccine link to disease was indicated.[1350]
1979	Legionnaire's Disease	Wabasha County
1979	Parasites	Outbreak in Goodhue Schools
1979	Head Lice	An outbreak occurred throughout the state.[1351]

[1338] MDH, *Minnesota's Health,* Vol. VII, No. 4, April 1953, p. 2.
[1339] Ibid., p. 3.
[1340] MDH, *Minnesota's Health,* Vol. 11, No. 10, December 1957, pp. 2-3.
[1341] Abram S. Benenson, editor, *Control of Communicable Diseases Manual,* American Public Health Association, 16th Edition, 1995, p. 256.
[1342] Michael Osterholm, et al. "A 1957 Outbreak of Legionnaires' Disease Associated with a Meat Packing Plant," *American Journal of Epidemiology*, Vol. 117, No. 1, January 1983, pp. 60-67.
[1343] MDH, *Minnesota's Health,* Vol. 20, No. 3, March 1966, p. 2.
[1344] MDH, *Minnesota's Health,* Vol. 11, No. 10, December 1957, p. 3.
[1345] MDH, *Minnesota's Health,* Vol. 20, No. 3, March 1966, p. 2.
[1346] BOH, *Minutes,* January 9, 1968, MHS, p. 23.
[1347] E.L. Matteson, et al, "Epidemiology of Lyme Disease in Olmsted County, MN, 1975-1990," *Journal of Rheumatology*, Vol. 19, No. 11, November 1992, pp. 1743-1745.
[1348] *St. Paul Pioneer Press,* "Swine Flu Clinics to Be Discussed," June 24, 1976, p. 18.
[1349] *St. Paul Pioneer Press,* "Health Agency Committed to Swine Flu Fight," September 9, 1976, p. 35.
[1350] *St. Paul Pioneer Press,* "Swine Flu Program Hated While Disease Link Probed."

1979	Measles	Cases were reported in Brainerd, Hibbing, Cold Springs, and West St. Paul.
1980	Influenza	Shakopee schools closed due to illness, possibly flu.
1980		Unknown illness closes St. Luke's in February.
1983	Psittacosis	Outbreaks are widespread throughout the state.
1983	Lyme Disease	
1986	Listeriosis	Affected ice cream is recalled.
1987	Mumps	The number of reported cases was down to less than 10 a year when an outbreak occurred. Eighty-four cases were reported by February. Most were in St. Paul Highland Park High School.[1352]
1988	Acute diarrhea	NWA flight
1990	Measles	Outbreak occurs among Amish population.
1994	Influenza	Pineapple at Governor's Mansion
1995	Strep	Four deaths occurred in Goodhue County.
1995	Legionnaire's Disease	Outbreak reported in Luverne and Mankato.
1997	Campylo-bacteriosis	Outbreak reported in chickens.
1997	Parasites	Drinking fountain water at Minnesota Zoo infects children.

Illnesses Related to Meat

In the 1980s and 1990s several illnesses were linked with hamburger, processed meat and beef:

1985 – Thyroid ailments resulted in beef recall

1988 – Bacteria linked to hamburger in Coon Rapids

1990 – HUS illness (hemolytic uremic syndrome) linked to undercooked beef

1997 – Recall on Hudson Food Company ground beef

1999 – Listeria Monocytogene linked to processed meat

[1351] *St. Paul Pioneer Press,* "Head Lice are Becoming Itchy Story in State," p. 9.
[1352] *St. Paul Pioneer Press*, "Major Rise in Cases of Mumps Reported," February 4, 1987, pp. 1A and 4A.

Other Illnesses

Other significant illnesses reported during the 50-year period included:

1952 – Rocky Mountain Spotted Fever: A seven-year-old Minnetonka boy died of Rocky Mountain spotted fever in 1952, the first fatal case since 1931.[1353]

1955 – "Silo-Filler's Disease": In 1955 three deaths occurred in men ages 43, 31 and 28 who had all been exposed to silage. A new illness, silo-fillers disease, was identified. The same gas that caused the deaths of persons at the Cleveland Clinic and the Memorial Hospital in New York in the 1920s, when x-rays caught fire, caused the deaths. Farmers were warned to stay away from silos during and shortly after filling them.[1354]

1996 – Mad Cow Disease

1989 – L-tryptophan contributed to blood disease/death

Epidemiologists

In 1949 the primary Health Department team conducting outbreak investigations consisted of Dr. Dean Fleming, disease prevention division director, and Dr. C. Barton Nelson, epidemiology section head. Dr. Fleming retired in 1975 and Dr. Nelson retired in 1982. From 1984 to 1999 the state epidemiologist position was held by outgoing and visible Michael Osterholm, Ph.D.[1355] He and his team gained an international reputation for hunting down food-borne outbreaks.

[1353] MDH, *Minnesota's Health,* Vol. VI, No. 7, September 1952, p. 3.
[1354] MDH, *Minnesota's Health,* Vol. 10, No. 7, August-September 1956, p. 2.
[1355] *St. Paul Pioneer Press,* "Osterholm's New Job Title: CEO," February 5, 1999, pp. 1A and 16A.

Chapter 16

Targeted Populations

> ***"No intelligent person can fail to recognize that we, as a nation, have the best health and medical care facilities in the world. Yet, in our population there are some minority groups whose health is sorely neglected. These are: the aged with their chronic degenerative diseases and the accompanying health, social, economic, educational, recreational, and housing problems; the disabled who need both treatment and rehabilitation; and the mentally ill who need not only treatment and rehabilitation but frequently a helping hand from a neighbor to maintain their place in society."***[1356]
>
> **Dr. Robert Barr, 1954**

Throughout its history, the Minnesota Health Department has targeted populations having or being at greater risk for health problems. Targeted populations have included American Indians, migrant workers, pregnant women and mothers, refugees, juveniles, the elderly – any concentrated group at greater risk for increased mortality or morbidity.

American Indians

Some of the department's earliest targeted interventions were directed at the American Indian population.

In 1950, there were an estimated 13,000 American Indians in Minnesota. The average age at death was 41.4 years, compared with 63 years for the population as a whole. [1357]

In 1951, the five leading causes of death among American Indians were accidents (15.9 percent of total deaths), heart disease (12.6 percent), pneumonia and influenza (9.9 percent), tuberculosis (7.9 percent) and intra-cranial vascular lesions (7.3 percent). By comparison, the leading causes of death for the general population were heart disease (36.1 percent of total deaths), cancer (16.1 percent), vascular lesions (13.4 percent), accidents (6.5 percent), and general arteriosclerosis (2.6 percent). The American Indian population was disproportionately affected with dysentery, trachoma, poor nutrition and tooth decay. Diabetes was common, but cancer was not.[1358]

For many years the greatest health problem of American Indians in Minnesota was tuberculosis, but considerable improvements had been made by 1949. There were 18

[1356] MDH, *Minnesota's Health,* Vol. 9, No. 5, May 1955, p. 2.
[1357] MDH, *Minnesota's Health,* Vol. VII, No. 8, September 1953, pp. 1-2.
[1358] MDH, *Minnesota's Health,* Vol. IV, No. 7, July 1950, pp. 1-5.

deaths from tuberculosis in 1948, compared to 64 in 1936.[1359] For early detection of tuberculosis cases, when treatment could still be successful, the department visited reservations with a mobile x-ray unit. A 1950 article in the department's newsletter noted that if tuberculosis was to be wiped out among American Indians, they needed better nutrition, frequent x-rays to detect cases early, adequate sanatorium facilities, and segregation of infected individuals. [1360] Beginning in April 1950, outpatient clinics were held at the Red Lake Hospital and other hospitals. Tuberculosis case registries were established at the Chippewa health unit in the Red Lake, Cass and White Earth areas. [1361]

The year 1953 was a milestone year in American Indian health in Minnesota. It was the first time there were no recorded deaths from tuberculosis. While the average life span of American Indians was about 20 years less than the average life span of the general population, headway was being made. An infant mortality rate of 89.1 per 1,000 live births in 1944 dropped to 41.5 in 1954.[1362]

In addition to tuberculosis, health improvements were made in trachoma and other conditions and diseases, but American Indians' health still lagged behind the general population. In 1956, the mortality rate for all diseases in Minnesota was 34 per 100,000 people. For the American Indian population it was almost three times as great at 105.3 per 100,000. The American Indian death rate of 33.2 per 1,000 live births in 1956 compared to 21 per 1,000 for the general population. [1363] Underlying causes for poor health were cited as poor nutrition, inadequate housing, lack of proper sanitation and low economic status.[1364]

It was often difficult for American Indians to find adequate employment. At a board meeting in February 1950, members asked about employment and forms of assistance for American Indians in Minnesota. Dr. Percy Watson, local health services division director, responded:

> I think there is one misunderstanding, generally. The Indians received only $25.00 per capita in 15 years. They do get out of jobs in the winter and they need someone to help find jobs for them. The Welfare Department this year is trying very much to give them jobs and not to give them handouts.[1365]

The primary challenges to preventing and treating diseases among American Indians were scattered populations, impassable roads during bad weather, lack of equipment, and the scarcity of trained American Indian personnel. There were no American Indian doctors on Minnesota Indian reservations. Public health nurses became very important in improving the health of American Indians in Minnesota.

[1359] MDH, *Minnesota's Health,* Vol. VIII, No. 6, June 1949, pp.1-2.
[1360] MDH, *Minnesota's Health,* Vol. IV, No. 7, July 1950, pp. 1-5.
[1361] MDH, *Minnesota's Health,* Vol. V, No. 4, April 1952, pp. 1-2.
[1362] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1363] MDH, *Minnesota's Health,* Vol. 12, No. 2, February 1958, p. 3.
[1364] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1365] BOH, *Minutes,* February 14, 1950, MHS, p. 73.

Dr. Albert Chesley, executive officer and board secretary, said: "Putting public health nurses in to the field was the most important move made in relation to Indian health."[1366] Several public health nurses from the department worked with American Indians for many years and developed close friendships. Often they worked in primitive conditions. The weekly clinic at Onigum was held in a dilapidated building where there was no running water and no artificial light.[1367]

Miss Adele Northrup worked as a public health nurse with American Indians until her retirement in 1951. She worked for the department a total of 23 years, the last 15 on the White Earth reservation. On retirement, an educator who knew her well described her work:

> She ministered to the physically, spiritually, and emotionally ill people of her area. Every part of community life was of interest to her. She was the fully occupied person who could always be depended upon to do more when the best interests of the community were involved. Her compensations cumulate from her exemplary, devoted service to the Chippewa people whom she has served so well in these past fifteen years.[1368]

Mrs. Mary Stolze succeeded her.

Herbert Bosch's philosophy, stated below, is one that has been respected by public health workers in Minnesota. Minnesota was the first state to use American Indian nurses to serve the American Indian population. In an effort to reach out to all populations, the department hired two Chippewa nurses again in 1938 to work with the American Indian population.[1369] These nurses, trained in the 1920s, knew the language and made a significant difference in improving the health of American Indians.

"I believe that in attempting to help human beings with their problems one must have knowledge of their cultural patterns so that any suggestions that are made will not violate these patterns."[1370]

Herbert Bosch, State Board of Health Vice President, 1960

With the support of the Soroptimist Club, Minnesota continued the tradition of using American Indian nurses. In 1949, Beverley Estey and Louise Webster completed their nursing degrees.[1371] Shirley Ann Barney, a nurse from Sawyer, Minnesota; was the first American Indian to receive a scholarship for dental hygiene. The scholarship was awarded by the Department of Education through the office of Roy Larson, assistant

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1367 MDH, *Minnesota's Health,* Vol. VII, No. 8, September 1953, pp. 1-2.

1368 MDH, *Minnesota/s Health,* Vol. V, No. 6, June 1951, p. 3.

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1370 MDH, *Minnesota's Health,* Vol.14, No. 4, April 1960, p. 3.

1371 MDH, *Minnesota's Health,* Vol. VIII, No. 6, June 1949, pp. 1-2.

director of Indian schools in Minnesota, with assistance from the Health Department's dental health division.[1372]

One of the department's leading epidemiologists, Herman Kleinman, M.D., chief of the chronic disease section, worked closely with the American Indian population. It was on a reservation where he first met Dr. Chesley, another person who regularly made visits and befriended this population. Dr. Kleinman was convinced the key to improvement in American Indian health was preventive medicine.[1373] As an epidemiologist, Dr. Kleinman conducted research of infectious hepatitis and acute Bright's disease among the Chippewa Indians. In 1950 they gave Dr. Kleinman a special name, "Shining Sky."[1374]

Four American Indian hospitals operated in the state in 1955: White Earth, Cass Lake, Red Lake and Cloquet.[1375] Dr. Albert Chesley was influential in the passage of Public Health Law 568 by the 83rd Congress. This law transferred hospital and health facilities for American Indians from the Bureau of Indian Affairs to the U.S. Public Health Service effective July 1, 1955. This change allowed better coordination of public health programs, with a resulting improvement in American Indian health. Two Minnesotans sponsored the Act: Sen. Edward J. Thye and Rep. Walter H. Judd, M.D. Dr. Chesley chaired the Indian affairs committee of the conference of state and territorial health officers and spearheaded the change.[1376]

In 1957, federal legislation authorized the U.S. Public Health Service to help construct new or remodel old hospitals that were used by American Indians. The state's legislative interim commission on Indians contacted members of Congress to try to persuade them to use the Public Health Service money for building hospitals in Minnesota that were used by American Indians and the general population. They thought using existing community hospitals, rather than building separate hospital facilities for the Indians, was a more efficient use of resources and better integrated the population. In September 1957, Dr. Robert Barr, executive officer and board secretary, along with Ray Lappegaard, deputy commissioner of Public Welfare; Cyrus Magnusson, the governor's representative; five Minnesota state senators and five state representatives gathered in Washington, D.C. to meet with officials of the Public Health Service to advocate for the hospitals and garner support for other health issues concerning the Minnesota American Indian population.[1377]

Another initiative of Dr. Barr's was support for legislation which would help build safe water supplies and sewage systems in areas where American Indians were densely settled. In the late 1950s, gastrointestinal infections were a serious problem with American Indians all over the country. [1378]

[1372] MDH, *Minnesota's Health,* Vol. V, No. 9, September 1951, p. 3.
[1373] MDH, *Minnesota's Health,* Vol. 18, No. 3, March 1964, p. 1.
[1374] MDH, *Minnesota's Health,* Vol. 9, No. 10, December 1955, p. 4.
[1375] MDH, *Minnesota's Health,* Vol. 9, No. 6, June-July 1955, pp. 1-4.
[1376] MDH, *Minnesota's Health,* Vol. 8, No. 9, October 1954, p. 2.
[1377] BOH, *Minutes,* July 30, 1957, MHS, p. 127.
[1378] BOH, *Minutes,* January 13, 1959, MHS, p. 13.

The department worked with many others in trying to improve the health of American Indians. Other agencies and groups included the Public Health Service, Bureau of Indian Affairs, Chippewa Tribal Council, the state departments of Welfare and Education, the U.S. Indian Health Service, state and local voluntary health agencies, nursing and educational groups, church organizations that maintained the mission schools, and mission workers. They worked together with American Indians and other members of their communities, but there was concern that the help provided was preventing them from developing their own leadership skills.

On January 4, 1975, Congress enacted Public Law 93-638 Title I, the Indian Self-Determination Act and Education Assistance Act. On the belief that previous programs for American Indians had served to retard the progress of the Indian communities by depriving them of their ability to develop leadership skills, this act was intended to assure maximum participation in all federal services. [1379]

Migrant Workers

In the 1950s almost 5,000 migrant workers came to Minnesota each year to help with seasonal farm work. This work included sugar beet thinning and hoeing, asparagus transplanting, hoeing and snapping; vegetable hoeing and harvesting; cucumber picking; and potato and sugar beet harvesting.

Migrant workers were economically disadvantaged. While the median income of all U.S. households in 1956 was $4,783, the average income of migrant workers was $2,256. Their income was low and their health problems were high. Migrant workers had high infant mortality rates, suffered from nutritional deficiencies, diarrheal diseases and communicable diseases. Living conditions were often not good. In 1961 a public health nurse visited a migrant family of nine who had three children ill with whooping cough and found them living in a house where the only heat came from the top burners of a gas cook stove. The only bed coverings were two blankets, given by a neighbor. Another family of 18 lived in two rooms, and the children slept on concrete floors. [1380]

The board decided it needed to become more involved in the health care of this transient population. When it was discussed at a board meeting in 1950, they questioned whether or not it was appropriate:

> Dr. Ruth Boynton: "I wonder if we would be in difficulty if we interfered in the field of migrant labor and not in some other fields. There are poor conditions in some other fields, I am sure. I think it is something we would have to think through very carefully and . . .of all the different groups."
>
> Dr. Dean Fleming: "Our approach has always been on things that are of a public nature. To protect the public. If a private individual does something that affects the public we feel we have a responsibility. If it is a matter between private individuals then we feel it isn't so much our

[1379] P.L. 93-638 (25USC450) Title I, enacted January 4, 1975.
[1380] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.

responsibility but local authorities. That same sort of wheedling out of a situation applies for all these agencies." [1381]

The counties with the largest migrant worker populations were Clay, Faribault, Freeborn, Kandiyohi, Marshall, Norman, Polk, Redwood, Renville, Sibley and Steele.[1382] Many migrant workers lived in migrant labor camps. Some camps, such as the ones in the Red River Valley, were equipped with refrigerators. Others, however, did not meet state regulations. Beginning in 1958, the department began inspecting the state's 230 migrant camps. Due to a shortage of personnel, however, it was difficult to follow up on the 1,345 violations that were found between 1958 and 1961.[1383]

A survey of all but six of the 823 migrant labor camps in the state was conducted in 1963. The camps varied considerably, ranging from one-room cottages to abandoned farmhouses to specially constructed facilities. Only 23 percent complied with regulations. Major deficiencies were unscreened windows, inadequate sewage disposal and unsafe water supplies.[1384]

State agencies and local groups worked together to offer educational classes for adults and organized activities for migrant workers' children. They conducted food and clothing drives and provided better medical and health services. Migrant worker families did not usually have medical records. To address this, in 1961, the department provided all migrants entering the state with a personal health record card. [1385]

Limited use was made of the personal health record. Public health nurses and sanitarians reported the head of the family usually determined whether a member of the family was ill or not and what should be done about it. Nurses found a basic obstacle to good health, in many cases, was the lack of information. Sometimes a demonstration, such as the correct method of garbage disposal, was all that was needed to change behaviors.[1386]

In 1959, at the request of the governor's migrant workers committee, the department produced an English-Spanish recipe book for use by volunteers conducting food preparation classes for the migrant workers and for migrant mothers. The book contained 22 recipes selected based on cultural eating habits, facilities and availability of food. "Libro de Recetas" took into account limited income and facilities.[1387] The department also translated a pamphlet, "Getting Your Child Ready for School," into Spanish.[1388]

[1381] BOH, *Minutes,* December 21, 1950, MHS, p. 556.
[1382] MDH, *Minnesota's Health,* Vol. 17, No. 4, April 1963, p. 3.
[1383] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.
[1384] MDH, *Minnesota's Health,* Vol. 18, No. 1, January 1964, p. 1.
[1385] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, p. 6.
[1386] MDH, *Minnesota's Health,* Vol. 19, No. 4, April 1965, pp. 1-4.
[1387] BOH, *Minutes,* August 11, 1959, MHS, p. 210.
[1388] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, pp. 4-5.

While these measures helped, the Department newsletter noted that:

> ***"...in order to achieve better health, migrants need more than measures aimed directly at disease prevention and control. They need better general education, opportunities for vocational training, adequate housing, and more opportunities for permanent employment."***[1389]

Two one-year grants from the U.S. Public Health Service in 1964 expanded health services to migrant workers. The grants, totaling $42,110, were used to employ several public health nurses to work with migrant families and to expand and complete the survey of migrant housing. The public health nurse provided health counseling and nursing care. The nurses were assigned to District VII, the Fergus Falls office, but they moved with migrants around the state. Co-directors of the project were D. S. Fleming, M.D. and William Harrison, MD.[1390]

During 1964, seven public health nurses made 304 camp visits and 436 visits to individual families of migrant workers. A total of 175 persons received counseling on specific problems and 149 were put in touch with physicians and other community resources. That year, each camp was visited and inspected by a sanitarian. One public health nurse reported visiting a 10-month-old baby with diarrhea, high fever, and lung congestion. Both parents were out in the field, leaving their 10-year-old daughter to care for the baby and six siblings. The three youngest had measles, the two-year-old and four-year-old had diarrhea. The baby came down with measles four days later.[1391] The project continued in 1965 with seven public health nurses and three sanitary inspectors.

In 1966 the department received a $233,084 grant from the Office of Economic Opportunity and expanded services to migrant workers to include day-care centers and summer school classes. This was the first statewide program to educate children of migrant families. Under the direction of Judith Bieber, migrant health project coordinator, the department conducted vision, hearing and dental screening at the schools for the children of migrant families. If needed, the department followed up with treatment.[1392]

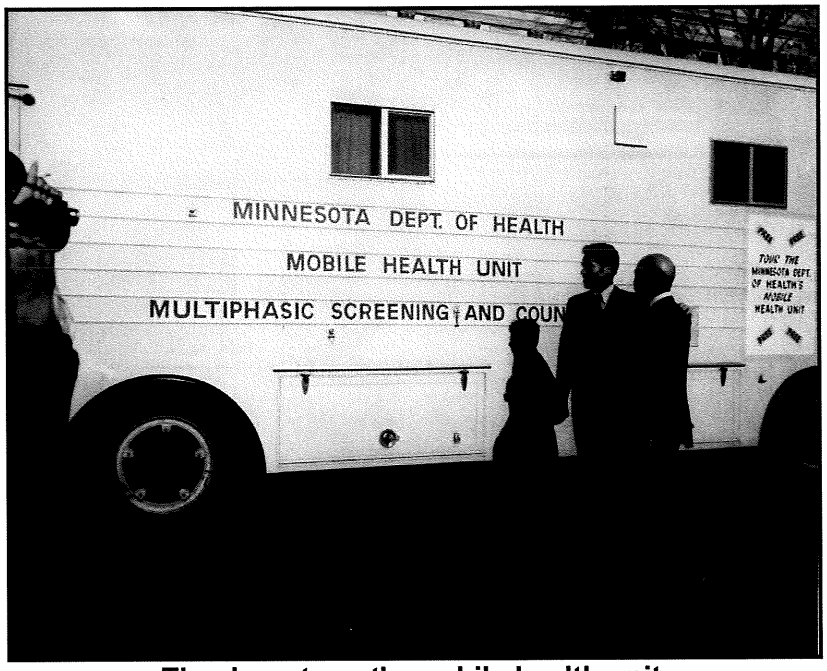
In 1971 a boon to the health of migrant workers and American Indians came with the passage of legislation providing funding for a mobile health clinic. This clinic traveled throughout the state, following the route of migrant workers and providing basic health services. Ernest Kramer, community service development division director, was in charge of the mobile health unit in 1976. It remained in operation in 1999.

[1389] MDH, *Minnesota's Health,* Vol. 15, No. 7, August-September 1961, pp. 4-5.
[1390] MDH, *Minnesota's Health,* Vol. 18, No. 6, June-July 1964, p. 1.
[1391] MDH, *Minnesota's Health,* Vol. 19, No. 4, April 1965, pp. 1-4.
[1392] MDH, *Minnesota's Health,* Vol. 20, No. 6, June-July 1966, p. 3.

144.076 Mobile health clinic.

The state commissioner of health may establish, equip, and staff with the commissioner's own members or volunteers from the healing arts, or may contract with a public or private nonprofit agency or organization to establish, equip, and staff a mobile unit, or units to travel in and around poverty stricken areas and Indian reservations of the state on a prescribed course and schedule for diagnostic and general health counseling, including counseling on and distribution of dietary information, to persons residing in such areas. For this purpose the state commissioner of health may purchase and equip suitable motor vehicles, and furnish a driver and such other personnel as the department deems necessary to effectively carry out the purposes for which these mobile units were established or may contract with a public or private nonprofit agency or organization to provide the service.

HIST: 1971 c 940 s 1; 1975 c 310 s 3; 1977 c 305 s 45; 1986 c 444



The department's mobile health unit.

Maternal and Child Health

Earlier than in most states, the Minnesota Health Department had programs targeted at women and children. Two persons deserve special recognition for the work they did to begin activities in maternal and child health. Dr. William Harrison, working in local health services, and Dr. A. B. Rosenfield, head of maternal and child health, advocated programs for mothers and children during the 1940s and 1950s.

In 1951, the department newsletter proclaimed that 348 mothers and 3,400 infants were alive in Minnesota who would have died if 1915 mortality rates had prevailed in 1950. While the infant mortality rate was dropping, the department was still concerned about the number of deaths.[1393] Infant and maternal mortality was at an all-time low in 1949, but Dr. Rosenfield thought it could be lower. Two studies, one on maternal deaths and the other on infant deaths, were undertaken to try to figure out what could be done. In the meantime, the department advocated for local health programs on a community or county basis to promote better health and lower death rates for infants and mothers.[1394]

A state maternal mortality committee was formed in 1941 to study maternal deaths, but it was discontinued during World War II. Restarted in 1950, the committee was a joint undertaking of the department and the state medical association. Eleven obstetricians and Dr. Rosenfield served on the committee. They made a detailed study of every maternal death that occurred in the state to determine if the death was preventable. Findings were used to develop an educational program to reduce maternal deaths.[1395] The committee established minimum standards for adequate prenatal care. Surveys of physicians indicated they were becoming more careful and conservative in their treatment.[1396]

The focus on maternal and child health continued at the department with the establishment of the maternal and child health division in 1983. To provide input and support for maternal and child health, the Legislature established a maternal and children's health advisory task force in 1982. Meeting regularly with persons outside the department, this task force remained in operation in 1999.

Women's Health

From 1949 to 1999 women's health issues changed considerably in Minnesota. The difference is noted in an excerpt from a speech given by Dr. Walter C. Alvarez of the Mayo Clinic on April 21, 1949, as reported in the Health Department newsletter. He spoke at the Ramsey County Health Day in St. Paul, and his speech, "What Makes Women Nervous," was said to be very popular.

> Women get nervous for many reasons. Some were born with the tendency; some earned it with much hard work; others had it thrust upon them by much sorrow and misfortune. Many women are constantly blowing ten dollars' worth of energy on a ten-cent problem." Dr. Alvarez cautioned women against "trying to make a saintly little Lord Faunteroy out of a normally noisy and active boy" or "trying to make over into a Charles Boyer an ordinary good, kind, but prosaic husband." Many women, he said, are too much concerned about health--their own and their family's--too conscientious about little things, too busy to get enough rest, doing too many things outside the home. Others get too upset about old sorrows or hug their grief too long. [1397]

[1393] MDH, *Minnesota's Health,* Vol. 6, No. 7 & 8, July-August 1951, p. 2.
[1394] MDH, *Minnesota's Health,* Vol. IV, No. 1, January 1950, pp. 1-2.
[1395] MDH, *Minnesota's Health,* Vol. 6, No. 7 & 8, July-August 1951, p. 2.
[1396] MDH, *Minnesota's Health,* Vol. 8, No. 7, July-August 1954, p. 6.
[1397] MDH, *Minnesota's Health,* Vol. III, No. 4, April 1949, p. 3.

Commissioner Marlene Marschall was the first commissioner to strongly emphasize the need to focus on women's health issues. A specific division or unit directed at women has not been created, but women's health has begun receiving greater emphasis.

Elderly

Dr. Walter C. Alvarez spoke about the elderly at Hennepin County's community health day in November 1954. The department's newsletter reported on his speech:

> Too many old people are persecuted and repressed in the name of prolonging their lives. They are subjected to constant nagging by well-meaning relatives who insist on literal observance of doctor's orders. The old person is told he must not smoke, must not eat what he wants, must not exert himself. Hampered and frustrated by endless prohibitions, he is likely to become mentally sluggish and childish and may suffer a complete breakdown. [1398]

In 1953 there were 25 Minnesotans age 100 or older.[1399]

Tuberculosis was more common in the older population. Ninety percent of the tuberculosis deaths in 1958 were in people age 45 and older.[1400]

Disparity in Health Status by Race

Like early tuberculosis and cancer patients, American Indians and other groups, people of color dealt with discrimination. In 1961, the department received objections to the inclusion of "race" on birth certificates. Some people feared the certificate could be used as a basis for discrimination.[1401] In response to these concerns, the board made a decision to eliminate "race" from the birth certificate. The information was transferred to the section for medical and health use only on the bottom of the birth certificate. It became confidential information on a certificate of live birth, as was already the case on the certificate of fetal death. The information would still be available for statistical review, but it would not appear on any copies of the certificate.

In the 1970s, increased attention was directed to the disparities in health status between racial groups in Minnesota. The department compiled a study based on data collected from 1978 and 1982. Findings from this study indicated that the infant mortality rate for people of color, including American Indians, was twice that of the rest of the population, high-risk births (mothers who were under age 17 or over age 39) occurred more frequently in the non-white population, cirrhosis of the liver occurred four times as frequently in American Indian women as in American Indian men, and the overall death rate for the American Indian population between ages 25 and 44 was nearly four times that of the rest of the population.[1402]

[1398] MDH, *Minnesota's Health,* Vol. 8, No. 11, November 1954, p. 4.
[1399] MDH, *Minnesota's Health,* Vol. 9, No. 1, January 1955, p. 1.
[1400] MDH, *Minnesota's Health,* Vol. 14, No. 1, January 1960, p. 3.
[1401] BOH, *Minutes,* January 31, 1961, MHS, p. 22.
[1402] *St. Paul Pioneer Press,* "Minorities Face Poorer Health," December 13, 1986, pp. 1A and 4A.

Based on these and other findings, in 1986 the department produced recommendations for improving the health of minorities. Key to improving health was the reduction of poverty. The study found that 25 percent of Minnesota minorities lived below the poverty line. [1403]

The 1986 report listed 19 recommendations for improving the health of minorities. Among those emphasized were:

- Educational efforts to reduce teen-age pregnancy.
- Prenatal programs for pregnant teenagers.
- Access to preventive care.
- Availability of safe and warm houses.
- Prevention of chemical dependency.
- Health promotion efforts in diet and health screening.
- Access to employment.

Paul Gunderson, Ph.D., director of health statistics, noted the broad approach taken by the report and the involvement needed to improve minority health:

> We were particularly interested in establishing statements that adequately depicted what would have to be done to address the problem in the State. The public sector can't do it all, the private sector can't do it all. I think there's clearly a role for the philanthropic sector, particularly in developing strategies capable of intervening in injury among adolescents, in helping families cope and in working with youth organizations to focus on changing self destructive behavior.[1404]

In 1990 the infant mortality rate for people of color was still disproportionately high. While the state had reached an all-time low of 7.8, the infant mortality rate for people of color was about 2-½ times that of the rest of the population.[1405]

Driven by the need to improve the health status of a targeted population, the department established an office of minority health in 1995. The mission of this unit is:

> ...to assist in improving the health of people of color in Minnesota. Our goal is to reduce the burden of preventive disease and illness by promoting health promotion and disease prevention initiatives; supporting positive health care delivery systems, programs and strategies for people of color; and working to eliminate disparities in the health status of people of color.

[1403] Ibid.
[1404] Ibid.
[1405] *St. Paul Pioneer Press,* "Infant Death Rate Reaches All-Time Low in Minnesota," December 19, 1990, pp.1B, 5B.

Chapter 17

The Health of Minnesota – 1991 to 1999

Commissioner, 1991 to 1993
Marlene M. Marschall

Commissioner, 1993 to 1995
Mary Jo O'Brien

Commissioner, 1995 to 1999
Anne Barry

Commissioner, 1999 to
Jan Malcolm




In the 1950s a recommendation was made to abolish the Board of Health and have the governor, rather than the board, select the head of the agency. A prediction was made that if this change occurred it would result in frequent turnover of the agency commissioners. The prediction seems to have some merit. From its beginning in 1872 to the demise of the board in 1977, a period of 105 years, there were six secretaries/executive officers heading the agency.[1406] From 1977 to 1999, a period of 22 years, there were seven commissioners.[1407] The change has not been limited to commissioners but assistant commissioners and deputy commissioners, as well.

[1406] Dr. Charles Hewitt, Dr. Henry Bracken, Dr. Charles Smith, Dr. Albert Chesley, Dr. Robert Barr and Dr. Warren Lawson.

[1407] Dr. Warren Lawson, Dr. George Pettersen, Sister Mary Madonna Ashton, Marlene Marschall, Mary Jo O'Brien, Anne Barry and Jan Malcolm.

Since 1977, a new commissioner has taken office with each new governor. From 1991 to January 1999, however, there was only one governor but four new commissioners of Health and four acting commissioners. A department unused to such frequent change in the executive office was forced to adjust to several changes in leadership within a few years.

The change began with the unusual governor's race in 1990. The IR-endorsed candidate for governor was charged with improprieties that had allegedly taken place several years earlier. He withdrew as a candidate. One week before the election, Arne Carlson became a candidate. It was too late to have his name printed on the ballot. In order to vote for him, people had to write in his name. Arne Carlson won the election, winning over the incumbent governor.

Following the results of the election, Sister Mary Madonna Ashton, health commissioner, resigned. She left the department in January 1991, after serving eight years. Deputy Commissioner Daniel McInerney temporarily filled the position of commissioner. He left in February 1991 to begin work in the private sector but not until he had spent some time orienting the new commissioner, John McCally.

It was a time of crises worldwide, and the appointment of the new health commissioner received small notice in the Minnesota press. Amid news headlines of the conflict in the Persian Gulf area, increasing dissention in Bosnia, and unrest in South Africa, the appointment of Commissioner John McCally, on February 1, 1991, was noted several pages from the first page. Within the announcement of his appointment, Commissioner McCally stated his goals for the department: greater public access to health care without increasing the cost and greater emphasis on the prevention of health problems, particularly for children and pregnant women. He stated affordable health care could be provided for less than the $150 million called for in recent state studies.[1408]

John McCally, a Republican and longtime friend of Gov. Carlson, was a native of Michigan, had a bachelor's degree in economics, and had worked at two health maintenance organizations, Group Health Inc. and United Health Care, as a health analyst; at the San Jose Medical Clinic, the Mayo Graduate School, and the Detroit Medical Center as an administrator; and at Ernst and Whinney as a health consultant. He had also spent time as a stockbroker and as Olmsted County clerk. John McCally did not have a strong background in public health, but said his management experience was appropriate for the times. "I think there's a great deal more focus on escalating health care costs in the 90s than there is on epidemiology."[1409]

Charges of cronyism were made when it was learned that Gov. Carlson had chosen John McCally, even though he wasn't one of the three candidates recommended by the selection committee for the $67,500 post. The selection committee's top choice had been Dr. Jean Harris, president and chief executive officer of the Ramsey Foundation, and former president of Control Data.

[1408] *St. Paul Pioneer Press*, "McCally Appointed Health Commissioner," February 2, 1991, pp. 7A and 10A.
[1409] *St. Paul Pioneer Press,* "Official Allegedly Pushed Athletic Club for Free Membership," March 20, 1991, p. 6A.

John McCally was a decided contrast to Sister Mary Madonna. The St. Paul Pioneer Press pointed out some challenges and differences: "After taking the job, McCally faced other problems of both substance and style. His expensive suits and Mercedes-Benz automobile made for a striking contrast with the woman he replaced, Sister Mary Madonna Ashton, a nun."[1410]

Charges were made that Commissioner McCally was not well qualified for the position. Spending much of his time in St. Paul, department employees didn't get a chance to get to know him. Used to the stability of Sister Mary Madonna, the department struggled with the change.

While McCally's appointment did not make front-page news, he received front-page coverage on March 20 when the headlines read: "Official Allegedly Pushed Athletic Club to Gain Him Membership."[1411] According to the St. Paul Athletic Club's membership director, Peter Gavin, Mr. McCally had asked about a free membership and was told it was for elected officials only. At that point Gavin said McCally reminded him that the department inspects the club's swimming pool and food service. Gavin said, "He went on to say that we may want to reconsider who Mr. McCally is and how we treat him. After rethinking our position on this matter he would like me to give him a call."[1412] Commissioner McCally said he had asked about a membership, but he denied making any threats.[1413] He saw the activities as part of an attack, "I keep saying, gee, somebody is out there just having a ball trying to throw things at me."[1414]

State Acting Human Rights Commissioner Frank Gallegos investigated the charges by the club and found them credible. John McCally submitted his resignation to Gov. Carlson on March 25 and made front-page news the next day when the headlines read: "State Health Chief Quits Under Fire."[1415] McCally explained: "As you know, I've officially acknowledged that this was a mistake in judgment for which I've apologized. The subsequent political and press ramifications are very unfortunate and I now realize that they make it exceedingly difficult to do my job effectively."[1416]

Gov. Carlson accepted the resignation, but he said he thought McCally was driven out through gossip and innuendo. He targeted the media who, he felt, had run a vicious McCarthy-style rumor campaign forcing McCally out of office.[1417]

Difficult situations were occurring in other agencies, and Tim Droogsma, Carlson's press secretary, told the media he thought the DFLers were making trouble. He said

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[1410] *St. Paul Pioneer Press,* "State Health Chief Quits Under Fire," March 26, 1991, p. 6A.
[1411] *St. Paul Pioneer Press,* "Official Allegedly Pushed Club for Free Membership," March 20, 1991, pp. 1A, 6A.
[1412] Ibid.
[1413] Ibid.
[1414] Ibid.
[1415] *St. Paul Pioneer Press,* "State Health Chief Quits Under Fire," March 26, 1991, p. 1A.
[1416] Ibid.
[1417] *St. Paul Pioneer Press,* "Carlson Rips Media for McCally Stories," March 27, 1991, pp. 1B and 7B.

that every time Gov. Carlson's administration replaced appointed officials "they go whining to the media."[1418] .

The episode was an unfortunate one, for individuals and the organization. It pointed out the challenges of having a leader who doesn't professionally connect with the department, the power of a media campaign, and leaves unanswered the political charge by the governor's office of interference in the administration of appointments.

After John McCally's resignation, Mary Jo O'Brien, who had been appointed deputy commissioner of health in February 1991, became acting commissioner.

Commissioner Marlene Marschall

At a department staff meeting in May 1991, Acting Commissioner O'Brien told employees they would approve of the person selected as the new commissioner of health. She was right. Marlene E. Marschall was appointed commissioner on May 8, 1991. With an uncanny physical resemblance to Sister Mary Madonna, Marlene Marschall had a calming effect on the department. She made a point of making as little disruption as possible. When asked how she wanted something done, she would ask, "How was it done by the previous administration?"

Commissioner Marschall was scheduled to retire from her position as chief executive officer of St. Paul Ramsey Medical Center at the end of 1991, but Gov. Carlson persuaded her to resign from that post earlier and accept the health commissioner position.[1419] When making the announcement of her appointment, Gov. Carlson said he wanted Commissioner Marschall to focus on making the department more visible and active, particularly in family planning and in health care access.

Commissioner Marschall, educated as a nurse, had worked her way up the ranks at St. Paul Ramsey Medical Center. She had earned her R.N. degree at Ancher Hospital School of Nursing, her B.S. at Vitterbo College and her M.A. at the University of Iowa.

Commissioner Marschall was, as Barbara Carlson stated on one of her radio shows during an interview, "a very nice person." She frequently wrote notes and letters of praise that employees often proudly displayed. She arrived at work early and participated in all department activities. She made a practice of walking through the halls of each and every division, often stopping to talk.

Commissioner Marschall's management team included Deputy Commissioner Mary Jo O'Brien and assistant commissioners Barbara Nerness, Andrea Walsh and Thomas Maloy. In August 1991, Commissioner Marschall announced she had appointed Christine Moore as director of public and legislative affairs and Beverly Krogseng,

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[1418] *St. Paul Pioneer Press,* "Carlson Aide Says Surviving DFLers are Making Trouble," March 28, 1991, pp. 1C-2C.
[1419] *St. Paul Pioneer Press,* "Carlson Picks Hospital Executive to Lead State Health Department," May 9, 1991.

former manager of health services at Unisys Corp., as assistant commissioner for the Bureau of Health Protection.

Commissioner Marschall was confronted with a high-profile situation soon after accepting the position. A Minneapolis physician with AIDS had been treating patients between May 1990 and February 1991. On receiving this information, the department notified all of the doctor's patients, and they were tested for the presence of the HIV virus. While none of the 240 tests indicated the presence of the virus, questions were raised about the need to protect the public from infected health care professionals.[1420] The department conducted a four-month study and in October 1991 issued recommendations for reducing the risk of spreading the HIV virus through health care workers.[1421]

Commission on Reform and Efficiency in Government

Before he had officially been sworn in, Gov. Carlson expressed alarm at the state's budget situation and the need for improved efficiency. The Legislature and Gov. Carlson established the Commission on Reform and Efficiency in Government (CORE) to conduct a comprehensive effort to improve management in state agencies.[1422]

The 22-member commission began work in August 1991, under the leadership of Chair Arend J. Sandbulte, President and CEO of Minnesota Power, Duluth. Initially, short-term savings within agencies were identified, and then the commission focused on long-term improvements in efficiency and effectiveness.[1423] The commission selected nine areas for closer attention. A recommendation from one area, environmental services, called for the transfer of the department's environmental health division to the Pollution Control Agency.[1424] A recommendation within the human services area called for the combination of the Health Department with the Department of Human Services.

The Health Department took a stand against both recommendations, pointing out that the expected efficiency of operations from combining units would be offset by the resulting separation. Commissioner Marschall further advocated keeping the environmental health division within the department to best protect the health of the population. The Pollution Control Agency protects the environment, while the Health Department protects people. Commissioner Marschall emphasized that that focus may be lost, to the detriment of people's health, if a move such as the one recommended by the commission was made. In the end, the commission had little impact on the organization of the department, except for a small number of transfers to the new Department of Children, Family and Learning.

[1420] *St. Paul Pioneer Press,* "Many Wonder Why AIDS Probe Took So Long," June 23, 1991.
[1421] *St. Paul Pioneer Press*, "Health Worker-AIDS Study Spurns Mandatory Testing," October 24, 1991.
[1422] Laws of Minnesota 1991, Chapter 345, Article I, Sec. 17, Subd. 9.
[1423] Minnesota Commission on Reform and Efficiency, "CORE Project Recommendations," April 1993.
[1424] Minnesota Commission on Reform and Efficiency, "Reforming Minnesota's Environmental Services System," March 1993.

Health Status of Minnesota

The state continued to enjoy a remarkably high level of health in the 1990s. While Minnesota had dropped to second place in 1991, in 1992 the Northwestern National Life Insurance Company again ranked Minnesota the healthiest state in the country. A 1992 report by Minnesota State Planning placed average life expectancy in the state at an all-time high: 80 years for women and 74.6 years for men.[1425] Commissioner Marschall enjoyed the first administration where no deaths were reported from any of the major communicable diseases that had been the leading causes of death a century earlier. Cases of measles, tuberculosis, typhoid and whooping cough were reported, but there were no deaths. No cases of diphtheria were reported, the first administration to boast such an accomplishment. The infant mortality rate continued declining, and the department set a goal to decrease infant mortality to 5.0 deaths per 1,000 live births by the Year 2000.

With an increasing focus on chronic disease prevention and health promotion, the department emphasized the need for healthy lifestyles. A $6.4 million grant from the National Cancer Institute for anti-smoking campaigns was received in 1991.[1426] The department supported the "Five-A-Day for Better Health" campaign that promoted eating more fruits and vegetables.[1427]

Despite these advances, needs continued to arise. Communities of color continued to experience a much higher infant mortality rate, and many Minnesotans were without health care access. A chemical spill near Duluth raised environmental health concerns.[1428] A mobile home park balked at installing storm shelters as safety rules required.[1429] The department warned citizens of the dangers of cantaloupe contaminated with salmonella in the summer of 1991.[1430] While other diseases were declining, the 1,000th case of AIDS in Minnesota was reported in October 1991. Of these, 654 had died.[1431] Concern about costs and care of the growing number of elderly resulted in the formation of the Long-Term-Care Access Commission of which Commissioner Marschall was a member in 1993.

The area receiving the most attention during Commissioner Marschall's administration was health care reform, under the leadership of Deputy Commissioner O'Brien and Andrea Walsh, assistant commissioner of health care resources and systems. In 1992 health care reform legislation was passed. This legislation, designed to provide health

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[1425] *St. Paul Pioneer Press*, "Minnesota Ranked Healthiest State Again, Wisconsin Tied for Third," September 17, 1992, pp. 1A and 6A.
[1426] *St. Paul Pioneer Press,* "Anti-Smoking Campaign to Target Minorities State Awarded Grant for New Seven-Year Programs," October 5, 1991.
[1427] *St. Paul Pioneer Press*, "Take Five/Minnesota Has Introduced Campaign Encouraging its Denizens to Eat Five Servings of Fruit and Vegetables Daily," July 7, 1993.
[1428] *St. Paul Pioneer Press,* "It's Eerie What's Going on Down There/Toxic Cloud Empties Duluth," July 1, 1992.
[1429] *St. Paul Pioneer Press,* "Mobile Home Park Stalls Safety Rules," May 8, 1991.
[1430] *St. Paul Pioneer Press,* "Holiday Picnic Food Warning Issued/Health Officials Link Outbreak of Salmonella to Tainted Cantaloupe," July 4, 1991.
[1431] *St. Paul Pioneer Press,* "Minnesota Posts 1,000th AIDS Case," October 13, 1991.

insurance for the uninsured of Minnesota, was first named "Health Right" and renamed MinnesotaCare.

(Note: The department's role in health care access is described in Chapter18.)

Compared to some earlier administrations, Commissioner Marschall's time at the department was relatively peaceful. Effective August 31, 1993, she resigned from her appointment, after serving 27 months. She had planned this as a temporary assignment and now wanted to retire, as she had originally planned two years earlier. On August 5, 1993, an announcement was made that the new health commissioner would be Deputy Commissioner Mary Jo O'Brien. [1432]

Commissioner Mary Jo O'Brien

Mary Jo O'Brien was appointed commissioner of health in September 1993. Prior to her appointment as deputy commissioner of health in February 1991, Commissioner O'Brien was legislative relations director for the Minnesota Medical Association. From 1984 to 1988 she was director of rehabilitation and medical services/workers' compensation at the Minnesota Labor and Industry Department.[1433] She held a master's degree in rehabilitation counseling.

After joining the department in 1991, O'Brien spent the next 2½ years playing a key role in the development and implementation of health care reform initiatives in the state. Legislation passed in 1992 resulted in the creation of "MinnesotaCare," originally designed to provide health care insurance for more than 70,000 people on a sliding fee scale.

Health care reform continued as Commissioner O'Brien's main focus during her administration. She worked closely on health care reform with Elizabeth Quam, assistant commissioner of health care resources; Christine Moore Rice, assistant commissioner of health protection; and Anne Barry who joined the team as deputy commissioner in 1993. Together, with the state's health care commission, they worked on cost containment and a plan for providing insurance coverage for the estimated 400,000 Minnesotans without coverage. The MinnesotaCare program provided coverage for 90,000 people during its first two years, at a cost of $60 million to the state. In addition, the program had directed more than 30,000 people to obtain coverage through Medicaid or other government programs.[1434]

Policy questions emerged as to whether or not health care insurance should be required. Curt Johnson, the governor's senior advisor, questioned in 1994: "Does it mean offering coverage for all who want it or does it mean forcing everyone to have coverage?"[1435]

[1432] *St. Paul Pioneer Press,* "Carlson Picks Two to Lead Department," August 6, 1993, p. 5C.
[1433] Ibid.
[1434] *St. Paul Pioneer Press,* "Commission Moves Ahead on Health Care," October 5, 1994, pp. 1A and 6A.
[1435] Ibid.

In addition to her work on state health care legislation, Commissioner O'Brien served as a White House adviser on national health care reform. She led a National Governor's Association consultative team, emphasizing the role of states in federal health care reform. She received national attention for her work in health care reform. In 1994 City and State magazine picked Commissioner O'Brien as one of 20 people in the country who were expected to make news within the next 12 months.[1436]

An issue from Sister Mary Madonna's administration, the high incidence of mesothelioma in men in northeastern Minnesota, resurfaced during Commissioner O'Brien's administration. For 10 years the department had been requesting funding in order to identify the source of the asbestos-related cancer, first called to the attention of the department by a physician from Virginia, Dr. Ronald Seningen. To date, no funding had been provided for further investigation. By this time, a large number of asbestos-related cancer was being seen in the men from the Iron Range. When Iron Range residents went to their legislators in 1994, the issue gained attention.

Commissioner O'Brien pressed the need for a study and requested funding for it in a letter sent to the Iron Range Resources and Rehabilitation Board (IRRRB). The IRRRB recommended spending $50,000 for the study – the same amount spent to renovate the Judy Garland museum – but the funds weren't approved. The American Iron Ore Association sent a letter to the IRRRB indicating a study was unnecessary, as the taconite industry had conducted health studies and found no evidence of asbestos-related illness.[1437]

Another issue that was highlighted during Commissioner O'Brien's administration was the salmonella outbreak caused by Schwann's ice cream in October of 1994. Less than four months later, in January/February 1995, a meningitis outbreak occurred in Mankato, resulting in several deaths. The department reacted rapidly, and set up an emergency makeshift immunization clinic in Mankato, preventing further fatalities.

It was a challenging period. In November 1994, after 2½ years as deputy commissioner and 1½ years as commissioner, Commissioner O'Brien resigned from her position, effective early 1995. Curt Johnson, chief of staff to Gov. Carlson, explained, "This is just normal turnover after four years of a tough job. We're very pleased with the work she's done. She's been one of the truly outstanding commissioners, a national figure for what states are doing on health care reform."[1438]

Commissioner Anne Barry

Anne Barry, acting commissioner following Commissioner O'Brien's departure, was appointed commissioner on June 29, 1995.[1439] By that time, Anne Barry had 18 months' experience as deputy commissioner and four months as acting commissioner.

[1436] *St. Paul Pioneer Press,* "Minnesota Named as Newsmaker to Be," January 23, 1994, p. 2B.
[1437] *St. Paul Pioneer Press*, "Cancer Mystery Ignored," December 21, 1997, pp. 1A and 10A.
[1438] *St. Paul Pioneer Press,* "O'Brien Resigns From Post as State Health Commissioner," November 30, 1994, p. 5B.
[1439] *St. Paul Pioneer Press,* "Anne Barry Will Lead Department," June 30, 1995, p. 2B.

Commissioner Barry had a master's degree in public health administration from the University of Minnesota School of Public Health. In addition, she had a law degree from the William Mitchell College of Law. She had substantial experience in state government. She had worked at the departments of Human Services and Finance, and she drew from these experiences in building her management team.

Kirsten Libby, a Finance employee who had been an executive budget officer for the Health Department, became director of the office of budget and legislation, and later served as deputy commissioner. Kelli Johnson was appointed director of the office of policy in 1995, assistant commissioner of health protection in 1996, and later served as deputy commissioner. Barbara Colombo was appointed assistant commissioner of health systems and special populations.

Commissioner Barry's first months were filled with activity. The department was in the midst of handling a meningitis outbreak in Mankato when she assumed the position of acting commissioner. In March 1995 she supervised the department's response to a strep A outbreak in the Rochester-Wanamingo area. She also helped repair the MinnesotaCare program through legislation. Commissioner O'Brien's departure had come at a critical time for health care reform. The state was assessing MinnesotaCare to determine whether it should be expanded and how it should be financed. In July 1995 there was an outbreak of Legionnaire's disease in Mankato and Luverne.

When appointed, Commissioner Barry said her biggest hurdles would be to ensure the department maintained its standard of quality in the face of impending funding cuts. Cuts were expected in several federal programs, including Medicare, Medicaid and block grant programs.[1440]

1995 --- Study by the Management Analysis Division.

1996 --- Program of Shared Leadership.

Midway through her administration, in 1997, Commissioner Barry was faced with continuing attention to a situation where public health, politics and economics collided – the increasing number of mesothelioma cases in northeastern Minnesota. The department had been advocating for funding to pinpoint the source since 1984. They could not get legislative support. The mining industry charged that the department was using scare tactics to get funds for the study. While the taconite industry reported it had found no health problems, it did not seem eager to support a study that would eliminate suspicion.[1442]

> ***"Here was a warning sign and nobody took action....It is a matter of regret...that nobody decided to do anything."***[1441]
>
> **Dr. David Muir**
> **Professor of McMartin University in Ontario, Canada**
> **(Member of 1984 Blue Ribbon Panel looking at x-rays from northeastern Minnesota), 1997**

[1440] Ibid.
[1441] *St. Paul Pioneer Press,* "Cancer Mystery Ignored," December 21, 1997, p. 10A.

Recent data indicated mesothelioma was affecting men in northeastern Minnesota at a rate 70 percent higher than the people in the rest of the state. While mesothelioma is a rare cancer, at least 40 cases had been reported in five northeastern Minnesota counties between 1988 and 1995. [1443]

Dr. Alan Bender, chief of the chronic disease and environmental epidemiology section, pointed out that the cancer cases were just part of the concern: "Mesothelioma is probably the tip of the iceberg. It should raise a red flag anywhere. What makes this unique is the continuing concerns. We've got problems elsewhere, but what makes this so problematic is it continues to recur."[1444]

The St. Paul and Pioneer Press made an inquiry and devoted several pages of the December 21, 1997, paper to the problem of mesothelioma in northeastern Minnesota. Family members of victims were interviewed. The probability of funding increased, and Gov. Carlson backed $300,000 for a study.[1445]

Efforts to promote healthy behaviors, begun by Dr. Arne Rosenfield, director of special services, in the early 1950s and continued by many other public health professionals at the department, were beginning to show success by the end of the century. Health promotion activities were thriving, but external forces still created many obstacles. One of the most powerful was the tobacco industry. During Commissioner Barry's administration one tobacco company, drawing from the health food industry, attempted to market a new cigarette as "pure," containing "no additives" and "100 percent natural" ingredients. Commissioner Anne Barry noted the power of marketing by the tobacco companies: "They know exactly what they're targeting – a culture that wants to know that what they eat and drink is free of carcinogens and other dangerous stuff." [1446]

Tobacco Settlement

Internally, the department was becoming more physically dispersed during the 1990s. The building at 717 Delaware St., constructed 30 years earlier, had been designed with the idea it could be expanded by adding additional floors. When pursued, however, the department discovered this option wasn't possible. Due to overcrowding, divisions and sections were forced to relocate in other buildings. The first to move, in the late 1980s, had been the division of health resources. Through the 1990s, more divisions and parts of divisions relocated. By 1999, the department was operating in offices in the Metro Square Building in St. Paul, Energy Park in St. Paul, the Golden Rule Building in St. Paul and the Health Department Building in Minneapolis. The executive office moved from Minneapolis to St. Paul in 1997. The cost of the moves was high and contributed to a financial crisis for the department in 1998.

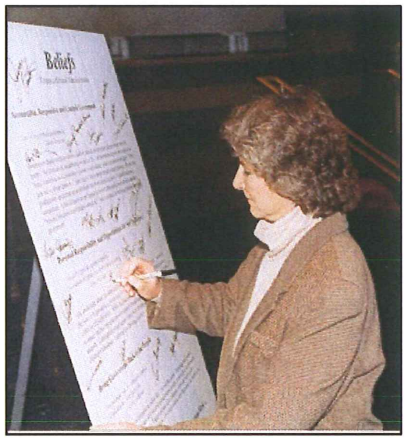
[1442] Ibid.
[1443] Ibid.
[1444] Ibid.
[1445] Ibid.
[1446] *St. Paul Pioneer Press*, "Marketing 'Pure' Cigarettes Too May Face Obstacles," November 23, 1998, pp. 1A, 3A.

Commissioner Anne Barry left her position in 1999. Newly elected Gov. Jesse Ventura appointed Kelli Johnson as acting commissioner in January 1999.

Jan Malcolm – Last Commissioner of Century

Jan Malcolm was appointed commissioner of health on January 19, 1999. Prior to her appointment, Commissioner Malcolm had been vice president for public affairs at Allina Health System, and from 1990 to 1994, she served as senior vice president at Health Partners.

Commissioner Malcolm served on the board of directors of Courage Center and the United Way of Minneapolis. She had also served on the Governor's Commission on Health Plan Regulatory Reform and the Minnesota Health Care Commission. She was president of the Minnesota Council of Health Plans and had been a member of the Minnesota Partnership for Action against Tobacco. Commissioner Malcolm had a bachelor's degree in philosophy and psychology from Dartmouth College.



Commissioner Malcolm began her administration with a focus on the inequities in health status among population groups. While the overall health status measures for the state were good, she wanted to focus on those smaller populations that had below average health status. Commissioner Malcolm also supported increased investment by the state in disease and injury prevention. Health care access was another concern, and Commissioner Malcolm stated:

> I think there's at least a question about whether we ought to be working on the safety net or whether we should be getting back to the conversation to how do we make sure everybody has access to coverage. One is treating the symptom and the other is really trying to get at the underlying cause of the problem. Should we be satisfied that we have a system that produces such a big need for charity care? If we're going to rely on it, let's make it solve the health care problem economically as smart – efficiently – as it can.[1447]

During her first year, Commissioner Malcolm dealt with a public health issue that had been addressed by Commissioner Warren Lawson, the power line controversy. The location was different, Dakota County, but the concerns of the population were similar. Residents feared for the health problems the line would cause. Commissioner Malcolm wrote the Environmental Quality Board that she felt further study was needed before the proposed upgrading by Northern States Power was allowed.[1448]

[1447] *St. Paul Pioneer Press,* "Sound Investment/New Health Commissioner Jan Malcolm Looks at how to best make our health care system – and health care dollars – work," March 21, 1999.

[1448] *St. Paul Pioneer Press,* "More Power-Line Study Urged Health Chief Supports South St. Paul Residents," September 24, 1999.

Some of the other health issues Commissioner Malcolm addressed during her first year included: health care access, health care costs, $6.1 billion tobacco settlement, disparities in health status within the population, and data privacy. Her management team consisted of Julie Brunner, deputy commissioner; Aggie Leitheiser, assistant commissioner of health protection; Richard Wexler, assistant commissioner of access and quality improvement; and Gayle Hallin, assistant commissioner of family and community development.

At the end of 1999, the department produced its health strategic directions for 2000-2001 for the future. Summarized, these directives were:

1. Eliminate disparities in health status.
2. Improve readiness to respond to emerging health threats.
3. Reduce tobacco use and improve the health of Minnesota's youth.
4. Bring the community together on public health goals.
5. Prepare Minnesota for the next wave of health reform.[1449]

One of the most significant changes for the department came in 1999 when Dr. Michael Osterholm, state epidemiologist, announced he was leaving after 24 years to pursue a career with a private consulting company he was forming. Dr. Osterholm, described as "one of Minnesota's most visible and trusted infectious disease experts,"[1450] had brought attention to a department that typically didn't pursue the spotlight. He had brought even greater attention to public health. At the end of his career with the department, Dr. Osterholm raised concerns about several areas that could negatively impact the public's health. One of these was bio-terrorism. Another was infectious disease. Still rampant in other countries, he pointed out that infectious diseases becoming resistant to antibiotics could make a comeback.[1451] He commented on the future of people's health in a Star Tribune article: "We're not going to continue to see this increase in life expectancy. I think, if anything, life expectancy will level off a bit, and we'll probably see it drop."[1452]

Public Health: 1949 to 1999

Despite all the challenges of the 50-year period, the Minnesota Department of Health made dramatic progress between 1949 and 1999. Early public health leaders, Dr. Hewitt, Dr. Bracken and Dr. Chesley, would have been proud of what the department had accomplished. Minnesota ended the century with an enviable health report. For the fourth year in a row and for the seventh time within a 10-year period, Minnesota was named the "healthiest state in the nation."[1453]

[1449] Jan Malcolm, "Governor Sets Ambitious Goals for Improving Health," *MetroDoctors: The Journal of the Hennepin and Ramsey Medical Societies*, January/February 2000, pp. 12-13.
[1450] *St. Paul Pioneer Press,* "Osterholm's New Job Title: CEO/Epidemiologist Leaves Health Department for Private Venture," February 5, 1999.
[1451] *Minneapolis Star Tribune,* "Living Longer, Living Healthier," May 16, 1999, pp. A10 & A11.
[1452] Ibid.
[1453] *St. Paul Pioneer Press*, "Minnesota Ranks First in Health Report/Low Smoking Rate Among Key Factors," November 16, 1999.

Chapter 18

Health Care Access

The need for better health care access has been a concern of the Health Department for many years. Dr. Charles Hewitt and Dr. Bracken, early executive officers of the Board of Health, and other early public health leaders advocated for services to reach all members of the population, especially the poor, the old, the sick.

In 1949, at a meeting of public health workers in Winona, Minnesota, agreement was reached that, "Not until everyone is able to benefit from medical science can a community be said to have adequate or ideal health services."[1454]

There had been a strong current of support for national health insurance in the early 1940s, but instead the federal government backed the Hill-Burton Act that provided funding for states to assist in constructing health facilities. Supporters of Hill-Burton thought this was a better way to address unmet health needs in the country. States could make their own decisions rather than letting the "Federal government to take over the entire medical care program of the United States."[1455]

While Dr. Albert Chesley, executive officer to the board; Dr. Robert Barr, deputy executive officer; Dr. Thomas Magath, board president and others wanted all Minnesotans to have access to health services, they didn't believe the proper route was through government-administered health insurance:

> Barr: "Last month I attended the Rural Health Conference. Dr. Chesley should have gone but didn't go. I haven't been able to learn why. The one thing that came out of it was that at the first conference one group, the Farmers Union, the most radical farm group, thought that everything should be socialized about medicine, and some of the medical groups and dental groups were pretty much the other way. That whole thinking is changed, and people in rural areas must have a doctor within 10 or 15 miles of them. They are trying to do everything to attract...a hospital within ten miles." [1456]

In 1950, the 18-month-old National Health Service Act in Great Britain was discussed. Dr. H. S. Diehl, dean of medical sciences and professor of public health at the University of Minnesota, said that the national medical system in Great Britain was adopted to meet an emergency. The conditions here were so entirely different from that of Great Britain as to make it pointless to discuss the possibility of a comparable health plan for the United States.[1457]

[1454] MDH, *Minnesota's Health,* Vol. III, No. 5, May 1949, p. 2.
[1455] Jack Bess, "If You Build It...," *American Hospital Association News,* July 20, 1998, p. 7.
[1456] BOH, *Minutes,* February 14, 1950, MHS, p. 29.
[1457] MDH, *Minnesota's Health,* Vol. IV, No. 3, March 1950, p. 3.

Any attempt by government or other organizations to control health care fees was met with strong resistance. The Southwestern Minnesota Medical Society and the Radiological Society challenged a program funded by the Kellogg Foundation because of proposed fee schedules the foundation set. Dr. Barr explained the resistance at the August 1, 1950, board meeting: "I think the point is that they attempted fee schedules which are approximately what we have in Minnesota at the present time. Somebody yelled, 'Socialized Medicine and Ewing,' and then the fat was in the fire. I am afraid that is going to happen time and time again."[1458]

The feeling of the time was voiced by Dr. J. D. Camp of Rochester at a special board meeting on June 13, 1950: "I think it would be a sorry day in medicine if the doctors permit government and public health to dictate to us the charges for examination."[1459] Board members were sensitive to appearing as if they supported a program similar to Great Britain's or appearing as though they supported socialized medicine. When reviewing a draft of the report of the review committee in 1954, one revision was made for the following reason: "I think the use of the word 'program' here is not good. Smacks of state medicine and if published in that way might make the Board suspect on this point."[1460]

The high cost of health services and the resultant access problems began to receive more and more attention during the 1960s and 1970s. Title 19 of the 1965 federal Social Security Amendments (Public Law 89-97) went into effect January 1, benefiting many of Minnesota's children and needy adults. Gov. Karl Rolvaag called this program a milestone in the state's efforts to help the needy. "Now, at least the factor of inadequate financial resources will no longer prevent these children from getting the...health care they deserve."[1461] While the program helped some children, others were still without access to health care services, primarily for economic reasons.

One of the early supporters of improved access to health care in Minnesota was state Sen. John Milton, head of the Senate Health Subcommittee. In 1973 he planned a three-day fact-finding trip through Clinton, Marshall, Worthington, Trimont, Albert Lea, Rushford, Winona and Plainview to get input from the population on the availability, quality and cost of health care in their communities.[1462]

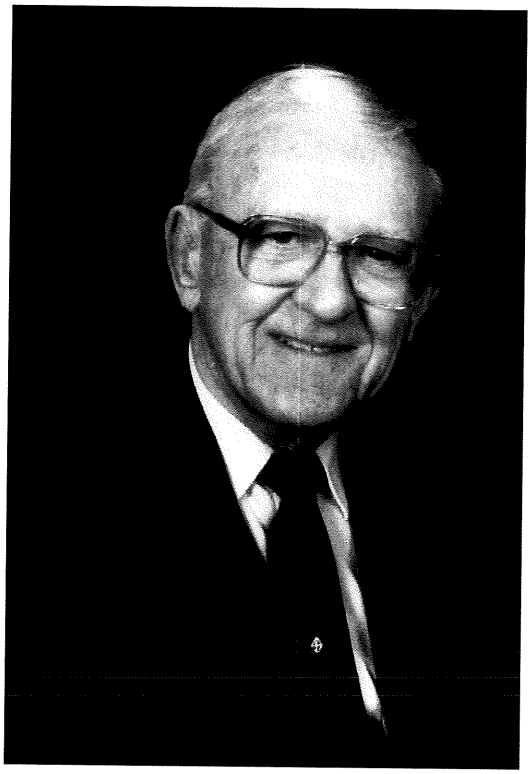
Health Plan Regulatory Reform
Minnesota Health Care Commission.
Health Care Access Commission

Minnesota Care -- Because of the negative feeling toward "socialized medicine," it would have been very difficult for the heads of the agency in the 1950s to support a program such as Minnesota Care.
(Note: Additional coverage of health care reform is provided in Chapter 17.)

[1458] BOH, *Minutes,* August 1, 1950, MHS, p. 359.
[1459] BOH, *Minutes,* June 13, 1950, MHS, p. 287.
[1460] BOH, *Minutes,* May 11, 1954.
[1461] MDH, *Minnesota's Health,* Vol. 20, No. 4, April 1966, p. 1.
[1462] News release from the state Sen. John Milton, August 28, 1973.

Chapter 19

Public Health Laboratory



"Work was not work. It was a stimulant to my life. I was constantly challenged, searching for answers."

Dr. Henry Bauer, 1999

Henry Bauer, Ph.D.
Director of Minnesota Public Health Laboratory, 1949 to 1976

In 1949, the public health laboratory, though housed in an old dilapidated building, continued to be the backbone of the Health Department. Headed by Dr. Henry Bauer, who succeeded Dr. Paul Kabler as director, it was a "people's lab." Dr. Bauer believed strongly that the department served the citizens of the state. He stressed that the laboratories belonged to the people of Minnesota and invited them to come and visit. He said he was always glad to answer questions by mail or telephone.[1463]

Fifty years later, the laboratory is named the Henry Bauer Laboratory, in honor of Dr. Bauer who first worked for the department in 1938 as a bacteriologist, was named director of the medical laboratory in 1949, and continued as the director for 27 years, retiring in 1976. From 1960 to 1966 he also worked as the deputy to the executive

[1463] MDH, *Minnesota's Health*, Vol. IV, No. 3, March 1950, p. 2.

officer, Dr. Robert Barr. It was in this role that he was influential in getting a new building for the department at 717 Delaware Street.

A native of Minneapolis, Dr. Bauer received degrees from the University of Nebraska and later a Ph.D. in bacteriology from the University of Minnesota. During World War II he served in the South Pacific as chief of the bacteriology section of the Sixth Army medical laboratory.[1464]

Experiences during World War II enhanced and honed Dr. Bauer's skills in public health. In Guadalcanal he encountered skin lesions on hospitalized American troops. The surprising cause turned out to be diphtheria, which rarely affects the skin. Once the organism was identified, Dr. Bauer needed to find the source. To do this, he wanted to take throat cultures and test the sputum of local residents. Here he encountered one of the non-scientific challenges of public health. The local population did not want any part of themselves removed. They were suspicious of his motives. He had to figure out a way to work with the people, in the same way he would later figure out how to successfully work with legislators, other public health professionals, national and international figures and the people of Minnesota.

Dr. Bauer was committed to the Minnesota Department of Health, and in 1961 he declined a position with the World Health Organization in view of his duties at the department. On hearing the decision, Board President Frank Krusen, M.D., said: "This is a devoted public servant speaking, and we should be proud to have such a man on our staff." [1465]

During Dr. Bauer's 27 years as head of the public health laboratories, he supported the department's long-time history of helping people throughout the state. Doctors often called him for advice. Believing in the importance of informed professionals and an informed public, Dr. Bauer taught classes at the University of Minnesota School of Public Health and the University of Minnesota Medical School. He began teaching at the university in 1947 and continued through his career at the Health Department.

At his retirement in 1976, Dr. Bauer identified what he saw as his three outstanding achievements during his work with the department: 1) research and development of a single-dose polio vaccine containing the three types of virus, 2) author or co-author of 61 medical publications and 3) acquisition of a building for the department.

(Note: The department's role in the eradication of polio is described in Chapter 3.)
(Note: Acquisition of the department's new building is described in Chapter 7.)

Throughout his career in public health, Dr. Bauer strongly endorsed and promoted the public health model shown below:

[1464] MDH, *What in Health's News,* Vol. 4, No. 26, December 17, 1976.
[1465] BOH, *Minutes,* October 31, 1961, MHS, pp. 381-382.

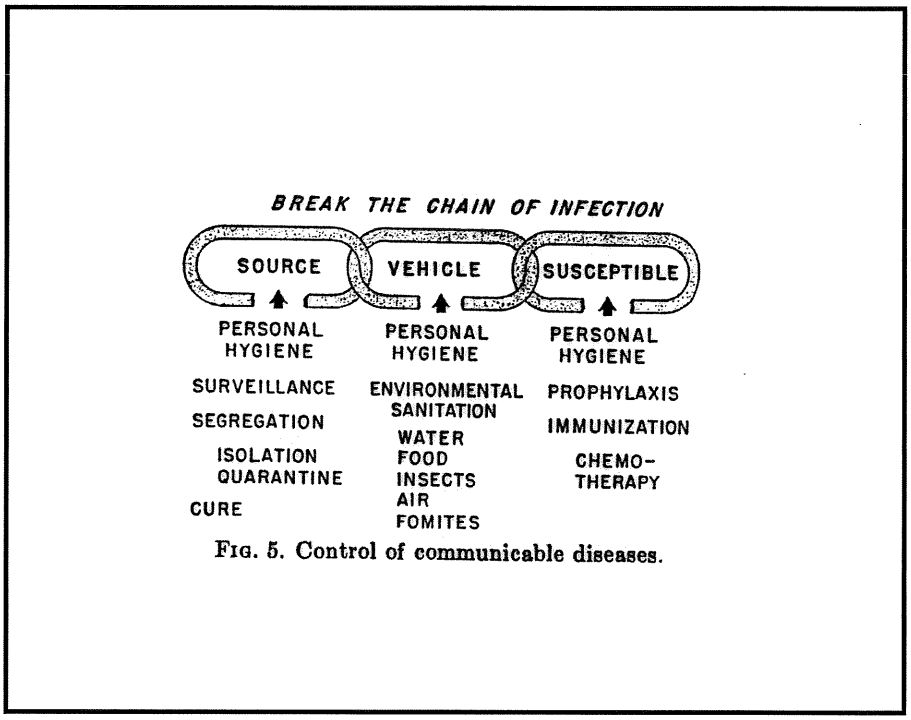


FIG. 5. Control of communicable diseases.

He distributed copies and pointed out that 50 years later, the model remains as applicable as it did in 1949. Only the diseases and conditions most commonly encountered have changed.

The Laboratory in the 1950s and 1960s

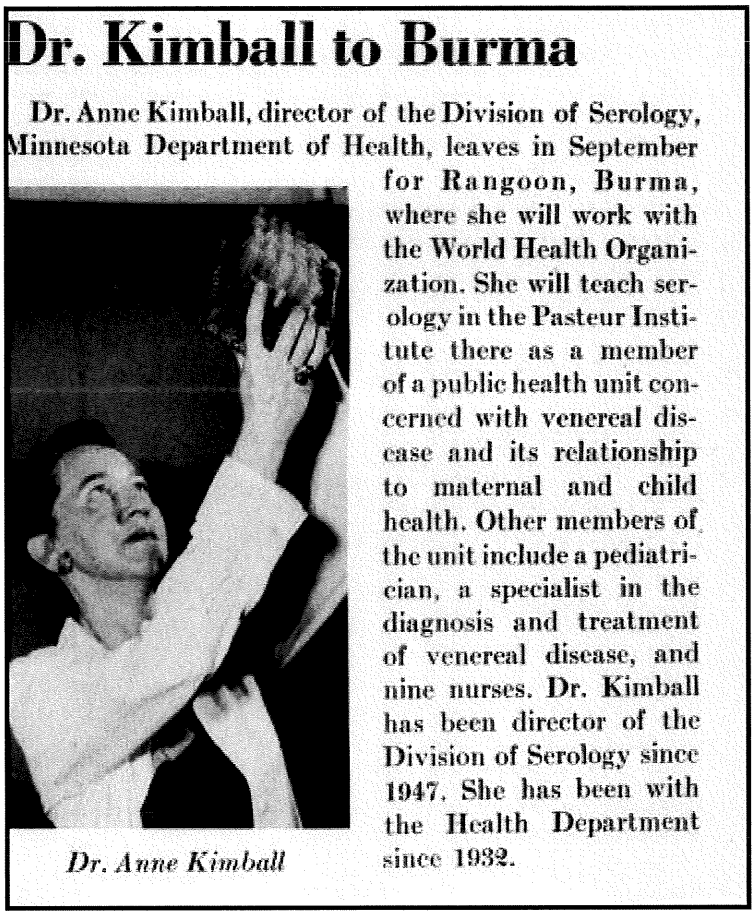
As described by Dr. Bauer, laboratory workers of the 1950s were like detectives, testing specimens, and searching and probing to uncover disease organisms. All registered physicians in the state could and did depend on the department to assist them in the accurate diagnosis of disease. In 1949, 475,910 tests from specimens throughout the state were performed in the department's laboratories. Of these, 322,023 were done in the serology section; 142,526 were done in the microbiology section; and 11,361 were done at the Duluth branch laboratory.[1466]

In the 1950s most of the blood tests in the serology section were conducted in search of syphilis. Syphilis was present in tissues of an infected person and couldn't be grown on a culture medium. Therefore, tests were made on the blood serum to determine if any changes in blood might indicate syphilis.

In addition to testing for syphilis, the serology section also searched for typhoid fever, paratyphoid fever, undulant fever, tularemia and Rocky Mountain spotted fever. Anne Kimball, Ph.D., was head of the serology section in 1949. When she temporarily left the

[1466] MDH, *Minnesota's Health,* Vol. VI, No. 5, May 1952, p. 3.

department in 1952 to work overseas with the World Health Organization, Yvonne Pinke stepped in. When Dr. Kimball returned to the department, she assumed leadership of the special laboratory studies section, and Yvonne Pinke remained as head of serology through 1973.



Dr. Kimball to Burma

Dr. Anne Kimball, director of the Division of Serology, Minnesota Department of Health, leaves in September for Rangoon, Burma, where she will work with the World Health Organization. She will teach serology in the Pasteur Institute there as a member of a public health unit concerned with venereal disease and its relationship to maternal and child health. Other members of the unit include a pediatrician, a specialist in the diagnosis and treatment of venereal disease, and nine nurses. Dr. Kimball has been director of the Division of Serology since 1947. She has been with the Health Department since 1932.

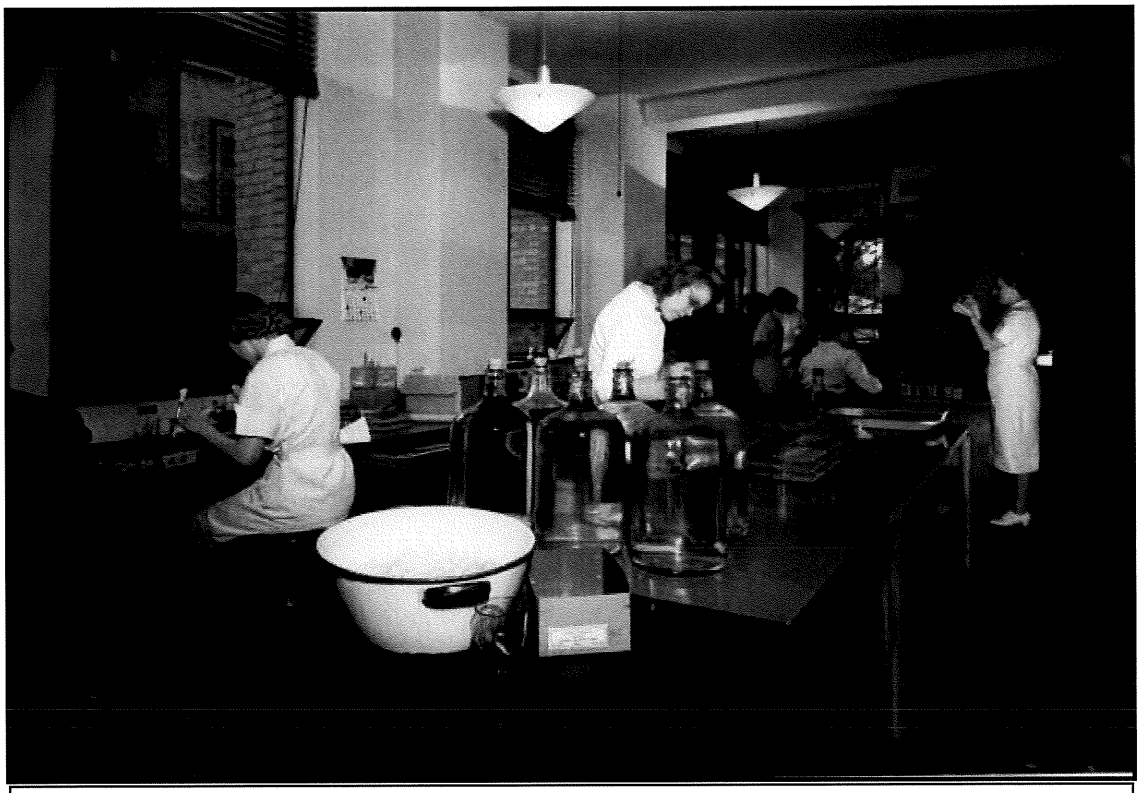
Dr. Anne Kimball

The medical laboratory's microbiology section examined stool and sputum samples under the microscope. Stool samples were examined for the presence of bacteria-causing diseases such as typhoid fever, paratyphoid fever and dysentery – diseases transmitted through invasion of the intestinal tract by bacteria contained in fecal material. Sputum samples were examined for tuberculosis. Nose and throat cultures were studied to determine if a person had diphtheria. Some of the other communicable diseases identified in the microbiology section included dysentery, undulant fever, tularemia, gonorrhea and malaria. Mary Giblin, M.S., was chief of the microbiology section in 1949, and continued as head until 1960 when Leon Damsky, Ph.D., assumed the position.

The viral laboratory had been established in 1937, with Rockefeller Foundation funding. Its original purpose was to study the influenza virus, as there was concern at this time over a possible outbreak similar to the one in 1917-19. In the 1950s the virus and rickettsia unit continued to hunt for influenza, as well as mumps, toxoplasmosis antibody, amebic dysentery and other organisms much smaller than bacteria. Rabies belonged in this category, and during the 1950s a large number of tests were conducted searching for an indication of rabies.[1467] Marion Cooney, B.A., headed the viral and rickettsia unit in 1949, and she continued in this position through 1966. Robert Siem, Ph.D., became head of the unit in 1967.

[1467] MDH, *Minnesota's Health,* Vol. IV, No. 3, March 1950, pp. 1-2.

Laboratory tests changed, as the incidence of a disease changed. In 1949, a notable decrease was apparent with gonorrhea. 12,701 specimens were tested in 1940, compared with 9,158 in 1949. The number decreased to 7,938 in 1950.[1468]



Minnesota Department of Health Serological Laboratory in Campus Building

The laboratory structure changed as needs changed. For a period in the 1970s there was a cytogenetics unit. A genetic metabolic lab, later named hereditary/metabolic and viral diseases, was added in 1980. In the 1980s the serology section was replaced by an immunology section. In 1985 all sections were reorganized and renamed. The three sections remaining in 1999 were: clinical labs, the chemical labs, and lab services.

The chemical laboratory section has tested environmental samples for the department's environmental health division, as well as for several other state agencies and local governments in Minnesota. Environmental testing has been done for potential contaminants in samples of air, water, waste water, sludge, sediment, soil, wildlife, vegetation and hazardous waste; physical agents; chemical and bacterial contaminants; and radiation.

[1468] MDH, *Minnesota's Health,* Vol. VI, No. 5, May 1952, p. 3.

The clinical laboratory section has tested human specimens for bacteria, parasites, fungi, viruses and other infectious disease agents. Some services, not available elsewhere in the state, have been obtained here. For example, the department has been the only facility in the state that does rabies testing. For some uncommon tests the lab has served as a referral center for specimens sent to the U.S. Centers for Disease Control and Prevention.

Minnesota Department of Health Laboratory in Campus Building

When the division reorganized in 1985, the medical laboratory's name was changed to public health laboratory division.

(Note: The department's role in communicable disease is described in greater detail in Chapter 2.)

(Note: The department's role in outbreaks and outbreak investigation is described in greater detail in Chapter 15.)

(Note: The department's role in STD/AIDS is described in greater detail in Chapter 14.)

The public health laboratories division has historically worked closely with other divisions, particularly the preventable disease division. In fact, in the 1950s clerical employees were pooled between the two divisions. Another indication of their close relationship was the recommendation by the Governor's Efficiency in Government

Commission in 1950. It proposed that the medical laboratories division be made a section within the division of preventable diseases. [1469]

When the state laboratory was reviewed by the U.S. Public Health Service in 1951, three weak features were identified: 1) discontinuation of intra-state evaluation program (due to inability to find personnel); 2) heavy dependence on federal funds – about 47 percent of laboratory's budget; and 3) low salaries at the extremes of professional grades.[1470]

Overall, however, the laboratory received high marks. E. J. Tiffany, senior surgeon in charge of the laboratory consultation service of the U.S. Public Health Service's communicable disease center, said after his visit to the laboratory in 1951:

> ***"It is the opinion of this consultant that the organization and administration of this laboratory, its relationship with the State University, the interest shown in investigations and problem studies, and the quality of the work performed and service rendered, have earned for it a place among the better state department of health laboratories in this country."*** [1471]
>
> **Dr. E. J. Tiffany, United States Public Health Service, 1951**

Dr. Bauer was especially pleased with the evaluation. He spoke about it at the April 30, 1951 board meeting: "The fact that he considers our laboratory one of the better ones in the United States is something. Some laboratory directors in other states have said, 'Be careful of him. He'll tear you apart.' "[1472]

The medical laboratory's achievements were made despite unsafe and unpleasant working conditions through the 1960s. The department's new building, completed in 1969, housed a new and safe laboratory, a dramatic change from the one at the previous building on the University of Minnesota campus. The new lab was safer for other department employees, as well. With the laboratory located in the center of the floor, surrounded by large hallways, negative pressure was established. In the new laboratory air moved from inside into the center laboratory area – not from the laboratory to the outside. This prevented infectious material from escaping into the hallway.

Duluth Laboratory

The public health laboratory, located in Minneapolis, had a satellite office in Duluth for many years. The Duluth laboratory was established in 1905 to serve physicians in northern Minnesota, using space in St. Mary's Hospital.

[1469] J.L. Jacobs & Company, "State of Minnesota Organization and Management of Public Health Agencies: Summary Report for the Efficiency in Government Commission," October 1950, p. 90.
[1470] BOH, *Minutes,* April 30, 1951, MHS, pp. 103-105.
[1471] MDH, *Minnesota's Health,* Vol. V, No. 5, May 1951, p. 2.
[1472] BOH, *Minutes,* April 30, 1951, MHS, pp. 103-105.

An era ended with the closing of the Duluth branch laboratory on July 1, 1958, following the death of Harold Hoff, bacteriologist in charge. With his death, no specimens were received and no work was done there. The work was being sent to the main laboratories in Minneapolis. The board decided it was time to close the Duluth laboratory permanently.[1473]

The closing of the laboratory did not go unnoticed. Dr. Edward Tuohy, a native of Chatfield, who began working as a bacteriologist at the Duluth laboratory in 1905, commented on its passing. Now working in California, he reflected on the importance of the Duluth laboratory:[1474]

> It is easy to see why it should be closed at this time. Typhoid, tuberculosis, water and milk supervision---all have passed under routine inspection, and probably the most notable routine work with which I had some busy periods was the matter of throat cultures for B. Diphtheria.
>
> Over and beyond that line of laboratory routine, which should be entered on the Medical History side of the work, was the certainty that the first organized effort to control tuberculosis in the area stemmed from the laboratory and its personnel. Then it should be recalled that the support which I received from Doctors H. M. Bracken and F. F. Wesbrook[1475] enabled me to tie into the teaching facilities of the University of Minnesota the most stimulating incentives to develop the work of the clinical and Post Mortem work in both of the major Duluth hospitals. Thus do I wish to pass some further judgment upon the life tenure of what to many seem only a passing and unessential detail of passing events.[1476]

Improving the Quality of Laboratories and Technicians

The quality of laboratory work done in many facilities in Minnesota was not satisfactory in the 1940s and 1950s. Because of this, the department didn't encourage bacteriology in hospitals and laboratories. As Dr. Bauer explained in 1951:

> ...one of the reasons for our success with syphilis serology is that practically 90 percent has been done here and we have controlled it and know what is going on in the State. That is the policy we are going to try to follow along as far as public health bacteriology and laboratory work are concerned and try to go along with the developing of the clinical aspects of it....[1477]

Using Public Health Service grants and Kellogg Foundation funds, the department began to survey hospital laboratories in the 1950s. For a six-month period, unknown specimens were sent each month to hospital laboratories. Performance was classified, and those laboratories with poor performance were offered special help. Dr. Bauer wanted uniform laboratory procedures throughout the state. He wanted the standards raised, and he advocated for continual training for lab workers.[1478]

[1473] BOH, *Minutes,* May 22, 1958, MHS, p. 146.
[1474] MDH, *Minnesota's Health,* Vol. 13, No. 1, January 1959, p. 4.
[1475] Dr. H. M. Bracken was BOH executive officer from 1897 to 1919, and Dr. Frank Wesbrook was laboratories director from 1895 to 1911.
[1476] BOH, *Minutes,* August 13, 1958, attachment: letter to Dr. Robert Barr from Dr. E.L. Tuohy, dated August 2, 1958, MHS, p. 218.
[1477] BOH, *Minutes,* October 16, 1951, MHS, p. 324.
[1478] BOH, *Minutes,* May 23, 1962, MHS, pp. 216-217.

Some laboratory technicians weren't getting the continuing education they needed, and in 1952 Dr. Bauer proposed refresher courses for laboratory technicians. He received strong support from the Board of Health. Board member Prof. Bosch said:

> I think the State should take a leadership in improving each of the groups that affect the public health. Anything that the State can do to improve his training or his knowledge will reflect ultimately to the value of the State. We are carrying out refresher courses in a number of fields.[1479]

First given in St. Gabriel's Hospital in Little Falls in 1952, the refresher courses for lab technicians were sponsored by the University of Minnesota, the Minnesota Hospital Association, the Minnesota State Medical Association, the Minnesota Society of Clinical Pathologists, the Minnesota Society of Medical Technologists, the Third District Society of Medical Technologists, and the Minnesota Department of Health. Emphasis was placed on routine procedures.[1480] Additional classes were given in Hibbing, Morris and Red Wing.

The public health laboratory has continued its monitoring function by providing reference and confirmatory testing of specimens from hospitals, clinics and other clinical labs throughout the state. In 1999 this included the certification of environmental laboratories that do environmental testing for government agencies.

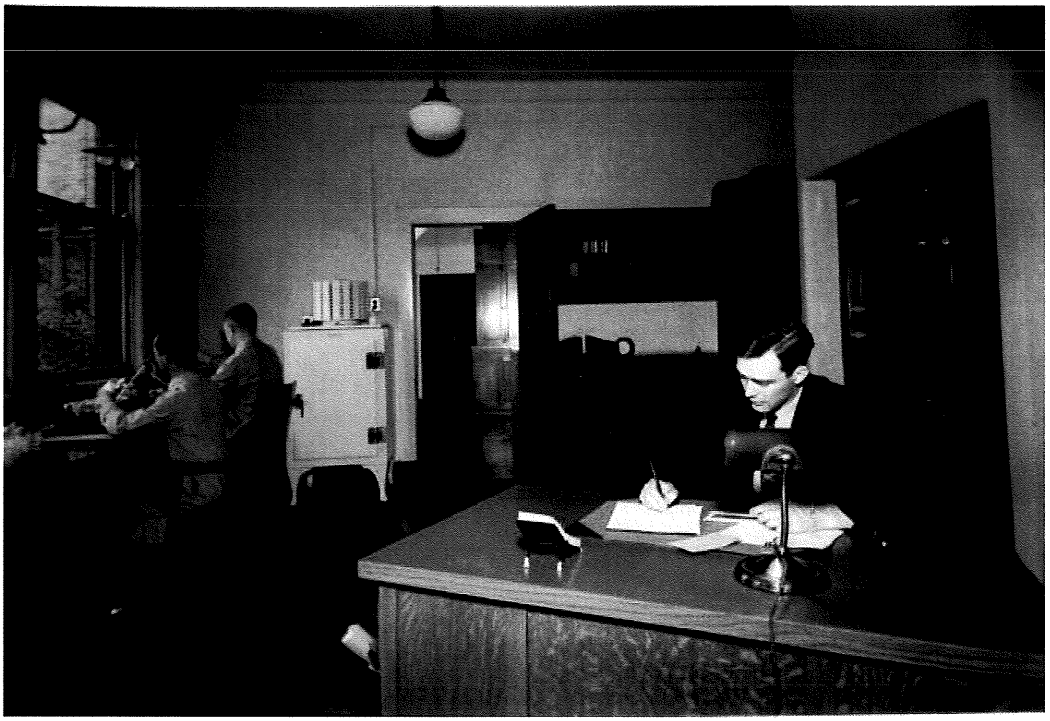
One of the reasons for the poor quality of laboratory work in some facilities in the 1950s appeared to be the result of inadequate technique training received by technicians. Several schools in Minnesota were considered borderline. One school in particular was severely criticized, and it brought forth a slander suit against the Hennepin County Medical Society. Legislation to control these schools had been proposed but always defeated. In 1963 the board decided to seriously consider adoption of regulations governing the general sanitation and health service requirements of trade schools. [1481]

Dr. Bauer thought fraudulent schools could be eliminated by setting standards for lab technicians. The schools would be forced to raise their standards.

Innovative Activities

The department's laboratory has been innovative and drawn national attention for a number of its activities. It made many contributions in the polio eradication effort, especially in the development of oral polio vaccine. In 1961 the polio studies in Minnesota were identified as the most carefully controlled of all studies to date. [1482] The medical laboratory was also influential in establishing a blood bank system in Minnesota in the 1950s.

[1479] BOH, *Minutes,* May 27, 1952.
[1480] MDH, *Minnesota's Health,* Vol. VI, No. 4, April 1952, pp. 3-4.
[1481] BOH, *Minutes,* January 22, 1963, MHS, p. 22.
[1482] BOH, *Minutes,* May 23, 1961, MHS, p. 164.



D. M. Taylor, Bob Merman and John Wilson
Health Department Laboratory on University Campus

(Note: The department's role in establishing the blood bank system is described in Chapter 4.)

From 1948 to 1958, the laboratory conducted studies on toxoplasmosis, trying to identify the elusive source. Anne Kimball, Ph.D., took the lead in these research investigations, which included parts of Meeker, Renville, Sibley, McLeod, Kandiyohi, Wright, Hennepin, Anoka and Ramsey counties. In 1959 findings from studies indicated an association between toxoplasmosis and contact with farm animals.[1483]

In 1956 the laboratory, working with the University of Minnesota, identified the Coxsackie B-5 virus as the cause of an epidemic of aseptic meningitis. [1484]

Between February 1961 and January 1962 the laboratory joined with the University of Minnesota in studying staphylococcal infections at the new 17-bed isolation unit at the University of Minnesota Hospital. [1485]

[1483] Anne Kimball, Ph.D. et al., "Epidemiological Studies on Toxoplasma Antibodies in Obstetrical Patients," *University of Minnesota Medical Bulletin*, Volume XXX, Number 8, February 15, 1959, pp. 226-249.

[1484] Jerome T. Syverton, M.D. et al., "Outbreak of Aseptic Meningitis Caused by Coxsackie B5 Virus," *Journal of the American Medical Association*, Vol. 164, No. 18, August 31, 1957, pp. 2015-2019.

In 1962, the laboratory, working with the University of Minnesota, identified the Giles virus, which caused an outbreak of aseptic meningitis in the state in 1960.[1486]

Beginning February 1, 1963, the public health laboratories offered drug sensitivity testing for tubercle bacilli and other acid-fast organisms. This was available to Minnesota physicians to determine the effectiveness of drug therapy using isoniazid, streptomycin and p-amino salicilate.[1487] Private physicians had begun caring for an increasing number of tuberculosis patients when sanitariums were closed. There were no facilities in the state where physicians could have sensitivity tests done on acid-fast organisms.[1488] Dr. Henry Bauer suggested that more attention and work be done in the area of acid-fast bacteriology. He suggested terminology be changed from "tuberculosis" to "diseases due to acid-fast bacteria."[1489]

In 1967 the laboratory began performing tests to determine if pregnant women had German measles. This service was available to physicians in the state, and Minnesota was one of several laboratories in the nation to offer this service.[1490]

Newborn Screening – Phenylketonuria (PKU)

One of the major initiatives by the department in the 1950s and 1960s was led by the medical laboratory and resulted in the prevention of serious morbidity and early death to a number of Minnesota children. While the number of children affected each year was small, the potential for changing their lives and cumulative effect of the initiative was enormous.

Every year a few Minnesota children were born with phenylketonuria (PKU), a hereditary metabolic disease. Without treatment, most became profoundly retarded. In 1962, Dr. Robert Guthrie of Buffalo, New York, developed a test that made it possible to identify which infants were affected with this disease.[1491] Dr. Guthrie, originally from Minnesota, had a daughter afflicted with PKU disease. With Dr. Guthrie's test, it was now possible to distinguish those children who could, through a diet low in phenylalanine, escape the devastating effects of the disease, as scientists in Germany had discovered.

Beginning in 1957, a PKU screening pilot study was done in Clay, Becker, Otter Tail, and Wilkin counties by the Four-County Project, working with the Clay-Becker-Park Region medical societies. The project was jointly sponsored by the Health and Public

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[1485] Ward E. Bullock, M.D. et al., "A Staphylococal Isolation Service," *Annals of Internal Medicine*, Volume 60, No. 5, May 1964.
[1486] MDH, *Minnesota's Health,* Vol. 16, No. 4, April 1962, p. 2.
[1487] MDH, *Minnesota's Health,* Vol. 17, No. 4, April 1963, p. 1.
[1488] BOH, *Minutes,* January 16, 1962, MHS, p. 36.
[1489] BOH, *Minutes,* February 24, 1959, MHS, p. 37.
[1490] MDH, *Minnesota's Health,* Vol. 21, No. 8, October 1967, p. 1.
[1491] BOH, *Minutes,* July 10, 1962, MHS, p. 332.

Welfare departments.[1492] In 1961, the board approved a study to promote testing statewide.[1493]

To prevent PKU from developing in any child born in Minnesota, the department supported screening all infants born in the state. This was contrary to the recommendations of the American Medical Association and the American Academy of Pediatrics, which recommended voluntary physician participation. The department initiated a statewide screening program for all newborns on a voluntary basis in 1964.[1495]

Reflection on PKU Pilot Program

"The pilot program was successful, and I will never forget how some of us wept at the discovery of the first victim with the realization that proper measures would insure a productive human being who would otherwise have been a helpless dependent person."[1494]

Representative of St. Paul Association of Retarded Citizens, 1976

The PKU screening was available on a voluntary basis, but the board pushed for mandatory testing for all infants. When a bill for mandatory testing was presented to the Legislature, Dr. Bauer demonstrated to legislators, through graphs and presentation, the value of such legislation. In 1964 PKU legislation passed, and the following year PKU testing became required in Minnesota. All newborns born July 1, 1965, or later, had to be tested.[1496]

Dr. Bauer, made arrangements with Dr. Robert Fisch, pediatrician at the University of Minnesota, to treat all cases identified. Families of affected infants were instructed on the proper diet that would prevent the disease. The department supplied the food for these cases. All cases received screening and follow-up, as well as genetic and nutritional screening, from the department's division of special services.

PKU testing was challenged several times, as to whether or not the expense was worth it. In 1975, 10 years after the screening became mandatory, Dr. Henry Bauer and Dr. Ronald Campbell, chief of the department's maternal and child health division, responded to a newspaper article that suggested that PKU testing was one of the costly tests that may not be necessary for every baby:

> In 1975, it cost the Minnesota Department of Health Laboratory $25,214 to perform 72,160 tests or approximately thirty-five cents per test. In this year, three infants were found with PKU at a cost to the Department of $8,404.67 per infant. Without treatment, these individuals would be severely retarded and would likely need institutional care for their entire lives. The current daily custodial and medical cost in the institution for mentally retarded is $48.55 per day, or $16,735 per infant per year. If these three infants had not been discovered and were placed in a State institution, it would cost the state $50,205 per year. Multiply this by 25, which is the average number of life years of the untreated PKU patient in institutions; there is a potential total cost of $1,255,143 plus the tragic loss of three children and the anguish of their parents. This tabulates

[1492] MDH, *Minnesota's Health,* Vol. 15, No. 5, May 1961, p. 1.
[1493] BOH, *Minutes,* April 24, 1961, MHS, p. 104 and p. 131.
[1494] Letter from Franklin Smith to the *Minneapolis Star*, August 28, 1976.
[1495] *St. Paul Pioneer Press,* "State Starts Program to Screen Babies for Retarding Disorder," September 6, 1964.
[1496] Minnesota State Statute 61, Sec. 144.159.

just one year's experience; each year we detect three or four children through the screening program.[1497]

The PKU legislation had strong support from the St. Paul Association for Retarded Citizens. A representative of the organization wrote: "We are grateful to the State Health Department for their cooperation, but I especially want to mention Dr. Henry Bauer."[1498]

By 1999, state legislation had mandated the testing of newborns for phenylketonuria, hemoglobinopathy (sickle cell) and other inborn errors of metabolism as prescribed by the commissioner of health.[1499] These included galactosemia, hypothyroidism and congenital adrenal hyperplasia. The public health laboratory has conducted the testing for these hereditary metabolic diseases in conjunction with the family health division.

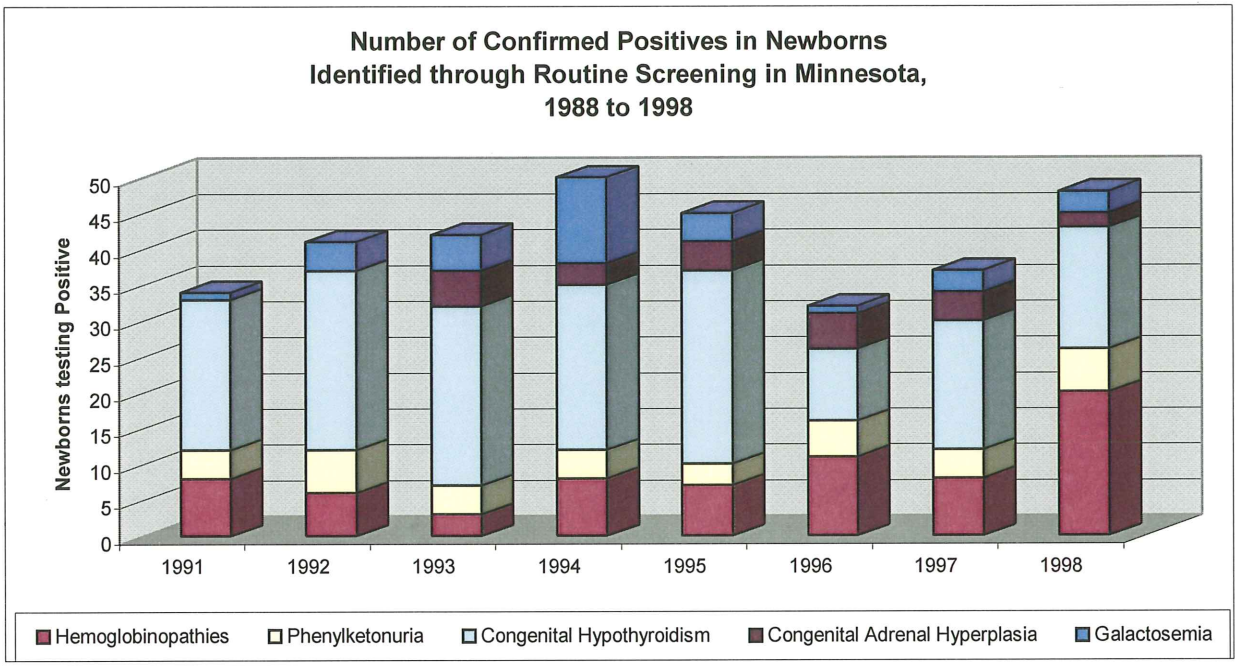
Testing done on Minnesota newborns, along with the estimated incidence, are listed in the chart below. The chart also identifies the effects of the disease, if undetected and untreated. Testing has made it possible to identify diseases and initiate treatment before harmful effects occur.

DISEASE	INCIDENCE	EFFECTS	TREATMENT
Phenylketonuria (PKU)	1:13,900* (1:12,000)**	Mental Retardation	Low phenylalanine diet
Galactosemia	1:31,800* (1:50,000)**	Failure to Thrive, Mental Retardation, Death	Avoidance of milk products
Hypothyroidism	1:4,500* (1:4,000)**	Mental Retardation	Oral thyroid hormone
Hemoglobinopathy (sickle cell disease)	1:12,600* (1:12,000)** (1:500 in African-Americans)	Sickle crises, Death	Prophylactic penicillin
Congenital Adrenal Hyperplasia	1:16,500* (1:12,000)**	Adrenal crisis, Ambiguous genitalia in females, Death	Glucocorticoid mineralocorticoid

* Minnesota incidence
** National incidence

[1497] *Minneapolis Star*, "Value of Mandatory Tests on Newborns," August 19, 1976.
[1498] Letter from Franklin Smith to the *Minneapolis Star*, August 28, 1976.
[1499] Minnesota Statute 144.125.

The graph below indicates the number of confirmed positives found from 1991 to 1998 through the routine testing of Minnesota infants. This chart shows the number of infants who have escaped or who have had reduced distress from a serious disease. The cumulative cost savings in the prevention of institutional and medical care has been significant. The value to the potentially affected children and their families in the prevention of pain and suffering is un-quantifiable.



Public Health Laboratory – 1872 to 1999

The first focus of the department, when it began with one person in 1872, was laboratory work. Dr. Hewitt used his own laboratory in Red Wing to develop vaccine, which he distributed throughout the state. In 1893 the department's laboratory was moved from Red Wing to the University of Minnesota campus. In 1999 it remained close to the University of Minnesota, housed in 717 Delaware Street S. E., while much of the rest of the department had relocated to St. Paul.

The technical areas addressed in the public health laboratory in 1999 contained some terms unheard of by Dr. Hewitt:

- inorganic non-metals
- inorganic trace metals
- microparticulate
- organic chemistry
- radiochemistry
- water microbiology

- bacteriology
- enteric bacteriology
- immunology
- molecular epidemiology
- mycology
- mycobacteriology
- newborn screening
- parasitology
- rabies
- sexually transmitted diseases
- virology

Dr. Bauer, retiring as director of the labs in 1976, contemplated the possibilities present in 1999 and somewhat wistfully noted the exciting times ahead for the laboratory. With advancements such as molecular identification of organisms, new opportunities presented themselves and the potential for making a difference in the health of the people of the state increased.

Postscript

By Dr. Henry Bauer

Many wise people have asked the question: "Why write the history of the Minnesota Department of Health?" My reply is: "How can one who doesn't know the past understand the present, and certainly, if one doesn't understand the present how can one predict the future?"

Perhaps the quote from Lucretius on "Life and Death," as modified by Mr. W. H. Mallock, may help.

> "No single thing abides; but all things flow.
> Fragment to fragment clings – the things thus grow
> Until we know and name them. By degrees
> They melt, and are no more the things we know."[1500]

This may seem unrelated to prevention, control, and treatments of disease, but it applies to the story of poliomyelitis, tuberculosis, typhoid, salmonellosis, brucellosis, smallpox, diphtheria and others. As this history has shown, it is possible to eradicate disease, often by degrees.

There are three chains to the process of disease eradication: source, vehicle and susceptibility. Where does the disease come from? How does it get from one place to another? Who is susceptible to contracting the disease and suffering the ill effects?

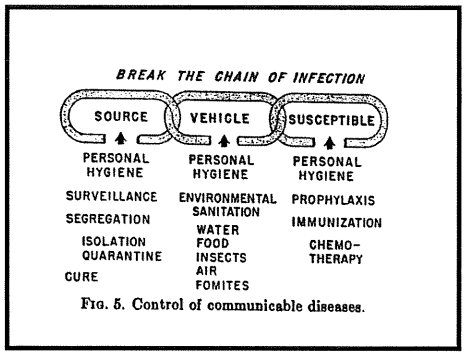


Fig. 5. Control of communicable diseases.

The model for breaking the chain of transmission and eliminating disease applies today, as it did in the early 1950s, as it did in the beginning of our Minnesota State Health Department, and as it has throughout human history. Before the prevention and control procedure can be implemented, we must know the cause of the disease.

In the history in these pages, we have read about how the fragments of knowledge cling and grow until we know the course and mode of transmission. Once that is determined, we move forward. "By degrees they melt, and are no more the things we know."

Henry Bauer, Ph.D.
Director of Public Health Laboratories, 1949 to 1976
Deputy Executive Director, 1960 to 1966
Minnesota Department of Health, 1938 to 1976

[1500] W.H. Mallock, *Lucretius on Life and Death* in the metre of Omar Khayyam to which are appended parallel passages from the original, (Adams and Charles Black: London, 1901), p. 15.

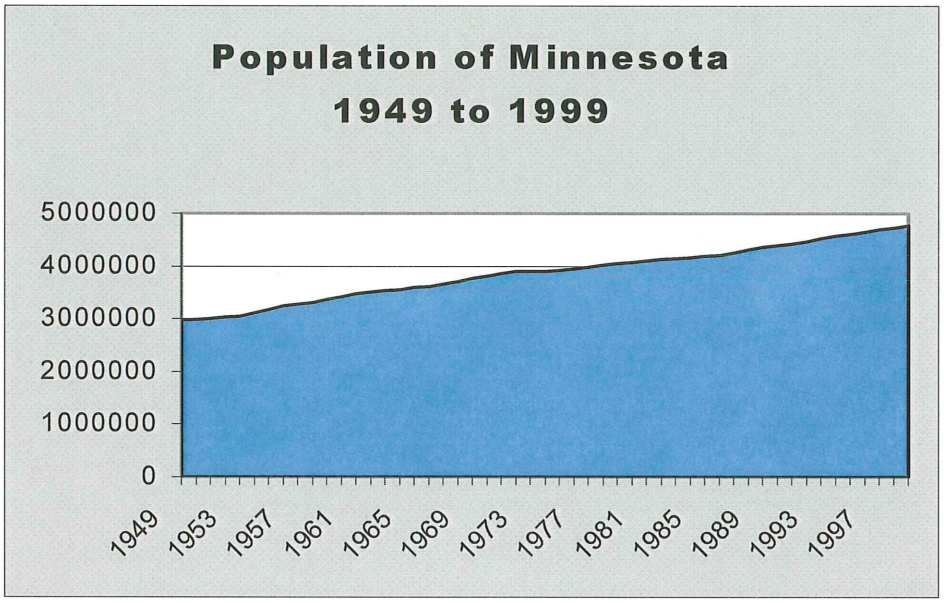
Appendix A:

Minnesota's Health Status

Note: Unless otherwise noted, all data are from the Minnesota Department of Health.

Population

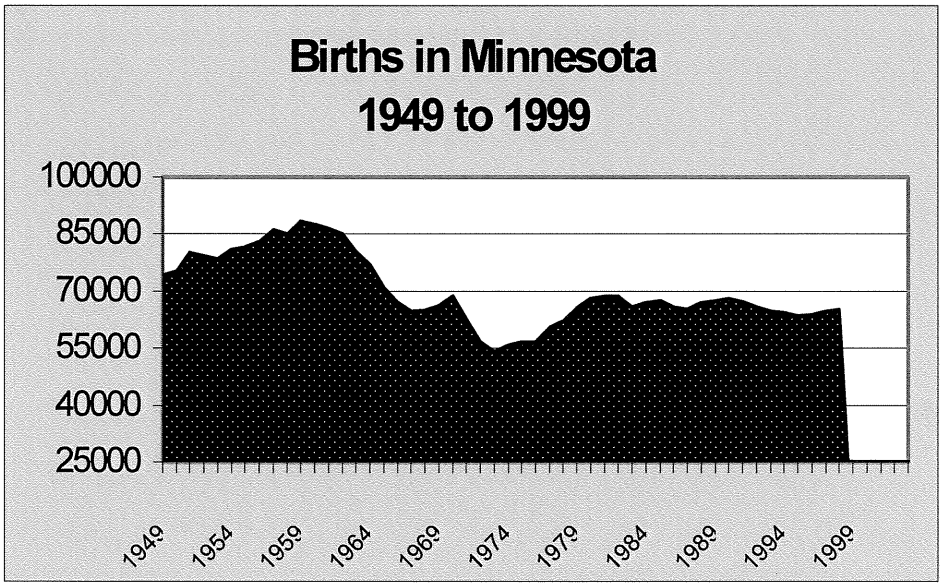
From 1949 to 1999, the population of Minnesota increased more than 60 percent, from 2,977,005 in 1949 to 4,775,508 in 1999. [1501]

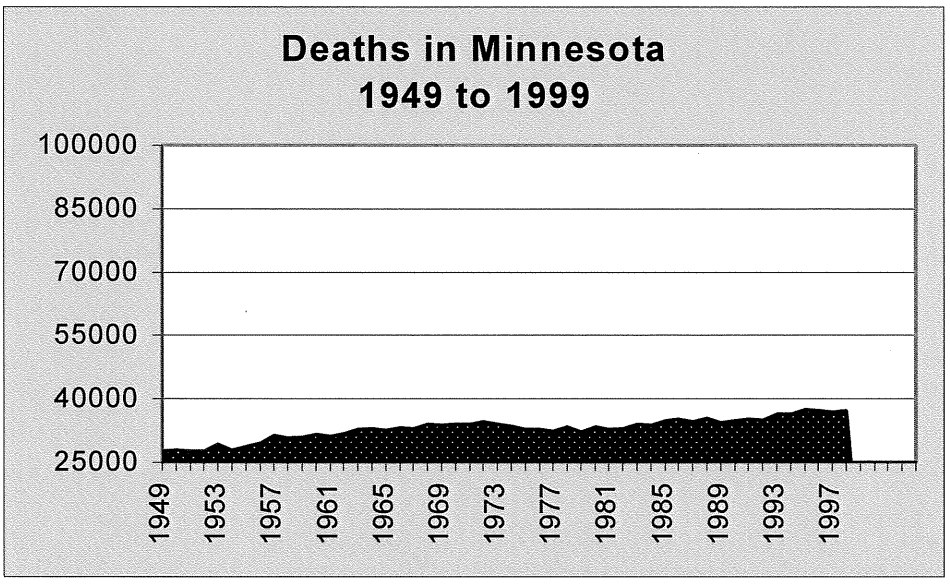


[1501] Data from Minnesota state demographer's office.

Births and Deaths in Minnesota[1502]

There were 73,929 births in Minnesota in 1949, compared to 65,207 in 1998. There were 27,719 deaths in Minnesota in 1949, compared to 37,152 in 1998.

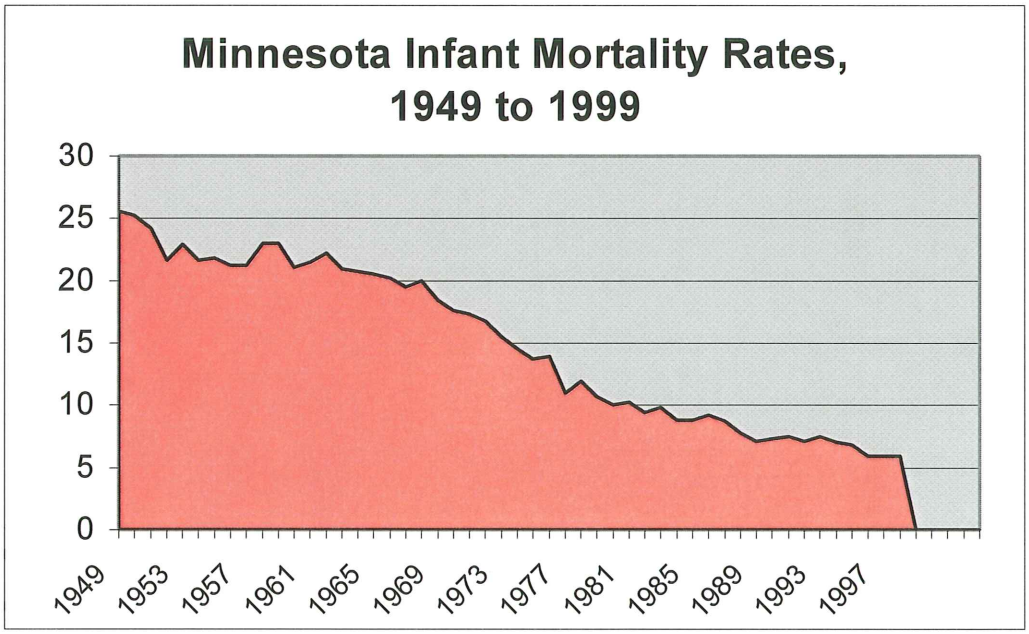




[1502] Data from Minnesota state demographer's office.

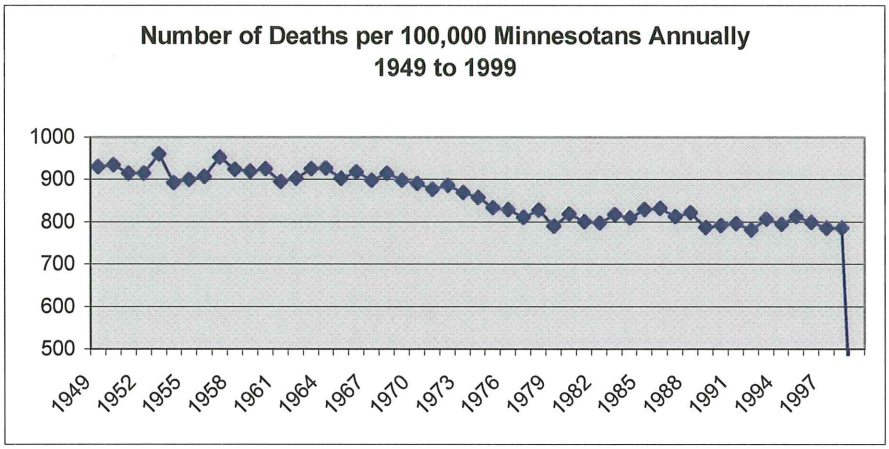
Infant Mortality

Infant mortality dropped from 25.6 deaths per 1,000 births in 1949 to 5.9 deaths per 1,000 births in 1998. National infant mortality rates were 29.2 in 1950 and 7.2 in 1998.



Death Rate in Population

The death rate in Minnesota changed from 931 per 100,000 people in 1949 to 786 per 100,000 people in 1998.



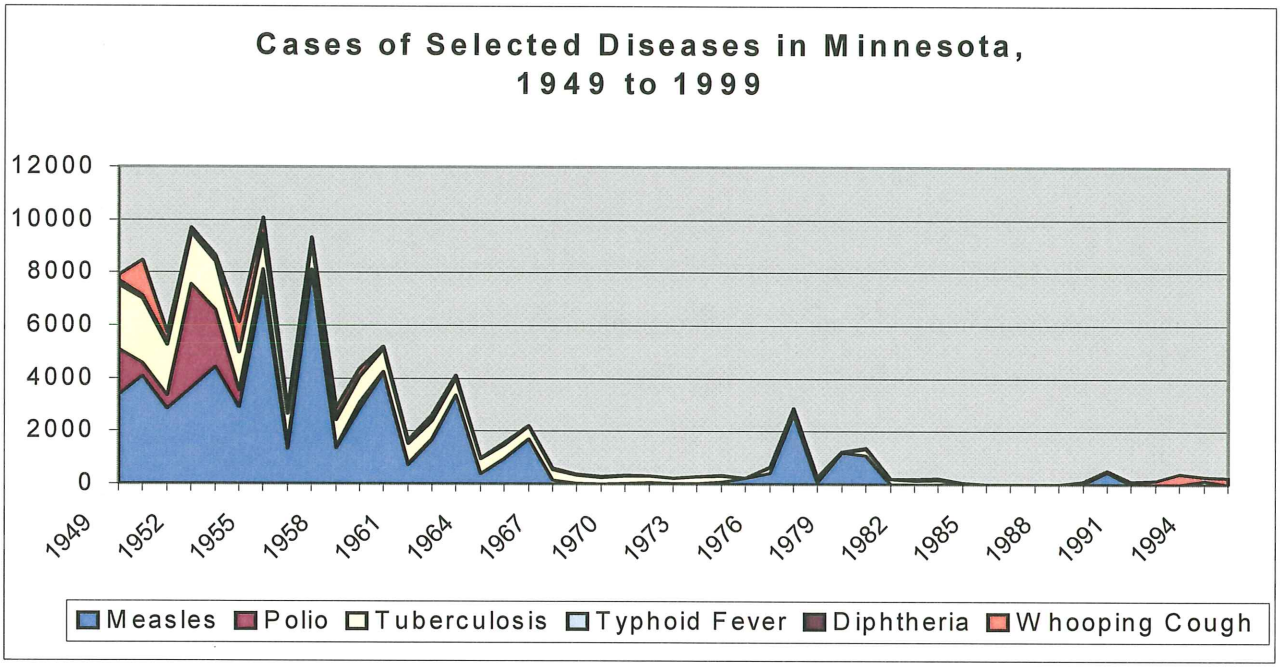
Leading Causes of Death in Minnesota – 1910, 1949 and 1999

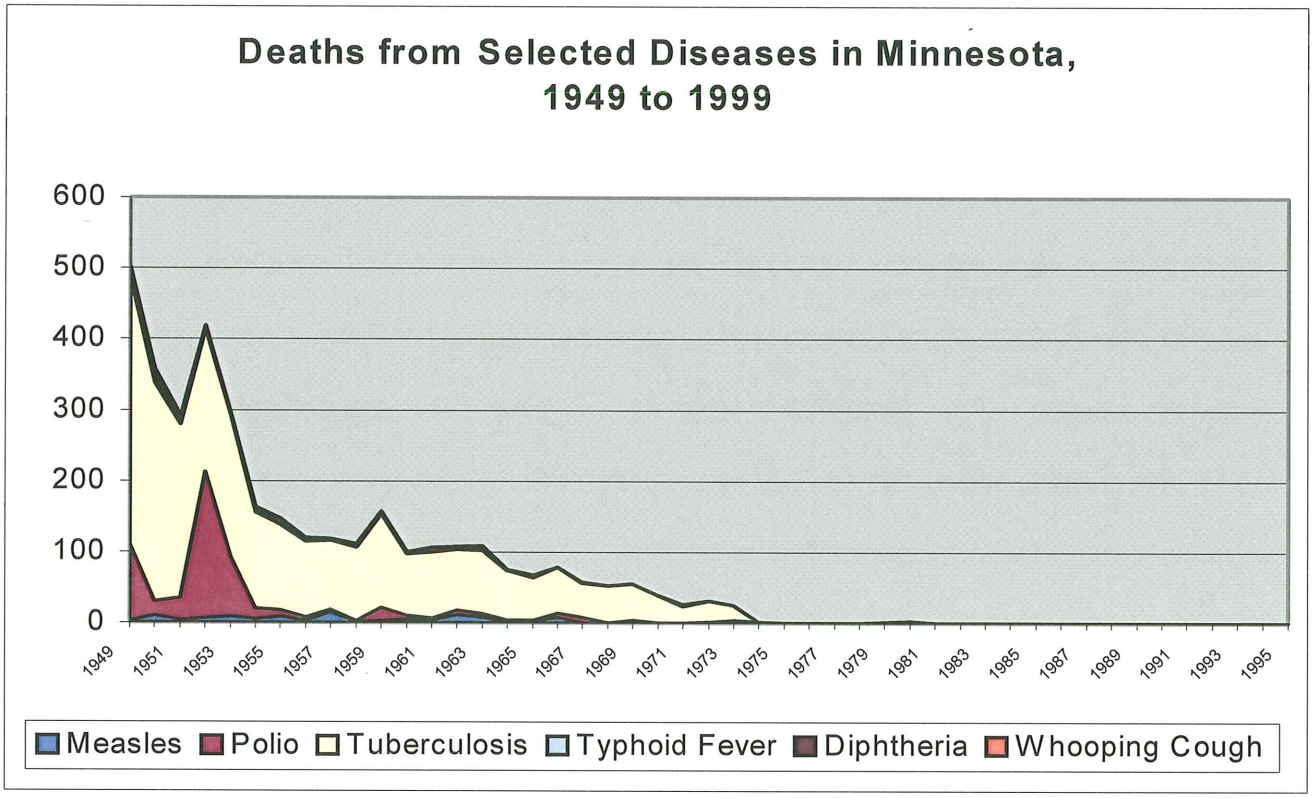
1910	1949	1998[1503]
1. Tuberculosis	1. Heart disease	1. Heart disease
2. Heart disease	2. Cancer	2. Cancer – malignant neoplasms
3. Pneumonia	3. Intracranial lesions of vascular origin	3. Cerebrovascular disease
4. External causes	4. Accidental deaths	4. Chronic obstructive pulmonary diseases and allied conditions
5. Cancer	5. Pneumonia	5. Unintentional Injuries – motor vehicle and falls
6. Diarrheal diseases of children	6. Diabetes	6. Pneumonia and Influenza
7. Nephritis	7. Nephritis	7. Diabetes Mellitus
	8. Arteriosclerosis	8. Nephritis, Nephrotic Syndrome, Nephrosis
	9. Premature birth	9. Suicide
	10. Congenital malformations	10. Hypertensive Disease without mention of heart disease

[1503] 1998 leading causes of death are listed, as 1999 data were unavailable.

Cases and Deaths from Selected Diseases in Minnesota

Disease	Cases 1949	Deaths 1949	Cases 1997	Deaths 1997
Diphtheria	166	10	0	0
Measles	3356	2	8	0
Polio	1715	108	0	0
Tuberculosis	2455	376	161	-
Typhoid Fever	14	1	1	0
Whooping Cough	181	6	545	0



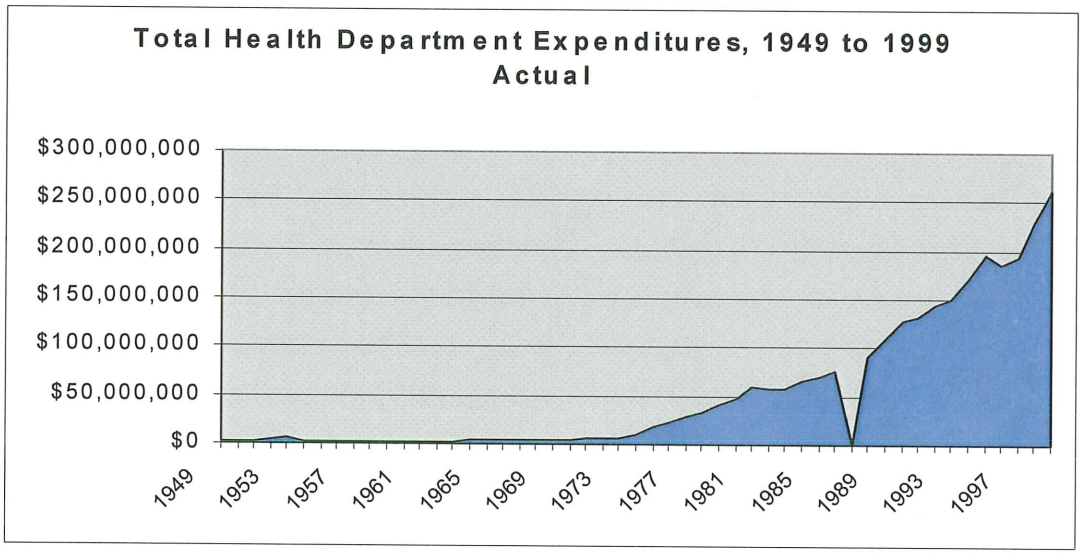

Deaths from Selected Diseases in Minnesota,
1949 to 1999
600
500
400
300
200
100
0
1949
1951
1953
1955
1957
1959
1961
1963
1965
1967
1969
1971
1973
1975
1977
1979
1981
1983
1985
1987
1989
1991
1993
1995
Measles
Polio
Tuberculosis
Typhoid Fever
Diphtheria
Whooping Cough

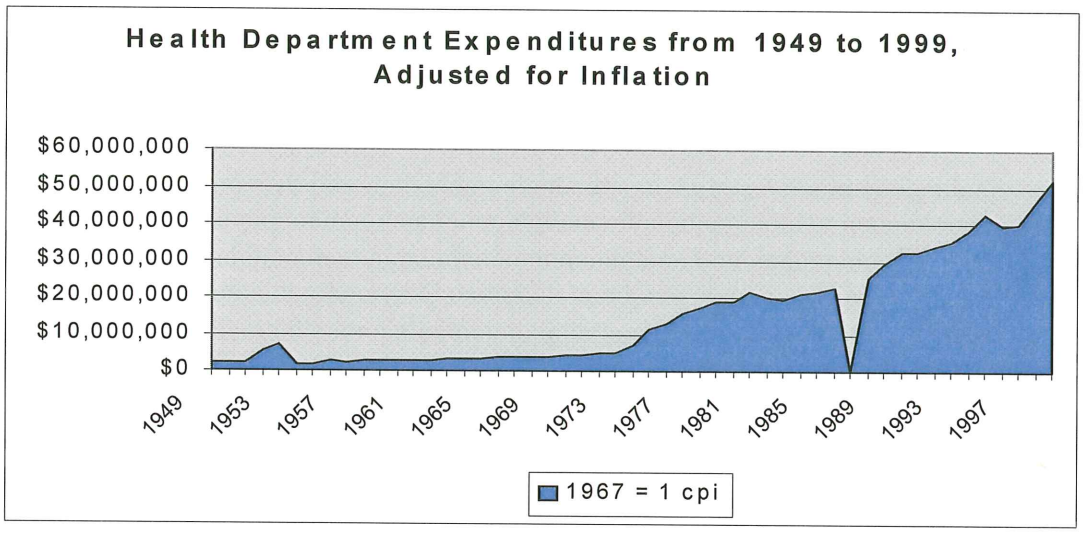
Appendix B:

Expenditures, Employees, Leadership

Minnesota Health Department Expenditures[1504]

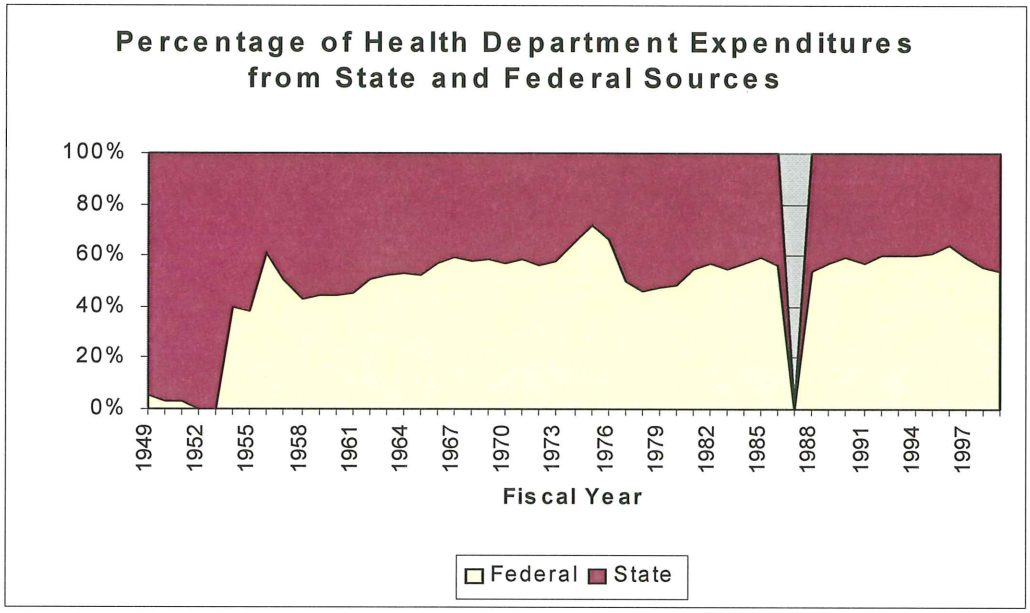
Data include all appropriated funds, general, state government special revenue, health care access, trunk highway and environment funds, and endowment.



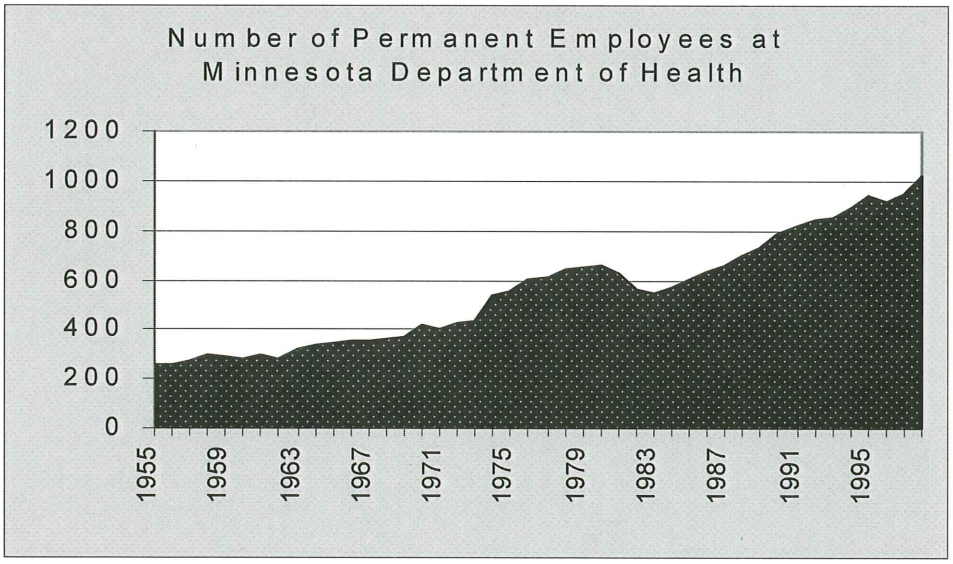


[1504] Data from MDH; 1987 data not available.

Proportion of Federal and State Funding for MDH



Number of Employees at Minnesota Department of Health



Minnesota State Board of Health Presidents

(Board abolished in 1977)

Thomas B. Magath, M.D. – 1949

Ruth E. Boynton, M.D. – 1950 to 1951

Frederick W. Behmler, M.D. – 1952 to 1954

Frank H. Krusen, M.D. – 1955 to 1963

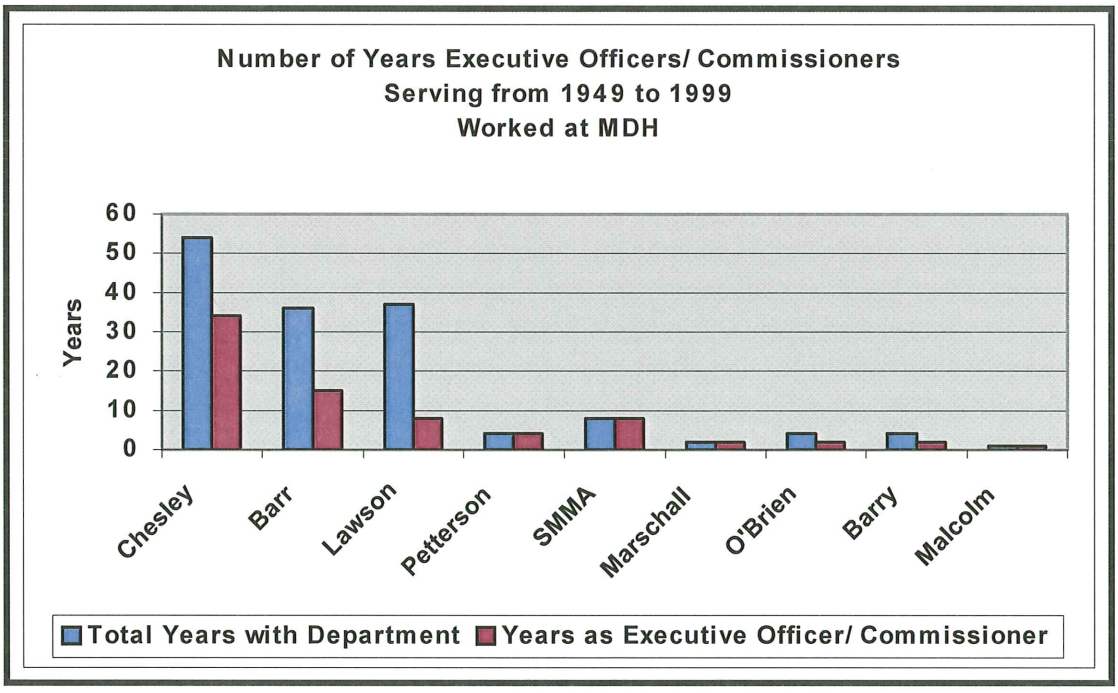
Raymond J. Jackman, M.D. – 1963 to 1970

Arnold D. Delger, B.S. Pharm – 1971

John H. Westerman, M.H.A. – 1972 to 1975

Robert Willmarth – 1976

Valentine O'Malley, M.D. – 1977



Executive Officers and Commissioners[1505] at Department of Health

Albert J. Chesley, M.D. – 1949 to 1955 (Executive Officer since 1921)
Deputy Robert N. Barr, M.D., 1949 to 1955

Robert N. Barr, M.D. – 1955 to 1970
Deputy Jerome Brower, L.L.B., M.A., 1955 to 1959
Deputy Henry Bauer, Ph.D., 1960 to 1966
Deputy Warren Lawson, M.D., M.P.H., 1967 to 1970

Warren Lawson, M.D., M.P.H. – 1970 to 1978
Assistant Executive Officer of Administration, Duane H. Johnson, 1973 to 1978
Assistant Executive Officer of Programs, Ellen Fifer, M.D., 1973 to 1978
Assistant Commissioner of Community Development, Robert Hiller 1976 to 1978

George Pettersen, M.D. – 1979 to 1983
Deputy Commissioner Duane H. Johnson, 1980 to 1982
Assistant Commissioner of Administration, Duane H. Johnson, 1979 to 1980
Assistant Commissioner of Administrative Services, Thomas Maloy, 1980 to 1982
Assistant Commissioner of Programs/Health Services, Ellen Fifer, M.D., 1979
Assistant Commissioner of Community Development, Robert Hiller, 1979
Assistant Commissioner of Health Resources, James Brunsgaard, 1979 to1981

Sister Mary Madonna Ashton – 1983 to 1991
Deputy Valentine O'Malley, M.D., 1983 to 1986
Deputy Daniel McInerney, L.L.B., M.P.H., 1986 to 1991
Assistant Commissioner of Community Services, Daniel McInerney, L.L.B., M.P.H., 1983 to 1984
Assistant Commissioner of Health Delivery Systems, Daniel McInerney, 1984 to 1986
Assistant Commissioner of Health Protection, Michael Finn, 1986 to 1991
Assistant Commissioner of Health Delivery Systems, Nancy Feldman, 1986 to 1991
Assistant Commissioner of Administration, Thomas Maloy, 1983 to 1991

Marlene M. Marschall, R.N. – 1991 to 1993
Deputy Mary Jo O'Brien, 1991 to 1993
Assistant Commissioner of Health Delivery Systems, Barbara Nerness, 1991 to 1993
Assistant Commissioner of Administration, Thomas Maloy, 1991 to 1993
Assistant Commissioner of Health Protection, Beverly Krogseng, 1991 to 1993
Assistant Commissioner of Health Protection, Christine Rice, 1993 to 199
Assistant Commissioner of Health Care Resources and Systems, Andrea Walsh, 1991 to 1993

Mary Jo O'Brien – 1993 to 1995
Deputy Anne Barry, M.P.H., 1993 to 1995
Assistant Commissioner of Health Delivery Systems, Barbara Nerness, 1993 to 1994
Assistant Commissioner of Health Protection, Christine Rice, 1993 to 1995
Assistant Commissioner of Health Care Resources & Systems, Elizabeth Quam, 1993 to 1995

[1505] Includes only those commissioners who were approved during Senate hearings.

Anne Barry, M.P.H. – 1995 to 1999
Deputy Christine Rice, 1995 to 1997
Deputy Kirsten Libby, 1997 to 1998
Deputy Michael Moen, M.P.H., 1998 to 1999
Deputy Kelli Johnson, 1999
Assistant Commissioner of Health Quality Assurance, Elisabeth Quam, 1995
Assistant Commissioner of Health Protection, Kelli Johnson, 1996 to 1999
Assistant Commissioner of Health Systems & Special Populations, Barbara Colombo, 1996 to

Jan Malcolm – 1999
Deputy Julie Brunner, 1999
Assistant Commissioner of Health Protection Bureau, Aggie Leitheiser, 1999
Assistant Commissioner of Access and Quality Improvement Bureau, Richard Wexler, 1999
Assistant Commissioner of Family and Community Development Bureau, Gayle Hallin, 1999

Name of Division	Division Director	Dates Served
Environmental Sanitation	Herbert M. Bosch, M.P.H.	1949-50
Environmental Sanitation (*Renamed Environmental Health in 1964*)	Frank L. Woodward, M.P.H.	1950-68
Environmental Health	Frederick F. Heisel, M.P.H.	1968-76
Environmental Health	David Giese	1977
Environmental Health	Richard Wade, Ph.D.	1977-78
Environmental Health	Roger DeRoos, Ph.D.	1979-83
Environmental Health	Ray Thron	1983-92
Environmental Health	Patricia Bloomgren	1992-99
Medical Laboratories	Paul Kabler, Ph.D., M.D., M.P.H.	1949
Medical Laboratories	Henry Bauer, Ph.D.	1949-76
Medical Laboratories	D. Stickle, Ph.D. (Acting Division Director)	1977
Medical Laboratories	C. Dwayne Morse, Dr. P.H.	1978-83
Public Health Labs	H. Markowitz	1984-86
Public Health Labs	Dr. Robert Lindner	1987-89
Public Health Labs	Pauline Bouchard	1989-99
Public Health Labs	Norman Crouch	1999
Preventable Disease *(Renamed Disease Prevention and Control in 1973; Renamed Personal Health Services in 1975)*	D. S. Fleming, M.D., M.P.H.	1949-75
Personal Health Services	Barry Levy, M.D. (Acting Division Director)	1975-76
Personal Health Services	Grace Gumnit (Acting Division Director)	1976-78
Personal Health Services	Warren Lawson, M.D.	1979
Disease Prevention and Control	Andrew Dean, M.D.	1979-84
Disease Prevention and Health Promotion	Michael Moen, M.P.H.	1984-
Disease Prevention and Control	Aggie Leitheiser, M.P.H.	
Disease Prevention and Control	Martin LaVenture	To 1999
Departmental Administration *(Renamed Administrative Services in 1956)*	Jerome W. Brower, L.L.B., M.A.	1949-59
Administrative Services	Henry Bauer, Ph.D.	1960-66
Administrative Services	Warren Lawson, M.D., M.P.H.	1966-72
Asst Executive Officer for Administration	Duane Johnson	1972-80
Asst Commissioner for Administration	Tom Maloy	1980-94
Finance and Administration	Tom Maloy	1995-96
Finance and Administration	Christine Everson	1996-98
Finance and Administrative Services	Dave Johnson	1999
Health Information and General Services	Robert Hiller, Ph.D.	1991-92
Health Information and General Services	Tom Maloy	1994

Special Services	Robert N. Barr, M.D., M.P.H.	1949-53
Local Health Services	Robert N. Barr, M.D., M.P.H.	1953-55
Local Health Administration	Hilbert Mark, M.D.	1956-58
Local Health Administration	William Harrison, M.D.	1958-73
Community Services and Development	Robert Hiller, Ph.D.	1973-75
Community Services and Development	Ernest Kramer, M. H.A.	1975
Community Services	Jerry Nida, M.D.	1980-82
Community Health Services	James Parker	1984-91
Community Health Services	Ryan Church	1991-99

Hospital Services *(Renamed Health Facilities in 1973)*	Helen Knudsen, M. D., M.P.H.	1956-74
Health Facilities	Vacant	1975
Health Facilities *(Renamed Health Systems in 1979; Renamed Health Resources in 1984)*	Janet Brodahl	1976-87
Health Resources	Michael Tripple	1987-90
Facility and Provider Compliance	Linda Sutherland	1990-99

Special Services	A. B. Rosenfield, M.D., M.P.H.	1956-72
Services for Children with Handicaps	Grace Gumnit (Acting Division Director)	1982-83
Maternal and Child Health	E. Hendricks	1983-84
Maternal and Child Health	Carolyn McKay, M.D.	1986-91
Maternal and Child Health	Pati Maier (Acting Division Director)	1991-92
Maternal and Child Health *(Renamed Family Health in 1995)*	Donna Peterson, Ph.D.	1992-95
Health Promotion and Education	Richard Welch	1987-94
Family Health	Bert Hirschhorn, M.D.	1995-98
Family Health	Jan Jernell	1998-99

Policy and Communications	Patricia Conley	1999

Health Manpower Services	Connie Larson	1976-81
Health Systems Development	Kathy Burek	1987-91
Health Care Delivery Systems *(Renamed Occupational and Systems Compliance in 1995)*	Nanette Shroeder	1991-9x
Health Care Delivery Policy	Mary Kennedy	1995
Health Policy and Systems Compliance	David Giese	1996-99

Appendix C:

Organizational Structure of the Department

The organizational structure of the Department of Health has changed several times from 1949 to 1999, ultimately driven by responding to or efforts to prevent public health problems in Minnesota. These changes can be propelled by federal and state legislation, state studies and analyses, and by internal policies and decisions.

The first Board of Health began in 1872 with one employee, Dr. Charles Hewitt, organizing the work around the control of communicable disease. By 1897 there were six employees: an assistant bacteriologist, a temporary assistant, a janitor and medical students who kept the laboratory clean and did odd jobs, and staff providing clerical support.[1506] There were no designated units in 1897, but as the number of employees grew, sections were formed, each headed by a director who was in charge of program operations. Divisions and the units within highlight public health concerns for the day. In 1914, for example, the divisions of the organization included tuberculosis, venereal disease, and child conservation.[1507]

In 1946 the department reorganized into five sections along functional lines: environmental sanitation, medical laboratories, preventable diseases, departmental administration and special services. This structure remained in place in 1949, and the divisions of each, along with the heads, are listed below:

ORGANIZATION OF MINNESOTA DEPARTMENT OF HEALTH[1508]

1949

Section of Departmental Administration – Jerome W. Brower, LL.B., M.A., Chief
- Division of Public Health Education – William Griffiths, M.A., Director
- Division of Vital Statistics – J. W. Brower, Acting Director
- Division of Administration – J. W. Brower, Acting Director
  - Embalmers and Funeral Directors Unit - Charles Amann, Supervisor
  - Fiscal Unit – B. J. Estlund, Supervisor
  - Central Stores and Service Unit – F. Michaelsen, Supervisor
  - Library Unit – Eleanor Barthelemy, B.A., B.S. in L.S., Librarian

Section of Preventable Disease – D. S. Fleming, M. D., M.P.H., Chief
- Mental Health Unit – William Griffiths, M.A., Acting Supervisor
- Division of Cancer Control – N.O. Pearce, M.D., Acting Director
- Division of Epidemiology – C. B. Nelsen, M.D., M.P.H., Director
- Division of Tuberculosis – Hilbert Mark, M.D., M.P.H., Director
- Division of Venereal Disease – H. G. Irvine, M.D., Acting Director

[1506] Philip Jordan, *The People's Health,* p. 79.
[1507] Ibid., p. 98.
[1508] MDH, internal report on organization of department, 1949.

Section of Medical Laboratories – Paul Kabler, Ph.D., M.D., M.P.H., Chief
Virus and Rickettsia Unit – Marion Cooney, B.A., Supervisor
Laboratory Evaluation Unit – Henry Bauer, M.A., Supervisor
Services Unit – Albert Anderson, Supervisor
Division of Serology – Anne Kimball, Ph.D., Director
Division of Microbiology – Mary Giblin, M.S., Director
Duluth-St. Louis County Branch Laboratory – H. E. Hoff, M.P.H., Bacteriologist in charge

Section of Environmental Sanitation – Herbert M. Bosch, M.P.H., Chief
Division of Municipal Water Supply – O.E. Brownell, C.E., Director
Division of Water Pollution Control – Harvey G. Rogers, Director
Division of General Sanitation – Frank L. Woodward, B.E., Director
Laboratory Unit – Dean M. Taylor, B.Ch.E., Public Health Engineer in charge
Plumbing Unit – W. J. Cannon, Supervisor
Division of Industrial Health – George S. Michaelsen, M.S., Acting Director
Division of Hotel and Resort Inspection – Harold S. Adams, B.S., Director

Section of Special Services – R. N. Barr, M.D., M.P.H., Chief
Division of Maternal and Child Health – A.B. Rosenfield, M.D., M.P.H., Acting Director
Nutrition Unit – Irene Netz, B.S., Supervisor
Division of Hospital Services – Helen Knudsen, M.D., M.P.H., Director
Hospital Licensing Unit – Ethel McClure, R.N., M.P.H., Supervisor
Division of Public Health Nursing – Ann S. Nyquist, R.N., Director
Division of Dental Health – W. A. Jordan, D.D.S., M.P.H., Director
Division of Local Health Services – Percy T. Watson, M.D., M.P.H., Director

Four of these sections remained as divisions, with slightly different titles, in 1999: departmental administration became finance and administration, preventable disease was renamed disease prevention and control, environmental sanitation continued as environmental health, and medical laboratories had changed to public health laboratories. Special services evolved through the years, developing into five separate divisions in 1999: family health, community health services, facility and provider compliance, health care delivery policy and occupational and systems compliance.

From 1949 to 1999 the organization of the department changed several times. The most significant changes occurred in 1953, 1956, 1973, 1979, 1982, 1984, 1988, 1991 and 1995.

Organizational Changes in the 1950s

On September 25, 1952, the board approved a new organizational structure, effective January 1, 1953. [1509] In keeping with the 1951 recommendations made by the Governor's Efficiency in Government Commission, changes were made to more appropriately reflect common groupings of functions. Public health education was moved from administration to local health services. The laboratory unit in environmental sanitation was transferred to the laboratory service section in the medical laboratories section.

[1509] MDH, *Minnesota's Health,* Vol. VI, No. 11, December 1952, p. 4.

Section/Division Structure of Department of Health	
1949[1510]	**1953**[1511]
Section of Departmental Administration	Division of Departmental Administration
Section of Preventable Disease	Division of Disease Prevention and Control
Section of Medical Laboratories	Division of Medical Laboratories
Section of Environmental Sanitation	Division of Environmental Sanitation
Section of Special Services	Division of Local Health Services

The 1953 reorganization of the department's structure reflected reduced infectious disease problems and increased attention to chronic diseases and problems of the elderly as public health issues. The name of the preventable disease division was changed to disease prevention and control. Within that division, the sections of epidemiology, tuberculosis, venereal disease, and heart disease and cancer control were combined to form just two sections: communicable diseases and chronic disease and geriatrics.[1512]

Other changes in the 1953 reorganization emphasized more and better hospitals, and an enlarged rehabilitation program. In addition, to decentralize services and make them more accessible to citizens, new district offices were established. The division of special services was renamed local health services.

During the 1953 reorganization, the terms "division" and "section" were reversed, following a recommendation by the Governor's Efficiency in Government Commission. The consultants who reviewed the Health Department felt the naming of the organization's structural units was backwards. Only two health departments, Minnesota and Wisconsin, used the term "section" to refer to the major segments of their agency's structure.

The second major departmental reorganization between 1949 and 1999 occurred October 3, 1956, when the number of divisions increased from five to seven.[1513] The local health services division was divided to create three divisions: hospital services, local health administration, and special services.

Dr. Helen Knudsen assumed leadership of hospital services, Dr. Hilbert Mark headed the local health administration division, and Dr. Arne Rosenfield became head of special services. Dr. Mark's position was previously held by Dr. Robert Barr, now secretary and executive officer.[1514]

The new special services division reflected the growing attention to non-communicable disease and included maternal and child health, nutrition, dental health, public health education, preventive mental health services, alcoholism and the library.

[1510] MDH organizational chart, September 1949.
[1511] MDH organizational chart, 1953.
[1512] MDH, *Biennial Report, 1953-1955,* pp. 2-3.
[1513] BOH, *New Dimensions for Minnesota: Planning Guide for 1963-1973,* 1962 p. 3.
[1514] MDH, *Minnesota's Health,* Vol. 10, No. 9, November 1956, p. 1.

Division Structure of Department of Health	
1953	**1956**[1515]
Division of Departmental Administration	Division of Administrative Services
Division of Disease Prevention and Control	Division of Disease Prevention and Control
Division of Medical Laboratories	Division of Medical Laboratories
Division of Environmental Sanitation	Division of Environmental Sanitation
Division of Local Health Services	Division of Local Health Administration
	Division of Hospital Services
	Division of Special Services

Legislation passed in 1957 created a poison information center that was placed in the special services division and headed by Dr. Warren Lawson.[1516] This center became operational in 1958.[1517] Legislation passed in 1959 resulted in a human genetics program at the department.[1518] It was added to the special services division and became operational in 1960 when a geneticist, Lee Schacht, Ph.D., was appointed to head the unit.[1519]

Organizational Changes in the 1960s

In 1962, a rehabilitation and aging services unit, with Dr. Bernard Woleyn as chief, was added to hospital services, and a state tuberculosis services unit, with Dr. E. P. K. Finger as consultant, was identified in disease prevention and control. Also in 1962, a civil defense coordinator, Marvin Tyson, was added to the local health administration division.

A number of departmental programs were added or relocated in 1963. The supplies and services section was transferred from the medical laboratories division" to the administrative services division. A school health unit, with Paul Riddle as coordinator, was established in the maternal and child health section, and public health nursing was transferred from the local health administration division to the administrative services division. This was also the year when the environmental sanitation division was renamed the environmental health division.[1520] After receiving authorization from the state Department of Administration, these changes were officially adopted by the Board of Health in January 1964.[1521] Later in 1964, the migrant health program, headed by Judith Bieber, was added to the disease prevention and control division.

To address federal Medicare legislation, in 1965 a special unit, Medicare services coordination, with Dr. Donald McCarthy as coordinator, was added to the department's organizational structure. This unit reported directly to the secretary and executive

[1515] MDH organizational chart, July 1956.
[1516] Minnesota State Statute 144.055, passed in 1957.
[1517] BOH, *New Dimensions for Minnesota: Planning Guide for 1963-1973,* 1962, p. 109.
[1518] Minnesota State Laws, Chapter 572, Session Laws 1959.
[1519] BOH, *Minutes,* October 18, 1960, MHC, pp. 395-396.
[1520] BOH, *Minutes,* October 8, 1963, MHC, p. 464.
[1521] BOH, *Minutes,* January 14, 1964, MHC, p. 1.

officer. During the same year, the family life education section, supervised by Genevieve Danskroger, was added to the special services division.

In 1967 water pollution control activities became part of a separate state agency, the Minnesota Pollution Control Agency. The same year, the health mobilization unit (civil defense) was transferred from local health administration to environmental health, as increased focus was placed on the health risks of radiation.

In 1968 the rehabilitation and aging services unit was eliminated as a separate entity within hospital services. Also in 1968, the health mobilization unit was transferred from environmental health to special services. Reflecting a rise in cases, in 1969 a new unit, venereal disease control, was added to the disease prevention and control division.

Organizational Changes in the 1970s

Major changes in the organization's structure were made when Dr. Warren Lawson became head of the department. In 1973 he created a new line of command, with the positions of assistant executive officer for administration and assistant executive officer for programs. Initially, these appointed positions were held by Duane Johnson (administration) and Dr. Ellen Fifer (programs). Division heads no longer reported directly to the secretary and executive officer but rather to the assistant executive officers.

With an increasing regulatory role and in keeping with the country's focus on planning, a legal officer and a planning officer, both of whom reported directly to the head of the department, were added in 1973. These positions were initially filled by Margaret Tanna (planning) and Richard Wexler (legal).

Significant reorganization of the department took place in 1973. The hospital services division became the health facilities division. One year earlier, on October 1, 1972, the Medicare services unit, which reported directly to the commissioner, was merged with hospital services to prevent duplication of efforts.[1522] The Medicare services unit, responsible for federal certification requirements for Medicare facilities since 1966, was conducting some of the same field survey activities being done in the hospital services division for state licensing.[1523]. This new health facilities division was now responsible for survey, federal certification, state licensing, technical services, and emergency medical services. Emergency medical services included injury control and the health mobilization unit, in addition to ambulance response.

Reflecting Dr. Lawson's strong commitment to the development of a community health system, the local health administration division was replaced with the community services and development division in 1973. Initially directed by Robert Hiller, this

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[1522] Memo from Dr. Helen Knudsen and Ellis Olson to all licensing and certification program personnel in the hospital services division, November 29, 1972.

[1523] Memo from Dr. Warren Lawson to Administration Commissioner Richard Brubacher, November 28, 1972.

division included three sections: community nursing, community services, and community development. It also had oversight for the regional offices.

The disease prevention and control division and the special services division were reorganized into the personal services division in 1973. This became a very large division including the following sections and units: maternal and child health, family planning, human genetics, dental health, nutrition, poison information, infant and child health, adult health, chronic disease, aging, disease prevention and control, venereal disease, zoonosis control, immunization, epidemiology, tuberculosis control, chemical dependency and state employee health services. Dr. Dean Fleming, who had been with the department since 1938, continued as head of this new division. An additional change during this reorganization was the placement of health education within administration.

One significant change during this time was Dr. Lawson's title. Though the board was still intact, 1973 legislation changed the title of the head of the agency from secretary and executive officer to commissioner. The assistant executive officers" became assistant commissioners.

Division/Bureau Structure of Department of Health		
1956	**1970**[1524]	**1973**[1525]
		Assistant Executive Officer for Administration
Division of Administrative Services	Division of Administrative Services	
		Assistant Executive Officer for Programs
Division of Disease Prevention and Control	Division of Disease Prevention and Control	
		Division of Personal Services
Division of Medical Laboratories	Division of Medical Laboratories	Division of Medical Laboratories
Division of Environmental Sanitation	Division of Environmental Health	Division of Environmental Health
Division of Local Health Administration	Division of Local Health Administration	
Division of Hospital Services	Division of Hospital Services	Division of Health Facilities
Division of Special Services	Division of Special Services	
		Division of Community Services and Development

In 1976, Dr. Lawson announced several organizational changes, the most significant being increased organizational focus for the development of community health services.[1526] Along with the position of assistant commissioner of administration and

[1524] MDH organizational chart, 1970.
[1525] MDH organizational chart, August 1973.
[1526] Memo from Commissioner Warren Lawson to division directors and activity managers, February 6, 1976.

assistant commissioner of programs, an assistant commissioner of community development position was created to ensure development of a community health services system. This bureau included the former community services development division as well as two other sections. The technical support section would provide the framework and technical support to community health services agencies. A special projects section would operate as a liaison between federal and state agencies and private and public organizations.

Division/Bureau Structure of Department of Health		
1973	**1976**[1527]	**1979**[1528]
Assistant Commissioner for Administration	Assistant Commissioner for Administration	Bureau of Administration
Assistant Commissioner for Programs	Assistant Commissioner for Programs	Bureau of Health Services
Division of Personal Health Services	Division of Personal Health Services	Division of Disease Prevention and Control
Division of Medical Laboratories	Division of Medical Laboratories	Division of Medical Laboratories
Division of Environmental Health	Division of Environmental Health	Division of Environmental Health
Division of Health Facilities	Division of Health Facilities	
Division of Community Services and Development	Division of Health Manpower	
	Assistant Commissioner for Community Development	Division of Community Services
		Bureau of Health Resources
		Division of Health Systems
		Division of Health Manpower

Another addition to the department in 1976 was the creation of a health manpower section to centralize the department's function in oversight of health providers and service delivery, such as hospital administration registration. In keeping with this centralization, the mortuary science section was transferred from administration to the health manpower division.

Organizational Changes Under Dr. Pettersen (1979 to 1982)

Commissioner George Pettersen began using the term "bureaus" to refer to the level of command between the commissioner and divisions. In 1979 he renamed them bureau of administration, bureau of health services, and bureau of health resources and rearranged the divisions within these bureaus. As funding for hospitals through Hill-Burton was no longer available and as the regulatory roles of the department were increasing, the health facilities division became part of the new health systems divisions

[1527] MDH organizational chart, February 1976.
[1528] MDH organizational chart, June 1979.

and existing health manpower division. At the same time the community services division was recreated.

Division/Bureau Structure of Department of Health	
1979	**1982**[1529]
Bureau of Administration	Bureau of Administration
Bureau of Health Services	Bureau of Health Services
Division of Disease Prevention and Control	Division of Disease Prevention and Control
Division of Medical Laboratories	Division of Medical Laboratories
Division of Environmental Health	Division of Environmental Health
	Division of Services for Children with Handicaps
Division of Community Services	
Bureau of Health Resources	
Division of Health Systems	Division of Health Systems
Division of Manpower Services	

After his initial restructuring, Dr. Pettersen did not make further changes to the organizational chart until June 1982, six months before his administration ended. An executive office report explained that organizational changes were driven by financial cutbacks.[1530] State funding for department programs had been reduced by 18.6 percent for the biennium ending June 30, 1983. Federal funding had been reduced in many programs and categorical funds had been consolidated into block grants, which permit funds to be used to meet state rather than federal priorities.

In response to the cutbacks, Dr. Pettersen eliminated the manpower division by transferring its functions to the health systems division. The community services division and the bureau of health resources were also eliminated. Most of the activities within the community service division were transferred to the disease protection and control division. The disease prevention and control division was expanded with the following: maternal and child health, public health nursing, nutrition, dental health, family planning, human genetics, hearing and vision screening and child health screening. The federal Women, Infants and Children (WIC) program was transferred to the bureau of administration. One new division was created: the services for children with handicaps division. The executive office memo explaining these changes was not optimistic: "These reductions do not appear to be short term but rather will continue into the future and could potentially increase."[1531]

Organizational Changes Under Sister Mary Madonna Ashton

Despite the bleak report of Dr. Pettersen, the changes made in 1982 were short lived. Within three months after assuming her new position as health commissioner in 1983, Sister Mary Madonna Ashton had re-established the maternal and child health division and had transferred the WIC program from administration to the maternal and child

[1529] MDH organizational chart, July 1982.
[1530] MDH (executive office), "Organizational Changes – 1982," June 1982.
[1531] Ibid.

health division. She moved the services for children with handicaps division to a section within that division. Commissioner Mary Madonna established a bureau of community services, which included the maternal and child health division and the health systems division.

In 1984 Commissioner Mary Madonna re-established the community health services division, changed the name of the bureau of community services to the bureau of health delivery systems, and transferred public health nursing back to community health services. Continuing the expansion, in 1987 the health promotion and education division and the health system development division were formed. Nutrition and dental health were moved to the health promotion and education division.

Two significant additions to the department occurred in 1987. The AIDS prevention services section was created in the disease prevention and control division, and the nonsmoking and health section," led by Kathy Hardy, became part of the health promotion and education division.

Division/Bureau Structure of Department of Health		
1982	**1984**[1532]	**1988**[1533]
Bureau of Administration	Bureau of Administration	Bureau of Administration
Bureau of Health Services	Bureau of Health Protection	Bureau of Health Protection
Division of Disease Prevention and Control	Division of Disease Prevention and Health Promotion	Division of Disease Prevention and Control
Division of Medical Laboratories	Division of Medical Laboratories	Division of Public Health Laboratories
Division of Environmental Health	Division of Environmental Health	Division of Environmental Health
		Division of Health Promotion and Education
Division of Services for Children with Handicaps		
	Bureau of Health Delivery Systems	Bureau of Health Delivery Systems
Division of Health Systems	Division of Health Systems Development	Division of Health Systems Development
	Division of Community Health Services	Division of Community Health Services
	Division of Health Resources	Division of Health Resources
	Division of Maternal and Child Health	Division of Maternal and Child Health

By 1988, the organizational structure of the department was as large as it had ever been with eight divisions and three bureaus. The health delivery systems bureau included these divisions: community health services, health resources, health systems development and maternal and child health. The health protection bureau included:

[1532] MDH organizational chart, September 1984.
[1533] MDH organizational chart, January 1988.

disease prevention and control, environmental health, health promotion and education, and public health laboratories. The third bureau was administration.

Organizational Changes in the 1990s

During Gov. Arne Carlson's administration, from 1991 through 1998, there were three health commissioners: Marlene M. Marschall, Mary Jo O'Brien and Anne Barry.[1534] Several changes were made to the organizational structure during this period, most of them occurring during the first three years and most focusing on the administration's emphasis on health care access.

Division/Bureau Structure of Department of Health		
1988	**1991**[1535]	**1995**[1536]
Bureau of Administration	Bureau of Administration	
		Division of Finance and Administration
Bureau of Health Protection	Bureau of Health Protection	Bureau of Health Protection
Division of Disease Prevention and Control	Division of Disease Prevention and Control	Division of Disease Prevention and Control
Division of Public Health Laboratories	Division of Public Health Laboratories	Division of Public Health Laboratories
Division of Environmental Health	Division of Environmental Health	Division of Environmental Health
Division of Health Promotion and Education		
Bureau of Health Delivery Systems	Bureau of Health Delivery Systems	Bureau of Health Systems Development
Division of Maternal and Child Health	Division of Maternal and Child Health	Division of Family Health
Division of Community Health Services	Division of Community Health Services	Division of Community Health Services
Division of Health Resources	Division of Health Promotion and Education	Division of Health Care Delivery Policy
Division of Health Systems Development		
	Bureau of Health Care Resources and Systems	Bureau of Health Quality Assurance
	Division of Health Resources	Division of Facility and Provider Compliance
	Division of Health Care Delivery Systems	Division of Occupational and Systems Compliance

In 1991 Commissioner Marlene Marschall added a fourth bureau to the department. The health care resources and systems bureau included the health resources division and the health care delivery systems division. This bureau had responsibility for regulation of long-term care facilities, health economics, and health maintenance

[1534] Only those commissioners who were confirmed by the Senate are included.
[1535] MDH organizational chart, December 1991.
[1536] MDH organizational chart, March 1995.

organizations. It also focused on health care access, where much of this administration's emphasis was placed.

Commissioner Mary Jo O'Brien made several organizational changes during her two-year administration. She eliminated the bureau of administration and formed a new health quality assurance bureau. Commissioner O'Brien combined the maternal and child health division and the health promotion and education division to form the family health division. The health information and general services division was renamed finance and administration. The center for health statistics section was transferred from finance and administration to the community health services division, and district services were relocated from community health services to finance and administration.

In 1995, Anne Barry assumed leadership of the department and made further changes to the structure. The health protection bureau remained as it was, but the other two bureaus were replaced by the access and quality improvement bureau and the family and community health bureau. The family and community health bureau consisted of the community health service and family health divisions. The access and quality improvement bureau focused on the department's regulatory responsibilities in the areas of health facilities, health providers and health systems. The organizational structure in 1999 plus the heads of the divisions are given on the following pages:

ORGANIZATION OF MINNESOTA DEPARTMENT OF HEALTH

1999

Bureau of Health Protection – Aggie Leitheiser, Assistant Commissioner

Disease Prevention and Control Division – Martin LaVenture, Acting Director

- Acute Disease Epidemiology – Richard Danila
- Acute Disease Prevention Services – Alan Lifson
- AIDS/STD Prevention Services – Jill DeBoer
- Cancer Control – Jonathan Slater
- Chronic Disease and Environmental Epidemiology – Alan Bender
- Epidemiology Field Service – Jack Korlath

Environmental Health Division – Patricia Blomgren, Director

- Drinking Water Protection – Gary Englund
- Environmental Surveillance and Assessment – Rebecca Lofgren
- Environmental Health Services – Gary Englund
- Asbestos, Indoor Air, Lead and Radiation – Robert Einweck
- Well Management – Daniel Wilson
- Division Services – Robert Einweck

Public Health Laboratory – Norman Crouch, Director

- Chemical Laboratory – Jean Kahilainen
- Clinical Laboratory
- Laboratory Services – Allen Tupy

Bureau of Access and Quality Improvement – Dick Wexler, Assistant Commissioner
Facility and Provider Compliance Division -- Linda Sutherland, Director
Case Mix Review – Ann Lutterman
Engineering Services – Jim Loveland
Information Analysis – Cecilia Jackson
Licensing and Certification – Mary Absolon
Office of Health Facility Complaints – Arne Rosenthal

Health Policy and Systems Compliance – David Giese, Director
Data Analysis Program – Lee Habte
Health Economics Program – Scott Leitz
Health Occupations Program – Tom Hiendlmayr
Managed Care Systems – Kent Peterson
Mortuary Science – David Benke
Information Clearinghouse – Carol Southward

Bureau of Family and Community Health – Gayle Hallin, Assistant Commissioner
Community Health Service Division – Ryan Church, Director
Center for Health Statistics – John Oswald
Community Development – Patricia Lind
Office of Rural Health and Primary Care – Estelle Brouwer
Public Health Nursing – Mary Rippke
Health Systems Development – Debra Burns

Family Health Division – Jan Jernell, Director
MN Children with Special Health Needs
Center for Health Promotion – Don Bishop
Maternal and Child Health – Ron Campbell
Supplemental Nutrition Programs – Betsy Clarke
Tobacco Prevention and Control – Gretchen Griffin

Finance and Administrative Services Division – Dave Johnson, Assistant Commissioner
Budget – Tom Maloy
Facilities Management – Rick Kantorowicz
Financial Management – Dave Hovet
Human Resources – Ron Olson
Information Systems – Denton Peterson
Workforce Diversity – Sonia Alvarez

Policy and Communications Division – Patricia Conley, Director
Communications – John Steiger
Intergovernmental Relations – Lin Nelson
Library – Diane Jordan
Policy – Marie Dotseth

Department of Health Functions

Changes in the organizational structure and management of the department reflect changes in its purpose and role.

In 1999 the department was described as the state government agency dedicated to the prevention of disease and disability, the protection of health, and the promotion of healthy behaviors and conditions that lead to improved health for all Minnesotans. [1537] This general description of purpose was just as applicable in 1949 when the powers and duties of the Board of Health were exercised through the department. General powers and duties of the board as they were in 1949 are given below:

- Exercise general supervision over all health officers and boards,
- Take cognizance of the interests of health and life among the people,
- Investigate sanitary conditions,
- Learn the cause and source of diseases and epidemics,
- Observe the effect upon human health of localities and employments, and
- Gather and diffuse information upon all subjects to which its duties relate.
- Gather, collate, and publish medical and vital statistics of general value and
- Advise all state officials and boards in hygienic and medical matters, especially those involved in the proper location, construction, sewerage and administration of prisons, hospitals, asylums, and other public institutions.
- Report its doings and discoveries to the legislature at each regular session thereof, with such information and recommendations as it shall deem useful. [1538]

In addition, the board had special powers and duties in the areas of reporting and regulation. It had specific authority in the areas of polluted drinking water, offensive trades, hotels, restaurants, resorts, small boats, plumbers, embalmers, funeral directors, narcotics, hospitals, rest homes, maternity homes and homes providing chronic and convalescent care for the aged and infirm.[1539]

In its audit, the state's public examiner enumerated the functions of the department. The 1949 report listed those above, plus registration of superintendents or administrative heads of hospitals and sanitariums and the inspections of children's camps and migrant labor camps.[1540]

[1537] MDH, "Minnesota Department of Health Strategic Direction: For protecting, maintaining and improving the health of all Minnesotans," http://www.health.state.mn.us/news/strategy.htm, May 2000.
[1538] Minnesota Statutes 1945, Section 144.05
[1539] BOH, "The Minnesota State Board of Health Organization and Functions," 1949, p. 4.
[1540] *Report of Public Examiner on the Financial Affairs of Department of Health, 1949.*

Few changes were made to the auditor's list of functions during the 1950s and 1960s. In 1959, they were expanded to include: "develop and conduct by exhibit, demonstration, health education, public health engineering activity, or any other means, a home safety program." Also added was "procure and store blood typing serums and provide disposable blood containers in which to collect citrated whole blood for transfusion purposes."[1542] The functions of the department, as given in the public examiner's report, remained unchanged from 1959 through 1964.

In the 1970s the state auditor rewrote the functions of the department in its report. In keeping with Dr. Lawson's emphasis on community health service, there was a greater focus on coordination of activities at all levels of government. Regulatory activities, which were becoming an increasing part of the department's functions, were condensed into one function: "establish and enforce health standards for the protection and the promotion of the public's health such as quality of health services, reporting of disease, regulation of health facilities, environmental health hazards and manpower."[1543]

The 1999 responsibilities of the department include attention to healthy lifestyles and health care access. The basic responsibility of the department, assessment of disease and support of appropriate interventions to assure the health of the people of Minnesota, remains in the forefront, as it has since 1872.

Functions of Minnesota Department of Health in 1977

- **Conduct studies and investigations, collect and analyze health and vital data, and identify and describe health problems;**
- **Plan, facilitate, coordinate, provide, and support the organization of services for the prevention and control of illness and disease and the limitation of disabilities resulting there from;**
- **Establish and enforce health standards for the protection and promotion of the public's health such as quality of health services, reporting of disease, regulation of health facilities, environmental health hazards and manpower;**
- **Affect the quality of public health and general health care services by providing consultation and technical training for health professionals and paraprofessionals;**
- **Promote personal health by conducting general health education programs and disseminating health information;**
- **Coordinate and integrate local, state and federal programs and services affecting the public's health;**
- **Continually assess and evaluate the effectiveness and efficiency of health service systems and public health programming efforts in the state; and**
- **Advise the governor and legislature on matters relating to the public health.**[1541]

State Audit Report, 1977

[1541] *Audit Report: Department of Health Five Years Ended June 30, 1977*, pp. 13-14.
[1542] *Report of Public Examiner on the Financial Affairs of Department of Health, Years Ended June 30, 1957, 1958 and 1959*, p. 2.
[1543] *Audit Report Department of Health Five Years Ended June 30, 1977*, pp. 13-14.

Minnesota Department of Health

1999

As the state's leading agency on health-related issues, we:

- **monitor disease trends and detect and investigate disease outbreaks**
- **research the causes of illness, including cancer, and operate programs to prevent diseases from occurring**
- **provide laboratory services to support public health and environmental programs**
- **help people make healthier lifestyle choices**
- **develop strategies to improve the health of vulnerable populations, including children**
- **safeguard the quality of health care by regulating many of the people and institutions providing that care**
- **develop and implement strategies to contain health care costs, while working to assure that all Minnesotans have access to affordable, high quality health care**
- **identify and evaluate potential health hazards in the environment**
- **safeguard the quality of the food we eat in restaurants, the water we drink, and the air inside our homes and places of work**
- **work closely with Minnesota's local public health agencies, providing support and technical assistance in planning and providing services at the local level**
- **develop working relationships with a broad spectrum of community and statewide agencies on health-related issues.**[1544]

Minnesota Department of Health, 1999

[1544] MDH, "Minnesota Department of Health Strategic Direction: For protecting, maintaining and improving the health of all Minnesotans," http://www.health.state.mn.us/news/strategy.htm, May 2000.

Appendix D:

Minnesota State Board of Health Members

The board consisted of nine members until 1973 when it was expanded to 15 members. The board was abolished in1977.

Arnold C. Anderson, A.M.S., 1961-66, Montevideo
George Arvidson, D.C., 1975-77, St. Paul
Lawrence M. B. Atkinson, R.Ph., 1959-61, Minneapolis
Frederic E. Bass, C.E., 1931-52, Minneapolis
Thomas J. Beaulieu, Jr., 1960-61, Graceville
Frederick W. Behmler, M.D., 1940-54, Morris
Verna Mae Blomquist, R.N., 1967-71, St. Paul
Herbert Bosch, M.P.H., P.E., 1952-62, Minneapolis
Ruth E. Boynton, M.D., 1939-61, Minneapolis
Alyce Clay, R.N., 1971-73, St. Paul
Bridget R. Coleman, 1974-77, St. Paul
Patrick M. Daugherty, 1974-77, Minneapolis
Arnold D. Delger, B.S. Pharm, 1962-71, St. Paul
John B. Dougherty, B.S. Biology, 1966-69, Hibbing
Katharine D. Dreves, R.N, 1961-67, St. Paul
Reynold P. Flom, M.D., 1966-69, Roseville
Theodore Garcia, 1975-77, Crookston
H.Z. Giffin, M.D., 1950-52, Rochester
Joseph Gitis, 1974-77, Golden Valley
Harold C. Habien, M.D., 1954-56, Rochester
James W. Halvorson, M.D., 1953-56, Goodhue
M. Sidney Hedeen, D.O., 1947-52, St. Paul
Hibbert Hill, P.E., 1963-71, Excelsior
John W. Hoepner, A.M.S., 1969-72, Redwood Falls
Edgar J. Huenekens, M.D., 1955-67, Minneapolis
Raymond J. Jackman, M.D., 1961-70, Rochester
Elizabeth M. Kalisch, 1974-77, White Bear Lake
Michael E. Keable, M.A., 1973-77, St. Cloud
Keith K. Keller, 1956-59, Minneapolis
Frederic J. Kottke, M.D., 1964-67, Minneapolis
Frank H. Krusen, M.D., 1955-63, Rochester
Odin M. Langsjoen, D.D.S., 1968-71, St. Cloud
Van Lawrence, 1976-77
John William Lawrow, M.D., 1971-75, Minneapolis
Helen Lee, 1975-76, Inver Grove Heights
Sister Marybelle Leick, M.H.A., 1969-72, Duluth
Felix Litman, D.D.S., 1956-61, Duluth
Ruth Howe Loevinger, R.N., 1956-61, Duluth
Inez B. Madsen, Embalmer, 1953-56, Worthington
Thomas B. Magath, M.D., 1939-49, Rochester
Burton Magnuson, B.S. Pharm, 1973-77, Duluth
Maurice D. McCollar, D.C., 1971-74, White Bear Lake
John T. McGregor, D.D.S., 1965-68, Cloquet
Winston Miller, M.D., 1954-55, Red Wing
William B. Neinaber, D.D.S., 1972-74, Minneapolis
Charles V. Netz, PhmD, 1947-55, Minneapolis
Valentine O'Malley, M.D., 1972-77, St. Paul
Russell G. Peterson, 1957-60, Minneapolis
Robert M. Reed, D.D.S., 1961-65, Faribault
Philip K. Schumacher, M.H.A., 1966-68, Eveleth
Arlen Simi, D.D.S., 1975-77, St. Cloud
Beverly Smerling, 1977
Bertram Strimling, 1971-74, Minneapolis
Donald C. Sundberg, 1968-71, Cambridge
Horatio B. Sweetser, M.D., 1967-71, Minneapolis
Theodore H. Sweetser, M.D., 1948-54, Minneapolis
Arnold O. Swenson, M.D., 1961-66, Duluth
Leo M. Thompson, Embalmer, 1940-57, Little Falls
Roberto E. Trevino, 1974-75, Moorhead
Martin Van Herik, M.D., 1970-72, Rochester
W. Lester Webb, D.D.S., 1944-53, Fairmont
Tha Loyce Wells, 1976-77
Harold A. Wente, M.D., 1957-61, Rochester
John H. Westerman, M.H.A., 1972-77, Minneapolis
W. W. White, M.D., 1953-56, Ruthton
Roberta Williamson, R.N., 1974-75, Eagan
Robert Willmarth, 1974-77, Rochester
Marlys Wolf, 1974-75, St. Cloud

Appendix E:

Hill-Burton Projects

General Hospitals and Beds

Location	Date of Bid Opening	Date Opened	Beds Per Construction Plan	Addition or New Hospital
Baudette	1948	1950	23	New, including sisters' quarters
Benson		1950	38	New
Crookston, St. Francis		1950	144	New
Greenbush	1948	1950	20	New
Bagley	1949	1950	30	New
Blue Earth	1949	1950	32	New
Sauk Centre	1949	1950	50	New, including sisters' quarters
Wells	1949	1950	32	New
Wheaton	1949	1950	22	New
Olivia	1949	1951	41	New
Slayton	1949	1951	48	New, including nurses' quarters
Worthington	1949	1951	80	New
Buffalo	1950	1951	28	New
Morris	1950	1951	50	New
Pelican Rapids	1950	1951	23	New
Red Lake Falls	1950	1951	20	New
Appleton	1950	1952	20	New
Litchfield	1950	1952	62	New
New Prague	1950	1952	39	New
Ortonville	1950	1952	60	New
Redwood Falls	1950	1952	41	New
Breckenridge, Nurses Residence	1951	1952	(60)	New
Breckenridge, St. Francis Hospital	1951	1952	123	New
Brainerd	1951	1953	129	New
Crookston, Bethesda	1951	1953	62	New
Hastings	1951	1953	50	New, including sisters' quarters
Madison	1951	1953	30	New, including nurses' quarters
Minneapolis, Mayo	1951	1954	106	New
Glenwood	1952	1953	25	Addition/Alteration
Shakopee	1952	1953	25	New, including sisters' quarters
St. Cloud Hospital	1952	1953	44	Alteration
St. Cloud Nurses' Home	1952	1953	(120)	Addition

Thief River Falls	1953	1955	64	Addition/Alteration
Aitkin	1953	1955	36	New
Cambridge	1955	1956	30	New
Long Prairie	1955	1956	30	New
Paynesville	1955	1956	25	New
Sandstone	1955	1956	25	New
Fergus Falls	1955	1957	42	Addition/Alteration
Two Harbors	1955	1957	37	New
Virginia Municipal	1955	1958	69	Addition/Alteration
Willmar	1955	1957	40	Addition/Alteration
Chisago City	1956	1957	25	New
Rush City	1956	1957	20	Addition/Alteration
Cloquet	1956	1958	76	New
Grand Marais	1957	1958	12	New
Hallock	1957	1958	34	New
Hendricks	1957	1958	30	New
Karlstad	1957	1958	7	Addition/Alteration
Tyler	1957	1958	34	New
Warren	1957	1958	37	New
Detroit Lakes	1957	1959	36	Addition/Alteration
Mahnomen	1957	1959	25	New
Buffalo	1958	1958	16	Addition/Alteration
Cook	1958	1959	18	New
Perham	1958	1959	33	New
Staples	1958	1959	18	Addition/Alteration
Wadena	1958	1959	Services	Addition/Alteration
Bemidji	1958	1960	30	Addition/Alteration
Faribault	1958	1960	71	New
Northfield	1958	1960	22	Addition/Alteration
Aurora	1959	1960	445	New
Little Falls	1959	1960	35	Addition/Alteration
Mountain Lake	1959	1960	25	Addition
Owatonna	1959	1960	27	Addition/Alteration
Bagley	1960	1961	9	Addition/Alteration
Fosston	1960	1961	35	New
Marshall	1960	1961	5	Addition/Alteration
Mora	1960	1961	10	Addition/Alteration
Tracy	1960	1961	42	New
Wabasha	1960	1961	45	Addition/Alteration
Lake City	1960	1962	11	Addition
Winona	1960	1962	110	New
Caledonia	1961	1962	37	New
Jackson	1961	1962	30	New
Princeton	1961	1962	14	Addition/Alteration
Spring Valley	1961	1962	35	New
Warroad	1961	1962	22	Addition
New Prague	1961	1963	10	Addition/Alteration
New Ulm, Loretto	1961	1963	65	New
Park Rapids	1961	1963	17	Addition/Alteration
Sleepy Eye	1961	1964	18	Addition/Alteration
Roseau	1962	1962	35	New
Canby	1962	1963	27	New
Gaylord	1962	1963	10	Addition/Alteration

Luverne	1962	1963	5	Addition/Alteration
Moose Lake	1962	1963	20	New
Waconia	1962	1963	45	New
Crosby	1962	1964	36	New
New Ulm, Union	1962	1964	13	Addition/Alteration
Ada	1963	1964	30	New
Farmington	1963	1964	45	New
Glencoe	1963	1964	25	Addition/Alteration
Littlefork	1963	1964	20	New
Pipestone	1963	1964	44	New
Big Fork	1963	1965	15	New
Edina, Fairview Southdale	1964	1965	225	New
Graceville	1964	1965	30	New
Rochester, Methodist	1964	1966	500	New
Milaca	1965	1966	25	New
Red Wing	1965	1967	96	Addition/Alteration
St Paul, Bethesda	1965	1967	60	Addition
Rochester, Olmsted Community	1966	1968	25	Addition/Alteration
St. Cloud	1966	1968	36	Addition/Alteration
St. Paul, St. Luke's	1966	1968	52	Addition/Alteration
Cambridge	1966	1969	18	Addition/Alteration
Minneapolis, Eitel	1966	1968	--	Addition/Alteration
Duluth, St. Luke's	1967	1969	268	Addition
Duluth, St. Mary's	1967	1969	174	Addition
Hutchinson	1968	1970	55	New
St. Paul, The Samaritan	1968	1970	93	Addition/Alteration
International Falls	1969	1970	63	New
Duluth, Miller	1969	1971	172	Addition
Fridley, Unity	1970		145	Addition
Brainerd, St. Joseph's	1970	1972	--	Addition/Alteration
Fairbault, Dist. Hosp.	1970	1972	33	Addition/Alteration
Fairmont	1970	1972	75	New
Willmar Hospital	1971		68	Addition/Alteration
Mpls., U of M Health Service	1971	1972	48	Addition/Alteration
Waconia, Ridgeview Hospital	1971		43	Addition/Alteration
Milaca, Area Hospital	1971	1972	18	Addition/Alteration
Alexandria Douglas	1971		56	Addition/Alteration
Moorhead, St. Ansgar	1971		15	Addition/Alteration
Benson, Swift County	1972		38	Addition/Alteration
Wadena, Wesley Hospital	1972		56	New & Alteration
Anoka-Coon Rapids, Mercy	1972		144	Addition/Alteration

Federal funds given these hospitals ranged from $37,973 for Benson (the new 38-bed hospital in Benson cost $371,610 in 1950) to $2,000,000 each for Fairview Southdale and Mayo Memorial.

Public Health Centers

Location	Date of Bid Opening	Date Opened	Type of Construction
Rochester		1950	New
Mpls., University Health Service	1949	1950	New
Minneapolis	1949	1958	New
St. Paul	1956	1958	New
Mpls., University Health Service	1956	1959	Addition
Mpls., University Health Service	1958	1968	Addition
Minneapolis, Lab Facilities for State Board of Health Building	1967	1969	New
Moorhead	1967		New
	1972		

Hill-Burton funds for these projects ranged from $23,625 for the Moorhead PHC to $1,517,431 for the State Board of Health laboratory.

Rehabilitation Centers

Location	Date of Bid Opening	Date Opened	Type of Construction
Minneapolis, Kenny Institute	1956	1957	Addition/Alteration
Minneapolis Rehab. Center	1959	1960	New
St. Paul Rehab. Center	1961	1965	Addition
Minneapolis Rehab. Center	1964	1965	Alteration
Mankato Rehab Center	1964	1965	New
Duluth Nat. G. Polinsky Rehab	1966	1967	New

Hill-Burton funds ranged from $45,143 to the Minneapolis Rehabilitation Center in 1965 to $339,466 for the Minneapolis Rehabilitation Center in 1960.

Mental Hospitals and Psychiatric Units of General Hospitals

Location	Date of Bid Opening	Date Opened	Type of Construction
Anoka Receiving	1950	1952	New
St. Paul, Miller Psych Unit	1951	1953	Addition/Alteration
Moorhead Psychiatric Unit	1958	1959	Addition
Minneapolis, St. Mary's	1957	1959	New
St. Paul, St. Joseph's	1958	1960	Addition
Duluth, St. Luke's Psychiatric Unit	1951	1953	Addition/Alteration
St. Paul, Mounds Park Psychiatric		1951	Addition

Hill-Burton funds ranged from $13,076 for St. Luke's Psychiatric in Duluth to $458,022 for Mounds Park Psychiatric in St. Paul.

Chronic Disease, Chronic-Psychiatric Units, Chronic TB and Rehabilitation

Location	Date of Bid Opening	Date Opened	Type of Construction
Mpls., Variety Heart (chronic)	1948	1951	New
Duluth, St. Luke's Infirm. (chronic)	1949	1951	Addition
St. Paul, St. John's Chronic Unit	1951	1953	Addition/Alteration
Duluth, St. Mary's Chronic and Psychiatric Unit	1954	1956	New
Mpls., Fairview Chron & Psych Unit	1951	1957	Addition
Mpls., U of M Children's Rehab	1962	1964	New
St. Paul-Ramsey TB Psych. And Rehab Units	1962	1965	New
Thief River Falls, Chronic Unit	1963	1964	Addition/Alteration
Mpls., Variety Heart (Chronic)	1963	1966	Addition
Mpls., Swedish, St. Barnabas Hosp	1964	1968	Addition/Alteration
Fergus Falls, Lake Region Hospital	1966	1968	Addition
St. Paul, St. Joseph's Hospital	1967		Addition/Alteration

Hill-Burton funds for these projects ranged from1971 $281,386 for Thief River Falls Chronic Unit to $911,663 for Minneapolis Swedish, St. Barnabas Hospital.

Diagnostic and Treatment Facilities

Location	Date of Bid Opening	Date Opened	Type of Construction
St. Paul, The Samaritan	1964	1965	Addition
Mpls., U of M, Diagnostic Lab Exp	1965	1966	Addition/Alteration
Mpls., Mount Sinai	1969	1970	Addition/Alteration
St. Louis Park, Methodist	1970	1972	Addition/Alteration

Hill-Burton funds for these projects ranged from $142,464 for the Samaritan in St. Paul to $555,338 for Methodist in St. Louis Park.

Nursing Homes

Location	Date of Bid Opening	Date Opened	Beds Per Construction Plan	Type of Construction
Mpls., Masonic N.H. (Hosp Unit)	1957	1958	80	New
St. Paul, Bethesda Inf. (Hosp Unit)	1958	1960	102	New
Granite Falls (Hosp Unit)	1959	1960	58	Addition
St. Paul Wilder	1959	1961	147	New
Minneapolis, Augustana	1960	1961	99	New
Albert Lea, St. John's Lutheran Home	1960	1962	57	New
Faribault, St. Lucas (Hosp Unit)	1960	1961	59	Addition/Alteration
Winona, St. Anne's Hospice	1960	1962	69	New
Northfield (Hosp Unit)	1961	1963	40	Addition
Aitkin (Hosp Unit)	1962	1963	48	Addition/Alteration
Mpls-Fairview (Hosp Unit)	1962	1963	150	Addition
Marshall (Hosp Unit)	1962	1964	76	
Montevideo, Luther Haven	1963	1964	60	New
Bemidji (Hosp Unit)	1963	1964	60	Addition
Paynesville (Hosp Unit)	1963	1964	37	Addition
Appleton (Hosp Unit)	1964	1965	25	Addition
Hastings, Regina Mem. (Hosp Unit)	1964	1965	60	Addition
Mpls, Augustana Home	1964	1965	68	Addition/Alteration
Winona, (Hosp Unit)	1964	1966	100	Addition
Elk River, Guardian Angels	1964	1967	60	New
Long Prairie (Hosp Unit)	1965	1967	27	Addition/Alteration
Austin, St. Mark's N.H.	1966	1967	42	Addition/Alteration
Ely (Hosp Unit)	1966	1968	40	Addition
Farmington (Hosp Unit)	1966	1968	25	Addition
St. Paul, St. John's Hosp	1967	1969	100	Addition
Two Harbors (Hosp Unit)	1967	1968	50	Addition
Minneapolis, Swedish-St. Barnabas Hosp	1967	1969	108	New
Hallock (Hosp Unit)	1967	1968	40	Addition
Mpls., St. Mary's (Hosp Unit) 46	1967	1969	250	New
Little Falls, St. Otto's Home1	1967	1968	75	New
Cloquet (Hosp Unit)	1968	1969	46	Addition
Chisago City (Hosp Unit)	1968	1969	40	Addition/Alteration
St. Cloud (Hosp Unit)	1968	1970	100	Addition

Hill-Burton funds used for nursing homes ranged from $87,304 for the hospital unit in Appleton to $900,000 for the hospital unit in Worthington.

Mental Retardation Facilities

Location	Date of Bid Opening	Date Opened	Type of Construction
Wayzata, Hammer School	1966	1967	Addition/Alteration
Richfield, Frazer School	1966	1967	New
Fergus Falls, Lake Park Wild Rice and Children's Home	1967	1968	Addition/Alteration
Victoria, Mount Olivet Rolling Acres	1967	1969	New
Chisholm, Range Center	1970	1972	New
St. Paul, ISD Child Center	1971	1972	New

Hill-Burton funds ranged from $101,510 for the Hammer School in Wayzata to $929,600 for the ISD Child Center in St. Paul.

Mental Health Centers

Location	Date of Bid Opening	Date Opened	Beds Per Construction Plan	Addition or New Hospital
Mpls, St. Barnabas-Swedish, Psych Unit	1966	1969	52	Addition/Alteration
St Cloud Hosp, Psych Unit	1966	1968	30	Addition/Alteration
St. Cloud MHC	1968	1969		New
Thief River Falls, Psych Unit	1968	1970	6	Addition
Virginia, Range MHC	1969	1969		New
Hutchinson Hospital West Central MHC	1970	1971		New
Willmar Sheltered Workshop	1970	1972	12	New
Willmar, West Central MHC	1970	1972		New
Willmar, Hospital Psych. Unit	1970			Addition/Alteration
Duluth, Bethany Home	1971/1972		19	New

Hill-Burton funds for Mental Health Centers ranged from $131,068 for the St. Cloud Mental Health Center to $827,968 for the St. Barnabas-Swedish Psych. Unit in Minneapolis.[1545]

[1545] MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. VIII, pp. 5-25.

Appendix F:

33 Recommendations for Programs and Policies, 1954

1. The licensing program for hospitals and hospital personnel should be brought into conformity with regulations governing the standards for such facilities and personnel adopted by the State Board of Health.

2. With the increasing problem of the aged, more emphasis should be placed on the supervision of nursing homes.

3. A study should be made of the possibility of utilizing part-time nursing care in the patient's home rather than institutional care either in a hospital or in a nursing home.

4. It is recommended that steps be taken to obtain State appropriations for the support of Dental Health and Industrial Health.

5. It is recommended that the long-time fiscal policy of the State Board of Health be directed toward the eventual use of the General Health funds for the following purposes:
    A. To explore, initiate, and carry through projects in new areas of public health work.
    B. Encouragement of local health services and subsidy to local health departments.

6. Training of health department personnel both at the local and State level.

7. So that the budget reflects the thinking and the policies of the State Board of Health, it is recommended that a committee be appointed to meet with the Secretary and Executive Officer and his staff to review significant Board policies and points of view relative to the allocation of State and Federal monies for "core" and ancillary programs.

8. As a matter of general policy, it is recommend that the long-time planning of the State Board of Health contemplate a smaller number of employees in the central office of the State Department of Health.

9. It is recommended on appointments to the positions of section chiefs or to higher classification that there be prior consultation with the State Board of Health.

10. It is recommended that in those instances where it is necessary to obtain special permission from the Civil Service Commission to retain employees after their normal Retirement age, there be prior consultation with the State Board of Health before such permission is requested.

11. It is recommended that consideration be given to preparing in mimeographed form and generally distributing general Board of Health and Health Department policies which affect personnel and programs of the State Board of Health.

12. It is recommended that the Department of Health study thoroughly the possibility of consolidating its statistical services and the adoption of mechanized methods of accumulating and analyzing statistical data.

13. It is extremely important that the Board expand its program of health education.

14. Every effort should be made to better utilize the skills of the Section of Public Health Education in all State Health Department activities which are education in nature.

15. It is recommended that well-planned and regularly conducted staff conferences be instituted in the central office of the State Health Department.

16. It is recommended that the general operation of the district offices be coordinated by the Chief of the Section of Local Health Administration.

17. It is recommended that the filling of the position referred to in 16 above be given highest priority.

18. Serious consideration should be given to designating one of the full-time professional persons in each district office as the administrative officer. It is recommended that any designation so made at this time be on an acting basis in order not to commit the Chief, Section of Local Health Administration at the time of his appointment.

19. It is recommended that there be an extension of local health services, with continued emphasis on its development on a county or multi-county basis under the provisions of the existing laws.

20. It is recommended that the Division of Environmental Sanitation continue to study the feasibility of a plan which would utilize local health services for inspection purposes and which would return to such local health services a portion of the fees collected for the licensing of the establishments inspected.

21. As a parallel study to that recommended in 19 above, there should be an investigation of the possibility of utilizing more generally local health departments for the inspection of milk shipped both in inter- and intra-State traffic.

22. It is recommended that a study be made of the feasibility of placing most of the law enforcement inspectors of the Section of Hotels, Resorts, and Restaurants in the district offices.

23. It is recommended that the State Board of Health take no action before the legislature protesting the duty of licensing small boats for hire. It its budget presentation, however, the cost of this inspection work should be pointed out.

24. The educational and training qualifications for law enforcement inspectors should be raised to a higher level.

25. It is recommended that the Board of Health study continuously the status of the branch laboratory at Duluth.

26. It is recommended that the number of State-owned cars operated by the State Department of Health be reduced to a minimum.

27. This committee urges that the State Board of Health take necessary steps to obtain an appropriation from the legislature for the construction of a new State Board of Health building.

28. It is recommended that a careful study be made of the desirability of introducing a bill before the legislature to amend the present public health nursing law to include all county public health nurses for aid within the limitation of one public health nurse per 5,000 population.

29. It is recommended that the Board reaffirm its policy of very close cooperation with all units of the University of Minnesota.

30. It would seem desirable to make maximum use of advisory groups (to the State Board of Health) made up of representative citizens from various fields.

31. It is recommended that additional support be sought to expand the alcoholism program in keeping with its importance.

32. It is recommended that the Divisions of Local Health Services and Environmental Sanitation develop a joint program to determine the causes of home accidents and methods of reducing their incidence.

33. It is recommended that the State Board of Health place greater emphasis on publicizing the activities of the State Health Department and that there be a general extension of its public relations programs.

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